1. A Meeting of Experts on the Rising Cost of Medical Care under Social Security was held in Geneva from 17 to 20 May 1977, in accordance with the decisions of the Governing Body of the International Labour Office at its 201st (November 1976) and 202nd (March 1977) Sessions.

2. Eighteen experts were invited to attend the meeting, of whom six had been selected from among senior government officials, and six each had been nominated after consultation of the Employers' and Workers' groups of the Governing Body.

3. Observers from the following international organisations were present at the meeting: World Health Organisation; Council of Europe; European Economic Community; Organisation for Economic Co-operation and Development.

4. Observers from the following international non-governmental organisations were also present: International Social Security Association; International Organisation of Employers; International Confederation of Free Trade Unions; World Confederation of Labour.

5. A list of persons actually attending the meeting is provided in Annex I.

Agenda

6. The agenda of the meeting, as approved by the Governing Body, was as follows:

1. National trends in rising medical care costs under social security.
2. Causes and their future implications.
3. Possible cost containment measures.

Opening of the meeting

7. The meeting was opened by Mr. S.K. Jain, Deputy Director-General, on behalf of the Director-General of the ILO. Having welcomed the participants, Mr. Jain emphasised the importance attached by the ILO to the question of ensuring in member States a sound development of social security systems, especially those designed to provide medical care guarantees to the population. For this purpose, studies had been carried out and their findings were now submitted for appraisal by the meeting, so that distinguished international experts might assist the ILO in providing member States with guidelines and recommendations on the specific issue of how to deal with the rising costs of the medical care programmes implemented through social security legislation. Since the matter was closely related to national health policy, the ILO had sought the collaboration of the World Health
Organisation, as well as maintaining contact with the various health insurance administrations through the International Social Security Association. Both these agencies had contributed to the preparation of technical documentation for the meeting. Although the ILO’s research findings concentrated on the situation in industrialised countries, the results of discussions at the meeting would undoubtedly be of great use and interest to developing countries where problems similar to those in developed countries would emerge as they expanded medical care systems. Having briefly recalled the major causes for the rising cost of medical care, and the fact that in many countries employers’ and workers’ organisations were - together with governments - concerned by the social and financial implications of such alarming trends, Mr. Jain emphasised the need to face and tackle the issues, and invited the meeting to express views on what basis and criteria governments and the social partners could develop a policy for the future - a policy where the people’s essential right was preserved to obtain from society a statutory guarantee of access to medical care, which was compatible with requirements of the national economy. It was important that such a policy should be formulated on the basis of the widest possible consensus of views among social partners and governments.

8. The meeting elected its officers as follows:

Chairman: Mr. W. Scott-Moncrieff,
Under-Secretary,
Department of Health and Social Security,
United Kingdom.

Reporter: Mr. A. Kvalheim,
Division for Planning, Research and Studies,
Directorate of Health Services,
Norway.

Documents and procedure

9. The meeting had before it the following working documents (the authors are shown in brackets):

D.1 Purpose and agenda (Social Security Department, ILO);

D.2 Cost trends, causes, and possible cost containment measures (Social Security Department, ILO);

D.3 Summaries of national studies undertaken for selected countries - Belgium, France, Japan, the Netherlands and Spain (Social Security Department, ILO);

D.4 Public health expenditure in Finland in 1965-75 and its relationship to health policy (ISSA);

D.5 Comments on causes and possible cost containment measures (WHO);

D.6 The rising cost of health care under social security in the United Kingdom (Mr. W. Scott-Moncrieff);

D.7 Health care costs under social security in Canada (Mr. W.A. Mennie);

D.8 Report on the increase in health expenditure met by social security in France (Mr. P. Schöpflin);

D.9 Analysis of costs and expenditures for health care in Poland in 1971-75 and earlier (Dr. M. Miskiewicz);

D.10 Rising costs and the development of the health system in the Federal Republic of Germany (Mr. A. Holler);

D.11 National experience and policy in Norway (Mr. A. Kvalheim).

10. The meeting agreed to proceed first to consideration of the findings and the assessment of the international organisations (Working Documents Nos. D.2 to D.5). This would be followed by examination of national experience (Working Documents Nos. D.6 to D.11). The meeting would then finally undertake a general policy review of the factors influencing the rapid increase of the cost of social security programmes dealing with medical care, and of possible remedial action.
11. The representative of the World Health Organisation (WHO) stated that his organisation was approaching the problems which were faced by social security programmes as a result of rising medical care expenditure, in the wider context of WHO concern with health policy issues in general. Social security programmes should not be viewed, in this context, simply as financing devices, but an integral part of the health services system. All the components of a health system were suffering the impact of increasing costs; consequently one had either to look for possible savings within the existing system and practices, or to consider far-reaching reforms in the delivery of health services - for a number of reasons. First, there was a trend towards the improper use of available medical technology, namely an imbalance between, on the one hand, highly sophisticated - i.e. costly - treatment serving a relatively small section of the sick population, and, on the other hand, the vast need for simpler methods of treatment which had to be met for the overwhelming majority of cases. An imbalance in health manpower was also developing: many more medical functions could be entrusted to less professionally skilled persons, and consideration should also be given to using non-professionals and the techniques of self-care, whenever this was possible and feasible. Obviously this approach to cost containment could not be applied equally in industrialised and developing countries, since its effectiveness would depend on the general level of health and culture of the population. But the concept was gaining ground even in developing countries, particularly with regard to clearly defined and simple medical functions. A third element of a cost containment policy was to be found in the further development of preventive measures, provided that these were carefully designed and applied having regard to the actual return expected from investing in this area of health maintenance. Finally, the representative of WHO referred to its increasing concern with better planning of the development of delivery services, because of the many weaknesses detected in the proper co-ordination and complementarity of the various stages of health services made available within the public sector. The search for greater effectiveness and efficiency was a means of coming to grips with cost containment and the optimum use of available resources.

