NATIONAL HEALTH INSURANCE

(A Collection of Articles and Congressio
Record Excerpts Describing Pending
Proposals and Major Policy Issues)

KAY CAVALIER
and
MARK NEWBERGER

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INTRODUCTION

During the latter part of the 1960's, mounting public concern with regard to the delivery and financing of health care in America led to the enactment of several far-reaching programs designed to remedy some of the "ills" afflicting the nation's health care system. Legislation was passed to establish the "Partnership for Health," Regional Medical Programs, Medicare for the aged and Medicaid for the poor and medically indigent, etc. Recently, however, increasing speculation has been raised as to whether these programs, judged by some critics to be "piecemeal" or "stop-gap" measures, can serve as an effective means to curtail rising medical costs, to promote efficiency and accessibility in health services throughout the country, and to assure to all Americans, regardless of age or income, an adequate level of health care.

Such considerations have acted as a stimulus for a renewed debate on the potential merits of a national health insurance program, a subject which first attracted national attention during the New Deal Administration of the 1930's. As early as 1935, advocates of national health insurance had attempted, unsuccessfully, to include universal compulsory health insurance as part of the Social Security program.

Since that time, legislation on behalf of national health insurance has been periodically introduced into Congress but has passed neither the House nor the Senate. During the 91st Congress, more than forty separate

bills embodying a variety of forms of Federally-financed or Federally-assisted health insurance were introduced into Congress (see appendix #I). Most of these proposals have already been reintroduced into the 92nd Congress (see appendix #II).

In response to the heightened public interest attached to the issue of national health insurance, the Congressional Research Service has selected excerpts from the Congressional Record and other sources describing briefly some of the major proposals for health insurance now being considered in Congress and elsewhere. In some cases, we have included a description of a proposal originally introduced during the 91st Congress with a footnote to indicate whether this proposal has been reintroduced into the 92nd Congress in its original or a modified form.

At the time this publication was prepared, the Administration's plan for a "National Health Insurance Partnership" had not yet been drafted into legislative form. Therefore, this report makes reference only to the general approach of the Administration plan as laid out by President Nixon in a message to Congress on February 18, 1971. A more detailed analysis of the Administration plan is anticipated for some time in the future when the actual legislation embodying the proposal is introduced.

In examining the many legislative alternatives for health insurance, the reader will note that the expression "national health insurance" has come to mean different things to different people. The proposals described in this report reflect a diversity of opinion as to the role envisioned for the Federal Government in the area of health insurance protection. Many of the bills differ markedly with regard to the voluntary or compulsory nature of the program, financing arrangements, extent of coverage, level of benefits, Federal and/or State responsibility, effect on the private insurance industry, and proposed reorganization of the health care system.

In addition to a brief description of each of the major health insurance proposals, this report contains selected journal articles and newspaper commentary on problems in the health care system in general and on the potential advantages or disadvantages of a national health insurance program. We have attempted to provide a representative sampling of opinion on all sides of the issue.

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THE "GRIFFITHS BILL," H.R. 15779*

NATIONAL HEALTH INSURANCE PROGRAM

(Mrs. GRIFFITHS asked and was given permission to address the House for 1 minute, to revise and extend her remarks, and include extraneous matter.)

Mrs. GRIFFITHS. Mr. Speaker, I am introducing today a bill which will establish a national health insurance program under the social security system, and which will give to middle Americans those health and medical benefits presently being developed for the poor and aged, and which the wealthy already have simply because they can afford to pay for them.

This bill would relieve State and local governments of health service tax burdens, currently estimated to be about $7 billion annually. In addition, since this bill would eliminate medicare and medicaid, the $10 billion supporting these programs would become available for the comprehensive national health program.

My bill would also preserve free choice of physicians; preserve traditional professional freedom of practice and methods of payment; and maintain, indeed, utilize the authority of local medical and dental associations and societies.

At the same time, my bill would make it possible for doctors and dentists to bypass time-consuming business administration and bookkeeping functions and permit them to concentrate on the practice of medicine and dentistry. It recognizes that the business of doctors is administering health and medical care. They should not have to be bookkeepers or credit collection agencies.

Mr. Speaker, most Americans who incur extended or serious illnesses and mishaps today, cannot afford to live. In fact, the cost of a major illness is such that 9 out of 10 Americans are medically indigent right now. They can not afford to pay the high costs of care without severe economic sacrifice. Health expenditures now amount to $294 for every man, woman, and child in the Nation. For some middle Americans, this means spending from 10 to 25 percent of their income on uncontrollable health and medical services. For some middle American families, of course it is even more, while for some, it is less.

At the same time, middle Americans are supporting health care for the rest of America, and the income tax system gives them little credit for doing so. Current tax deductions for medical expenses favor the rich, simply because they can afford large expenditures for health care and therefore receive large tax deductions for them. The fact is, the more they spend, the more they get back. Middle Americans, though, find that while their medical expenses consume a proportionately large share of their income, a tax deduction, while welcome, is still an unaffordable luxury.

My bill would eliminate this regressive feature in health care tax deductions and remove the burden of supporting a major share of the Nation's health costs from the backs of hard-working middle American wage and salary earners, who are paying for health care at all costs, for all people.

It is widely acknowledged that we face a crisis in health care. Symptomatic of the stress in the health delivery system is the recent outpouring of books dealing with the problem. Recently published books such as "The Doctors" by Martin Gross; "The Troubled Calling, Crisis in the Medical Establishment" by Selig Greenberg; "Medicine in Transition" by Dr. Iago Goldstein; "Ferment in Medicine" by Dr. Richard Magraw; "The Coming Revolution in Medicine" by Dr. David Rutstein; "Professional Power and American Medicine" by Alton Tayack; and "Hospital Regulation: Dilemma of Public Policy" by Anne R. Somers.

More and more articles are being published in magazines and periodicals about the crisis. On July 10, 1969, Secretary Finch and the Assistant Secretary for Health and Scientific Affairs of the Department of Health, Education, and Welfare stated:

> This Nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector.

So there is little dispute, today, as to nature of the health care crisis. The health delivery system, itself, is sick. Those who have expertise with regard to the organization and delivery of health services stress that increased medical knowledge with resulting specialization of function has not been accompanied by a growth of organization or a financing system that will permit equal opportunity of access to the system. The result has been fragmentation of services with no well-defined point of entry into the system by the consumer-patient.

Symptoms of the breakdown are many. I intend to cite only a few, the first of which emphasizes concern of Congress and the public over the runaway escalation of health care costs.

The inflationary facts of health services are astonishing. The Nation's spending for health reached $60.3 billion in fiscal 1969.

*H.R. 15779, the original "Griffiths Bill," received the public endorsement of the AFL-CIO. During hearings conducted by the Senate Labor and Public Welfare Committee in September 1970 on the subject of national health insurance, AFL-CIO President, George Meany, suggested that proponents of national health insurance, including elected officials, various labor organizations, consumer groups, etc., should work together to help formulate a program which would combine the best aspects of the many national health insurance proposals introduced up to that time, including the Griffiths bill, the Health Security Act introduced in 1970 and again in 1971 by Senator Edward Kennedy, a bill introduced by Senator Jacob Javits calling for extension of Medicare to all Americans, etc. On the opening day of the 92nd Congress, Congresswoman Griffiths introduced H.R. 22, the Health Security Act of 1971, a proposal identical to S. 3 introduced into the Senate by Senator Kennedy and discussed elsewhere in this report. Apparently, in the drafting of the Health Security Act of 1971, any differences which existed between the original Griffiths proposal and the Health Security Act of 1970 had been worked out to the satisfaction of both House and Senate sponsors of the new legislation.

Per capita health expenditures rose 11 percent in fiscal 1969, as compared to fiscal 1968. Public outlays for health rose nearly 15 percent in 1 year. Payments for hospital care increased 17 percent in 1 year and reached a total of $22.5 billion in fiscal 1969. The American Hospital Association recently testified before the House Ways and Means Committee that the average daily room rate would rise to nearly $100 a day by 1973. Daily room charges already exceed $100 a day in some of our teaching hospitals. Expenditures for physicians' services also rose 9 percent for fiscal 1969 over the prior year. The December 8, 1969, issue of "Medical Economics" predicts that gross receipts of private physicians will average "at least 10 percent higher" for calendar year 1969 as compared to 1968.

Small wonder, then, that health care has absorbed an increasing proportion of the gross national product. In 1950, health expenditures accounted for 4.6 percent of the GNP. In 1960, 5.3 percent and in 1969, 6.7 percent. In fact, if health expenditures continue to absorb an increasing proportion of the gross national product at the same rate as has occurred in recent years, by the year 2077, 108 years from now, health expenditures will consume the entire gross national product leaving nothing for food, clothing, or shelter.

What are we getting for our money? In relation to huge health expenditures, the United States is faring rather poorly in comparison with other countries in the Western World. Exorbitant costs and expenditures are begetting inadequate results and inferior services. Objective statistical measurements of infant mortality, maternal mortality, and life expectancy not only show we rank below most other Western countries, but that our relative position has been declining. In 1964, the United States ranked 16th among the countries of the world in infant mortality. However, in 1950, the United States ranked sixth and in 1960 the United States ranked 11th. Maternal mortality rates—the percentage of mothers who die in childbirth—show the United States to be 11th place. With regard to life expectancy, the United States ranks 18th for males and 11th for females.

Significantly, all of the countries that rank ahead of the United States with regard to these objective health indexes have a national health program which either provides or finances health services for the vast majority of their citizens. It is also significant that these countries are providing health services to their respective populations at a lower per capita cost than in the United States. For example, in 1965, the Social Security Administration estimated that the United Kingdom spent 4.2 percent of its gross national product on health. In that year, the corresponding U.S. expenditure was 5.9 percent of the GNP.

The questions we must ask are:

Why has American medicine failed to live up to its potential?

Why is it not the best in the world?

The crux of the problem is that we have a system of 20th century technology shackled to a 19th century organizational pattern and attitudes.

First, physicians seek to maximize their financial return to the time and effort they must expend to provide care. In short, they are human beings with the same needs and interests as other human beings. It is no reflection on their integrity nor their compassion to suggest that other things being equal, they will choose to practice in a manner which will maximize their incomes. There is a grain of truth, though, in the cry of young medical students heard recently: "Hip! Hip! Hippocrates. Up with service. Down with fees!"

Idealism, though, however necessary and commendable it is, is not enough. We need to change the incentive system in manner which will reward efficiency and penalize inefficiency and outright fee-inflationary practices.

Under the present system, the physician is financially rewarded in proportion to his patient's immediate malady. Instead, we must give the doctor a financial stake in keeping the patient in good health at the lowest possible cost. Such a system would financially penalize unnecessary hospitalization; unnecessary surgery; and unnecessary medical services. Reward would be based on efficiency and quality care.

So the bill I am introducing today is designed to accomplish far more than simply paying for health services. Our experience under the medicare and medicaid program has amply demonstrated the fallacy of having the Government underwrite the cost of health care largely determined by the providers. But we must not overlook the fact that these two programs have substantially helped some 38 million Americans. This bill would not only contain the rising costs of health care within the limits of the 6.7 percent of the gross national product we are now spending, but it also has the potential of actually reducing cost as a percentage of the GNP over the years.

How is cost control achieved? It is accomplished by having the Federal Government contract for health, hospital, and dental services with organized groups of physicians, with hospitals and with groups of dentists. Contractual relations between free parties is a cornerstone of our private enterprise business and industrial system. It is a time-tested system in the health field as well.

For over two decades, the prepaid group practices plans—which might be regarded as mini-national plans—such as the Kaiser Foundation health plan have contracted with medical groups for comprehensive health services. These contracts place the medical group under a budget. The budget is liberal. If the cost of providing services is actually less than the amount stipulated in the contract, the physicians receive a bonus at the end of the year. Thus, the more efficiently the medical group provides services, the more they make in monetary rewards.

The cost savings achieveable under the contract system are nothing short of spectacular. For example, the President's Commission on Health Manpower studied the Kaiser plan in depth. The Commission's conclusion was that the Kaiser plan provided as good or better care than was available in the general community at from 20 to 30 percent less cost.

In addition to Kaiser, all other prepaid group practice plans have demonstrated the capability of reducing hospitalization and the number of surgical procedures. A recent study of the Federal employees health benefits program showed the group practice prepayment plans had but one-half the number of nonmaternity hospital days per 1,000 subscribers, as the alternate coverage. Federal employees have a choice, from among five different types of coverages, including an indemnity plan and Blue Cross-Blue Shield. The group practice prepayment plans also had 42 percent fewer surgical procedures than Blue Cross-Blue Shield.

My bill does not abolish the fee-for-service system and I specifically allow for it, but only under conditions which would provide effective cost control. Under the bill, the Federal Government could not only contract for medical services with organized medical groups, but with local State and county medical societies as well. Where physicians in a county desired to be reimbursed on a fee-for-service basis, the medical society could contract with the Federal Government to provide services. The physician-members of the medical society would, therefore, be assuming group responsibility for providing services within the terms of the contract. However, distribution of the money among members would be determined by the group. The Federal Government would have no concern nor, in fact, would promulgate no regulations dealing with compensation of individual physicians.

My bill does, however, require that where a medical society does assume responsibility for delivering medical services, it must establish a system of peer review and administration procedures to assure beneficiaries that the care they receive is of optimal quality. The medical society would receive a 5 percent bonus payment to cover their administrative expenses for providing this service.

This reimbursement method is time tested. The San Joaquin Medical Foundation was established in 1964 and makes good use of the self-policing concept. Last year the San Joaquin Medical Foundation contracted with the State of California to provide medical services to medicaid eligibles. At the end of the year the foundation returned $200,000 to the State of California. Quite a contrast to those few who were able to twist the program into a get-rich-quick scheme.

Under my bill, the medical society or a foundation organized by the medical society would not be required to refund cost savings to the Government. If physicians curtail unnecessary hospitalization, unnecessary surgery; and use paramedical personnel more effectively, I feel they should be rewarded for their efforts. From the standpoint of Government, we should be interested in a fair contract at a fair price. If care is rendered more efficiently, then efficiency should be rewarded.

A refinement to the San Joaquin concept is the Physicians Association of Clackamas County in Oregon. Here the medical society contracted with the State of Oregon to provide not only medical services, but assumed the responsibility of paying for hospital and pharmacy services as well. This introduces a concept approaching that of comprehensive group practice plans, where the plan assumes responsibility for providing all services required by the patient.

Comprehensive payments for comprehensive services offer the greatest hope for containing medical costs, because the health plan gains financially whenever the patient's medical needs are met by a less expensive form of treatment. Only when payments cover the entire spectrum of medical needs, is the physician free to substitute less costly outpatient services for inpatient services; less costly nursing home services for hospital services; and less costly home health services for nursing home care.

My bill would, therefore, provide incentives for medical and dental groups, county medical societies, hospitals and other non-profit organizations to provide or arrange for comprehensive health services under a single contract. The incentive is a 5 percent extra allowance when any of the above organizations indicate an interest in providing comprehensive care. I would like to add, that only under a system of comprehensive payments for comprehensive services, can an organization really plan, program and budget their income and expenses and make effective use of systems analysis.

The bill I am introducing would provide financial access to comprehensive health services on an equal basis for all men, women, and children who have 1 year's residence in the United States. This would achieve a most desirable result: physicians, dentists, and hospitals would be assured of adequate remuneration whether they practice in a poverty or affluent area; in the city or in the country. For there is an urban-rural imbalance in the availability of doctor care. In the countryside, over 412,000 people in 115 counties scattered through 23 States do not have access to a physician at all. One out of 50 Americans cannot get a doctor under any circumstance.

There is also a doctor imbalance inside our large cities. New York City, for example, has an overall physician-population ratio of 278 doctors per 100,000 residents. We call it a well-doctored community. Yet, in the shadows of the city's affluence, the ratio is only 10 doctors per 100,000 residents in poor areas and ghettoes.

