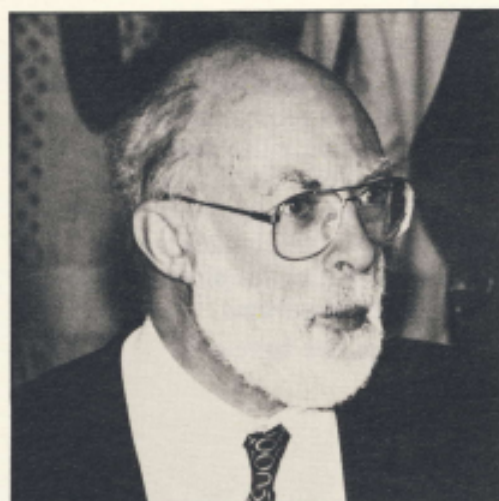


# The Medical Adviser: Friend or Foe?\*

— R De Smet



Dr René De Smet  
Professor in General Practice  
State University in Gent.

## Curriculum vitae

Prof Dr Rene De Smet was born in Heverlee (Belgium). He qualified as a general practitioner at the University of Leuven and was in solo-, duo- and group practice from 1950 to 1980. From 1972 to 1980 he also lectured in general practice at the University of Leuven. In 1980 he was the founder of a new chair in General Practice at the State University in Gent. He has been a member of the Flemish College of General Practice since its foundation in 1964, as a council member from 1969 to 1981 and as president from 1972 to 1976. He has also been a member of SIMG (International Society of General Practice) since 1973 and was a board member in 1974 and president from 1982 to 1985. In 1975 and 1984 he organized the SIMG congresses and has read papers at six of these congresses.

**A**s a young general practitioner (already some decades ago) I was unhappy with the medical advisers. They were rude to my patients and hardly made any contact with me.

Many years later I had to organise a study-day on the topic: "The relationship between the General Practitioner and Medical Adviser." The preparatory talks between a group of GPs and a few medical advisers, were for me, an eye opener. I learned that the task of the medical adviser was going to change radically. And, it did!

## Summary

*The whole of the Belgian population is insured against the risk of illnesses. The many sick funds are now linked to politico-ideological parties and play an important role in the social and political scene. Every sick fund has its medical adviser, whose task it is to make sure that all legal aspects are respected and that the patient is helped in the best way; recently he has been getting more involved in social problems and paying more attention to prevention and health education. He is at the intersection between sick funds, patients and the activities of health care providers, where conflicting interests meet. Aspects of the medical adviser, patient, general practitioner in this triangular relationship are illustrated. Patients see the medical adviser as a controller, who will send them back to work. GPs think he is an official, requesting too many forms, ignorant of the specific social conditions of his patient. The medical adviser on the other hand would like patients and doctors to understand his role better.*

S Afr Fam Pract 1988; 9: 447-53

**KEYWORDS:** Social Insurance; Medicaid; Family Practice; Belgium; Interprofessional Relations

*\*Paper presented at the 6th General Practitioners Congress, Cape Town.*

Before illustrating this evolution in more detail, I have to explain our Health Care System. I need to illustrate some of the details, which are closely linked to the medical adviser's task.

## The structure

At the end of the 19th century a catholic priest, working in an industrial town, was confronted with widespread inability of blue collar workers to work, due to chronic diseases. In order to reduce these disastrous social consequences, he

---

### *The Belgian Health Care System is part of the social and political structure*

---

established "Mutual Funds" where, for a small contribution, labourers were entitled to get financial support in case of longstanding inability to work. This idea gained ground. Similar actions were initiated by many members of the Christian clergy. This movement rapidly spread all over the country.

In the next stage the Government agreed to support these Mutual Funds. From that moment on, the labour party and later professional organizations, started with similar "mutualities".

It is important to realize that up to now, the Health Care System in Belgium is still strongly linked to the major political parties. After the Second World War, the system was reorganised and enlarged. Insurance against illnesses and invalidity was made compulsory for all employees. The Social Security Act of 1963 was a further step in the development of the whole social welfare system. Nearly 99% of the population is not only

---

### *There seems to be a natural tension in the relationship between the GP and the medical adviser*

---

insured against the consequences of illnesses, but it has also the right to claim a pension, to get children's allowances and if necessary, unemployment benefits.

The whole of this organisation is centralised in the "National Institute for Social Security". It collects the contributions employers and employees have to furnish to the Social Security

and the part the Government has to pay to the same organization. It has to dispatch this financial flow to the different branches.

Concerning the Health Care System, the management is conducted by The National Institute for Sickness and Invalidity.

It has four sections:

1. reimbursement of medical services
2. benefits in case of sickness and work incapacity
3. medical control
4. administrative control.