12. The representative of the International Social Security Association (ISSA) explained that the Association had for many years been carrying out a series of studies on the cost of sickness insurance schemes, the results of which had been published. Thus, in addition to general surveys as to the development of sickness insurance costs, a study on the volume and cost of the supply of medicaments had been undertaken in conformity with a decision to investigate more closely the background to the extent and development of costs in individual branches of expenditure. Subsequently, ISSA prepared a study designed to reveal the general causes of the increase in sickness insurance expenditure on medical care. On the basis of these studies, it was concluded that more information was needed about the nature of the relationship between health expenditure, the method of financing health services and the type of medical care organisation, since the earlier results achieved did not provide sufficiently clear indications. Thus the Permanent Committee on Medical Care and Sickness Insurance of the ISSA decided in 1973 to conduct a study on "possible correlations between, on the one hand, the level and the evolution of health expenditures and, on the other, the type of organisation of production and distribution of health care and the system of collective coverage of expenditure". The method adopted for this study was to undertake the preparation of a series of national monographs on selected countries, analysing such correlations in a way which would be suitable for comparison between countries. The document submitted by ISSA to the meeting: "Public health expenditure in Finland in 1965-75 and its relationship to health policy", was to form an example of the type of national studies undertaken by ISSA.  

13. The International Labour Office (Social Security Department) recalled first the nature and scope of the studies undertaken for the present meeting. They were focussed, in terms of social security policy and administration, on the trends observed in selected countries as well as on the main causes of the gradual, or sudden, but indeed substantial increase of the share of the Gross National Product earmarked for the medical care part of national social security expenditure. More alarming still was the trend towards increases in relative costs (e.g. per insured person, per patient, per item of service) in various medical care sectors, ...

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1 The experience of Finland, outlined by the ISSA representative, has been included in section II ("National Experience") of this report.
particularly when one looked at hospital care. It was recognised that comparative studies in this field were difficult because the statistical definitions used by various countries did not always cover comparable items of expenditure. The ILO had therefore opted for an analysis of selected national situations, attempting comparisons only to the extent that data could be derived from the on-going ILO International Inquiry into the Cost of Social Security. Taken together, the results tended to demonstrate that, in most industrialised countries, the expenditure on medical care programmes financed and/or administered through social security had in recent years gone up at a rate faster than expenditure on other social security benefits (such as pensions and family benefits), and faster than the various national economic indicators. However, the increase in absolute terms of social security expenditure was, in the medical care sector, partly offset by a decrease of private household expenditure on health — amounting to a shift from private to public provision — so that the over-all health expenditure of the nation might have increased less than the aggregate social security data indicated. The fact remained that the impact of the features of a health insurance system on cost was significant, raising a number of difficult policy issues submitted to the meeting for discussion. Moreover, available studies indicated that although a balance had to be held between what could be spent on the sick and on other needs such as pensions for the old and family benefits for the young, governments faced exceptionally exacting issues of priorities, because public expenditure could not be unlimited and social budgets tended to suffer in times of inflation and recession. It was perhaps against this background that the various causes, trends and cost containment possibilities discussed in the ILO policy paper would need to be examined.

14. The representative of the European Economic Community (EEC) emphasised the importance of the agenda of this meeting in the light of the tendency for total social security expenditure to rise in Europe — particularly as regards pensions and benefits for old age and sickness. During the period 1967–73, such expenditure tripled or even quadrupled among EEC member States and they faced serious problems of cost control. The main factors in the rising cost of medical care under social security which were currently identified in the documentation submitted to the meeting were all important. However one would like to determine the relative weight of each factor on the basis of further research in various countries. The EEC was currently engaged in carrying out four studies within its member States: (1) systems of health care in general; (2) the costs of hospitalisation; (3) consumption of drugs; (4) physicians' incomes. It was recognised however that the problems were pressing and that one could not wait for the results of such studies to remedy the situation. The speaker wondered whether or not it would be necessary to examine problems relating to the supply of medical care and infrastructure of the care system, such as, for example, accessibility to hospitals, doctors' fees, profit of the pharmaceutical industry, etc. It was also emphasised that problems concerning cost sharing should be carefully examined, since it could most seriously affect the poorest groups.

15. Expressing keen interest in the subject of the meeting, the representative of the Council of Europe stated that in the autumn of 1978 a Conference of European Ministers would be discussing questions as regards the effect of preventive medicine as a factor in reducing medical care expenditure, and the financing of medical care systems, analysing them to see the effect of the system on costs. Accordingly, the conclusions of the ILO meeting of experts would, in this connection, be especially useful. They would also be important to the forthcoming revision of the European Code of Social Security and its Protocol, the instruments containing provisions concerning medical care and cost sharing.

16. The representative of the Organisation for Economic Co-operation and Development (OECD) said that his organisation, bearing in mind its economic purpose, was especially concerned with the evolution of public health expenditure and with the development and implementation of health policies, as these were integrated with policies in other socio-economic sectors such as housing, transport, education and the provision of recreational facilities. Indeed any imbalance in one of these fields might well react on the health sector. As a result of various OECD projects, certain conclusions had already emerged in relation to the trends of public health expenditure, the training of health personnel, health facilities, and the application of computers in the health care field. Research was being undertaken on the relationships between environmental and other pollution, and the health of the population. OECD accordingly shared with the ILO a continuing concern with the problems of health insurance.
II. NATIONAL EXPERIENCE

Canada

17. The Government expert from Canada explained that national health insurance in Canada comprised two distinct government programmes - for universal pre-paid hospital care and universal pre-paid physician care. All ten provinces had joined the former by 1961; physicians' services insurance came ten years later, having been in operation in all provinces only since 1971.

18. Both programmes were financed by the provinces, with federal subsidies conditional on the provincial programme meeting national standards of services contained in federal legislation. Except for contributory premiums in a few provinces, covering only part of the provincial share of the cost, the programmes were tax-financed: this was regarded as offering stronger incentives for cost containment because of competing claims on the general revenue.

19. It might perhaps be argued that, if the two programmes could not have been started simultaneously, it would have been better to introduce them the other way round, on the ground that the financial incentive to patients to seek care in insurance-covered facilities had promoted hospital bed provision and so had disproportionately increased programme costs. On the other hand, Canadian experience under health insurance had been that change in the overall usage of health services was roughly proportional to change in the volume of health services available - supply tended to create its own demand. Over the 1961-74 period, the numbers of hospital beds, of patient days and of total population had all gone up by around 25 per cent. What had increased dramatically following hospital insurance was the demand for all specialised services within hospitals. This had meant far more intensive care per patient day, pushing up staff-patient ratios and the staff skill mix. This, allied to very substantial hospital wage increases, had been the main cause of cost growth: expenditure on the hospital programme, expressed as a percentage of GNP, had doubled between 1961 and 1975.