So the imbalance is not only between urban and rural areas—appalling as that is—but between poor and affluent areas within cities.

If this bill should become law, we would certainly witness a migration of physicians from the "overdoctored" areas to the "underdoctored" areas of the United States, since the money will be there, whether the area is rural or poor or affluent. My bill, then, would motivate doctors to serve not on the basis of a community's wealth, but on the basis of the peoples' need for health care in the area.

Most importantly, this bill would stimulate the development of improved health delivery systems so that the quality of care and the efficiency by which it is delivered would be improved. The bill is designed to resolve the principal problem we face today; namely, a sophisticated 20th century technology shackled to 19th century organizational patterns.

My bill would not only provide free choice of primary physician, but also allow beneficiaries free choice of health delivery systems—solo or group practice.

Moreover, beneficiaries would choose their personal physician when they were well and not under the stress of illness.

Physicians would be guaranteed that there would be no interference with the clinical practice of medicine. They would be free to participate or not to participate in the national health insurance program. Participation could be on either a full-time or part-time basis. In fact, physicians would have the greatest professional freedom they have ever known. Within the framework of a budget, they would be able to establish their own methods of compensation. They could, if they so choose, eliminate all paperwork in connection with claims and concentrate on that which they were so magnificently trained to do: Practice medicine. In my opinion, this bill will enlist significant support from many members of the medical profession.

Let me turn, now, to the benefits my bill will provide:

First. Coverage for every man, woman, and child who has resided in the United States for 1 year or more.

Second. Comprehensive health benefits, including hospitalization, as required and without limits; physician services, including surgery, subject to a small $2 cost sharing charge per visit after the first visit; preventive care and physical examinations, nursing home care as required and without limits, home health services subject to a $2 charge per visit and rehabilitation services.

Third. Comprehensive dental services for all children under age 16 subject to a $2 cost sharing charge per visit after the first visit. Dental examinations and prophylaxis provided at no cost to the patient.

Fourth. Eye care including an allowance for eyeglasses and frames.

Fifth. Prescription drugs.

These benefits would be financed under the social security program. Employers would pay 3 percent of payroll, employees 1 percent of payroll, and the Federal Government would match the employer contribution from general revenues. Employer taxes are higher than employee taxes to take into account that employers are now paying the entire cost of most employee health insurance benefit programs. If the employer contributions were less than 3 percent, some employers would enjoy a windfall, in the sense that their contribution would be less than their current payments into voluntary health insurance programs. The Federal contribution would not be much more than current Federal, State, and local combined expenditures for health services. Thus, the Federal Government would be relieving the tax burden of State and local government for health services.

If this bill is enacted, the United States could rank first among all nations, in providing high-quality health care at reasonable cost for all people. In my opinion, the national medical and health crisis can only be resolved through a national comprehensive health insurance program, with comprehensive financing.

The time is long overdue to make health care for all Americans in all income levels a matter of right, rather than a matter of privilege or pity.

The Senate Finance Committee has just recommended that fees be established for doctors. I reject this solution and I offer this bill as a better means of better health for every American at a lower cost; with the traditional rights of American medics guaranteed.

National health insurance is an old idea, but a "Now" solution. Its hour has arrived.

S. 3711—INTRODUCTION OF A BILL TO ESTABLISH A SYSTEM OF NATIONAL HEALTH INSURANCE*

Mr. JAVITS. Mr. President, I rise this morning to introduce the National Health Insurance and Health Improvements Act of 1970. I send to the desk the bill, together with a section-by-section analysis of the bill and a separate statement of the level of benefits which would result from its enactment.

Mr. President, in cooperation with many technical experts and distinguished people interested in the field throughout the country, I have had his measure in preparation for months. It represents the culmination of an enormous amount of effort. I introduce it as my own contribution to what I am confident will be a significant debate and, in my judgment, within a year or two, at the most, will result in the successful adoption of a national health program which will assure high quality health care to every American, whatever may be his economic need.

This is one of the really basic reforms of our time, standing on a level with social security, unemployment compensation, the tremendous Civil Rights Act of 1964, the war on poverty, the Economic Opportunity Act, and other recognitions by our country of the great social needs of our people, which have developed over the decades. This bill is my own way of meeting that need.

A number of other bills have been and will be introduced. I hope very much the administration will come forward with its program. I believe that, as we did with medicare and medicaid, where I worked so closely with the most distinguished and beloved Senator from New Mexico (Mr. ANDERSON), we may all soon see the fruition of the day when high level medical care will be truly available to every American.

Mr. President, the establishment of the system I urge, which I shall describe in the next half hour or so, would initiate the process of change in the organization and delivery of health services which is essential if the promise of adequate health care for all Americans is to become a reality.

Almost 40 years ago President Herbert Hoover equated the right to public health with public education. In his inaugural address he said:

> Public health service should be as fully organized and as universally incorporated into our governmental system as is public education. The returns are a thousand-fold in economic benefits, and infinitely more in reduction of suffering and promotion of human happiness.

I quote President Herbert Hoover, Mr. President, because he was no wild-eyed radical. It is a conservative point of view, which he always espoused and of which he was very proud; and this is a conservative bill.

It is self-financed in the main, and insofar as it is not self-financed, but requires a resort to the general revenues, it involves an enormous contribution to the health of the country, and therefore to an increase in its resources, as well as its tax take, because of the millions of people whom it will enable to do more and better work.

In addition, my bill draws very heavily on the private enterprise system. This has always characterized the health measures that I have worked on. The major one, notably, with the Senator from New Mexico (Mr. ANDERSON), was essentially premised on the utilization of the private enterprise system of the United States, as is my present bill.

Today, Mr. President, despite the enormous growth of governmental programs and private health insurance plans; despite the $38 billion in private expenditures by Americans for health care; despite the $60 billion health industry—the fastest growing unsuccessful big business in America—that goal remains illusory.

My relationship to this problem goes back a very long time. Twenty-one years ago, in 1949, I introduced H.R. 4919 in the 81st Congress, a bill for a system of national health insurance. One of its cosponsors, was then Congressman, now President, Richard M. Nixon, and others included the late very distinguished Secretary of State, Christian Hereter, and former National Republican Chairman, Thruston Morton, who served with such distinction in this body.

Since then, along with many Members of the Senate, I have been actively engaged in the long struggle to provide health insurance to the aged. The landmark medicare legislation, finally enacted in 1965, was the culmination of an effort in which I had been engaged from the time I entered Congress. However, neither title XVIII—medicare program—nor the then little-noticed title XIX enacted at the same time—medicaid—has proven adequate to meet an exploding demand for quality health care or—and this is critically important—to control a rapid and inflationary escalation of health care costs.

The situation is much the same for private health insurance. Although about 85 percent of the American people have some form of private health insurance, such insurance covers only a third of their health-care expenditures. In contrast, the bill I introduce today, when fully effective—and it will take a period of years to make it fully effective—will cover approximately 80 pecent of the cost of personal health services.

Perhaps most serious of all, there is no Federal program and almost no system of private prepaid care to change the dangerously haphazard organization of health care in America. Thus, even as additional Americans have obtained the financial ability to "purchase" health care, there has been insufficient expansion of, or new allocation of, medical resources.

In mid-1969, President Nixon, Secretary Finch, and the Assistant Secretary for Health and Scientific Affairs, Dr. Roger Egeberg, met at the White House to tell the Nation that it "faces a breakdown in the delivery of health care. Expansion of private and public financing for health services has created a demand for services far in excess of the capacity of our health system to respond." They continued:

> Our overtaxed health resources are being wastefully utilized, and we are not adding to them fast enough to keep pace with rising demand. Our health priorities are critically out of balance.

I call the health industry in the United States today a "cottage industry," because it is so incredibly wasteful in terms of economics and productivity. We are dealing with the lives and welfare of all Americans, and the issue of adequate and accessible health care, therefore, has become an imperative of social justice.

Almost 1 year ago I pledged myself to the introduction of a national health insurance bill. Since then, public awareness of and support for this concept have grown dramatically. It is now clear that some form of mandatory prepaid health care for all Americans is an idea whose time has arrived. The bill which I introduce today is intended as a contribution to what will, I believe, be an extensive examination of this subject. I have no doubt that in the next few years such a program will be enacted.

Like the oft-embattled hospital—the public symbol of modern medicine—national health insurance legislation will soon find itself the subject of much controversy and debate. However, I am confident that this national health insurance bill will come to be a part of our Nation's new commitment to solve the great and complex problems of providing health care rationally and effectively for all.

OUTLINE OF BILL

My bill includes the following provisions:

First. Eligibility for basic benefits under title XVIII of the Social Security Act would be available without limitation to all resident citizens of the United States, without regard to age.

In recognition of the fact that such a massive expansion of health insurance coverage cannot be imposed immediately upon our present health-care system, these benefits would not be extended to all Americans until July 1, 1973. It may be necessary to defer even that for a year or perhaps two. This would give the care system time to "gear-up" for the greatly increased demand and to allow the vast reorganization which other parts of this bill would stimulate. I am hopeful that in

*Senator Javits has reintroduced this proposal into the 92nd Congress as S.836.

the interim—that is, beginning now and in the course of the next 2 to 4 years—the disabled, the unemployed, and the poor may be phased into the system sooner, if the system cannot be extended to all Americans by the date specified—to wit, July 1, 1973.

Second. Before health insurance is extended to all, the following improvements would be made in the present medicare system: Merger of parts A and B of that system; a single tax would provide for both hospital and physicians' benefits for the elderly; and extension of these benefits to the disabled under age 65. These changes would become effective July 1, 1971.

Third. At the same time health insurance is extended to all Americans, a new benefit would be added to the package: the financing of a limited prescription drug benefit. This would be available, with a $1 copayment per prescription, for long-term maintenance drugs. The Secretary also would be authorized to conduct studies relating to maintenance drug utilization, efficacy and cost, and to establish a committee to assist with the drug program.

This is an enormous problem, and it involves the whole question of the cost of generic and trademark drugs, and it should be part of the package of health insurance which we propose to the American people.

Fourth. One year after the effective date of extending medicare benefits to the disabled under 65, two new benefits would be added—and it may very well be that we could not add these benefits until we have actually expanded the system by 1975 or 1976 to include all Americans: dental care for children under 8 years of age restricted to examination and diagnosis, oral prophylaxis and the filling and removal of teeth; and a diagnostic benefit, providing for annual physical checkups, and eye and ear examinations. There is, of course, the risk of abuse of this benefit, but so crucial is its role in preventing more serious and costly illnesses and hospitalization, that it should be included in the benefit package. A recent national conference on multiphasic screening noted that technology has not caught up with our need to identify the most serious symptoms of illness. Thus, there is a problem of unnecessary tests and skyrocketing costs. However, I believe that the incentives in this bill which seek to move the system to greater comprehensiveness and coordination in care, as well as new powers it would afford the Secretary of Health, Education, and Welfare in cost and utilization review and reimbursement modes, would counteract the possibility of abuse in extending the physical checkup benefits to all.

Fifth. Continuation of a separate trust fund for the elderly and a new trust fund for those under 65. Thus, the soundness of the medicare trust fund would be protected. To simplify administration, however, both trust funds would be financed from a basic payroll tax split between the employer and the employee. The Secretary of Health, Education, and Welfare would be authorized to apportion revenues between the two trust funds.

Sixth. Health insurance would be financed by a tax on employers, employees, and the self-employed. The earnings base would be increased to $15,000 for all employees and self-employed. Public assistance recipients and the unemployed would receive full health benefits, the cost of which would be underwritten by Government subsidy. The contribution rates from all—as set forth in the actuarial cost estimates developed by the Social Security Administration for my bill—would be, with respect to wages paid during the calendar year 1971, 0.7 percent; 1972, 0.9 percent; 1973, 2 percent; 1974, 3.1 percent; and 1975 and thereafter, 3.3 percent. I believe a contributory health insurance system is far preferable to the financing of all health services out of general public revenues. Beneficiaries make a direct financial contribution to the system and, consequently, have a personal stake in its fiscal health. Extremely important in the scheme of my bill is the exclusion from the imposition of the tax of groups which have contracted with the Secretary of Health, Education, and Welfare to provide health services equivalent to the benefits provided under the bill and to encourage rational organization of health care services. That is a very important point and ties in the bill directly to the working private enterprise system.

Seventh. Significant changes would be established in the administration of health insurance financing. These changes would seek, at the same time, to preserve the pluralistic strength of the present health care system and to provide significant incentives and leverage to move that system to greater cohesiveness and coordination.

Eighth. The rational organization of health care would be encouraged by the Secretary of Health, Education, and Welfare by entering into a variety of administrative arrangements with comprehensive health service systems—that is, prepaid group practice, one or more providers of health services, health insurance carriers, or a combination thereof—private, profit or nonprofit—for comprehensive health insurance benefits. Such organization would receive reimbursement for costs and incentive payment to bring about a reduction of costs without impairment of services. This incentive payment would depend on the suppliers achieving an average cost for services which is less than the average cost for services for which payment is made, to comparable population groups under comparable circumstances in the local regional area. So that the incentives would represent the actual saving which lower costs produce.

Ninth. The Secretary would be mandated to undertake a comprehensive study of compensation methodologies for providers of services, soliciting the widest possible expression of views from interested persons and organizations, including health insurance carriers. He then would present a proposed regulation, no later than December 1, 1972, regarding modification of methods of compensation.

Let me add that a late addition to the bill is an interesting one, especially, I believe, to those who have been students in this field. I propose to require the Secretary to study methods of compensation designed to encourage responsibility by the medical associations, which are largely regional in character, in regard to this question of methodology, compensation, and the rationalization with which services should be provide to improve—through peer review and otherwise—the quality of health care. I believe that this is an entirely legitimate responsibility which the Government has a right to impose upon State and local medical societies, which are legally recognized professional organizations, and which exercise very great leadership and authority. This is a public responsibility which they should share. I consider this to be a very important point.

Tenth. "Reasonable" charges as presently called for by title XVIII would be modified to provide that wherever that phrase appears, it would be subject to the modification of "appropriate." The reason for that modification is that the charges should be what the service is really worth when efficiently delivered, in view of the fact that the bill carries so many incentives, including a broad division of the actuarial risks, to rationalize and improve materially the health service which is rendered.

Eleventh. The Secretary of Health, Education, and Welfare would be authorized in his discretion to require physicians providing services under this bill to meet standards of continuing professional education; national minimum standards of licensure, if licensed after standards promulgated, and certain professional specialty board standards of qualification for the performance of major surgery or certain other specialty services.

Twelfth. To the extent practicable and consistent with good medical practice, the Secretary of HEW would encourage the training and employment of allied health personnel and other subprofessionals in the rendering of comprehensive health services. I would explain that I have waged almost a single-handed campaign to bring medical corpsmen, 30,000, as released from the Armed Forces every year, in an important way into the provisions of health services. This is a critically important question, as we are dreadfully short in health manpower, and medical corpsmen, given proper and added training, and the inducement of good compensation, represent an enormously effective pool of already almost fully trained men for this particular purpose.

Thirteenth. The Secretary of Health, Education, and Welfare would be authorized to make loans and grants and to provide technical assistance to contracting comprehensive health service systems to help them develop the capability to administer the program. These systems would include such comprehensive health services as can be established in given communities with Federal aid which do not have them now. Enrollment would be open to all residents of a "primary" service area, so that the members, for a fixed annual capitation fee, are assured continuity of care and provided comprehensive health service.

This is especially applicable to group

practice units, established by a medical school, a hospital medical staff, or a medical center, or similar arrangement among providers of services, which are uniquely adaptable to this kind of comprehensive health care.