It is responsible for good financial management. It has to control the expenses, make a yearly budget and adjust existing rules and regulations to the changing medical technology and the fluctuating financial resources. The financial budget will be divided yearly among the five national sick-alliances which, as already said, are connected to the political parties.

In order of importance, we have a

1. Christian Alliance	44%
2. Socialist "	29%
3. Professional "	10%
4. Neutral "	10%
5. Liberal "	7%

---

### *The good medical adviser will look after the interests of the patient, the GP and the government*

---

At a lower level each Alliance has its "leagues". They have an intermediate function of stimulating and controlling the local "sick-funds" which you find in every village or district. In the same street three or more sick-funds, each of a different colour, live next to one another.

In exchange for a small supplementary contribution, they offer a lot of advantages to their members:

- lending orthopaedic and nursing apparatus
  - free assistance by nurses
  - reimbursement of funeral expenses
  - offering cheap holidays in Belgium or abroad for children and families
  - stay in recovery units
- and so on.

These parcels of non-legal advantages differ greatly from one Alliance to the other, and have been a means to attract people. The Alliances are also more and more interested in Health Education.

# The days of acute, uncomplicated lower UTI are numbered...



They organize conferences and send brochures on the topic to their members.

To summarize: Sick Alliances not only have to manage an important money flow in the Social Security System, they are also occupying a key position in the health policy of the Government. By offering supplementary advantages to their members, they are competitive among themselves. And, as they are subsidized proportionately to the number of their members, you can easily imagine the importance of their additional activities!

## Financial Aspects

The financial resources stem from contributions by the employees, by employers and by the state. Employees have to pay 12% of their gross salary for Social Security; on top of this the employer has to add 24-30% of the salary, which is a heavy burden on the real cost of wages. The Government, on its side, has agreed to pay 80% of the expenses for underserved people and 25% of the nursing costs in hospitals. As already said, the National Institute of Social Security has to distribute this amount of money to Health

Services, to Pension Funds and to Child Allowances Funds.

The Health Services get roughly 10% of the Social Security budget.

In 1980, 49% of this amount was allotted to hospitals and specialists

17% to medicines

15% to primary care

10% to administration

8% to collective prevention.

This was a pro capita expense of 15 000 BF per year and nearly 8% of our GNP. Since then, our GNP has increased by 7,5% yearly, whereas the Health Services expenses have increased by more than 10% a year. This growing deficit has led to a series of restrictive measures, mostly reducing the financial means of the hospitals, but without increasing the resources of primary medical care.

With this 15% of the expenses, we GPs are convinced that Primary Health Services are underfunded. The Government agrees, but is only paying lip service, and actually doesn't take any measures which could improve PHC.

One of the tasks of the Medical Adviser is to take care of the expenses of the Sick Funds. And

# JAN

1		3	4
8	9	10	11
15	16	17	18

this role is one of the conflicting components in his relationship with doctors, who see him as a representative of the Sick Funds.

The Health Services are bound to a number of legal obligations. I propose to consider them from the point of view of the user. Having paid his contributions to his Sick Fund, the citizen can claim a number of advantages that are regulated by law.

1. He can freely call on any doctor, either a GP or a specialist. Although we have no registered patients, most of the citizens have a GP and stay with him for many years. In larger cities, however, upper and even middle class people have their paediatrician and their gynaecologist.

The patient has to pay his doctor on a fee-for-service basis. He gets a form and his Sick Fund will reimburse him 75% of the official fee. Pensioners and widows are fully reimbursed. Technical procedures eg laboratory test, Rx, endoscopy are 90% reimbursed.

2. Medicines have to be paid for completely, partially, or not at all, depending on their category. For a number of medicines reimbursement requires a written consent of the medical adviser

in each particular case.

3. A written consent is also required for reimbursement of psycho-therapy, ergotherapy, rehabilitation, etc. In the previous years, more and more restrictions in these fields have been imposed.

4. When the patient is unable to work because of illness, the employer has to pay him for two weeks, if he is a blue collar worker, and for 4 weeks if he is a white collar worker. After that he can get a substitution income if his incapacity is at least 66%. The medical adviser has to decide on these conditions.

In cases of work or road accidents, the patient will be paid by his sick fund, but the medical adviser has to claim back this money from the related funds.

5. If the work incapacity exceeds one year, the patient will be helped by the "invalidity fund" or by the "fund for occupational diseases". His dossier will be prepared and defended by the medical adviser.

6. Hospital admission is free. The patient has to pay ward-fees, medical fees and technical examinations which are nearly totally refunded,

except when the patient asks for private services. The medical adviser can terminate a long stay in the hospital or send the patient to a less expensive unit. Special interventions to be carried out abroad can be agreed upon by the medical adviser.

I have to add that all reimbursements are higher, and very often total for pensioners, disabled and widows, with less than a certain income limit.