20. In these circumstances, the speaker emphasised that the provinces had begun to take action to reduce the number of hospital beds with associated promotion of lower cost alternatives to hospitalisation such as out-patient services and home care, to remove duplication, consolidate services generally, and to encourage regional and local planning. The budget review process for controlling hospital costs had been tightened in recent years by stringent limits on expenditure increases for existing and new services. But wage and salary growth continued to be a major cost containment problem.

21. In contrast to the hospital sector, the physician care programme had shown a slight reduction in its share of GNP between 1971 and 1975. Physicians were paid by way of fee for service, and were becoming accustomed to the idea of standard fees, peer reviews, and practice profiles used for comparison purposes. As a result, however, of the expansion in medical training facilities and extensive immigration of doctors, Canada had been facing the risk of a potential over-supply of physicians - the physician-population ratio (excluding interns and residents), having moved from 1 to 909 persons in 1968 to 1 to 690 in 1976. Immigration was now restricted, and discussions were commencing with the provinces concerning the appropriate levels of medical school enrolment and specialty training.

22. Finally, the representative from Canada said that beginning in 1977 there would be a new approach as regards federal support of provincial expenditure. This would consist of block grants, linked to the growth of GNP, as a more effective way of controlling costs than the previous concept of matching provincial expenditure dollars by federal dollars.

Finland

23. The representative of the ISSA, outlining the experience of his own country, said that it was necessary to consider the situation in Finland in terms of public health resources and public health expenditure, since the sickness insurance scheme introduced in 1964 was restricted to the provision of cash benefits, and to cover the cost of ambulatory care. The Finnish health services system, providing all-residents coverage, operated under the general control of the Ministry of Social Affairs and Health, and its National Board of Health: practically all hospitals were owned by the consumers, with their costs being partially reimbursed from central funds at a proportion which varied with the economic situation in the commune.
24. Like many other countries, Finland had experienced a continuing growth in health expenditure expressed as percentage of GNP - from 1.7 per cent in 1950 to 4.8 per cent in 1975. Accelerating hospital costs had been a prime cause, until, as a result of the hospital-oriented health policy in the 1950s and 1960s, hospital services had virtually reached a saturation point, with, in comparison, an unfulfilled demand for ambulatory care.

25. The Public Health Act of 1972 brought about a major reorganisation of the public ambulatory care services, and a shift of resources to that sector from the hospital service. Ambulatory services had in fact been extended, while the hospital sector (in which shortage of nurses was one problem) was being held at a constant level. The Act introduced a centralised planning and evaluation system, so that the two sectors of care could be considered as a single national health care plan. A main objective was to increase equity among different population groups in the use of health services, especially as between rural and urban areas.

26. There were four sources of financing - state revenues, commune revenues, the sickness insurance scheme, and the consumers (whose share, currently about 20 per cent, was steadily declining). Hospital doctors were salaried; general practitioners were paid by fee for service. Hospital expenditure was carefully controlled, by way of a detailed yearly budget for each hospital, which nevertheless contained enough latitude to avoid crisis situations.

27. The speaker considered that it could reasonably be concluded that the public health administration in Finland was succeeding in bringing rising medical care expenditure under control, primarily by centralised planning and budgeting, and in moving towards a more desirable distribution of services. Even so, constant monitoring of the use of the services and the effect on health status continued to be essential.

France

28. The Government expert from France said that the extent of medical care expenditure under social security must be considered against the proportion of the gross domestic product allocated to social security - which placed France in the middle range among the countries of the European Economic Community. About 98 per cent of the population was covered by sickness insurance, and a Bill designed to ensure coverage of the remaining 2 per cent was to be placed before Parliament before the end of 1977. Three-quarters of all health expenditure was borne by social security, which operated under a system allowing the patient free choice of medical practitioner and hospital (public or private), and freedom of prescription by the physician. The rate of increase of medical care expenditure under social security was high: hospital treatment, in particular, which represented 54 per cent of expenditure, showed an average annual rate of increase of about 20 per cent; the rate for 1976 rose as high as 35 per cent. A slight levelling-off in the rate of increase was expected in 1977, though there was still uncertainty as to its extent.

29. The general causes of this phenomenon were well known: they were technological (increasingly costly methods of treatment, a sometimes excessive increase in the number of items of expensive equipment); structural (division of responsibilities between those who dispensed medical care and therefore determined expenditure, and the social security system whose role was often limited to that of footing the bills); and psychological (recognition of the importance of health). The gravity of the situation was for some time masked by inflation, which raised the level of receipts before its effects on expenditure were felt. It was, however, highlighted by the recession, as the resources of social security were derived from contributions based on earned income and hence were highly sensitive to changes in the economic situation.

30. The expert raised the question whether, to remedy the situation, it was feasible to raise the level of resources, bearing in mind that social security contributions were not intolerably high in France. A slight increase in sickness insurance contributions was introduced in the autumn of 1976. A more extensive recourse to this solution would, however, be likely to meet with resistance. Furthermore, under the unified accounting system, transfers had already been made to the medical care sector within the limits of the comprehensive social security contribution, at the expense of family allowances and old-age pensions. The possibilities offered by such transfers and by government subsidies to balance the budget now appeared to be exhausted.
31. It also seemed difficult to reduce benefits since, in view of the fact that social security was regarded as a workers' success, any step in this direction would be considered retrograde. All that could be done was to try to rationalise expenditure.

32. The expert considered that the extent by which hospital costs could be reduced was small, because two-thirds of them consisted of personnel costs. At present, hospital budgets were merely indicative and might be accompanied by budgetary adjustments. It would be preferable to monitor the application of budgets month by month and to allow the social security system to have a greater say in fixing and controlling them. Hospital activities should be rationalised through the following measures - avoiding the duplication of diagnoses when patients were transferred from one service to another; raising the rate of occupancy of hospital beds (the cost of an empty bed was 80 to 85 per cent of that of an occupied bed); strengthening the medical control of the social security system over hospital treatment; reforming the hospital tariffs for the cost of a patient-day.

