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Health Service, Society, and Medicine

PRESENT DAY HEALTH SERVICES IN THEIR RELATION TO MEDICAL SCIENCE AND SOCIAL STRUCTURES

By

KARL EVANG, M.D.
Director General of Health Services of Norway

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To MONS *my wife*
who by instinct and intellect
served her patients
with full art

HEALTH SERVICE, SOCIETY, AND MEDICINE

PREFACE

THE stipulation in the Trust Deed of the Heath Clark Bequest that 'the general scope of the lectures to be given shall include the educational, cultural and humanistic aspects (as opposed to technical and manipulative training) of the History, Development and Progress of Preventive Medicine and Tropical Hygiene and their sanitary and social evolution both in temperate and tropical climates' puts the lecturer in the fortunate position of being invited to express his views in a field which is not already overloaded with publications, and at the same time gives him a wide choice. I feel the need for expressing my appreciation to the University of London for being given this opportunity.

Before the First World War I learned to know a little about health services in some western and eastern European countries. The Second World War brought me into closer contact with the health services of Great Britain, the U.S.A., and Canada, and after that war I have had an opportunity to see something of the health service structure in the U.S.S.R., Yugoslavia, South-East Asia, the Eastern Mediterranean area, and Mexico.

The ideas which I have tried to present in these five lectures in a rather personal and, I hope, not too indigestible form have ripened during the last twenty years, in which I have been serving as the head of my own country's health services. Few of the ideas, if any, are original; many have changed character and emphasis over the years, and may for all I know still change. My thanks go to those of my colleagues with whom I have had an opportunity to exchange opinions and whose

wisdom and insight have helped me—by contrast or agreement—in forming my own views, including C.-E. A. Winslow, Thomas Parran, John E. Gordon, and Milton I. Roemer of the U.S.A., M. Kovrigina and F. G. Krotkov of the U.S.S.R., Sir Wilson Jameson, James Mackintosh, and W. P. Forrest of Great Britain, Sir Arcot Mudaliar and C. Mani of India, Andrija Stampar of Yugoslavia, J. Zozaya of Mexico, A. T. Shousha of Egypt, Ch. Sheba of Israel, F. W. Jackson of Canada, J. A. Højer of Sweden, and many others.

But most of all I want to thank the World Health Organization and its Secretariat. This most inspiring and progressive organization has given me the opportunity during the World Health Assemblies, and otherwise, to meet colleagues from all parts of the world and to make myself acquainted with some of the conditions under which human beings struggle to protect their health and life.

The fact that the Heath Clark lectures are limited to a maximum of five explains why three topics are missing which might in a way round off my views on the problems before us: medical education in relation to health services; types of medical and auxiliary personnel; and specific health service problems in technically underdeveloped countries.

We should never forget that the majority of the peoples of the world still live in primitive villages.

K. E.

Oslo, November 1958

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INTRODUCTION

MAIN TYPES OF EXISTING HEALTH SERVICES

In the following five lectures some observations on the present-day practice of medicine are presented from the service angle. The over-all medical structure—including personnel, institutions, legislative and administrative background—will be scrutinized as a service organization, established by society to meet its need for a set of organizations to protect the population's health, and at the same time to constitute the workshop for medical personnel.

There are of course many more aspects of the broad field of activities which we name medical: the scientific aspect, the economic, demographic, social, and even political, not to speak of the cultural and educational, the humanitarian, and in a broad sense philosophical. These I am going to consider only to the extent to which it is necessary in order to throw light on my main line of approach. I felt it might be useful, at least to myself as a medically trained administrator of health services, to try to make up my mind as to the adequacy and efficacy of some of the more important constituents of the health services as they exist today.

The problem is placed, therefore, in its well-known practical context: to what extent have we been able to provide the individual and the society with health

services reflecting the results and present status of scientific medicine? To what extent are we utilizing the existing knowledge of the human body and mind, and of the complicated ecological situation in which man exists?

The declared policy of all nations—with increasing emphasis in later decades—is of course to make up-to-date health services available to the greatest possible number of people regardless of economic and social status, creed, or colour; and to reach this goal without unreasonable cost and in a way which on the one hand meets the health needs of the people, and on the other hand creates satisfactory working conditions for the medical profession and other medical personnel.