Fourteenth. The Secretary of Health, Education, and Welfare is authorized to establish a National Health Insurance Corporation, either a corporation or corporations. This is a very, very important point to me because there must be a recognition of something that took place in respect to medicare which I deplore very greatly.

When the Senator from New Mexico (Mr. ANDERSON) and I first joined in the development of the legislation which led to medicare, Mr. President, we relied very heavily upon the fact that the insurance carriers of the country, recognizing the great public interest involved, would support the administration of services and need not establish a Government bureaucracy. We thought that they had the machinery and the expertise and could do it most efficiently and economically.

To our dismay, the testimony before the House Ways and Means Committee revealed that the insurance companies would not perform. It was a very black day, indeed, for them and for the country.

Much as I regret it, we may face the same situation in national health insurance, which is coming as sure as day follows night. To provide against that contingency, either nationally or regionally, my bill provides for an autonomous Government corporation which can in a given area—I hope it will not be necessary nationally—function if the insurance carriers will not do so.

Mr. President, I wish to point out that when it came to the matter of health insurance for Government employees, we had a different situation. To the great credit of the insurance companies, they accepted it and, by the way, did very well with it. It may be an inspiration to other companies. We did find private enterprise willing to pitch in in that instance.

I hope very much that wiser counsel and judgment will prevail and that the insurance companies will, as they should, undertake this great public responsibility and great public opportunity which will be opened by the national health insurance bill—whether it is my bill, someone else's bill, or, as perhaps will be the case, some amalgam of many different ideas, some of which are contained in my bill.

Mr. President, I emphasize that because all plans must be carefully examined. We think it is a great hardship for the Government to meet and I think it is critically important that private enterprise assume this additional responsibility. They have a great responsibility to our Nation which they should perform. This would give them an ideal framework within which to perform it.

Mr. President, I introduce this bill to help arouse the conscience of the Nation to the urgent need for the development of a better system of health care—more readily accessible, more economical and more equitably distributed—and to stir the Congress to action in the enactment of legislation that takes a comprehensive and rational approach to the problems of health care. It not only must increase purchasing power and thereby equalize access, but it must also bring about significant change in the health care system.

It must be emphasized that no system of universal health insurance which does not take into consideration the inadequacies of the present "nonsystem" of health care and which does not seek to bring some order into it can truly increase the availability of quality health care.

A new system of national health insurance should not serve merely as a conduit for funds which reinforces existing inadequacies. That is one of the big things that I am pointing out about to many plans. All they are doing is making the supply shorter and complicating the already inefficient system. We cannot simply pay doctor bills and reimburse hospital costs. Quite the contrary, those funds and the power of reimbursement should be used to improve the delivery and availability of health care.

The health-insurance industry should undertake to foster better organization of health care and to reshape financing mechanisms to facilitate progressive change. It cannot stand aside and reap profits as conduits. The Nation needs their management talents, expertise and experience to make a national health insurance system work.

Mr. President, I wish to emphasize that I am all for profit based on service and efficiency. I think that the companies, if they get into this plan, will find that many of us feel that way. There is no doctrinaire effort not to understand that an efficiently functioning business deserves to make a profit, because if it is a profit enterprise, profit is equally important to have the ability to supply additional resources for the plowback which profits produce.

Furthermore, I feel Congress, in legislating such a program, should not be in the business of putting an established industry out of business. But this is what would happen if we bypassed the insurance carriers in establishing a national health insurance system. I hope very much they will not allow it to happen, but will do their part in the effort and do the job that I am confident they are capable of doing.

Let me emphasize at the same time that from a practical standpoint I believe a national health insurance program is far more likely to emerge from Congress if we utilize the existing health insurance industry. However, should hearings on national health insurance legislation indicate that the health insurance industry is not prepared to cooperate, then I will consider bypassing the carriers with the alternative of the establishment of an autonomous Federal corporation or corporations to administer the program, as authorized by title 5 of my bill.

This bill is designed to establish a system of national health insurance offering every American the means to purchase adequate health care and providing the best way to guarantee the accessibility of that care to him. Funds going into the health care system from the Government and from private third-party payers—properly directed—can be a force of change. That is the very essence of my bill.

We must seek to stem the inflationary cost spiral which most Americans view as the heart of the health crisis and which is a big factor in overall price inflation. There has been a fantastic increase in the cost of health services. While the general cost of living index rose 70 percent between 1946 and 1967, medical care costs increased almost twice as much—123 percent. The average cost of a day in a hospital in New York State, for example, went up from $10.72 in 1950 to $21 in 1960 to $58 in 1967. In 1968, 1 day of care in a hospital increased more than 12 percent over the 1967 figure. The average cost nationally now stands, according to the American Hospital Association, at $65.27 to treat a patient in a community hospital. In many hospitals in New York City the daily charge is now well in excess of $100 a day, with one hospital which is State approved for medicare reimbursement in excess of $150 a day. Costs of hospital care are still rising at 13 percent per year—more than twice the rate of other parts of the BLS cost of living price index.

Although we spend more money than any other in the world on health care, the quality of care remains uneven—and for many—particularly the poor—it is abysmally low, if not nonexistent.

The United States leads the world in many branches of medical science. Yet a national disparity in health services between rich and poor is mirrored by New York City figures. In 1964, Bedford-Stuyvesant contained 9 percent of Brooklyn's population but produced 24 percent of its tuberculosis deaths and 22 percent of its infant deaths. However, only four new physicians located in that area between 1960 and 1966. In 1964, a New York City child from a family earning less than $4,000 a year was half as likely to have had a polio immunization as a child from a family earning over $6,000. A former New York City health commissioner has rated poverty as the third leading cause of deaths in that city.

The health profession personnel and facilities are not presently adequate to meet the demand which would be established if these benefits were immediately made available to all Americans. Accordingly, my bill proposes that the level of benefits previously discussed, be phased-in to the system, with a priority to the aged, the disabled, the unemployed and the poor. In the interim, we should allocate sufficient resources—provided for by my bill and through other Federal legislation—to seek to remedy the deficiencies in health personnel and facilities. I do not believe we in the Congress should make a promise which cannot be fulfilled. We must allocate sufficient resources to establish a Federal commitment to assist in the development of the newest and safest in quality health care, treatment, personnel and facilities.

In the event we determine it is not possible for our health industry, either because of a shortage of manpower or

facilities, to deliver the total health benefit package, I believe we should consider authorizing the Secretary of HEW to curtail the package of health services.

If there are children who die whose lives can be saved; if there are adults who are handicapped when medicine has the capacity to heal; if the life expectancy of a nonwhite American is 7 years less than his white counterpart; if infant mortality rates are twice as great for nonwhites as for whites; if nonwhite maternal mortality is four times as great as the rate for whites—then it is clear that we are in a health care crisis. It is a crisis that merits our making a start at the establishment of an organized, coordinated and total health care system—a system which emphasizes delivery and accessibility to every American in need.

I believe that there is a growing willingness within the medical profession, particularly among medical students and young doctors, to establish and participate in such a system. Increasingly, leading medical schools have begun to emphasize community health and the delivery of health services, and several of them have initiated demonstration programs of prepaid comprehensive health care. And there seems to be a renewed interest among both private and public leaders in making this commitment to health care. There have been an increasing number of hearings in both Houses of the Congress on this subject and favorable statements from political leaders, businessmen, insurance companies and labor leaders.

We have talked about these issues for decades. We have made great progress, but that progress has been largely in the quality of available health care. This exceedingly high quality is a great tribute to the medical profession and to the hospitals and medical schools of this country. However, the sad fact remains that to many, many Americans, quality health care—indeed almost any health care—is still unavailable.

The eminent British statesman, Benjamin Disraeli, said:

> The health of the people is really the foundation upon which all their happiness, and all their powers as the state, depend.

If we are to begin to build upon a strong foundation—and I am convinced our country is by no means through; there is initiative, vitality, conviction, faith, tremendous energy, and capability in the American society—I am convinced that this is the year we must begin to move to enact national health insurance legislation as the means of improving and preserving quality health care and organizing a health care system which will benefit all Americans.

Mr. President, I wish to make a few additional observations. I would like to read to the Senate a telegram I have received from Gov. Nelson Rockefeller of my State, who has been one of the leading apostles of the "universal" health plan—that is his word for it—in this country. The telegram reads:

TEXT OF TELEGRAM SENT BY GOV. NELSON A. ROCKEFELLER TO SENATOR JACOB K. JAVITS

> We have shared a concern that the right to basic health care services become a reality for all Americans. This requires that we eliminate economic barriers which prevent an individual or family from receiving basic health services. At the same time, it requires encouragement of innovation to improve the delivery of these services. It is also important that the strengths and achievements of the private insurance industry be utilized.
>
> I am very pleased that you are introducing legislation to achieve these desirable objectives. I wish to congratulate you for your leadership in introducing the National Health Insurance Act of 1970 which would extend expanded Medicare benefits to virtually the entire population and would allow the utilization of the valuable skills of the private insurance industry.
>
> I have long advocated that the Federal government establish a university health insurance program which would put the financing of health care on a sound contributory fiscal basis. Such a program would then enable Medicaid to become a second line of defense against catastrophic illness costs not otherwise covered.
>
> Your bill also provides for developing improvements in the manner of providing comprehensive health services by encouraging preventative, diagnostic, ambulatory and rehabilitative services. In addition, it would stimulate group practice and other more efficient systems among physicians, hospitals and other providers.
>
> We can both be heartened that the national dialogue on universal health insurance is now earnestly under way and I congratulate you for introducing pioneering health insurance legislation.
>
> With warm regards,
>
> Sincerely,
>
> GOV. NELSON A. ROCKEFELLER.

Mr. President, I also ask unanimous consent to have printed in the RECORD a telegram from former Secretary of Health, Education, and Welfare, the Honorable Wilbur J. Cohen, with whom I have worked closely in this field. The telegram comments upon the contribution which this bill would make.

There being no objection, the telegram was ordered to be printed in the RECORD, as follows:

TEXT OF TELEGRAM SENT BY HONORABLE WILBUR J. COHEN TO SENATOR JACOB K. JAVITS

> Congratulations on introduction of your National Health Insurance bill. The bill is an important contribution to Congressional and public consideration. Your bill will do much to advance the dialogue of this important public policy issue. I hope it will be possible to have early and full hearings on the bill with a view to finding ways and means to bring insurance coverage to all persons in the United States with assurance of high quality medical care and access to services. Your leadership in this matter is appreciated.
>
> WILBUR J. COHEN.

Mr. JAVITS. Mr. President, I deeply appreciate the very generous assistance and advice of Governor Rockefeller and his staff, which were given most freely to me, as well as the assistance received from the Honorable Wilbur J. Cohen, who is such an eminent authority in this field, and his associates who helped us with this bill. Neither Governor Rockefeller nor Mr. Cohen are parties to the bill, but they have been of enormous assistance and I am grateful.

Finally, I have received some cost estimates respecting the bill I have introduced, because I think the Senate should have an idea of the cost involved. I wish to point out that the cost estimates do not take into account savings in medicare and medicaid which would result from national health insurance. I extrapolate and estimate these savings at something in the area of $4 billion to $4½ billion minimum when the program is in full operation, which very materially reduces the cost. The Social Security Administration cost estimates accept present cost, without reference to the diminutions which will occur from the tremendous increase in the number of people participating because we will have universal coverage.

Second, and very importantly, it fails to take into account the factor of the economy which will arise from the rational organization and delivery of health care, which will be provided by this bill.

Nonetheless, I wish the Senate to have these estimates and I submit them for the RECORD.

[In billions]

1971	$3.5
1972	5.2
1973	10.2
1974	19.2
1975	22.7

Mr. JAVITS. Mr. President, I ask unanimous consent that a section-by-section analysis prepared by the Legislative Reference Service of the Library of Congress, a description of the level of benefits of the act which I have introduced, and the text of the bill itself may all be made a part of my remarks.

The ACTING PRESIDENT pro tempore (Mr. ALLEN). The bill will be received and appropriately referred; and, without objection, the bill, section-by-section analysis, and level of benefits will be printed in the RECORD.

The bill (S. 3711) to provide a national health insurance program by extending the benefits, enlarging the coverage, expanding the role of private carriers, and otherwise improving the health insurance program established by title XVIII of the Social Security Act, and by establishing a new title XX to such act to provide comparable health insurance benefits to individuals not covered therefor under the program established by such title XVIII, by providing Federal assistance to develop local comprehensive health service systems, and authorizing the establishment of federally chartered national health insurance corporations, introduced by Mr. JAVITS, was received, read twice by its title, referred to the Committee on Finance, and ordered to be printed in the RECORD, as follows:

S. 3711

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act, with the following table of contents, may be cited as the "National Health Insurance and Health Services Improvement Act of 1970".

S. 3—INTRODUCTION OF A BILL TO CREATE A NATIONAL SYSTEM OF HEALTH SECURITY

Mr. KENNEDY. Mr. President, on behalf of Senator COOPER, Senator SAXBE, and myself, together with Senators BAYH, CASE, CRANSTON, GRAVEL, HARRIS, HART, HUGHES, HUMPHREY, INOUYE, MAGNUSON, MCGOVERN, METCALF, MONDALE, MOSS, MUSKIE, PASTORE, PELL, RANDOLPH, STEVENSON, and TUNNEY, I introduce for appropriate reference S. 3, The Health Security Act of 1971.

The bill is a legislative proposal to establish a Health Security program for all Americans. Through the mechanism of comprehensive national health insurance, it will bring health security to our people and end our current health crisis by improving each of the three basic aspects of our health care system—the organization, delivery, and financing of personal health services. We commend this legislation to our colleagues in the Senate for their favorable consideration and early action.

I believe that in America today, health care is a right for all, not just a privilege for the few. The basic goal of the Health Security program is to make that right a continuing reality, not just the empty promise it is today. Just as the Social Security program of the decade of the 1930's brought hope and new faith to a nation mired in the social crisis of the great depression, so I believe the Health Security program in the decade of the 1970's can guarantee high quality health care to our people and lead us out of the current crisis of confidence in our health system.

We know from recent experience that changes in the organization and delivery of health care in the United States will come only by an excruciating national effort. Throughout our society today, there is perhaps no institution more resistant to change than the organized medical profession. Indeed, because the crisis is so serious in the organization and delivery of health care, there are many who argue that we must make improvements in the organization and delivery system first, before we can safely embark on changing the financing system through national health insurance.

I believe the opposite is true. We must use the financing mechanism to create strong new incentives for the reorganization and delivery of health care. Thomas Paine declared at the founding of our American Republic, echoing the words of the ancient Greeks, "Give us a lever and we shall move the world." I say, give us the lever of national health insurance, and together we shall move the medical world and achieve the reforms that are so desperately needed.

The fact that the time has come for national health insurance makes it all the more urgent to pour new resources into remaking our present system. The existing organization and delivery of health care are so obviously inadequate to meet our current health crisis that only the catalyst of national health insurance will be able to produce the sort of basic changes that are needed if we are to escape the twin evils of a national health disaster or the total federalization of health care in the 1970's.

The use of the phrase "national health disaster" is not too strong. That the danger is great and imminent is a point on which both President Nixon and I agree. In July of 1969, President Nixon told a news conference that the Nation faced a massive crisis in health care, and that unless action was taken both administratively and legislatively to meet the crisis within the next 2 or 3 years, we would have a breakdown of our medical care system.

Our view of the problem is the same, but—on the basis of the information available about the administration's health program—we differ profoundly on the solution to be proposed. The central issue is how we can begin to move the health care system from where we are today to where we want to be tomorrow and in the years ahead. Neither the health security program nor the administration's program seeks revolutionary change in health care. The change that comes must be evolutionary change, but it must also be change that is capable of reaching the goals we share.