33. As regards care other than in-patient treatment, the doubling of the number of doctors by 1985 should solve certain problems in areas which were at present inadequately covered, but would create others because of the multiplication of medical activities it was likely to generate; this was a source of concern to both the social security system and the medical profession. Liberal medicine was really getting its last chance in France; if no way could be found out of the present financial difficulties, it would become necessary to seek alternative solutions which could imply a transformation of society.

34. The expert said that so far he had discussed influencing supply. He thought that influencing demand held only limited prospects of achieving savings, as the right to health was considered inalienable. Nevertheless, it should be possible to make insured persons aware of the costs by communicating to them the over-all amount of social security contributions and the amount of the expenses paid to hospitals under the direct payment system. More widespread efforts should be made to educate both doctors - whose university training as yet devoted little attention to the economics of health - and the general public. And, in conclusion, preventive medical care should be developed.

Federal Republic of Germany

35. The Government expert from the Federal Republic of Germany explained that in his country health care was provided by a diversity of sources - physicians and dentists in independent practice, and hospitals which were a mix of those which were publicly owned, those run by voluntary bodies, and some which were private. Some 92 per cent of the population was covered by statutory sickness insurance, which met about 55 per cent of total health expenditure; of the remaining population, most were insured with private companies.

36. Statutory sickness insurance was financed by employers and workers, who equally shared the contribution. This varied between funds: on average, it represented in 1976 about 11 per cent of gross earnings. Such contribution rates tended to promote among the insured a critical approach to cost trends in health care services. Total sickness insurance expenditure had increased on average by 10 per cent a year between 1965 and 1970: the average annual increase between 1970 and 1975 had almost doubled, to 19.4 per cent. More generally, total health and social care services represented almost a third of GNP in 1975; health care alone was about one-tenth.

37. Despite the heterogeneous institutions and financing methods, the speaker said that the people as a whole were well served. Nevertheless, a sharp debate was going on about what was generally regarded as the disproportionate cost of medical care services in relation to their output. This explained also the current debate in the Parliament on a new Bill concerning a reform of the health care system. As he would explain later, the focus was not only on cost reduction but also on improvement and the effectiveness of the services rendered.

38. The causes of expenditure increases were similar to those in many other industrialised countries. Changes in life style had had a marked effect on demand for services. Expectations were set much higher than in earlier years. Automation, new technologies, greater demands, reduction of infant mortality leading to an increase in persons with congenital birth defects, etc., had all led to a rapid rise
in expenditures and costs. As presently developed, the health care system was not geared to a cost/benefit outlook. "Consumers" had not yet been able to bring sufficient pressure to bear for a change to more needs-oriented services.

39. There was a lack of communications between different sub-systems, and a lack of continuity in treatment which resulted in duplication and waste of resources. There had been an overproduction of certain kinds of services and facilities. There was also an over-supply of hospital beds in relation to real needs. Management in many medical institutions was poor and control of expenses inadequate. Not enough attention had been given to alternative health care measures. As regards preventive measures and their potential for savings, evidence was not altogether conclusive. Since 1971, all women over 35 years of age and men over 40 years of age had been given the opportunity of yearly medical check-ups. But only 46 per cent of the women and 17 per cent of the men had taken the offer up. As for pharmaceuticals, costs had been growing yearly. Many physicians had little knowledge of the relative prices of drugs and had no economic reason for basing their prescriptions on the least costly products which would have the same therapeutic effect as costlier preparations.

40. Physicians - of whom half of those in independent practice were specialists - were at the head of the liberal professions in terms of income; their incomes had been growing faster than those of workers. Their freedom of practice had resulted in an unbalanced distribution of medical manpower. Cost increases in the ambulatory care sector were attributable more to increases in services than to higher fees: the more sophisticated the technical services, the greater was the fee earned.

41. The expert emphasised that there was a growing awareness of cost increases on the part of public opinion, the press and Parliament. Currently, the Parliament of the Federal Republic was debating a Bill due to come into force on 1 July 1977. Its purpose was to limit the rising cost of medical care and thereby the connected charges for employees and the economy, in order to secure more durable financing of the health care system. The level of benefits should be maintained and medical progress should not be impeded. State intervention would be avoided to the maximum possible extent. The autonomy of the 1,500 or so sickness funds, each with its own policy-making organs and management would not be affected: the new law would however provide for a better balance among the funds and their regional and federal associations. The autonomy of the medical profession would be preserved, but medical incomes would be linked more closely to the income development of employees. As regards pharmaceutical products, competition among manufacturers would be encouraged and a clearer price structure established. Physicians would be induced through price surveys and the possibility of increased control to give less costly prescriptions. To reduce hospitalisation expenditure, ambulatory care services would be strengthened and the sickness funds would be given a greater voice in the planning and financing of future hospital expansion. A containment of costs was also expected from a more intensive involvement of hospital physicians in outpatient care, and, vice versa, of freely practising general practitioners and specialists in hospital care.

42. In conclusion, the expert said that until recently there had not been sufficient data available on the health care system. Consequently, the Government in 1976 initiated a research programme with the object of co-ordinating research activities undertaken by a multiplicity of institutions and associations. The research would cover the causes of illness, risk factors, diseases of major importance from the point of view of health policy, structural improvement of the health care system and general improvement of the state of knowledge and techniques in the field of health.

Norway

43. The Government expert from Norway said that medical care in Norway was provided to all residents via a national insurance scheme. As regards institutions such as hospitals and nursing homes, the services were provided by the 19 counties. The insurance scheme currently met 50 per cent of the running costs of the health institutions in the counties - the share having been reduced to this figure from the 75 per cent which had operated over the 1970-76 period. Hospital treatment was free. Ambulatory care involved about 10 per cent of costs bearing by the patient; reimbursement of drugs, where a state institution had a marketing monopoly at the wholesale level, was in general limited to the more expensive medicaments.
44. Over the last four years, total public expenditure on health services had doubled and currently represented about 6 per cent of GNP. The expert said that public opinion did not so far seem to be unduly alarmed by these cost rises: these continued to be mounting demands for medical care, encouraged no doubt by the increasing flow of news about new methods of treatment and what could be premature announcements from some of those engaged in medical research. Even though wage and salary costs were now accounting for nearly three-quarters of total expenditure - due to wage rises themselves, to cuts in working hours requiring more staff, and a higher skill mix - the government long-term programme for 1978 to 1981 envisaged a 4.3 per cent annual increase in man years for public health services, whereas the total labour force was expected to grow by only 0.8 per cent a year.