On the other hand, independents such as lawyers, merchants, bakers, butchers, who have no fixed salary, are only insured against so-called "great risks" eg hospital costs. But these are free, and most of them do it, to effect an insurance against "small risks". It gives them the same advantages as the salaried people as far as medical costs are concerned, but they can't claim a substitution income.

---

*The medical adviser has to advise the GP and his patients of their benefits, administer the sick funds and be a spokesman for the patients in government organizations*

---

### The Medical Adviser

The medical adviser has more functions than could be expected from his title.

- He is a controller and an administrator
- He has to advise
- He has medico-social tasks.

#### *As a controller*

He has to check the inability to work of the patient who has been declared such by his GP. Moreover, if the patient is ill for a longer period, he has to decide on the degree and the duration of this inability to work. In these circumstances he has to check that the patient gets the replacement salary which is due to him and all the social advantages he can claim.

He has to make sure that the nomenclature of medical acts is applied correctly and in case of misapplication, he has to draw the doctor's attention to this fault.

In case of occupational diseases, social diseases such as cancer and tuberculosis, road injuries or work accidents, he has to be in touch with the proper institutions to arrange all the administrative and financial problems. He has to give permission for reimbursement of certain medicines, for physiotherapy, orthopaedic

apparatus and occasionally for repetitive, costly examinations in hospital.

#### *His advisory function*

This has many aspects. He can propose different kinds of professional and social rehabilitation eg. after injury or occupational disease, in case of psychic and social dysfunctioning. He can help the disabled by advising them how to adapt their home to their handicap. He has to defend the patient's interests, for instance, after injuries, when the permanent invalidity is not always fixed righteously. He has to apply the rather complicated social laws.

He has at his disposal, the social services of his sick fund. It is worth mentioning, that some fifteen years ago, most of the sick funds re-trained their nurses to social workers and in the same perspective the medical adviser was asked to pay more attention to the psychological and social aspects of disease.

Of course, he has to be very tactful in these matters. He should not interfere with the GP's management, but he can make some suggestions to the patients, he can consult with the GP and he can even ask his social worker to investigate and give some social support to the patient.

However, should the patient ask for therapeutic or diagnostic advice, he would not be entitled to give it.

Working in a privileged position in a geographic area, he has an overview of the epidemiology of a rather large group of people, and of its social supplies and demands. He can advise his local sick fund or his national league to take preventive measures or to offer specific social services. He can take initiative in training his social helpers in health education.

#### *The medical adviser's medico-social tasks*

He has to collect data on epidemiology of diseases and mortality, on diagnostic and therapeutic intervention, on the numbers of off-duty-days, on the expenses of the sick fund, etc. He is also the occupational physician of the employees of the sick fund. He has to be aware of occupational hazards, change, if necessary, the working conditions, and carry out preventive examinations.

He also has to be in contact with the group of doctors of his region, to give them information

- on the activities of the sick fund
- on their proper tasks
- on the social services within the region

● on the changing regulations in the health services.

Years ago, the primary function of the medical adviser was to be a controller. Most of the medical advisers were older doctors, who felt the burden of general practice too heavy. But for the last ten years or so, a number of socially involved younger doctors have been interested in these jobs. They brought in new ideas, such as the holistic approach and the importance of prevention. This change of emphasis has had repercussions on the medical adviser — GP relationship.

The medical adviser also has a role to play in different commissions within his sick fund, as well as at a higher level, in the Ministry of Health. He has had experience in the health care field and, from his position in the sick fund he has a realistic view on what is going on in the patient's world and in the doctor's field. He can be an experienced and skillful participant in advisory commissions. Thus, the medical adviser is working in a network of busy relationships.

He is appointed, and paid, by the Social Security Institute. He is responsible to the Chief Medical Adviser of his Sick Fund Alliance. Within his region he has to co-operate with the Chief Administrator of the sick fund, he is a guide for the sick fund personnel, he has to examine patients, control the hospitals, be in touch with the physicians of the region and appeal for social services. He may also be active in Governmental organisations.

So far I have roughly sketched the structure of our Health Care System, and illustrated the position of the citizen, (a potential patient) in this, and in detail, the role and tasks of the medical adviser.

---

### *Often the GP experiences the medical adviser as the one who creates unnecessary paper work*

---

Let us now consider the relationship between the Medical Adviser and the General Practitioners. A few examples will highlight different aspects of this rather complicated relationship.

#### Case 1

Jane, a young mother comes in with her 3 year old son. He has an upper respiratory infection, that will be treated symptomatically. I have to

write a prescription for the chemist and complete a form for reimbursement. This is an example of the most simple consultation!