In essence, our difference is over the question whether the existing health care system needs a major overhaul or simply a minor tuneup. The question is whether a coordinated and comprehensive new approach is needed, or simply the sort of patchwork approach we have been using for too long. To be sure, we do need health insurance for the poor, catastrophic illness insurance for middle America, more assistance for medical schools, a moonshot against cancer and a manhattan project against sickle-cell anemia, incentives for health maintenance, and all the other items likely to be unveiled in the administration's arsenal. But we cannot afford to take these steps alone. Such divided and categorical approaches have been tried under Government or private sponsorship in the past, and they have met with uniform frustration and defeat.

We propose that the Nation cannot afford to repeat the mistakes of the past. We must begin now to develop a more coherent health care system which provides for the efficient use of existing health services and resources, which encourages better services and resources for the future, and which offers a comprehensive, balanced and proportioned approach to the health care system as a whole. This is the goal of the health security program.

The experience of medicare and medicaid has demonstrated that money alone and health insurance alone are no longer adequate to deal with the health needs of the Nation. So long as the resources are insufficient and the organizational arrangements are inadequate, money alone will only make the problem worse. National health insurance is necessary, but it must now and for the years ahead be part of a broader program of health security.

To those who say that the health security program will not work unless we first have an enormous increase in health manpower, health facilities and our ability to deliver health care, I reply that until we begin moving toward such a health security program, neither Congress nor the medical profession will ever take the basic steps that are essential to improve the system. Without something like the health security program to galvanize us into action, I fear that we will simply continue to patch the present system beyond any reasonable hope of survival.

If we are to reach our goal of bringing adequate health care to all our citizens, we must have full and generous cooperation between Congress, the administration, and all the health professions. I believe that we shall have this cooperation. We know the dedication of the health professions, the heroic efforts of hospitals and other institutions, the conscientious efforts of Federal, State, and local government agencies and their health personnel. We know their strong desire to end the limitations under which they struggle today to meet the growing national need for better health care. We share a common goal, and I am confident that we shall prevail.

It is highly appropriate that we in the Senate launch this new debate over health care on this, our first day of legislative business in the 92d Congress. At last, the debate over health care has shifted from the halls of the universities to the hearing rooms of Congress. The anguished pleas of millions of our people are being heard.

In the weeks and months to come, a great national debate will take place. As the new chairman of the Senate Health Subcommittee, I intend to take this issue to the people in all parts of the country, and to make every effort to insure that the promise of good health care becomes a reality for every citizen.

Although the debate will be nationwide, the primary focus will be on Congress and the response we make to the challenge that so clearly exists. More and more, in recent years, Congress has shown itself capable of meeting great challenges with great responses, and I am confident that the 92d Congress will do no less. Indeed, there could be no finer tribute to the 92d Congress than to be recorded as the Congress that at last ended the crisis of health care in America and brought health security to all our people.

THE CURRENT CRISIS

If one thing is clear in the United States of 1971, it is that health care is the fastest-growing failing business in the Nation—$70 billion industry that fails to meet the urgent needs of our people. Today, more than ever before, we are spending more on health care and enjoying it less.

In spite our vaunted research and technology, unequalled by any other nation in the history of the world, America is an also-ran in the delivery of health care to our people.

Almost every family knows the cruel

burden of worry, frustration, and disappointment that mark our search for better health care. The average American lives in dread of illness and disability. He lives with the uncertainty of not knowing whether to seek medical care, or when to seek it, or where to find it, or how to pay for it.

For millions of our citizens, health care of any sort is simply not available at any price. For millions more, the quality of care available is so poor that it may be fairly said that the citizen will be worse off because of his contact with the system.

There is not a person in the Nation who has not felt the heavy burden of the soaring cost of medical care. There is not a family in the Nation that does not live in fear of sickness and ill health, and the very real prospect of financial ruin and worse because of accident or serious illness.

Our current health crisis cuts across all political, social, economic and geographic lines. It affects rich and poor, black and white, old and young, urban and rural alike. Of all the pressing domestic problems we face, none is more pervasive or more difficult to resolve than the deterioration of our once proud system of health care. Never have so many different elements in our population been so united in their demand for action.

COMPARISONS WITH OTHER NATIONS

We know very well the dismal health record of the United States compared to the other major industrial nations of the world. Our rates of sickness and mortality lag far behind the potential of modern health care in America, or the reality of such care in many foreign nations. Year after year, the statistics tell us how little progress we have been making in health care in recent decades compared to other nations. Our record is getting no better. Unless we stop the slide, the crisis will get worse, and the result will be disaster.

The comparisons are shocking:

In infant mortality, among the major industrial nations of the world, the United States today trails behind 12 other countries, including all the Scandinavian nations, most of the British Commonwealth, Japan, and East Germany. Half of these nations were behind us in the early 1950's.

We trail six other nations in the percentage of mothers who die in childbirth. In the early 1950's, we had the lowest rate of any industrial nation.

Tragically, the infant mortality rate for nonwhites in the United States is nearly twice the rate for whites. And nearly five times as many nonwhite mothers die in childbirth as whites—shameful evidence of the ineffective prenatal and postnatal care our minority groups receive.

The story told by other health indicators is equally dismal. The United States trails 17 other nations in life expectancy for males, 10 other nations in life expectancy for females, and 15 other nations in the death rate for middle-aged males.

THE ROLE OF PRIVATE HEALTH INSURANCE

The comparison with other nations, reveals one other very important point. The United States today is the only major industrial Nation in the world without a system of national health insurance or a national health service. Instead, we have placed our prime reliance on private enterprise and private health insurance to meet the need.

I believe that the private health insurance industry has failed us. It fails to control costs. It fails to control quality. It provides partial benefits, not comprehensive benefits; acute care, not preventive care. It ignores the poor and the medically indigent.

Despite the fact that private health insurance is a giant $12 billion industry, despite more than three decades of enormous growth, despite massive sales of health insurance by thousands of private companies competing with each other for the health dollar of millions of citizens, health insurance benefits today pay only one-third of the total cost of private health care, leaving two-thirds to be paid out of pocket by the patient at the time of illness or as a debt thereafter, at the very time when he can least afford them.

Nearly all private health insurance is partial and limited. For most citizens, their health insurance coverage is more loophole than protection. In 1968, of the 180 million Americans under 65:

Twenty percent, or 36 million, had no hospital insurance;

Twenty-two percent, or 39 million, had no surgical insurance;

Thirty-four percent, or 61 million, had no in-patient medical insurance;

Fifty percent, or 89 million, had no out-patient X-ray and laboratory insurance;

Fifty-seven percent, or 102 million, had no insurance for doctors' office visits or home visits;

Sixty-one percent, or 108 million, had no insurance for prescription drugs;

Ninety-seven percent, or 173 million, had no dental insurance.

As a result, it is fair to say that private health insurance today is a major part of our current crisis in health care. Nearly all private health insurance is partial and limited. It pays only about one-third of the total cost of personal health services in the Nation. Commercial carriers syphon off the young and healthy, leaving the old and ill to Blue Cross, vulnerable to escalating rates they cannot possibly afford.

Too often, private carriers pay only the cost of hospital care. They force doctors and patients alike to resort to wasteful and inefficient use of hospital facilities, thereby giving further impetus to the already soaring cost of hospital care and unnecessary strains on health manpower.

Valuable hospital beds are used for routine tests and examinations which, under any rational health care system, would be conducted on an out-patient basis.

Unnecessary hospitalization and unnecessarily extended hospital care are encouraged for patients for whom any rational system would provide treatment in other, less elaborate facilities.

Unnecessary surgery is encouraged. We know that far more surgery takes place in the United States than in other nations with far better health records. We know that under the Federal Employees Health Benefits program, more than twice as much surgery takes place on Federal employees enrolled in the indemnity reimbursement plan as on those enrolled in prepaid group practice plans in the Federal program. The figures are especially striking for female surgery and for surgical procedures like appendectomy and tonsillectomy.

This, then, is where we stand today. Private health insurance has done no more than this to provide health security for American families.

THE SOURCE OF OUR HEALTH CRISIS

Our system of health care is in crisis today largely because our knowledge of health care has evolved at a much greater rate than our ability to deliver health care. We are the richest Nation in the world in Nobel Prizes for medicine, yet we are among the poorest nations of the world in our ability to translate the triumphs of medical research into the reality of better health care. Our success in the laboratory is hollow indeed, in light of the cruel truth that good health care is simply not available to millions of our people.

In large part, our health care system has been buried under our magnificent advances of medical research. We have allowed ourselves to become so preoccupied with developing techniques to treat disease that we have ignored the delivery of health care. To be sure, the delivery system has evolved, but it has evolved more by neglect than design, to the point where it can no longer be called a system in a meaningful sense. We have severe shortages of family doctors and dentists, and a surfeit of surgeons. Rural practitioners retire, and hundreds of counties and thousands of small communities in America find themselves without access to a physician. Patients everywhere face a bewildering array of health personnel who know more and more about one disease or organ, but less and less about the whole patient.

It is important to understand how our present health crisis came about. About the turn of the present century, medical care in the United States began to take firm root in the emerging modern science. Soon after 1910, medical education itself became a university undertaking with a solid foundation in science.

The explosion of scientific knowledge made vast new resources available to medicine. The science and art of medical care developed at an unprecedented rate. As a result, specialization in medicine became necessary, and a number of specialties began to develop in medical schools and in the practice of medicine. The family physician began to disappear, replaced by an increasing variety of specialists, according to ages of life, categories of disease, organs of the body, and medical techniques.

Medical care became increasingly fractionated. No adequate resources were developed to take the place of the disappearing family physician, to provide

primary medical care, or to coordinate services of the emerging specialties. The quality and effectiveness of medical care became increasingly uneven.

The specialization of physicians was accompanied by an increasing variety and number of allied practitioners. And, inevitably, along with the increasing complexity in the function of physicians, a similar complexity developed in the services provided by hospitals—the essential workshops of most of the new specialists.

As a consequence of these developments, the cost of medical care began to rise, progressively pricing more and more medical care beyond the reach of more and more people.

At the same time, the system of medical practice in the Nation—which had developed over the centuries when medical care was simple and uncomplicated—became increasingly rigid and unchanging, and began to impede the availability of medical care for more and more people. It began to interfere with the development of the personnel, facilities, and organizations needed to make medical care actually available to the people.

In turn, the stagnation of the health care system had two further unfortunate developments—an increasing unavailability of medical care despite increasing public expectation and demand for better medical care; and steeply increasing costs. The system resisted the development of needed resources for the delivery of medical care, and it resisted organizational improvements to moderate the steep rise in costs.

These developments and progressions were not peculiar to the United States. They were also taking place in all developed countries of the world. As one nation after another faced the problem, it acted to deal with the situation. Some countries developed national health insurance programs. Others developed national health services. They met their problems as best they could, according to their own needs and resources.

The United States alone stood apart from these worldwide developments. We preserved our faith in the private sector. Although government did become involved in the effort to upgrade health care, the effort was always limited, categorical, and inadequate. We chose to leave basic planning and development of health care to professional leadership and to the play of the marketplace.

The crisis today reflects the fact that professional leadership alone was not able of meeting the national needs, and that the demands and needs of medical care do not lend themselves to satisfaction solely through the forces and the dynamics of the marketplace.

THE DEVELOPMENT OF THE HEALTH SECURITY PROGRAM

Recently, an important new chapter began in the long history of American health needs and social policy. Walter Reuther, the late president of the United Auto Workers, was among the first to see that financing programs like medicare and medicaid or extensions of private health insurance could not resolve the crisis of disorganization and the spiraling cost of health care. Walter Reuther understood that the Nation needed to take a bold step forward. In November 1968, he announced the formation of the Committee of One Hundred for National Health Insurance. As he said, in establishing the mandate of the committee:

> I do not propose that we borrow a national health insurance system from any other nation. No nation has a system that will meet the peculiar needs of America. I am confident that we have in America the ingenuity and the social inventiveness needed to create a system of national health insurance that will be uniquely American—one that will harmonize and make compatible the best features of the present system, with maximum freedom of choice, within the economic framework and social structure of a national health insurance system.

Joining Walter Reuther on that committee were Dr. Michael E. deBakey, president of Baylor College of Medicine; Mrs. Mary Lasker, president of the Albert and Mary Lasker Foundation; Mr. Whitney M. Young, Jr., executive director of the National Urban League; and other outstanding citizens from the fields of medicine, public health, industry, agriculture, labor, education, the social services, youth, civil rights, religious organizations, and consumer groups. I have had the honor of serving on that committee, along with my Senate colleagues, JOHN SHERMAN COOPER and WILLIAM SAXBE, and my former colleague, Ralph Yarborough.

In its efforts over the past 2 years, the committee has worked to develop a sound program for improving the organization, financing and delivery of health services to the American people. The committee's deliberations were based upon the premise that progress toward a more rational health system should be orderly and evolutionary. The members of the committee felt that a better system of health care for America should rest upon the positive motivations and interests of both consumers and providers of health services. They believed that no system could succeed if it were imposed by fiat through rigid legislation and administrative regulations.

Throughout its deliberations, the committee has been guided by the work of its distinguished technical subcommittee, chaired by Dr. I. S. Falk, professor emeritus of public health of Yale University and the most eminent authority in the field of health economics in the Nation. The committee consulted extensively with representatives of professional associations, consumer organizations, labor unions, business groups, and many other interested organizations. The Health Security program is the result of these efforts, and it gives careful consideration to the recommendations of all of these groups.

Last August, Senators COOPER, SAXBE, Yarborough, and I, together with 11 other Senators, introduced the original version of the Health Security program as S. 4297 in the 91st Congress. In September, the Senate Committee on Labor and Public Welfare held 2 days of hearings on the legislation, the first hearings to be held in Congress on comprehensive national health insurance since the critical problems of health care in America first became paramount 20 years ago. With the exception of the administration, testimony from a broad spectrum of witnesses was immensely favorable to the bill, and generated increased momentum for introduction of the bill in the 92d Congress.

At the time the bill was originally introduced last year, Congresswoman MARTHA GRIFFITHS of Michigan had already introduced legislation in the House of Representatives to create a national health insurance program similar in overall concept to the Health Security program. Her bill already received the strong endorsement of the AFL–CIO, under the leadership of President George Meany.

Before the 91st Congress adjourned last year, we had decided to pool our efforts and introduce a common bill in the 92d Congress. Hundreds of detailed differences between the two previous bills have been resolved, and the debate over the preparation of the new bill has led to the stronger Health Security program we introduce today.

As these and other developments make clear, we are now seeing the uniting of major American institutions to support the goal of Health Security. It is an issue destined to grow and remain before the American public until the goal of adequate health care for all is finally achieved.

MAJOR PROVISIONS OF THE HEALTH SECURITY PROGRAM

The Health Security program is intended to be comprehensive and extensive. At the conclusion of my remarks in the CONGRESSIONAL RECORD, I will include a section-by-section analysis of the bill and the text of the bill itself, so that the details of its provisions may be widely available to all. At this time, however, I would like to call attention to its main provisions:

BASIC PRINCIPLE

First, the basic principle is to establish a system of comprehensive national health insurance for the United States, capable of bringing the same high quality health care to every resident; and, to use the program to bring about major improvements in the organization and delivery of health care in the Nation.

The health security program does not envisage a national health service, in which Government owns the facilities, employs the personnel, and manages all the finances of the health care system. On the contrary, the programs proposes a working partnership between the public and private sectors. There will be Government financing and administrative management, accompanied by private provision of personal health services through private practitioners, institutions, and other providers of health care.

Second. Persons eligible for benefits—every individual residing in the United States, will be eligible to receive benefits. There will be no requirement of past individual contributions, as in Social Security, or a means test, as in Medicaid.

Third. Starting date for benefits—July 1, 1973. The 2-year tooling-up period prior to that date will be used to prepare the health care system for the program.