45. The key issue in Norway was whether the resources spent in the health sector had reached a volume which could be considered both optimal and reasonable - or, in other words, whether the output justified the expenditure, especially when compared with the results in other public sectors. These were difficult questions, involving many unquantifiable factors. Yet the potential was great measured in economic terms, when there had been a sharp rise in sick absence and in the number of people unable to work due to disablement. It might be noted that improved levels of social security benefits made it easier for people to take sick leave.

46. The speaker emphasised that the prime aim was to get more output from the resources deployed, including any desirable reallocation of them. Cost-benefit analysis could be a valuable instrument. Preventive measures were important although some could prove to be cost-increasing. Better public information programmes were needed, to persuade people to take better care of themselves. Cost awareness among medical care providers was essential.

47. It was a declared policy to treat or to take care of a patient at the minimum resource level which would be effective. Nursing home capacity had been enlarged and primary care was being strengthened. It was accordingly expected to be possible to reduce the number of acute hospital beds from 5.4 to 4.5 per one thousand population - this being a sector accounting for some 40 per cent of total public health expenditure.

48. In conclusion, the expert said that the Government intended to introduce new planning and financing systems to encourage local authorities to get more out of the resources available to them. The system of 50 per cent reimbursement for the running of health institutions would be replaced by lump-sum grants which would probably be calculated on the basis of population, age distribution, number of disabled persons and distances within each county. And the counties would also be induced to prepare longer-term plans to be submitted to the national authorities which thus would have a means of exerting control over the main lines of developments in the health care sector.

Poland

49. The Government expert from Poland explained that medical care was provided in Poland by way of a comprehensive health insurance system which, since its expansion to certain excluded groups in 1972, now covered the whole population. The system operated under the general control and planning of the Ministry of Health and Social Welfare, with lower levels of administration in the 49 provinces and some 400 catchment areas, containing community health centres. It was financed mainly from provincial budgets, but with some support from the central budget, principally to meet the cost of medical training. The system was organisationally uniform, and fully integrated in the sense that the various levels of curative care functioned together with preventive activities, social care and rehabilitation, and social services generally.

50. Between 1971 and 1975, total health care expenditure under the programme had increased by some 75 per cent - by 68 per cent on a per capita basis. These figures were very similar to the increases in the total wages bill in this labour-intensive service - this was about 73 per cent over the same period reflecting both wage rises and increases in the number of personnel employed. There were naturally wide variations when the cost of certain medical procedures and services were analysed. For example, the cost of intensive care for a hospital patient had increased by 128 per cent comparing 1970 with 1975: the cost of one dental prosthesis had varied very little over the same period. Expenditure on drugs and related materials - drug prices were determined by the Ministry of Health and Social Welfare and the manufacturer - was becoming a major problem: in 1975, it amounted to as much as 37 per cent of total health care expenditure.
51. The allocation, from the total state budget plan, for health care expenditure was centrally determined. Since the distributed national income in 1975 was about 73 per cent higher than in 1971, it followed that the increase in health care expenditure had been similar to the increase in the national income. In fact, the average ratio of health care expenditure to the national income ran at 3.29 per cent throughout the 1971 to 1975 period, with annual variations within the 3.26 to 3.36 per cent bracket.

52. The expert said that Poland however shared many of the problems being experienced elsewhere. Constant modernisation of the network of facilities and the inevitable development of new and expensive technology added to costs, as did the growing demand for increasing specialisation. Illness caused by environmental conditions was an emerging factor. And there was undoubtedly a need to strengthen the medical care services in rural areas.

53. A variety of measures had therefore to be considered. The speaker emphasised that prevention, early diagnosis, treatment and rehabilitation were the key issues. If every contact with the system was a contact with a physician, this resulted in overburdening physicians and raising costs. Rational limit of contact with doctors was called for, by sensible use of auxiliary personnel. Concentration of specialised groups of health professionals, and of apparatus and equipment — that, for example, for diagnostic procedures — could lead not only to savings but also to higher quality results. Objectives of this kind were accordingly being pursued.

United Kingdom

54. The Government expert from the United Kingdom explained that medical care was mainly provided in the United Kingdom by way of a National Health Service, with all-residents coverage, and directed and financed by the central Government. This had in 1948 replaced a system of national health insurance, based in effect on insurance funds covering only about half the population, and with fragmented services for delivery of medical care, the hospital sector having been especially diverse. The National Health Service currently employed about one million people, with staff costs amounting to over 60 per cent of total expenditure. There was in addition a small private sector.

55. Fundamental organisational changes had been made in 1974 when the previous compartmentalised organisation by function was replaced by a system of 14 regional health authorities and 90 area health authorities. Each area was in turn subdivided into districts, and at each level there was a unified administration covering the whole span of the National Health Service. Broad planning, monitoring, budgeting and over-all administration were exercised by the Department of Health and Social Security.

56. Given that there was a limit to public expenditure, its total was allocated between expenditure sectors, so that in financial year 1975/76, for example, 5,500 million pounds was allocated to health expenditure in England. Under a recently introduced system, the annual limit in cash (as opposed to volume) terms was determined at the start of each year, including a factor for inflation — an exception to this limiting process being the family practitioner services, bearing in mind that these services grew essentially in response to uncontrolled demand factors. The allocated limit was subdivided between the health authorities, who then produced an anticipated profile of their expenditure throughout the year and, during it, provided monthly expenditure records to be compared with the profile. In this way, expenditure was now effectively constrained; in the last financial year, the total spent had varied from the allocation by only a quarter of 1 per cent. The increasing proportion of GDP taken by the National Health Service was a reflection of the increase in public expenditure as a whole. Over the years the share of public expenditure taken by the National Health Service had remained more or less steady.

57. The cash limit system in no way inhibited policies of correcting geographical maldistribution of services by progressively balancing financial allocations, and of varying priorities according to changing population needs.

