Verzekerd leven : artsen en levensverzekeringsmaatschappijen 1880-1920

Summary

INSURED LIVES. PHYSICIANS AND LIFE INSURANCE COMPANIES 1880-1920

With the growth of modern wellfare states since the end of the nineteenth century physicians functioned as gatekeepers with respect to private and social insurances. In addition to their therapeutic work they started giving 'medical advice' to third parties like life insurance companies and social insurance institutions. This book discusses the question of how physicians became involved in welfare arrangements. I answer this question by focussing on the involvement of physicians in life insurance companies in the Netherlands (1880-1920). The main reason for choosing this case is that around 1900 large scale social insurance, although heavily debated, had not yet developed and commercial life insurance companies dealt with a realitively large part of the 'risks'. Moreover, commercial insurance business played a major role in developing manners and morals which have become a necessary condition for a modern, large-scale, bureaucratic organization of risk management.

In the introduction I explain why my analysis of the development of the gatekeeping function of the medical profession differs from most studies by medical historians or profession sociologists. Medical historians and professionsociologists usually explain the development of the gatekeeping function by referring to the progress of medical science, the professional monopoly of medicine or the needs of society at the end of the 19th century respectively. It implies that 'medical expertise', 'medical power' and 'the needs of society' are treated as static, given entities. How different these kind of explanations may seem, they share the fact that they are not thoroughly historical, in other words they are not constructivist enough. The theoretical scheme of 'explanation and explanans' implicitly introduces a distinction between things which are stable and things that change. When medical power, medical expertise or the need of society are used as 'an explanation' and are seen as fixed categories, the interesting question about their genesis is overlooked. For a radical hisorical and constructivist

analysis it makes more sense not to make anything static beforehand.

Inspired by the work of Norbert Elias and Bruno Latour I will make the development of medical expertise, medical power and a modern risk society not 'an explanation' but an object of study. In other words, instead of using medicine or society as static background scenes to explain the rise of the gate keeping function, I will demonstrate that the development of this functions went together with the co-evolution of medicine and society. I will show how a network developed of life insurance companies, medical advisers, examination physicians, agents, insurance candidates and how power relations in this network stabilized. I will also show how, together with this process, standards for medical expertise came into being, how medical technology with respect to physicial examination became reliable, how the human body became a public body, how health was defined as a risk and how risk management became more and more bureaucratic.

In chapter 1 I describe the first phase of growth of the network of life insurance companies, medical advisers, medical examiners, insurance candidates and the Dutch Society of Medicine at the end of the 19th century. It will become clear that in this phase life insurance companies claimed to be more trustworthy then the small, local insurance funds because of their scientific methods to select risks and to determine the premium to be paid. The contribution of medical science to life insurance made it possible for this business to unite their economic, social and ethical identity. Because of the scientific base of risk selection the companies could claim to be economically succesfull, to contribute effectively to the fight against poverty and to guarantee that selection was based on objective standards and not on social prejudice like social class, gender etcetera. So medical science served the commercial, the social as well as the ethical goals of the companies, which could not be distinguished sharply at that time. The following chapters will show that after 1900 commercial and ethical goals not only became differentiated, they also opposites.

In the first phase of growth of the network a distinction was made between the therapeutical work of physicians and medical advising, between patients and clients. Moreover, therapeutics and advising became related one to another in a hierarchical sense. Because the Dutch Society of Medicine appeared to be far more interested in therapeutics than in advising, they - unintendedly - minimized their influence on the introduction of medical examination and medical selection. So, in the network before 1900 life insurance companies were the most powerful party.

In the following three chapters I choose three different angles and three different themes to describe the building of this network. In chapter 2 I

discuss the integration of the medical examiner in the network in relation to the development of the medical examination. In my analysis I stress that the development of medical examination should not be seen as a simple process of diffusion of medical knowledge and medical skills from a therapeutic context to an insurance context. Instead of the diffusion of expertise I focus on the production of expertise.

Although physicians were asked to examine insurance candidates they were lacking the expertise and the skills to do so according to the standards of the companies and their medical advisers. Examination physicians were criticized for their poor work and insurance companies took the initiative in developing standards for medical examination. They stressed that a physical examination of an insurance candidate, which the doctor had never seen before, is far more complicated than an examination of a patient of his own, because physicians lacked the help of the candidate (who is supposed to lie about his health to get an insurance), the time (he does not know anything of the history of the candidate) and the disease (he cannot wait until some symptoms will develop in one direction or an other, but has to decide on that very moment). To compensate for this difficulty insurance companies introduced etiquette rules and standards for using medical technology to get reliable examination results. Moreover, the introduction of the examination form and the development of burocratic ties between the head office and the examination room more or less guaranteed that examination physicians would act according to those standards. The bureaucratization of the network meant that the position of examination physicians became even less powerfull then before. They got the instruments to gain more control over the examination candidates. At the same time, however, they were disciplined by the life insurance companies and their medical advisers to perform as they were prescribed.