Fourth. Covered benefits—with certain modest limitations, the program will provide comprehensive health benefits for every eligible person. The benefits available under the program will cover the entire range of personal health care services, including the prevention and early detection of disease, the care and treatment of illness, and medical rehabilitation. There are no cutoff dates, no coinsurance, no deductibles, and no waiting periods.

For example, the program provides full coverage for physicians' services, inpatient and outpatient hospital services, and home health services. It also provides full coverage for other professional and supporting services, such as optometry services, podiatry services, devices, and appliances, and certain other services under specified conditions.

The four limitations in the otherwise unlimited scope of benefits are dictated by inadequacies in existing health resources or in management potentials. They deal with nursing home care, psychiatric care, dental care, and prescription drugs, as follows:

Skilled nursing home care is limited to 120 days per benefit period. The period may be extended, however, if the nursing home is owned or managed by a hospital, and payment for care is made through the hospital's budget.

Psychiatric hospitalization is limited to 45 consecutive days of active treatment during a benefit period, and psychiatric consultations are limited to 20 visits during a benefit period. These limits do not apply, however, when benefits are provided through comprehensive health care organizations or comprehensive mental health care organizations.

Dental care is restricted to children through age 15 at the outset, with the covered age group increasing annually until persons through age 25 are covered. Persons eligible for coverage through age 25 will remain eligible for coverage throughout their lives.

Prescribed drugs are limited to those provided through hospital in-patient or out-patient departments, or through organized patient care programs. For other patients, coverage extends only to drugs required for the treatment of chronic or long-term illness.

Inevitably, simply stating these four limitations gives them a prominence they do not deserve. In all other respects, covered health services will be available without limit, in accordance with medical need.

Administration—the administration of the health security program will be carried out by a five-member full-time Health Security Board, appointed by the President with the advice and consent of the Senate. Members of the Board will serve 5-year terms, and will be under the authority of the Secretary of Health, Education, and Welfare.

A statutory National Advisory Council will assist the Board in the development of general policy, the formulation of regulations, and the allocation of funds. Members of the Council will include representatives of both providers and consumers of health care.

Field administration of the program will be carried out through the 10 existing HEW regions, as well as through the approximately 100 health subareas that now exist as natural medical marketplaces in the Nation. Advisory councils on matters of administration will be established at each of these levels. However, the Board will guide the overall performance of the program. It will coordinate its functions with State and regional planning agencies, and it will account for its activities to Congress.

Financing the program—the program will be financed through a Health Security Trust Fund, similar to the Social Security Trust Fund. Income to the Fund will derive from four sources:

Fifty percent from general Federal tax revenues;

Thirty-six percent from a tax of 3.6 percent on employers payrolls;

Twelve percent from a tax of 1 percent on employees' wages and unearned income up to $15,000 a year;

Two percent from a tax of 2.6 percent on self-employment income up to $15,009 a year.

Employers may pay all or part of their employees' health security taxes, in accord with arrangements established under collective-bargaining agreements.

Payment mechanism—The essence of the payment mechanism and the central cost control feature of the program is that the health care system as a whole will be anchored to a budget established in advance. A given amount of money will be made available for the program each year, based on the available estimates of the needs to be met and the services to be provided, with due regard for the resources of the system. As in every area of our economic life, the health care system will be obliged to live within its budget. In this way we can end the unacceptable escalation of costs within our present system. In this way we can end the long financial binge in which health care has had a signed blank check on the whole economy of the Nation.

Each year, the Health Security Board will make an advance estimate of the total amount needed for expenditure from the trust fund to pay for health care services in the program. The Board will allocate funds to the several regions, and these allocations will be subdivided among categories of services in the health subareas. Advance estimates, constituting the program budgets, will be subject to adjustments in accordance with guidelines in the act. The allocations to regions and to subareas will be guided initially by the available data on current levels of expenditure. Thereafter, they will be guided by the program's own experience in making expenditures and in assessing the need for equitable health care throughout the Nation.

Compensation of doctors, hospitals, and other providers—Providers of health services will be compensated directly by the Health Security program. Individuals will not be charged for covered services.

Hospitals and other institutional providers will be paid on the basis of approved prospective budgets. Independent practitioners, including physicians, dentists, podiatrists, and optometrists, may be paid by various methods which they may elect: by fee-for-service, by capitation payments, or in some cases by retainers, stipends, or a combination of such methods. Comprehensive health service organizations may be paid by capitation, or by a combination of capitation and methods applicable to payments to hospitals and other institutional providers. Other independent providers, such as pathology laboratories, radiology services, pharmacies, and providers of appliances, will be paid by methods adapted to their special characteristics.

Foundations, sponsored by medical or dental societies or other specified nonprofit organizations, are specifically recognized as a class of providers with which the Board may contract for services. Foundations would be required to have an enrolled population and to permit participation by all qualified physicians in the area. Foundations would be reimbursed by the same formula used for prepaid group practice plans.

In addition, drug addiction and alcoholic treatment centers are specifically included as eligible providers of services under the program.

Resources Development Fund—An essential feature of the program is the Resources Development Fund, which will come into operation 2 years before benefits begin. In the first year of this "tooling up" period, $200 million will be appropriated for the fund; in the second year, $400 million will be made available. Once the program benefits begin, up to 5 percent of the Trust Fund—about $3 billion a year—will be set aside for resources development. These funds will be used to support innovative health programs, particularly in areas like manpower, education, training, group practice development, and other means to improve the delivery of health care. The principal attribute of the Fund is that it can be used to channel far more money into areas like education and training than is possible under the existing system of congressional authorization and appropriation for ongoing programs.

Quality Control—The Health Security program includes various provisions designed to safeguard the quality of health care. The program will establish national standards more exacting than medicare for participating individual and institutional providers. Independent practitioners will be eligible to participate if they meet licensure and continuing education requirements. Specialty services will be covered if, upon referral, they are performed by qualified persons. Hospitals and other institutions will be eligible for participation if they meet national standards, and if they establish utilization review and affiliation arrangements.

In addition, the Health Security Board

is authorized to require prior consultation with an appropriately qualified specialist before the performance of designated nonemergency surgery, in order to allow administrative monitoring of surgical procedures that are frequently abused.

Incentives—Financial, professional and other incentives are built into the program to move the health care delivery system toward organized arrangements for patient care, and to encourage preventive care and the early diagnosis of disease.

In the area of health manpower, the program will supplement existing Federal programs. It will provide incentives for comprehensive group practice organizations, encourage the efficient use of personnel in short supply, and stimulate the progressive broadening of health services. It will provide funds for education and training programs, especially for members of minority groups and those disadvantaged by poverty. Finally, it will provide special support for the location of increased health personnel in urban and rural poverty areas.

Relation to existing programs—Various Federal health programs will be superseded, in whole or in part, by the Health Security program. Since persons of age 65 or over will be covered by the program, medicare under the social security system will be terminated. Federal aid to the States for medicaid and other Federal programs will also be terminated, except to the extent that benefits under such programs are broader than under the Health Security program. However, the bill does not affect the current provisions for personal health services under the Veterans Administration, temporary disability, or workmen's compensation programs.

Cost of the program and Federal revenue sharing—On the basis of data available for the fiscal year 1970 a total of $41 billion was expended for health care benefits that would have been covered by the Health Security program had the program been in effect for that year. In other words, if the Health Security program had been in effect in 1970, the cost of the program would have been $41 billion.

The $41 billion figure represents approximately 70 percent of the total actual expenditures for personal health care in the United States for that year. These expenditures consist of $30 billion in private health insurance payment and private out-of-pocket payments, $8 billion in payments by the Federal Government, and $3 billion in payments by State and local governments.

The cost of the health security program has been the source of enormous confusion and misunderstanding since the original version of the Health Security Act was introduced last year in the 91st Congress. The crucial point is that in no sense does the hypothetical $41 billion price tag for the health security program in 1970 represent new money. Rather, this is what Americans are already paying for personal health care under the existing system.

Thus, the health security program is not a new layer of Federal expenditures on top of existing public and private spending for health care. Instead, the health security program simply redistributes the health expenditures that are already being made. Although, of course, Federal expenditures in 1970 would have risen from $8 billion under the existing system to $41 billion if the health security program had been in effect, individuals and organizations throughout the Nation would have been relieved of $30 billion of private health insurance expenses and out-of-pocket payments for health care, and State and local governments would have been relieved of $3 billion, representing costs incurred largely in medicaid and other public assistance programs, and in city and county medical programs.

In a very real sense, therefore, the health security program is a direct form of Federal revenue sharing. It offers $3 billion in substantial and immediate Federal financial relief to State and local governments, thereby freeing scarce State and local funds for other urgently needed purposes.

Over the long run, by revitalizing the existing health care system and ending the excessive inflation in the cost of health care, the Health Security program will be far less expensive than the amount we will spend if we simply allow the present system to continue.

Even at the beginning, moreover, the Health Security program will provide more and better services without increasing the cost, since the initial savings achieved by the program will be sufficient to offset the cost of the increased services. In other words, from the day the Health Security program begins, we will guarantee our citizens better value for their health dollar, and achieve a substantial moderation of the current exorbitant inflation in health costs. Even in the first year of the Health Security program, the comprehensive health services provided will be available for the same cost we would have paid for the partial and inefficient services, of the existing system.

In 1970, for example, spending for health exceeded $70 billion. For the first time in our history, expenditures for health rose above 7 percent of our gross national product. If we continue to do nothing, the annual cost will exceed $100 billion in only 3 years.

CONCLUSION

In sum, the Health Security Act we submit to the Senate and to the people of the United States differs from all previous proposals for health care or national health insurance. It is not just another financing mechanism. It is not just another design for pouring more purchasing power into our already overstrained and overburdened nonsystem for the delivery of health care. It is not just another proposal to generate more professional personnel or more hospitals and clinics, without the means to guarantee their effective use.

Ours is a proposal to give us a national system of health security. Under this program, the funds we make available will finance and budget the essential costs of good health care for generations ahead. At the same time, these funds will be building new capacity to bring adequate, efficient and reliable health care to all families and individuals in the Nation.

I invite all Members of the Senate to study this proposed legislation and to join with us in seeking early enactment of the Health Security program.

Mr. President, in order that the details of this legislation may be widely available to all, I ask unanimous consent that the bill may be printed at this point in the RECORD, together with a section-by-section analysis of the bill.

The PRESIDENT pro tempore. The bill will be received and appropriately referred; and, without objection, the bill and section-by-section analysis will be printed in the RECORD.

The bill (S. 3) to create a national system of health security, introduced by Mr. KENNEDY, for himself and other Senators, was received, read twice by its title, referred to the Committe on Finance, and ordered to be printed in the RECORD, as follows:

S. 3

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as "The Health Security Act."

Senator Kennedy originally introduced this proposal into the 91st Congress in a slightly different form (S.4297) as the "Health Security Act of 1970." Hearings on this proposal were conducted by the Senate Labor and Public Welfare Committee in September, 1970.

THE "MEDICREDIT BILL," H.R. 18567*

THE FULTON-BROYHILL BILL: NATIONAL HEALTH INSURANCE THROUGH THE "MEDICREDIT TAX INCENTIVE PLAN"

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Tennessee (Mr. FULTON) is recognized for 15 minutes.

Mr. FULTON of Tennessee. Mr. Speaker, to say that the Nation faces a crises in health care is neither startling nor original.

We have heard this assessment from President Nixon; from former Secretary of Health, Education and Welfare Robert Finch; from various Members of Congress; and from a host of editorial writers, news commentators, academicians, and health professionals.

There are, in fact, few Americans who would argue the point any longer.

Despite burgeoning governmental programs; the tremendous growth of private health insurance plans in recent years; a $60 billion-a-year health industry; and a $38 billion outlay annually in private expenditures for their own health care, the people of this country are viewing—with mounting concern—the widening gap between the promises and the realities.

We say that health care is a right, not a privilege.

But the difference between a right denied and a privilege withheld of little moment to a person who needs health care and either can't get it when he needs it or cannot afford it when he finds it.

And so we are far from the point where the goal that all of us share—adequate health care for all Americans—seems readily attainable.

But the search for solutions is on.

The problem is no longer whether we assure the right to adequate health care to those who expect it and demand it.

The problem is how we should go about it.

Let us be thankful that there is no shortage of ideas on that score. Already we have a double handful of proposed solutions and the likelihood of a dozen more being introduced in the months ahead.

And whether we are talking about the Rockefeller approach, the AFL-CIO approach, the Kennedy approach, or the approach taken by the Committee of 100, all of them advocate sweeping changes in our health care system.

For all propose, in one form or another, a national health insurance plan.

These plans deserve the most careful scrutiny, Mr. Speaker, as will the alternatives they are certain to generate. For no thornier problem confronts us on the domestic scene, none cries out for a workable solution with more urgency, none poses a greater need for hard, original thinking.

As Victor Hugo once wrote:

Greater than the tread of mighty armies is an idea who time has come.

The idea of national health insurance is an idea whose time has come. The question is no longer whether or not we need a national insurance plan. The question is what plan? And when can we develop one that works?

Early in this session—to be precise, in January a year ago—I introduced a bill which seemed to me to have considerable merit.

It stemmed from an American Medical Association concept and was drafted after extensive discussions with AMA spokesmen.

Essentially, my bill took a split-level approach to the problem.

The first part was designed to meet the needs of those presently covered under the title 19 medicaid program. Under the plan, each low-income person or family would receive a certificate for the purchase of a qualified and comprehensive health insurance plan.

This protection would be made available to those unable to pay for health care without cost or contribution to themselves, since the cost of the program would be borne entirely by the Federal Government.

At the second level, tax credits would be granted on the basis of the individual's gross income for the purchase of qualified health benefits coverage. These credits would be based on a sliding scale of gross income and would be larger or smaller according to need.

Since the introduction of that bill, a great deal has happened, Mr. Speaker.

We have held continuous hearings on the Ways and Means Committee from October of last year until May of this year.

We have listened to hundreds of witnesses, heard dozens of ideas, and exchanged uncounted hours of dialog.

Not surprisingly, my own thinking has been modified and rechanneled as a result of the experience.

If it is possible to identify a common concern, shared it seems to me by most, if not all of my colleagues on the committee, that concern is how we are going to control the costs of these programs.

Medicare and medicaid, for example, are beset by soaring costs. And they are limited programs.

How, then, are we to control the costs of an across-the-board national health insurance plan without bankrupting the Nation or wasting billions of tax dollars?

Mr. Speaker, I am introducing today another national health insurance bill which represents, in my view, a vast improvement over its predecessor by reason of the fact that it encompasses a built-in mechanism for cost control.

I am being joined in this by my committee colleague, Representative JOEL T. BROYHILL of Virginia.

Let me outline the measure for you briefly.

"Medicredit," as the AMA has christened it, recognizes that our population falls roughly into three categories.

In the first are those who are unable to pay the cost of adequate health care for themselves or their families.

In the second are those who can pay a portion of this cost—small or large, but depending upon their respective abilities.

The third category consists of those with a reasonably full ability to pay.

For those unable to afford health insurance, the Federal Government would buy basic comprehensive health coverage by providing the individual, or head of the family, with a certificate that could be used to buy hospital and physicians' services.

Similar certificates would be provided for those with a low tax liability—say, $300 or less.

Those with a tax liability above that amount would be given income tax credits upon their establishment of expenditures for qualified health care plans. The amount of the credit would vary with tax liability. For example, a taxpayer with a $500 tax liability would receive 70 percent of the annual premium cost as a credit against the taxes he owed. A family with a $1,200 tax liability would receive 20 percent against its tax liability.

Let me stress that this bill is based on net taxable income rather than gross income, as provided in my original bill. This seems to me an improvement, in that net taxable income screens out inequities in tax liability—thereby reflecting more fairly a taxpayer's ability to pay—and for that reason furnishes a better yardstick of need than gross income.