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1 Apart from certain comparatively small charges levied on patients.
58. The expert explained that although the family practitioner services were not cash-limited, there were other constraints on them. General practitioners in the National Health Service were paid by way of capitation fees plus practice expenses; hospital doctors were salaried; fee-for-service applied to dentists and opticians but this was a cost-sharing sector; drug prices were negotiated with manufacturers; the number of new doctors was controlled via the places made available in medical schools. But United Kingdom residents had a free choice of doctor, and doctors in turn retained clinical freedom.

59. The speaker commented that it was true that the National Health Service could essentially be regarded as achieving cost containment by a system of controlling supply. But there were safeguards, such as various consultative and advisory councils, providing a valuable feed-back to the central authority. Finally, the importance of preventive medicine continued to be recognised - as the most effective money saver of all.

III. SUMMARY OF DISCUSSIONS ON TRENDS AND CAUSES

60. The national studies and presentations indicated very completely the broad picture of the development of medical care under social security programmes in the various countries. Although the available information did not at this stage allow for an exhaustive comparison between countries, the conclusion appeared to be that although there were considerable differences at any given time, there were marked similarities as regards development trends in general. Since the meeting was concerned with the future - in other words, with future developments - the causes of such developments needed to be summarised, under the demographic, economic and sociological aspects:

(a) Total medical care expenditure usually increased in the medium term faster than the Gross National Product; this trend was even more marked in periods of recession, when the GNP increased more slowly.

(b) Increases in medical expenditure were associated with more recourse to care and more items of patient care so making up an increasing volume, with rising standards of care, and with the increase in medical prices. These parameters - volume, quality and price - were not independent of each other since a factor common to them was the development and spread of care techniques which both widened the range of care available to patients and led to the use of more costly equipment and more qualified (and hence more highly paid) personnel - all of which might well increase inequalities between different groups of people. Medical care services were in any event extremely labour-intensive, with limited scope for rationalisation.

(c) Measurement of increased volume and prices in particular should take account of the changing significance of the units of measure used. For example, one patient day in hospital involved 2 to 3 times as much care today as it had 10 or 15 years ago, due in part to reductions in duration of stay which had meant that much of the diagnostic procedures and curative treatment was being compressed into a shorter period. Many countries had therefore found that the true price increased, therefore, less rapidly than would appear from the statistics while conversely the volume increased more rapidly.

(d) The over-all economic structure of medical expenditure had in the past been biased in favour of hospitalisation as part of the total care system, and this had been reflected in social security expenditure. This general trend was producing a no less general reaction, giving rise to measures aimed at a reduction in in-patient treatment, and the extended use of ambulatory medical care. Some participants pointed out that, in certain countries, the role of doctors as the providers of primary care had tended to decline, as they gave more attention to various laboratory tests and technological procedures, with subsequent economic consequences.

(e) The coverage and range of services provided under social security systems had been expanding to varying degrees in different countries. The extent to which this trend towards such wider scope would continue, where it still had some way to go, might be debatable. What was certain was that expansion of social security medical care programmes meant an increase in financial resources, which in itself raised the total expenditure on medical care.
61. The similarities, despite differences in legislative background, revealed that there was a pattern to the development of medical care from which it was difficult to escape. This pattern was created by a number of causes which were common to all countries:

(a) The Workers' representatives pointed out that, in many countries, some groups of people were less well provided with medical care than others, and in effect had less opportunity to have free access to such care. And inequalities between areas within countries could be marked. Reduction of inequalities such as these might well be costly, but should be an essential objective of society.

(b) It was generally agreed that health hazards due to conditions of life and work generated a demand for medical care, which thus became one way of compensating for such harmful social factors.

(c) The conditions governing the delivery of care occasioned a number of comments. In particular, the experts emphasised the role and responsibility of physicians: this was vital since it was the physicians who made key decisions determining expenditure by social security schemes. It was noted that their economic status appeared in many countries to be higher than that of other professionals or high-level wage earners. This was especially so where the payment method was by fee for each item of service: this was a system which seemed to have a considerable impact on increasing volume and price of services. The experts laid stress on the need for administrative controls, including various kinds of peer review procedures, which could be exercised at what was in effect the level of production. And they attached importance to the need to make physicians more aware of expenditure factors, such as the cost of their prescriptions.

(d) The experts noted that, in several countries, it was expected that the number of physicians would continue to increase. Obviously the number of available physicians could substantially influence medical care expenditure.

(e) As regards hospitalisation, some experts stressed the inflationary effect of new construction projects and the advanced technology which they commonly incorporated, together with the sometimes haphazard installation of sophisticated and costly equipment. Not only did developments of this kind involve substantial capital outlay, but they inevitably led to higher running costs. It was plainly important to consider cost-effectiveness before incurring such expenditure.

(f) General concern was expressed about the quality of management within the medical care field. The experts commented that emphasis on cost management in particular had been given insufficient attention in many countries. Inadequate or inefficient management led to waste, and thus to higher expenditure to be borne by social security programmes. It was observed that the hospital-day charge might include, as in France, cost items which would more appropriately be carried by the State.

(g) There was a wide measure of agreement that the progressive development of social security legislation to extend medical care coverage to further groups of the population had enabled a latent demand to be met - and had been a main cause of increased expenditure by raising the volume of care. However, it was important not to assume that the opposite would happen if the coverage were to be reduced. The representative of the Council of Europe pointed out that this extension, to such groups as the self-employed, had brought the coverage close to 100 per cent in many countries. This cause of expenditure increase would therefore be of less importance in the future.

62. All these various causes were analysed in the same way by experts from different countries with widely varying legislative backgrounds as regards access to care (whether this was free, or cost shared by the patient) and distribution of care (salaried or independent medical practice, public and private hospital sectors, distribution of pharmaceutical products, etc.).

63. The representative of the ISSA pointed out that some of the factors contributing to rising medical care costs could be inherent in the nature of the social security system itself, especially if, designed as a mechanism to finance curative services, it left little margin for preventive activities. Much in fact
depended on the priorities given to social security objectives in the field of medical care: additionally, there were organisational and administrative considerations, including the relationship between the social security system and the physicians and other health professionals.

64. However, the similarities in national analyses showed that, although from the qualitative point of view the causes were the same, it was difficult to identify the specific effects of each cause and to define the most economic means of distributing good quality care. The point was made here that data were currently insufficient to assess the cost-effectiveness of alternative health care expenditures except in a crude way. International co-operation in the field of research seemed to be indispensable to shed light on these aspects.