Chapter 3 deals with the position of the general practitioner in the network in relation to debates about medical secrecy. In my analysis I underline that medical ethical rules should not be understood as rules which are more or less inherent to the medical profession to protect patients from the power of medicine. This view disregards the conflicts within the medical profession about medical secrecy, the cultural processes that changed the meanings of secrecy and publicity, and the fact that medical secrecy also protected physicians by conceiling their lack of expertise. In my analysis I focuss on ethical rules from a more radical constructivist perspective.

Although in the network a distinction had been developed between medical advising and therapeutics, life insurance companies also needed the help of the general practitioner. Insurance companies said they needed

a certificate to state the cause of an insured person's death. These certificates served to control the quality of the physicical examination, to exclude fraude like committing suicide just after buying an insurance contract and to provide statistical insight into the causes of death of insured people. Only general practitioners were entitled to sign these certificates. The quest for death certificates generated heavy debates in the Dutch Society of Medicine and between this society and insurance companies for more then twenty years. In 1910 the debate was more or less stabilized. A compromise was reached, the so-called 'Tilburg peace treaty'. This compromise meant that general practitioners were allowed to inform insurance companies about the diagnosis of the disease which caused death after the insured sum of money was paid to the family. The central argument by which this compromise was reached was the scientific value of statistics. On the one hand the stabilization of this debate reflects the fact that the distinction between therapeutics and advising was not that sharp and that general practitioners were introduced to the life insurance network. On the other hand it underlines the importance of medical science in the network, for the consensus about the scientific value of statistics was the base for the compromise.

In chapter 4 the position of the medical adviser is analyzed in relation to the development of medical selection procedures and the construction of risks. I illustrate how procedures of medical selection were not an answer to the needs of society but contributed to the development of a risk culture. More specific, it will become obvious that life insurance practice, although reckoning with population statistics, contributed to the development of a vocabularly of risk as an individualistic risk.

Medical advisers in a way were the embodiment of risk selection: they determined if a candidate could be accepted or should be refused. They were heavily committed to fair selection procedures which they identified with scientific procedures, and that is why they were interested in the 'risks' that people represent and took initiatives to organize statistical research. They argued for the insurancability of the so-called 'unworhty lives' and proposed the accumulation of statistics of the causes of death of refused candidates as well as the implementation of periodical medical examination to get insights in the development of health risks. Debates on the insurancability of 'unworthy lives' or the periodical physicial examination in the period between 1910 and 1935, however, illustrate that proposals of medical advisers were turned down by the companies because these were too expensive.

Now that life insurance business was firmly settled the commercial and ethical goals of the companies became differentiated. The idea that companies should guarantee fairness in selection procedures and in the

determination of premium hight and that therefore medical knowledge or 'risks' was necessary, was considered less important than the commercial drive to make profit and reduce costs. At the end of the nineteenth century medical science was the base of fairness. Yet forty years later being fair was not that important any more and the need for statistical insights into risks was compensated by a profitable guess of the premiums to be paid.

With the differentiation of commerce and ethics the value of medical science was diminishing. That is to say, life insurance and medicine were strongly interwoven, but the meaning of medicine in the network changed. Instead of playing a substantial role medicine became an ideological legitimation for the selection policy of the companies. So, although really committed to statistical scientific research on risks medical advisers became less and less important in the insurance network. Together with the subordination of ethical motives to economical goals medical advisers had to put aside their own ideas about risk selection and they simply had to carry out the selection within the economic frame of life insurance companies.

In the last chapter I conclude that the analysis of the development of the life insurance network shows that the structure of the network cannot be explained by medical power, medical expertise and the needs of society. The changing roles of examination physicians, general practitioners and medical advisers in the network demonstrate that the power of medicine is diminishing and that life insurance companies set the standards for medical expertise. And 'society' was not a static background scene either. On the contrary. This large-scale welfare institution contributed to the development of a modern risk society and to the construction of a public body.

Finally I speculatively compare the development of the network around 1900 with the present role of medicine in life insurance. Because of the possibilities of medical technology like HIV diagnosis and genetic diagnostics, medicine, instead of a symbol of public trustworthyness and fairness, nowadays has become a symbol of danger and discrimination. However, the political debate about risk selection for private insurance is difficult because of the secrecy of medical selection procedures. My analysis reveals how this secrecy is historically linked with the refusal to develop a statistical body of knowledge. With regard to the reorganization of social insurance and the dependency of a growing number of people on private insurance institutions I argue for public control on medical selection just as there is public control on the financial base of private insurance.