In order to receive his tax credit, the taxpayer would need to show that he has purchased a qualified insurance or prepayment plan.

A qualified plan would be one where both the benefit package and the carrier or group had been approved by the appropriate State agency, which would follow established guidelines in developing this qualifying program.

A Health Insurance Advisory Board, to

*This proposal has been reintroduced into the 92nd Congress as H.R. 1283 by Rep. Fisher and H.R. 3167 by Rep. Tiernan.

be chaired by the Secretary of Health, Education, and Welfare and to include the Commissioner of Internal Revenue and public members, would provide the guidelines necessary to carry out the program; plan and develop programs for maintaining the quality of medical care; oversee the financial aspects of the program; and concern itself with the effective use of available health manpower and facilities. The Health Insurance Advisory Board would report annually to the President and the Congress.

As basic benefits under any qualified plan, medicredit requires 60 days of inpatient hospital services, including maternity services; all emergency and outpatient services provided in the hospital; and all medical services provided by an M.D. or a doctor of osteopathy, whether performed in the hospital, home, office or elsewhere. Supplemental benefits could also be provided under the plan and paid for either with tax credits or, in the case of those unable to pay, with certificates.

This approach does away with the need for medicaid, Mr. Speaker. Under title 19, we have been saying—even to the self-sufficient who can clothe, house, and feed themselves—"spend yourselves to the point of indigency, and then we will move in to help."

Medicredit reverses that thinking. It says, in effect:

"The Federal Government will see that you get insurance protection against the cost of illness so that you will not be reduced to indigency.

An advantage to the plan is that it takes into account the varying costs of health care from region to region by dealing with commercial insurance companies, Blue Cross, Blue Shield, or any prepaid group plan operating in any part of the country, on the basis of an acceptable program reflecting regional costs.

Before going into the third element of this legislation, Mr. Speaker, let me express my conviction that the use of the insurance mechanism is essential to any successful program of national health insurance. Without Blue Shield, Blue Cross and the commercial carriers under contract to the Social Security Administration, medicare would have been an administrative nightmare. In fact it becomes increasingly clear that the private sector should be involved even further in the medicare program, as should any other program that seeks to deliver adequate health care at a price Americans can afford.

To summarize, then, the bill does away with the need for medicaid and places all those presently covered by medicaid in the mainstream of health care.

For the higher income individuals and families, the bill offers realistic incentives to purchase comprehensive health care coverage on a voluntary basis.

The bill utilizes to the fullest extent the private carriers and plans and allows the competition of the marketplace to operate in maintaining cost control and insuring quality of care.

Medicare would be unaffected by this bill's passage, for only those under 65 years of age would be covered by medicredit.

Briefly, now, a word on costs and cost controls.

As wealthy as this country is, there are limits to what we can undertake.

An across-the-board national health insurance plan, operated regardless of need, will carry a price tag of sobering size. And no such plan I have yet seen includes—at least to my satisfaction—a mechanism which promises effective cost control of the taxpayers' money.

This brings us to an essential element of medicredit—its provision of peer review.

This bill calls for a constant and unremitting policing mechanism.

The appropriate medical societies would be charged with establishing a peer review mechanism that would, among other things, review individual charges and services, wherever performed; review hospital and skilled nursing home admissions; review the length of stays in hospitals and skilled nursing homes; and review the need for professional services provided in the institution.

The process of ongoing review can have nothing but a salutary effect on the providers of services, thereby cutting down on the occasional or unintentional abuses that would otherwise occur.

Patterns of abuse would be detected, and the abusers either suspended from or excluded from the program. Exclusion could follow action by the Secretary of Health, Education, and Welfare upon the recommendation of the peer review committee.

In the case of fraud, or other clear intentional misconduct, the peer review committee would be expected to bring charges before the appropriate licensing body.

And in the event that a peer review committee was not established by the medical society within a reasonable time, or if established was not fuctioning, the Secretary of Health, Education, and Welfare, in consultation with the medical society, would be empowered to appoint a peer review committee that would function.

I am frank to admit, Mr. Speaker, that I am chary at this point of offering cost figures on medicredit or any other of the plans now under discussion. We have seen the cost estimates of medicare and medicaid, for instance, drastically underestimated in the past.

I will say this, however:

Medicredit will cost a third as much, or a half as much, as some of the alternatives we have heard proposed. And its total net cost will reflect tax savings to the Federal and State Governments of the money spent on medicaid—about $5 billion a year presently, about $7 billion in projected increases.

"National Health Care
Program H.R. 19631*

PROPOSED NATIONAL HEALTH-CARE ACT*

(Mr. BURLESON of Texas asked and was given permission to address the House for 1 minute and to revise and extend his remarks and include extraneous matter.)

Mr. BURLESON of Texas. Mr. Speaker, I am today introducing the National Health-Care Act of 1970. The purpose of the proposal is to make adequate health care for all Americans a reality in the 1970's by strengthening the organization and delivery of health care nationwide and by making comprehensive health-care insurance available to all our people.

The bill I am introducing today represents a sound approach to the solution of an especially complex problem—the provision of good health care to all Americans at a cost their Government can afford. I believe that this bill and other legislative proposals introduced thus far, and others that may yet be introduced, deserve serious, thorough, and open-minded study. It is primarily for this purpose that I have today introduced the National Health-Care Act of 1970.

Few proposals in our Nation's history will have a greater potential for altering—for the better or for the worse—the health and well-being of our citizens and the soundness of our fiscal policy than these proposals for major changes in our health-care system. They must be studied long and carefully before any action is taken.

The principal features of the bill I have introduced today are designed to:

First, increase health manpower facilities and improve their distribution;

Second, promote the development of ambulatory care centers providing preventive as well as therapeutic services in order to make quality health care less expensive and more accessible, particularly in areas where health services are scarce;

Third, strengthen health planning by giving comprehensive health planning agencies greater authority and financial support;

Fourth, improve control over cost and quality of medical care by more effective methods of reimbursement and more effective utilization of professional services and health facilities;

Fifth, create a council of health policy advisers in the Executive Office of the President in order to provide national leadership in the health-care field; and

Sixth, make comprehensive private health insurance available to all Americans through a system of Federal income tax incentives. State pools of private health insurers, including all types of health costs prepayment mechanisms, would insure those unable to pay for or secure health insurance. The State pools would be spported by Federal and State funds and contributions by individuals, scaled to income.

Mr. Speaker, I have introduced this bill at this time so that interested members of the public and health-care industry will have a chance to study its many features. I am particularly impressed with the features of this bill which are aimed at increasing the availability of health manpower in rural and other areas where a scarcity now exists.

Mr. Speaker, I insert in the RECORD at this point a brief statement on the bill and a section-by-section analysis which is intended to facilitate the understanding and study of this measure:

GENERAL STATEMENT ON NATIONAL HEALTHCARE ACT OF 1970

It is agreed that every American should have access to quality health care. There is agreement as well that too many of our citizens now find it difficult to secure quality health care when they need it, where they need it, and at prices they can afford.

A number of bills have been introduced to date aimed at remedying this situation. These proposals range from some which may not go far enough, to those which perhaps would go too far in their efforts to come to grips with this national problem and thereby destroy that which has proven sound and workable.

The National Healthcare Act of 1970 goes to neither extreme. Instead, it attempts to demonstrate that the personal health care needs of all citizens would be served most effectively and at lower cost through full use of the present system's demonstrated strength and capabilities, coupled with significant reforms and additions where the present system, for one reason or another, does not meet the Nation's needs.

The matter of cost is an important factor in any deliberations regarding a national health insurance program for America. It would be possible to spend upwards of $75 billion a year in Federal tax dollars to confront this national problem. However, it is not necessary to tax our citizens so heavily to provide such a health plan.

The National Healthcare Act of 1970 would add less than $4 billion to present spending for health programs at the Federal level in the first year of operation, yet it would lead to assuring all citizens of access to quality health care no matter what their income might be.

This is made possible through a program which combines the flexibility, innovativeness, efficiency and managerial skills of private enterprise, the high scientific and technical competence of the medical and allied health professions, the fiscal and legislative capacities of government, and the talents and energies of the consumer at the community level.

The cooperative endeavor proposed in this bill could create a health care system of unprecedented scale and potential for serving the needs of all citizens on an economically sound basis, with the communities served participating in developing and maintaining the proposed programs.

There has been considerable criticism of our present health care delivery system. Doctors, nurses, hospitals, nursing homes, health insurers, government plans, have all come under attack from one quarter or another. Our present system admittedly has its shortcomings. However, it has much to recommend it. Our system is not a health care system on the wane. It is a growing system and it has growing pains. What must be provided now is the wherewithal to assure that this growth is continued and that the benefits of this system are extended to all men, women, and children regardless of their ability to pay for the health care they require.

The National Healthcare Act of 1970 proposes to lay the groundwork for improving the organization and delivery of health care by:

1. Increasing manpower through student loans for training in the health professions, grants for the planning and establishment of curriculums for training comprehensive ambulatory health care teams and grants to personnel in the health professions, allied health professions and nursing for service in areas of critical needs.

2. Promoting widespread development of comprehensive ambulatory health care centers to provide a broad range of services, including check-ups, diagnosis and treatment of most common ailments, rehabilitation, family planning, mental health care and vision and dental care.

3. Creating a Council of Health Policy Advisors in the Executive Office of the President. The three-member Council, appointed by the President, would formulate and recommend national policies to promote the improvement of health care. Each year, beginning in 1972, the President would be expected to transmit a Health Report to Congress setting forth among other matters, the status of the health care system of the nation and presenting a program for carrying out policy together with recommendations for legislation. The Council of Health Policy Advisors would assist the President in preparing this report.

4. Strengthening health planning in order to conserve scarce manpower and facilities by giving comprehensive community health planning agencies greater authority and financial support.

5. Instituting cost controls through the establishment of State Commissions to review and approve in advance, hospital and nursing home rates and through provisions requiring physicians to justify their services

*Rep. Burleson has introduced a similar proposal, H.R. 4349, into the 92nd Congress.

and charges unless these fell within professionally established guidelines.

As you can gather from the foregoing the bill is far more than a financing mechanism for health care. It recognizes that changes in the system must accompany any additional financing made available. Otherwise, the effect would be to inflate already high health costs and make less rather than more health care available to all Americans.

In 1965, we enacted Medicare. Medicare brought health, blessings and assistance to millions of Americans. But it complicated the problem. It provided more dollars—but not more services—so the price went up for all of us. We must not let that happen again.

Recognizing this, the Federal Government should encourage health care insurance benefits for all that will stimulate development of new forms of health care designed to shift the emphasis from high-cost inpatient hospital care to lower-cost types of institutional care and in particular, more easily accessible ambulatory and preventive care.

In addition, comprehensive health care insurance coverage would be made available to all people, building on the broad base of existing voluntary health insurance plans. Costs for most of the population would continue to be met by individuals and employers, and public funds would be used for those who need total or partial support in financing their health care.

To accomplish this, the bill proposes that standards of ambulatory, preventive and institutional health care benefits be established by the Federal Government. Federal income tax incentives would be employed to stimulate the extension of health care benefits to all employer-employee groups and to economically self-sufficient individuals not in such groups. All employer plans would have to meet Federal minimum standards in order to qualify for tax deductions.

The bill would make health care benefits available to persons of low income and to persons previously uninsurable. The latter would contribute on a reasonable basis in relation to their income. Those of low income would be covered regardless of their assets, through State health care benefit programs participated in by all insurers, including Blue Cross/Blue Shield, insurance companies and prepaid group practice plans. These health care benefits will be supported by State and Federal subsidies. These privately insured benefits would immediately reduce the need for Medicaid and would eventually eliminate it as a means of financing medical care.

In recognition of the present limitation of manpower and facilities, the proposed Federal benefit standards have been established on a priority basis. Initial benefits called for in the bill will be increased under a three-phase program as additional manpower and facilities become available.

Phase One of the program for private plans would go into effect in the 1973 tax year. It would cover charges for all physician's services in connection with surgery, radiation therapy and diagnostic tests, whether performed in a hospital, ambulatory care center or doctor's office. Limited coverage would be provided for visits to a physician in his office or in an institution. Well-baby care, including immunizations during the first six months after birth, the first 30-days of semiprivate, general or psychiatric hospital care per illness, the first 60-days of convalescence in a skilled nursing home and the first 90-days in an approved home care program would also be covered.

It is anticipated that Phase Two of the program would take effect in 1976. In that and subsequent tax years, the benefits would be improved and others added, including dental care for children under 19, prescription drugs for all people, rehabilitation services and maternity care.

In recognition of the greater need of low income people, the State health care programs would initially provide a level of benefits equal to that provided under private plans in 1976. When private plans enter the second phase of health care in 1976, State plans would move to Phase Three benefits.

In 1979, when it is assumed that all services will be available in the amounts required to meet demand, Phase Three will go into effect for all people. In this ultimate phase of health care benefits, there would be no maximum limits on ambulatory care and realistic limits on institutional care.

The benefits payable for catastrophic accident or illness could exceed the $50,000 maximum benefit currently provided under the Federal Employees' Government-Wide Indemnity Benefit Plan.

All members of the House should study this bill in detail. Comprehensive health care and the insurance to finance it should be made available to all our citizens. This dual goal can be achieved at lowest cost to the nation by enactment of this bill.

NATIONAL CATASTROPHIC ILLNESS PROTECTION ACT OF 1970*

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Maryland (Mr. HOGAN) is recognized for 30 minutes.

Mr. HOGAN. Mr. Speaker, I have today introduced a bill (H.R. 18008) on which I have been working for several months and which I consider to be an extremely important piece of legislation.

The legislation, the National Catastrophic Illness Protection Act of 1970, would, if enacted, allow our Nation's families to protect themselves against the scourge of catastrophic illness. The bill would provide the mechanism for such protection in a manner which could involve a very small Federal expenditure.

Catastrophic illness, by definition, would comprise those illnesses which require health-care expenses in excess of what normal basic medical or major medical coverage provides protection for. Once a family finds itself faced with having to pay for health-care costs of an extended nature, they are saddled with a financial burden that is staggering to comprehend.

Imagine, if you will, what it means to finance for years hospital care which will run between $80 and $100 a day after your routine insurance has been exhausted. For middle-income Americans who earn too much to receive welfare and who are not rich enough to even begin to meet such obligations, the result of catastrophic illness is instant poverty. The family is driven to its knees.

Such a family, which has probably already watched one of its members incapacitated and perhaps destroyed medically, also finds that its financial stability has disintegrated. Usually, private hospitals cannot afford to provide care after the family can no longer afford to pay for the hospital's services. This emans that the afflicted member of the family must be transferred to whatever public facility exists to treat patients under such circumstances. Unfortunately, these public institutions are often understaffed, underequipped, and horribly overcrowded. All too often they become depositories where families must leave their children or other loved ones, because the doors of all other possible assistance have been slammed in their faces.

Catastrophic illness does not refer to a specific or rare disease. It is any disorder—from the exotic calamity to the common coronary. It is the fall from a step ladder in a home, a highway accident, or even the untimely sting of a bee, which cost one family over $57,000. It is anything that happens to any of us that causes medical expense in excess of what the actuaries tell us we should expect. Virtually every family becomes medically destitute when that point is reached. Fortunately, only a small portion of medical cases are of such magnitude. But for the thousands of families who, through no fault of their own, find themselves pummeled into such an abyss, there is—currently—no hope.

While catastrophic illness is nondiscriminating in whom it attacks, when it attacks and where it attacks, it seems that a tragically high number of these cases involve children. When a child is the victim, the parents are often young marrieds who find themselves depriving their healthy children of a wholesome family life in order to finance the health care of a sick child. Often, the havoc is so great that the young couples must watch their dreams go down the drain as all present and future planning is marshaled toward the single goal of finding the money to pay for their ill child's care. While nearly all of the pediatric diseases that are catastrophic are individually rare, in the aggregate they afflict more families than most of us would imagine. The list of obscure diseases such as Tay-Sachs disease, Niemann-Pick disease, Gaucher's disease, Fabrey's disease, metachromatic-leukodystrophy, leukemia, muscular dystrophy, myasthenia gravis, and the scores and scores of other maladies that destroy our people at enormous emotional and financial cost to their families appears endless.