65. Although there was general agreement on the need for such further research, especially into the results of medical care in terms of reduced mortality or invalidity, the comment was made that evaluation of medical care expenditure in terms of the associated causes and trends contained an ethical dimension in so far as it could be regarded as setting a price on health and indeed on human life itself.

66. It was argued by the employers' representatives that constantly increasing medical expenditure was to a large extent the cause of an excessive growth of social security expenditure. This was an evolution which had to be regarded as a matter of major concern as regards production, and employment, especially against a background of economic recession. Naturally, it would not be feasible to specify as a general proposition what proportion of GNP should be devoted to medical care. Rather it was for each country to decide what was the appropriate proportion of GNP growth which, without disturbing the harmonious development of the economy, should be devoted to any necessary improvement of social security.

67. Finally, there was general appreciation that a key issue was that a large proportion of the social security expenditure on medical care was in practice committed expenditure and so was in effect automatic. The extent of this proportion could differ between countries, but, as a general proposition, it followed that only a limited proportion of total expenditure, as this had emerged under the system chosen for the financing and delivery of care, could be influenced by cost containment measures.

68. It was accordingly against this general background of their detailed examination of trends and causes of medical care expenditure under social security that the experts proceeded to consider questions concerning future policy.

IV. CONSIDERATIONS AND RECOMMENDATIONS CONCERNING FUTURE POLICY

69. The experts regarded the question of what action should be recommended to contain the rise in medical care expenditure under social security as one which went much wider than an attempt to construct a list of measures which hopefully would save money. Given the difficulty of meaningful cost/benefit analysis in this field, some participants were inclined to think that a prior issue was why, or rather to what extent, cost containment measures could and should be taken. At least the need for such measures would differ between countries, and nor was any one measure likely to be of universal application and value. No doubt it was common ground among countries that a main policy objective was to provide adequate medical care at acceptable cost - the difficulty was to quantify these phrases.

70. The consensus which emerged was that costs should not be so much contained as rationalised. Obviously, containment of increases did not mean reducing present levels of social security expenditure on medical care. What was needed was the elimination of superfluous or excessive expenditure, within a policy of achieving a better allocation of medical care resources so that, in particular, the appropriate treatment level, and no more, was applied.

71. Given these broad considerations, examination of policies aiming at a more rational and hence a more economic utilisation of health resources - which would attain a reasonable balance between the demand for and supply of services -
should be undertaken by first outlining the broader context within which social security programmes, and indeed health care systems in general, now operated. It should be accepted that health expenditure was related to and influenced by a number of factors connected with life patterns, working conditions, economic development, cultural levels, etc. It followed that corrective measures aimed at influencing health cost trends and improving health status could not be taken only within the health sector; other policies became very relevant, such as those bearing on housing, transport, leisure, town planning, education, etc.

72. Several experts emphasised that, in such a broad context, the question of improvement of conditions of work and life was of paramount importance. Yet the problem had two distinct aspects - on the one hand, better working conditions would bring about more safety, a reduction of health hazards of an occupational origin, less stress, fatigue and frustration - all these being factors which were conducive to health disorders. On the other hand, increased prosperity, higher living standards and indeed more leisure, with their effect for example on a variety of patterns of personal consumption of goods and services, were creating a new series of disorders and diseases which were no less expensive to treat. It was recognised that certain disorders should not necessarily be seen as a direct result of personal choice - alcoholism among young unemployed persons was one example of a societal effect. Although the net cost implications - in terms of health expenditure - of such evolution of industrial societies could not be accurately assessed, it was agreed that, whatever the cost, improvement of conditions of life and work particularly for the less fortunate categories of the population plainly commanded itself as a priority.

73. Another example of the relevance of other policy areas for health and social security programmes was provided by education. If the academic and indeed the post-graduate training of physicians and other professionals neglected subjects related to the social and economic aspects of health, as it seemed to do at the moment in many countries, they were bound to enter the medical care system and serve in it without the necessary background to assume and discharge a fully social function and, being insufficiently cost-conscious, might or indeed would generate avoidable health expenditures. Plainly, there was considerable room for improvement in these regards in the training of health professionals, and a need too for more objective information to decision-makers and the public about the advantages and disadvantages of various medical interdictions - all of which should help to reduce what seemed to be a growing enthusiasm for high technology.

74. Turning their attention to desirable policy measures, the experts agreed that rationalisation should be comprehensive - touching upon the use of financial resources, health personnel, facilities and knowledge. An optimum distribution and use of all the available resources had to be brought about, because it was desirable to achieve provision of the type of care best suited to individual needs. A distinction was made between medical care and health care, the latter conveying a broader concept, relevant to the discussion of the agenda, because social security programmes in this field had traditionally been concerned with the more restricted issue of providing medical care, while their future role should be wider.

75. Thus, for instance, it was made clear that preventive measures should play an increasingly important part in social security programmes, it being recognised that the measures needed in industrialised countries on the one hand and in developing countries on the other could differ. This approach, which was consistent with ILO standards and with its interconnected action programmes, such as its International Programme for the Improvement of Working Conditions and Environment launched in 1976, required to be properly qualified as to the content and cost implications of prevention. Several types of preventive measures could be contemplated. Some, such as sanitation, immunisation and similar collective services, were commonly practised and resulted in obvious ultimate savings in the health bill. Some items of personal preventive care, such as mass screenings and check-ups based on sophisticated and costly technology, were considered as less obvious priorities and disadvantages had been detected in some countries. But at school level, and in respect to underprivileged social groups and indeed to high risk groups of the population generally, better co-ordinated action on preventive measures was needed, involving as far as possible the population itself, by way of counselling and advice, a role that doctors had not so far sufficiently fulfilled. More resources should be devoted to detecting and identifying health hazards as they were generated by working and living conditions. This type of scientific approach to prevention might give higher returns than early screening to detect possible sickness in individuals.
76. Action by means of over-all budgeting and control of health services - and, more particularly, the indirect "rationing by supply" - was considered at length, since it had a direct bearing on the organisation of medical care under social security. Experts noted that, in several countries, social security objectives were attained by the method of operating a national health service of universal coverage, in which the right of the people to health care was guaranteed within the limit of given resources. This right was of course inherent in other types of schemes, but it was noted that a number of countries were moving in the direction of a national health service approach.