#### Case 2

Francis, a 36 year old clerk, came to the surgery 5 years ago with symptoms of a typical duodenal ulcer. An X-ray examination showed a duodenal ulcer. He was treated successfully with cimetidine. Five years later his complaints were identical. He is now, as he was then, obviously under stress, provoked by his working conditions. I decide to

---

### *GPs need to admit that medical advisers understand the health care regulations better than they do*

---

re-prescribe cimetidine; but for this medicine, there is no reimbursement, unless a recent proof of an active ulcer can be shown. Reluctantly I have to send the patient to the radiologist. As expected, a duodenal ulcer is visible.

Can I now prescribe the cimetidine?

Not yet! The chemist will ask for a written authorisation, approved by the medical adviser. And I, general practitioner, have to send the patient to the medical adviser, together with

- the X-ray and the protocol
- a request for reimbursement
- a form for work-incapacity (as I decided 2 weeks off-duty would help the healing process.)

Furthermore, I have to fill in

- a certificate for the employer
- a prescription for the chemist
- the sick fund form.

I'm a bit angry with the medical adviser because of all his administrative fuss!

But in my heart I have to admit, he is a better expert in medico-social law than I am.

#### Case 3

Arthur, a 55 year old carpenter, suffers from chronic bronchitis and, for the last 10 months, he has been unable to work. He shows me a letter from the medical adviser of his sick fund, asking me to send in all the documents in my possession and to argue the reasons why this patient could claim permanent work-incapacity.

Once again a tedious job imposed by this medical adviser!

## Case 4

John is a new patient. He moved to my town recently and handed over a number of specialist letters, telling me he is suffering from a serious familial disease, a progressive muscular weakness. He was a clerk and had increasing difficulties in walking, and asked me if he could not get some motorised help. I had no practical solution, but thought about my friend, the medical adviser. I submitted him the case, he saw the patient and after many efforts he succeeded: my patient received an adapted, motorised, three wheel vehicle. It enabled him to continue to work and to improve his social contacts. I'm grateful to my ally, the medical adviser!

## Case 5

Julia and Robert, a childless couple, have been married for thirty years. Five years ago, he suddenly started suffering from hypertensive encephalopathy. He lost not only his memory, but also his job. He became an angry and depressed man and needed constant supervision. Julia lost a friendly and helpful companion and was put in a kind of mother-caring role. For

---

*If both parties understand and accept each other's role, the GP and medical adviser could make a very good team*

---

financial reasons she continued to work and when some conflicts at work developed, she could no longer bear the heavy burden of the family and work, and became ill. I fully understood her situation and when, after a few weeks of sick-leave, the medical adviser demanded she return to work, I was very upset. In spite of all my efforts to persuade him to reconsider his decision, the patient was transferred to the unemployment insurance. For understandable reasons she was not satisfied, and left my practice. I was on bad terms with this medical adviser; in my opinion he didn't understand her psycho-social problems.

## Case 6

Richard, a 49 year old unskilled worker, has been out of work for many years. He is suffering from a heart disease, after having had diphtheria as a child. But this could not be confirmed. Actually, he is a neurotic man who is unable to cope with the strenuous rhythm of modern society. He gets allowances from the sick fund, but these are not

enough to care for his family of six. His wife works as a charwoman. It is a poor family, helped by different charity institutions.

The neurotic husband, who rather likes alcohol, cooks and cleans the house. But very often he needs the help of one or more of his children, who repeatedly stay out of school for several days. Because of the contact between the community social worker and the sick fund social nurse, the medical adviser was informed about this problematic situation. The medical adviser was concerned mostly about the future of the children, and by sending household help and asking his social nurse to take care of this family and the educational aspects, he had hoped the children would be able to make progress.

I could concentrate more actively on the somatic problems and by means of regular meetings between the social nurse, the medical adviser and myself — we made a jolly good team!

## Conclusions

The contact between the GP and medical adviser has to do mainly with the controlling and advisory functions of the latter and with everybody's understanding of his task. Some GPs are only interested in somatic aspects and hate all administrative obligations. Some medical advisers, on the other hand, are good managers but have difficulties in understanding the patient's emotional problems. A natural allergy between medical adviser and GP can harm a healthy cooperation. Even when they agree on matters of health, medicine and sick funds, there still is a tension in the medical adviser — general practitioner relationship.

The GP is flattered with the patient's request for help and, in his opinion, nobody else should interfere in this confidential relationship; he doesn't like to be controlled in this aspect. On the other hand, he needs the medical adviser, because he is more of an expert in health care regulations and can be of great help for the patient in these matters.

Many medical advisers experience the same difficulties with their role: they are willing to build up a friendly relationship with their colleagues and with their patients, but they have to be strict and defend the interests of the sick funds and the government.

The only solution is to have regular contact, where the competence and the rights of the other will be respected. The fact that in each region, as many as 5 different sick funds are active, is a problem peculiar to Belgium and sad to say, not the only one.