Obviously, when catastrophic illness strikes the head of a household—the breadwinner—the disaster is compounded.

We are too great a nation to stand idly by—leaving our families that are victimized by catastrophic illness to their own devices. They have no devices. They are alone.

The legislation which I am proposing will go a long way toward mitigating against the problems of catastrophic illness because it will stimulate our insurance industry to provide coverage that will allow any family to protect itself fully against the costs of catastrophic illness. The legislation would foster the creation of catastrophic illness—or extended care—insurance pools similar to those that have been successful in making flood insurance and riot insurance feasible.

Because all participating insurance companies would be required to promote the plan aggressively, and because we would be dealing, statistically, with a small minority of all claims, the cost per policy should be low. As more people buy this new protection as part of their health care program, thereby spreading the risk, the cost should drop even more. The Federal role would be limited to reinsuring against losses in those instances where insurance companies paid out more in benefits than they took in in premiums. As the insurance industry gained experience under the plan they would be able to sharpen their actuarial planning so that such losses should be limited, if they occur at all.

We have taken careful steps to preserve the State role in insurance administration and to allow the Secretary of Health, Education, and Welfare to participate in the actuarial review of the policy rate structure in order to assure that the rates charged for those new policies are fair to all parties concerned.

Perhaps the most attractive feature of this legislation is that it would be free of all of the constraints that are plaguing existing federally funded health care programs. We would not be overburdening an already overburdened social security system in order to finance the plan. Families whose choose not to participate in the program would not be required to do so. However, on the other hand, families desiring to secure this protection would be assured of an opportunity to do so.

Under my program a deductible formula would be used to stimulate each family to provide basic health care protection. It would only be when this deductible level had been exceeded that the catastrophic insurance protection plan would be utilized. Under our formula, a family with an adjusted gross income of $10,000 would have to either pay the first $8,500 of medical expense or have provided themselves with $8,500 worth of basic insurance protection to offset the deductible requirement. Coverage from existing basic health and major medical plans would generally be sufficient to satisfy this deductible amount. However, if a family with an adjusted gross income of $10,000 incurred expenses during the period of a year that exceeded $8,500, our catastrophic or extended care program would be available to see the family through the period of financial burden when they would ordinarily be left on their own without help.

Again, because relatively few families would experience medical costs of this magnitude in a single year, the costs for this insurance should be quite reasonable—especially as more and more of our citizens availed themselves of its protection.

I include the text of the bill and a summary of the provisions, as follows:

H.R. 18008

A bill to establish a national catastrophic illness insurance program under which the Federal Government, acting in cooperation with State insurance authorities and the private insurance industry, will reinsure and otherwise encourage the issuance of private health insurance policies which make adequate health protection available to all Americans at reasonable cost

*Representative Hogan has reintroduced an identical proposal, H.R. 817, into the 92nd Congress. Senator Boggs of Delaware has sponsored the companion bill in the Senate (S.191).

INTRODUCTION OF "EXTRA CARE" HEALTH PLAN *

The SPEAKER pro tempore (Mr. HOLIFIELD). Under a previous order of the House, the gentleman from Missouri (Mr. HALL) is recognized for 60 minutes.

(Mr. HALL asked and was given permission to revise and extend his remarks.)

Mr. HALL. Mr. Speaker, I am today introducing a bill that translates into legislative form an idea that has been germinating my mind for nearly 5 years. Our distinguished chairman the gentleman from Arkansas (Mr. WILBUR MILLS) of the Committee on Ways and Means, was kind enough to allow me to present the concepts of this proposed legislation earlier this year before his committee. This is in fulfillment of portions of that testimony.

Although it may come as something of a surprise to some of my professional colleagues, I am proposing a health insurance plan, national scope, which is designed to guarantee that no American citizen—rich or poor—need ever go bankrupt as a result of a prolonged, or so-called catastrophic illness or injury. I have entitled this plan the "extra care" plan.

Furthermore, my bill can accomplish this at a cost the taxpayer can afford.

I realize that it is standard operating procedure for every advocate of a measure that costs money to claim that the taxpayer can well afford it. But there is a limit to what the taxpayer can afford, and it is a limit that many have already reached.

I yield to none in trying to save the taxpayers money.

This is conveniently overlooked by some of my friends who back the various entries in the national health insurance derby regardless of the price tags they carry. I would remind them, Mr. Speaker, of our brief experience with medicare and medicaid—the costs of which were pathetically underestimated by their proponents—and suggest to them that programs initially priced at a mere $37 billion, might well cost a good deal more.

One such proposal actually carries that $37 billion estimate—$37 billion annually—that is only a "ball-park" figure, of course. The cost of preventing medical indigency via this approach, might well be twice that before we are finished.

In that case, we shall have succeeded in replacing medical indigency, with taxpayer indigency; after which we can all go home, having no further function as elected representatives for a bankrupt Nation.

But all this is not to say, that catastrophic illness is not a veritable spectre, that haunts most Americans. It does. Few are so rich as to view, with financial equanimity, the prolonged illness requiring hospitalization, continuing medical care, and the mustering of those enormously sophisticated—but enormously expensive—resources of modern medical science in all phases.

I have had considerable experience with catastrophic illness, in my own family, as a practicing surgeon, and as one on call for the great emergency wards of Manhattan as well as those of the emergency medical rooms of smaller hospitals in my hometown.

Mr. Speaker, people have the right to die with their boots on and if they could choose the right to go out the way they wish but they cannot choose the way they exit this earth at this time.

I am speaking of those long, debilitating, vegetabilizing illnesses as a result of brain injury, brain concussion, malignancy, the chronic diseases, or even tuberculosis.

It was my privilege to do the first bilateral thrombolumbar operation south of the Missouri River in my State for high blood pressure. One of the criteria for electing or allowing people to undergo this surgery was that they be young and that they have committed the threat of suicide for the pounding and intractable headaches before the devastating two-stage mutilating surgery, if you please, but prior to the discovery of reserpine, which is very effective. I am happy to say some of those people are still alive and working after having been snatched back from blindness, severe headache and, yes, even suicide.

In counseling these people as to how they might plan to retire one knows that they must not remove hope of their continuing in their way of life. One knows early that there must be some plan of retirement, and one must know that they must not fear the specter or the haunting holocaust of catastrophic diseases. Such cases are fortunately statistically rare, not that this is of any comfort to the bankrupt father whose son must mayhap abandon college and whose wife must go back to work in order to help pay the bills. Rare as they are, all of us either know someone who has been a victim of catastrophic illnesses, we have read of them, or we know someone who knows someone, and we say to ourselves with all reverence, "There but for the grace of God be I."

Mr. Speaker, the specter of catastrophic illness haunts the entire middle-income group of Americans, even those whom we would categorize as prosperous, but my bill would lay to rest that fear forever.

Mr. Speaker, let me explain it briefly. In essence this measure would serve a twofold purpose besides restating definitions and ways and means. It would provide for those who are unable to provide for themselves, and it would assist those who can care for their own needs and yet run the risk of being wiped out in the event of extensive and prolonged medical expenses.

Let us examine the first of those categories, those eligible for help under medicaid at this time. The various States define their indigents in need of aid and welfare. We are talking now of some 10.5 million people. As of now the program costs about $4.5 billion a year or somewhere in the neighborhood of $400 per person covered per year. Roughly 60 percent of that payout is now Federal, according to the social security actuaries' own figures. The bill I propose would replace the present title XIX program. Under those provisions, those who are presently covered would be provided with the basic health insurance policy purchased for them by the Federal Government. This policy would be bought from the regular established going concerns of private health insurance companies, including the blues—Blue Cross and Blue Shield—or any commercial carrier. The Federal Government would pay the premiums. It would be an annual authorized and appropriated sum directly from the Treasury. In order to preserve the Federal-State relationship, which is a right and proper one, the State would be asked to provide 15 percent of the cost to be applied whenever a beneficiary used up the benefits of the federally purchased coverage. Thus the average Federal share would be averaging 85 percent, and we could budget, plan, and depend upon it. Based on the $400 average cost of medicaid per person each year, the State's share of the matching funds would be sharply reduced, thus enabling the States to take on the responsibility of paying for the financially devastating but rarely encountered expenses of the so-called catastrophic cases.

I submit, Mr. Speaker, that the States would find this arrangement attractive for three reasons:

First. It would cost them far less than they are spending at present.

Second. It would enable them to plan, budget, and appropriate much more easily, for there would be a more accurate basis upon which to plan and work.

Third. The States would continue to

*Representative Hall has reintroduced an identical proposal, H.R. 177, into the 92nd Congress.

act in their traditional role of assuming responsibility for long-term care—just as they have assumed responsibility in decades past for the care of the chronic cases, such as the tubercular and the mentally ill.

As for the Federal Government, its cost under this phase of my bill, would be increased by about $1 billion a year. On the other hand, it too would be able to plan, budget, and appropriate more intelligently with the elimination of sudden fluctuations, unpredictabilities, and immeasurables, stemming from a variety of other causes—including various State executives on legislative determinations of level of family indigency, et cetera.

As for eligibility requirements, the bill provides for the flexibility which only state-set standards could provide. Clearly, eligibility requirements vary from area to area, and are determined by economics, definitions, and cost-of-living figures. Where the cost of living is high—as in New York City, or Washington, D.C. or Montgomery County—eligibility for this coverage might be set as high as $4,500 a year for a family of four. Where living is less expensive, the figure might be somewhere in the neighborhood of $2,600 a year.

The point is, Mr. Speaker, when the States set the standard individually, they are able to reflect these area differences. A national standard would be like a procrustean bed—"too long for some, too short for others, requiring that legs be lopped off or stretched in the name of uniformity."

So much for how the bill proposes we handle catastrophic illnesses encountered by those who are presently covered by medicaid.

What of the others? What of the vast majority of Americans who are financially able to buy their own basic health protection, but who cannot cope with the burdens imposed by a catastrophic illness?

This bill proposes a solution to their problem, too.

Upon discussion with insurance company actuaries, I learn that the average health insurance policy provides protection against costs up to about $5,000 per annum. Such policies assure the beneficiary of basic, high quality healthcare.

The problems arise when those benefits have been exhausted.

For like most of us, Mr. Speaker, nearly everyone who carries this protection becomes financially vulnerable, from that exhaustion point forward.

Here is what I propose we do to remedy matters:

First. The Secretary of Health, Education, and Welfare would establish a catastrophic health insurance program for every American with an income above the level of medical indigence.

Second. Those who contribute to social security would be required to pay an additional four-tenths of 1 percent on their taxable earnings, and an equal amount to be matched by employers.

Third. Those who are not in the social security framework would pay four-tenths of 1 percent of their taxable earnings, based on their income tax return, up to the maximum social security base, which is now $7,800 a year.

Fourth. All persons with gross nonearned income in excess of $2,000 would pay four-tenths of 1 percent on such earnings, on their income tax return. There would be the proviso that no one individual would pay more in total, than four-tenths of 1 percent, times the maximum taxable earnings base under social security.

Fifth. According to the estimates I have received, the income from these tax sources would approximate $2.5 million annually. It would be placed in a Federal health care trust fund.

Sixth. From this pool, the Social Security Administration would provide 80-percent reimbursement of the cost of health and medical expenses for the individual and his dependents, whichever exceeds the larger of two sums. The first of these is an expenditure of $5,000, whether or not it was derived from health insurance. The second would be 25 percent of the gross income of the individual and his dependents.

Those of our citizens who are 65 years of age or older are, of course, protected by medicare.

For these people, my proposal would apply to medical expenses, actually paid by the individual, in excess of the larger of two sums: First, 25 percent of the gross income of the individual and his dependents; or second, $1,000.

Mr. Speaker, these are the highlights of my proposal. Let me say that all Government efforts to date have been directed at providing first-dollar coverage. Invariably, first-dollar coverage entails high administrative costs, for it requires that many small claims be processed. Thereby the substance of the program is eroded. My aim is to amend and to protect existing law or substitute therefor so that the public can be insulated from disastrously high costs; give meaningful relief to those hardest hit by extensive medical expenses; make the existing program work easier; and at the same time make the greatest use possible of the dollars available.

Mr. Speaker, extra care will do just that.

THE "LONG AMENDMENT," as set forth in Senate Report 91-1431, on the Social Security Amendments of 1970, Senate Committee on Finance, 91st Congress, 2nd Session, December 1970.

V. CATASTROPHIC HEALTH INSURANCE PROGRAM

The Committee on Finance is concerned about the devastating effect which a catastrophic illness can have on families unfortunate enough to be affected by such an illness. Over the past decades science and medicine have taken great strides in their ability to sustain and prolong life. Patients with kidney failure, which until recently would have been rapidly fatal, can now be maintained in relative good health for many years with the aid of dyalysis and transplantation. Patients with spinal cord injuries and severe strokes can now often be restored to a level of functioning which would have been impossible years ago. Modern burn treatment centers can keep victims of severe burns alive and can offer the victim restorative surgery which can in many instances erase the after effects of such burns.

These are but a few examples of the impact which recent progress in science and medicine has had. This progress, however, has had another impact. These catastrophic illnesses and injuries which heretofore would have been rapidly fatal and hence not too expensive financially, now have an enormous impact on a family's finances. The newly developed methods of treating catastrophic illnesses and injuries involve long periods of hospitalization, often in special intensive care units, and the use of complex and highly expensive machines and devices. The net cost of a catastrophic illness or injury can be and usually is staggering. Hospital and medical expenses of many thousands of dollars can rapidly deplete the resources of nearly any family in America. These families are then faced not only with the devastating effect of the illness itself, but also with the necessity of accepting charity or welfare. Catastrophic illnesses do not strike often, but when they do the effects are disastrous—particularly in the context of soaring health care costs.

The Committee on Finance believes that Government and social insurance programs should be able to respond to the progress made in medical science. Medicine and science are now often able to mitigate the physical effects of a catastrophic illness or injury, and the committee believes that government, through our established social insurance mechanism should act to mitigate the financial effects of such catastrophes.

The committee has adopted an amendment which would establish a Catastrophic Health Insurance Program.

The program would be designed to complement private health insurance which has played the major role in insuring against basic health expenses. About 80 percent of people under age 65 have insurance against hospitalization expenses, but these policies all have a limit on hospital days which they will cover. The most common policies cover 60 days of care. Similarly, existing private policies designed to cover medical expenses have upper limits of coverage. Private major medical insurance plans are available, but are held by only

20 to 30 percent of the population. In addition, even the major medical plans have maximum benefits per spell of illness, usually ranging from $5,000 to $20,000.

The committee's Catastrophic Health Insurance Program would be structured to take maximum advantage of the experience gained by medicare. The program would use medicare's established administrative mechanism wherever possible, and would incorporate all of medicare's cost and utilization controls.

Eligibility

The committee amendment establishes a new Catastrophic Health Insurance Program[1] (CHIP) as part of the Social Security Act financed by payroll contributions from employees, employers and the self-employed. Under the committee's provision all persons under age 65 who are fully or currently insured under the social security program, their spouses and dependent children would be eligible for CHIP protection. All persons under age 65 who are entitled to retirement, survivors, or disability benefits under social security as well as their spouses and dependent children would also be eligible for CHIP. This constitutes about 95 percent of all persons under age 65.