This study, further, is an attempt at a critical analysis. I am not going to elaborate on the unprecedented progress made over the last 100 years. It has been stated without too much exaggeration that medicine has made greater progress in the last 75 years than in all the centuries of medical history before that time. Even if we limit ourselves to the short span of time after the Second World War, the achievements of medicine in rich and poor countries alike, in totalitarian as well as in democratic states, have been extraordinary. This I accept as a fact and bow my head in admiration, pride, and in justified hope for the future. What I am trying to do is to turn attention to some of the shortcomings, blind alleys, and perhaps obsolete parts of our present structure of service organizations for health.

Before entering into the discussion of any such shortcomings it may be useful also in the interest of terminological definition to try to list the service functions in question. As these are, of course, partly interlocking and

overlapping, listing is difficult, but it may be made in various ways. For example, as follows:

1. *Promotion of health generally* by improving the standard of living. From the health point of view we are in this connexion first and foremost interested in the three fundamental environmental factors: housing (including family life), nutrition, and working conditions (including human relations as well as material conditions).
2. *Preventive measures* in the stricter sense directed either towards the agent, the environment, or the host. Grotjahn had a clear conception of this classical triad when he used the expression: 'Between man and nature stands culture.'[1]
3. *Curative medicine* dealing with the diagnosis, treatment, and care of those who fall ill.
4. *Rehabilitation*, covering all activities aimed at making the patient return to his milieu, restoring his working capacity and social adaptability, meaning to cure him socially as well as medically.
5. *Provision for the care of the 'weak'*, meaning those who cannot be fully rehabilitated (chronic psychoses, feeble-minded, aged).
6. *Control of environmental health factors* and of presumably healthy groups of the population (babies, pregnant and nursing mothers, school children, athletes, recruits, employees, housewives, old age groups, &c.).
7. *Research, including biostatistics and recording of medical facts* and of social, economic, and other

[1] '. . . daß zwischen dem Menschen und der Natur die Kultur steht'. Alfred Grotjahn, *Soziale Pathologie*, 3 Aufl., Berlin, 1923, p. 2.

factors which take part in the multiple causation of disease.

8. *Training of health personnel*, including the qualitative and the quantitative aspects.
9. *International health work*, not only to exchange knowledge and experience, but also to plan and co-ordinate action in the increasing number of fields where only joint efforts can bring the desired results.
10. *Over-all planning and co-ordination, including study and evaluation* of the various types of personnel, institutions, equipment, and other tools of the health services.

Again I want to stress: it is with the greatest mental inhibitions that one undertakes such a listing of service functions. Even if these listed functions are all distinguishable parts of the whole, one easily loses sight of the main purpose of organized health work and the unity of endeavour. 'Health is indivisible.' Therefore, it will always be a matter of taste in what way one would like to list medical activities. Moreover, terminology offers a never-ending source for confusion and misunderstanding. No generally accepted international terminology exists in the field of medicine, and this, incidentally, provides a not unimportant task for the future. And finally, any splitting up like this violates the conception of integrated health work. Take as one example the relationship between preventive and curative medicine. If one speaks only of *prevention of occurrence* the line may not be too difficult to draw in most cases. If one also includes under prevention—which frequently is done today—the *prevention of pro-*

gress, the delineation will be another, and if one goes further and includes *early detection of disease* obviously one is establishing a new connotation of the word preventive.

The listing which I have presented will mainly serve to demonstrate in what way I shall be using these terms here.

Comparative inter-country or inter-regional studies of the quality of health services often suffer from lack of realization of the fact that the whole body of medical service organizations in any given country is a part of the social and administrative structure of the country concerned, and that therefore the main principles which govern national life in general, especially in politics and economy and other forms of inter-human relationships, reflect themselves in the health services. This, of course, complicates to a despairing degree the task of evaluation as soon as one steps outside one's own well-known national system.

One element, present everywhere, which is very difficult to describe in exact terms, the strength of which, however, to a high degree decides the type of quality of health services, is what may be termed 'respect for health and life'. Cultural anthropologists underline the general observation that this attitude varies not only with the economic, but also with the cultural and religious pattern of the country. 'Respect for life' is in other words not directly proportionate to the wealth of a country, although a high degree of correlation must be granted for the simple reason that health services necessarily must be bought at increasing cost. Where the 'customers', meaning the people, arrange for comprehensive prepaid health services, however, the economic

obstacles may be overcome surprisingly well even in countries with a relatively low level of national income. In the field of curative medicine where the cost has been skyrocketing during the last decades, pre-paid medical care programmes in one form or another are a condition for an even distribution of this form of medical activity.