77. In these national health service systems - the United Kingdom was an example here, as outlined in section II of this report - cost levels were a result of deliberate policy decisions, the delivery system causing hospital doctors to practise within a fairly rigid set of financial constraints, which also served to deter the duplication of facilities. A disadvantage of this approach was thought to be that one could not be certain at all times that an acceptable standard of medical care was actually being guaranteed to all categories of the population; moreover, yardsticks to assess what was an "acceptable" level were either lacking or tended to be subjective. Much progress could however be made towards desirable rationalisation and even reduction of unnecessary expenditure by gearing social security systems to such a pattern, where part of the health services was demand-determined and part supply-determined. Experts from countries where - on the contrary - social security was based on other criteria (i.e. reimbursement by social security to insured persons of expenditure incurred privately, fee-for-service remuneration of physicians within an agreed schedule, total or quasi-total independence of the medical profession, etc.), noted the high-cost implications of operating social security along such lines. Some doubts were expressed whether, for historical and political reasons, a movement was feasible towards a national health service type of programme simply as a means of coping better with the economics of health. Apart from this wider issue, they were ready to recommend corrective measures, as advocated below, together with the responsible authorities being given more power to control and monitor the so-called "health industry".

78. It was considered that, irrespective of the type of social security legislation, health services could be made more efficient and economic by an integration of the various components of the health services and by entrusting to the same authority responsibility for resource allocation, programme content and administration of services. The weakness of several schemes was that various levels of care were insufficiently connected, or even operated virtually independently. Thus the social security bill was inflated unduly by poor co-ordination, duplication of medical acts, and overlapping, etc. Remedial measures in this area were badly needed and social security administrations had a growing responsibility to make the delivery system for which they were responsible more effective and efficient - and more compatible with national health objectives and with any other sub-systems or schemes operating in the public sector.

79. Elaborating on the subject of cost-effectiveness, experts were unanimous in stressing the importance of primary medical care as opposed to sophisticated and expensive hospital treatment. Much could be said for a shift towards "lowest resource" treatment, or, in other words, the lowest technical level of effective care. The function of the general practitioner should be restored to the key role which it deserved; in order to achieve this goal, social security programmes should provide the necessary financial incentives when negotiating fees of the various health professionals, and eliminate existing disincentives. Academic training should not be such as to penalise those students who did not seek specialisation. On the contrary, education and professional training of general practitioners should be broadened to enable them to fulfil competently their many-sided role, and to achieve a status (and an income expectation) not lower than that of some specialists. Many experts gave a high priority to increased resource allocation to community health centres - recognised by and supported through the social security system - where primary care, preventive measures, counselling and social work could be blended together in units staffed by personnel of adequate but unspecialised ability, acting as the first point of contact with potential patients or persons with minor complaints, who were now too often going directly to expensive hospital units.

80. Some experts emphasised that the capacity of medical schools should be carefully adjusted to the need for new physicians, as assessed by national health authorities. This assessment should itself take account of the greater use of ancillary personnel, which was suggested - by WHO representatives among other
81. It was of course obvious that, notwithstanding determined containment of hospitalisation, the hospital sector would remain an area of major importance accounting for a large proportion of medical care expenditure. Apart from the need for more effective and more cost-conscious hospital administration and management, experts considered that it was important to rationalise hospital functions, viewing hospitals as collections of various technologies (rather than in terms of numbers of beds) which needed to be planned and co-ordinated on an area level to eliminate over-provision of complex and highly expensive treatment facilities.

82. The experts noted that cost-sharing by patients, at least for some of the services provided and at a variety of rates, was applied, often seemingly in a haphazard way, under many social security medical care programmes. This was an issue which attracted conflicting arguments. Some experts, opposed to any cost sharing, regarded it as an ineffective mechanism for limiting consumption, since the use of services was almost entirely determined by the provider - and any withheld demands for treatment might later prove only to have been deferred. Moreover, cost sharing increased inequality and in effect reduced coverage, while if it was selective in the sense that it applied for example to primary care in physicians' offices and not for instance to out-patient or in-patient treatment in hospitals, the pattern of delivery of care could be excessively distorted by excessive use of the free or comparatively free alternatives. Other experts were not prepared to reject cost sharing as a method of containing consumption; in any event, it could raise money, and it was desirable to make people aware by such part payment, subject to low income and other appropriate exemptions, of the value of the medical benefits they were receiving and that the cost to the community was large, increasing and had to be met.

83. Social security budgets devoted substantial expenditure to pharmaceuticals consumed by protected persons. This raised the inherent problem of the prescribing patterns of physicians. More generally, control of prices and ranges of drugs was welcomed by the experts and the positive results achieved in some countries were noted with satisfaction. Methods could vary. Some social security systems negotiated prices with manufacturers, while others enforced restricted lists of reimbursable drugs. A study by the International Social Security Association recently recommended measures that experts were willing generally to endorse, i.e.:

- greater control over therapeutic effectiveness;
- a clearer appraisal and some restriction of the vast variety of drugs;
- greater influence on price policy;
- greater objectivity in information and advertising.

Some experts thought that to this list one could add the desirability of exempting social security agencies from taxation of the pharmaceutical products they distributed or paid for.

84. The serious situation of many developing countries as regards the cost of pharmaceuticals was noted with concern. Lacking a national manufacturing industry, these countries had to import from abroad all the drugs needed, including even relatively simple preparations, and to pay the prices set by foreign manufacturers, which often were powerful multinational corporations. Consumption levels were dictated by the pattern of morbidity which was specific to those countries but household incomes could usually not afford the necessary drugs. There was the additional problem that people in such countries could readily be misled by
advertising claims. WHO representatives referred in this connection to the preparation by their Organisation of a list of essential substances for developing countries. Recognising the value of programmes carried out by WHO to help developing countries in this situation, the expert representing the Federal Republic of Germany— with unanimous support— asked that the conclusions of this meeting should include a request that the WHO and the ILO should jointly and urgently address a formal appeal to the pharmaceutical industry to supply to the least developed countries at minimum cost sufficient quantities of the basic 20 or 30 types of medicines required to meet the basic health needs of the majority of the population.
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