It is obvious that the establishment of comprehensive health services is getting more and more complicated as a consequence of the rapidly broadening and deepening scientific powers of medicine to promote and maintain health, to prevent, diagnose, and treat disease, to rehabilitate, and to care for the weak.

It should not be forgotten, however, that the task of adjusting health services to the present situation is influenced everywhere also by the changing attitude of the individual towards the health services. I refer *inter alia* to the spreading of knowledge of the potentialities of medicine, especially in the curative field. In the days of our parents, relatives of a patient were deeply grateful and sometimes even pleasantly surprised when a patient admitted to a hospital escaped from those 'death houses' with life and working capacity. Today, in the more advanced countries at least, relatives start to ask unfriendly questions and sometimes consult their lawyer if the patient dies in the hospital, or the treatment turns out to be unsuccessful. 'Something must have gone wrong. There is somebody to blame.' I am afraid that the time is still far ahead when people's thinking is governed by statistical laws. Even doctors only in exceptional cases seem to have reached that level.

And, finally, there is that unavoidable interaction between development and functions of health services and the changes in social and economic structure of a

country generally. Such changes are, in our century, coming about in many countries with such speed and in so many fields that the framework within which health services are working lacks the stability that the preceding generation of doctors—indeed ourselves in younger days—were accustomed to.

To get a starting-point it may perhaps be stated, although with a considerable amount of simplification, that there exist in the world today four distinguishable main types of systems for health services.

1. The 'Western European' type developed in its most characteristic form in central continental Europe, but with a number of features common to the whole family of Western European countries including the northern and southern groups.
2. The 'American' type to be found in the U.S.A., partly in Canada and other countries ideologically and geographically close to the U.S.A.
3. The 'Soviet Russian' type which was introduced through the Russian revolution in 1917 and spread from the Soviet Union to neighbouring peoples' democracies and later also to China and certain other countries in Asia.
4. The type gradually taking form in the so-called technically underdeveloped countries of the world.

No sharp demarcation line exists of course between these types. Especially during the period of rapid change of health services in which we find ourselves, many countries accept elements from more than one system and combine them with original contributions based on the history, tradition, and balance of power in that specific country. Nevertheless, it may for our purpose

today be of value to name some of the leading characteristics of each of these systems.

1. In the Western European countries society has gradually taken over a great deal of responsibility for health, but the dualism which was created at an early date, and which has never since been overcome, still exists between curative and preventive medicine. In what might be called the pre-scientific period of medicine, curative medicine in these countries was mainly left to free enterprise, the doctor being a 'freelance'. Already before much was known about the nature of disease, however, humanitarian forces pressed society to take over part responsibility, especially as far as poor people were concerned. As soon as something could be done to control communicable disease society took full responsibility in this field. Preventive medicine and curative medicine in these countries are more or less financed and administered through different channels, even today. Medical education was mostly left to a third set of organizations loosely connected with the other more directly involved service parts. The universities, which of course originated as centres for the learned and for training of scientists, gradually took upon themselves also the education and training of service personnel for the growing health services. Whether the university is the right place for the training of service personnel to a service with which the university has little direct contact is in itself a very interesting question.

On the basis of historical tradition a considerable part of medical activity was left to private enterprise and voluntary humanitarian endeavours, creating on the whole an extremely complicated picture, varying from country to country in Western Europe with the relative

strength and interplay of these factors. Western Europe differs from practically any other part of the world in that local initiative and responsibility were developed at an early date. This also put its mark, of course, on the establishment of health services, creating a decentralization whose strength and weakness can be easily observed today. A further characteristic of the Western European region is the relatively strong administrative position of the lawyer and other lay administrators, the health expert often being used mainly as adviser to the lay administrator, with no direct access to the political executive. This, of course, is a remnant of the days when the main functions of the central health administration were to promote, enforce, and interpret health legislation.

For similar reasons an important part was played by the health police (German *Gesundheitspolizei*), especially in the early days. Characteristic of the Western European type is also the fact that the central health administration is divided between a number of ministries. The health services are to a considerable extent financed through public sources (preventive medicine, health control, &c., mainly through taxation) or through public arrangements (curative medicine through public health insurance). Considerable variations exist between countries.

2. Under the 'American' system as much of the health services as is found compatible with health conditions is, as a matter of principle, left to private enterprise and free competition. General practitioners, practising specialists, and other types of medical personnel, hospitals and other medical institutions, drug houses, insurance companies, and producers of medical equipment