Persons over 65 would not be covered as they are protected under the medicare program which, in spite of its limitation on hospital and extended-care days, is a program with a benefit structure adequate to meet the significant health care needs of all but a very small minority of aged beneficiaries. The largest noncovered groups under age 65 are Federal employees, employees covered by the Railroad Retirement Act, and State and local governmental employees who are eligible for social security but not covered due to the lack of an agreement with the State. (There are a small number of people who are still not covered by social security or other retirement programs; the majority of these are domestic or agricultural workers who have not met the necessary social security coverage requirements.)

Federal employees are, however, eligible for both basic and major medical catastrophic health insurance protection under the Federal Employees Health Benefits Act, with the Federal Government paying 40 percent of the costs of such coverage. To assure equitable treatment of those Federal employees who also are eligible for social security, a special provision of the committee bill would require the Federal Employees Health Benefits program to make available to Federal employees who have sufficient social security coverage to be eligible under CHIP, a plan which supplements CHIP coverage; if such a plan is not made available to Federal employees, no CHIP payments will be available for services otherwise payable under the FEHB plan.

Buy-in for State and Local Employees

Under the committee bill, State and local employees who are not covered by social security could receive coverage under CHIP if the State and local governments exercise an option to buy into the program to cover them on a group basis. When purchasing this protection, States

would ordinarily be expected to include all employees and eligible annuitants under a single agreement with the Secreary. A determination by the State as to whether an individual is an annuitant or member of a retirement system or is otherwise eligible to have such coverage purchased on his behalf would, for purposes of the agreement to provide CHIP protection, be final and binding upon the Secretary. Each State which enters into an agreement with the Secretary of Health, Education, and Welfare to purchase CHIP protection will be required to reimburse the Federal Catastrophic Health Insurance Trust Fund for the payments made from the fund for the services furnished to those persons covered under CHIP through the State's agreement with the Secreatry, plus the administrative expenses incurred by the Department of Health, Education, and Welfare in carrying out the agreement. Payments will be made from the fund to providers of services for covered services furnished to these persons on the same basis as for other persons entitled to benefits under CHIP. Conditions are also specified under which the Secretary or the State could, after due notice, terminate the agreement.

Benefits

The benefits that would be provided under CHIP would be the same as those currently provided under parts A and B of medicare, except that there would be no upper limitations on hospital days, extended care facility days, or home health visits. Present medicare coverage under part A includes 90 days of hospital care and 60 days of post-hospital extended care in a benefit period, plus an additional lifetime reserve of 60 hospital days; and 100 home health visits during the year following discharge from a hospital or extended care facility. Part B coverage includes physicians' services, 100 home health visits annually, outpatient physical therapy services, laboratory and X-ray services and other medical and health items and services such as durable medical equipment.

The major benefits excluded from medicare, and consequently excluded from this proposal, are nursing home care, prescription drugs, hearing aids, eyeglasses, false teeth and dental care. Medicare's limitations on inpatient care in psychiatric hospitals, which limit payment to active treatment subject to a 190 day lifetime maximum, and the program's annual limitation on outpatient services in connection with mental, psychoneurotic and personality disorders are also retained. An additional exclusion would be for items or services which the Secretary of Health, Education, and Welfare rules to be experimental in nature.

Deductibles and Coinsurance

The committee believes that in keeping with the intent of this program to protect against health costs so severe that they usually have a catastrophic impact on a family's finances, a deductible of substantial size should be required. The committee's proposal has two entirely separate deductibles which would parallel the inpatient hospital deductible under part A and the $50 deductible under part B of medicare.

The separate deductibles are intended to enhance the mesh of the program with private insurance coverage. In order to receive both hospital and medical benefits, both deductibles must be met. If a person were to meet the hospital deductible alone, he would become eligible only for the hospital and extended care benefits. Similarly, if a family were to meet the $2,000 medical deductible, they would become eligible only for the medical benefits.

Hospital Deductible and Coinsurance

There would be a hospital deductible of 60 days hospitalization per year per individual.

After an individual has been hospitalized for a total of 60 days in one year, he would become eligible for payments toward hospital expenses associated with continued hospitalization. The program would thus begin payment with the 61st day of his hospitalization in that year. Only those posthospital extended care services which he receives subsequent to having met the 60-day deductible would be eligible for payment.

After the hospital deductible has been met, the program would pay hospitals substantially as they are presently paid under medicare, with the individual being responsible for a coinsurance amount equal to one-fourth of the medicare inpatient hospital deductible applicable at that time. Extended care services which are eligible for payment would be subject to a daily coinsurance amount equal to one-eighth of the medicare inpatient hospital deductible. (In January 1971, this coinsurance will amount to $15 a day for inpatient hospital services and $7.50 a day for extended care services.) Thus the coinsurance could rise yearly in proportion to any increase in hospital costs.

Medical Deductible and Coinsurance

There would be a supplemental medical deductible initially established at $2,000 per year per family. The Secretary of Health, Education, and Welfare would, between July 1 and October 1 of each year (beginning in 1972), determine and announce the amount of the supplemental medical deductible for the following year.

The deductible would be the greater of $2,000 or $2,000 multiplied by the ratio of the physicians' services component of the Consumer Price Index for June of that year to the level of that component for December 1971. Thus, the deductible could rise yearly in proportion to any increase in the price of physicians' services.

After a family has incurred expenses of $2,000 for physicians' bills, home health visits, physical therapy services, laboratory, and X-ray services and other covered medical and health services the family would become eligible for payment under the program toward these expenses. For purposes of determining the deductible, a family would be defined as a husband and wife and all minor and dependent children.

After the medical deductible had been met, the program would pay for 80 percent of eligible medical expenses, with the patient being responsible for coinsurance of 20 percent.

Deductible Carryover

As in part B of medicare, the plan would have a deductible carryover feature—applicable to both the dollar deductible and the hospital-day deductible—under which expenses incurred (or hospital days used) but not reimbursed during the last calendar quarter of a year would also count toward the satisfaction of the deductibles for the ensuing year. For example, an individual admitted to a hospital with a cardiac condition on December 10, 1972, and continuously hospitalized through February 19, 1973, would not, in the absence of the carryover provision, meet the hospital-day deductible unless he were to be hospitalized for at least another 10 days in 1973. With a carryover provision, however, the individual described above would meet the hospital deductible on January 30, 1973. Similarly, if a family's first eligible medical expenses in 1972 amount to $1,200 and were incurred during the months of November and December, and an additional $3,000 in eligible medical expenses are incurred in 1973, the family would, in the absence of a carryover provision, be eligible for payment towards only $1,000 of their expenses in 1973. With a carryover provision, however, the family described above would be eligible for payment toward $2,200 of their expenses in 1973.

Administration

Payments made to patients, providers, and practitioners under this program would be subject to the same reimbursement, quality, health and safety standards, and utilization controls as exist in the medicare program. Reimbursement controls would include the payment of audited "reasonable costs" to participating institutions and agencies, and "reasonable charges" to practitioners and other suppliers. However, the committee expects that appropriate modifications will be made to take into account the special features of this program, including a modification to exclude "bad debts" from those costs eligible in computing reasonable cost payments to institutions.

The utilization of services would be subject to review by present utilization review committees established in hospitals and extended care facilities and by the professional standards review organizations established under another committee amendment. The committee believes that all of the above controls should be applied to reimbursement of expenses for services rendered under the proposed catastrophic illness insurance program. In addition, the Office of the Inspector General for Health Administration established under another committee amendment would be expected to closely monitor the administration of the program and can be expected to provide valuable information with respect to increasing the efficiency of the program.

The proposal contemplates using the same administrative mechanisms used for the administration of medicare including, where appropriate, medicare's carriers and intermediaries. Using the same administrative mechanisms as medicare will greatly facilitate the operation of this program. The proposal also would encompass use of medicare's statutory quality standards, in that the same conditions of participation which apply to institutions participating in medicare would apply to those institutions participating in CHIP. These standards

serve to upgrade the quality of medical care and their application under this program should have a similar salutary effect.

The Social Security Administration, utilizing its network of district offices, would determine the insured status of individuals and relationships within families which are necessary to establish entitlement to CHIP benefits. The determination of whether the deductible expenses had been met would also be handled by the Social Security Administration in cooperation with carriers and intermediaries. The proposed administrative plan envisions establishing a $2,000 minimum expense amount before individual bills would be accepted. This would protect the administrative agencies from being inundated with paperwork.

Financing

The first year's cost of the program is estimated at $2.5 billion on an incurred basis and $2.2 billion on a cash basis. The committee provision would finance the program on a $9,000 wage base with the following contribution schedule: 1972–74, 0.3 of one percent of taxable payroll on employees and 0.3 on employers; 1975–79, 0.35; 1980 and after, 0.4. Rates for the self-employed would also be 0.3, 0.35, and 0.4 respectively.

The contributions would be placed in a separate Federal Catastrophic Health Insurance Trust Fund from which benefits and administrative expenses related to this program would be paid. The complete separation of catastrophic health insurance financing and benefit payments is intended to assure that the catastrophic health insurance program will in no way impinge upon the financial soundness of the retirement, survivors, or disability insurance trust funds or medicare's hospital and supplementary medical insurance trust funds. Such separation will also focus public and congressional attention closely on the cost and the adequacy of the financing of the program.

To provide an operating fund at the beginning of the program (in recognition of the lag in time between the date on which the taxes are payable and their collection), and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis without interest) during the first 3 calendar years of the program. The amount which could be drawn in any such calendar year could not exceed the estimated amount of 6 months of benefit payments during that year.

Relationship With Medicaid

The catastrophic illness insurance program would be supplemental to the medicaid program with regard to public assistance recipients and the medically indigent in the same way in which it will be supplemental to private insurance for other citizens. Thus, medicaid will continue to be the State-Federal program that is intended to cover the basic health needs of categorical assistance recipients and the medically indigent. The benefit structure of medicaid varies from State to State, but in general it is a basic rather than a catastrophic benefit package.

In addition, medicaid will continue to play a substantial role in financing the cost of nursing home care, which represents a cata-

strophic cost to many people, especially the aged. The catastrophic health insurance program will, of course, lessen the burden on the medicaid program to some degree, since those covered by medicaid who are eligible would have a large proportion of their catastrophic expenses covered by this program, leaving only the deductible and coinsurance amounts for the medicaid program to pay. This factor will not only enable the States to contain the costs of their programs, but may also encourage them to improve coverage of basic services.

Conclusion

The committee estimates that more than one million families of the approximately 49 million families in the United States annually incur medical expenses which will qualify them to receive benefits under the program. Of course, nearly all American families will receive the benefit of insurance protection against the costs of catastrophic illnesses. The program is not intended to meet the health costs which the population incurs for short-term hospitalization and acute illness. This program is intended to insure against those highly expensive illnesses or conditions which, although a potential threat to every family, actually strike only a relatively few. The committee believes that individuals should, during their working years, be able to obtain protection against the devastating and demoralizing effects of such costs.

These provisions and the taxes to pay for them would become effective January 1, 1972.

S. 4594—INTRODUCTION OF THE MINIMUM HEALTH BENEFITS AND HEALTH SERVICES DISTRIBUTION AND EDUCATION ACT OF 1970 *

Mr. PELL. Mr. President, I introduce, on behalf of myself and Mr. MONDALE, for referral to the Committee on Labor and Public Welfare, a bill to provide for the improved accessibility and availability of comprehensive health care services to all citizens, to provide for the creation of areawide health services and health education corporations, and to provide a minimum level of health benefits to employees and their families. My bill is to be entitled "The Minimum Health Benefits and Health Services Distribution and Education Act of 1970."

THE HEALTH CARE CRISIS

Mr. President, there are few other public policy problems of the magnitude, of the complexity, and of the seriousness of the health care crisis that is facing our Nation today.

By most every standard, the way this country cares for the health needs of its citizens can be judged inadequate.

We have an unorganized and very expensive nonsystem of health care which provides fine curative care to persons who can afford the care, which provides comparatively little curative care to most other persons, and which provides almost no preventive care to any person whether he can afford the care or not.

Babies die because their mothers were unable to obtain the prenatal and postnatal care they required.

Elderly persons die of diseases that could have been cured had they had regular medical examinations earlier in their lives.

Simple sickness becomes serious illness for the lack of early treatment.

Persons becoming suddenly ill or hurt can rarely obtain timely physician service and must be shuttled off to distant, crowded emergency rooms for cattle-car treatment of their illness or injury.

New miracle drugs are discovered, but they go unused because people cannot afford them.

Medical research provides us with machines and organs to assist or replace our hearts and our kidneys, but many people still die because costs and limited production make those advances unavailable to them. For example, in 1910 the death rate per 100,000 population was 287 for cardiovascular disease and 76.2 for cancer. In 1966 the death rate per 100,000 population was 520 for cardiovascular disease and 154.8 for cancer, that is nearly a doubling in the rates for those causes of death.

As the cost of health care continues to skyrocket, more people become reluctant to obtain the preventive health care they need.

Even with increased wages, more and more workingmen are becoming less and less able to pay for the health care their families need.

Medical care prices in the last 8 years have been rising at nearly twice the rate of the overall Consumer Price Index.

Although we spend more money on health care than any other country in the world, over $53 billion per year, and although we spend more money per capita than any other nation, $315 per person a year, we are still not bringing adequate health care to all of our people. We rank 11th in terms of female life expectancy, 12th in terms of maternal mortality, 14th among countries in terms of infant mortality rates, 16th in terms of the percentage of males who die between the ages of 40 and 50 years of age, and 18th in terms of male life expectancy.

Many people question this situation. They ask: "How is it that the country that can put men on the moon and that can put nuclear submarines under the North Pole, cannot put adequate health care services within the reach of each of its citizens?"

I suppose the answer rests in the nature of our national commitments. As I see it, the reasons why our American genius for developing sophisticated technology and for organizing armies does not extend to the provision of health care services are basically three in number.

First, we have organized ourselves to develop an industrial technology that is primarily required to provide for national defense. Nationwide corporations work hand in hand with our national defense machinery. Guns are exchanged for subsidized technological research. But no similar symbiotic relationship exists for health care. There is no overall organization or firm commitment to a national health care purpose within the health industry and within the public sector.

Second, we have had no awareness of the health crisis that faces us. We have been somewhat blinded by a dreamy-eyed faith in the capacity of the American economy and in the quality of American life. We have let Madison Avenue convince us that everyone is a member of the Pepsi generation—that no one gets sick in America.

And, third, we have somehow expected the invisible hand of the marketplace to supply us with all the health services we require. We have expected a cottage industry of private physicians and charitable hospitals to provide us with the same quantity of services as the quantity of goods we have been accustomed to receiving from our corporate dominated economy. We have expected health services to be produced as easily as we produce Fords and color televisions.

Even though we have had shortages of many thousands of doctors, nurses, and physicians; even though we have had and still have many areas of the country which lack needed medical facilities; even though we realized that private health insurance policies by their reimbursement policies were encouraging the needless use of the most expensive forms of health care, such as hospital bed care; and even though our medical schools are all going bankrupt, we still have been reluctant to make a national commitment necessary to the restructure of our system of delivering and financing health care.

A NEW APPROACH

Mr. President, I believe that the time is now at hand to act. I believe, as I mentioned in my speech a year ago, that, in the 92d Congress, we must act to provide for a radical restructuring of the financial organizational foundation of our Nation's health care system. I believe health care for all citizens should be our first priority. For that reason, I introduce today the Minimum Health Benefits and Health Services Distribution and Education Act of 1970.

I believe my bill represents a uniquely American and a uniquely comprehensive approach for solving our national health care crisis. It does not represent a plan for socialized medicine. It does not represent a plea for another large, never-ending Federal grant program. And, it does not represent a knee-jerk emotional approach toward a very complicated problem.

My bill is an attempt to develop a total systems approach to the health care problem. It is an attempt to create a closed system of health care financing, delivery, and education which will eventually be capable of operating as a self-sufficient system within our economy. And, it is an attempt to utilize some basic principles of public resource management and corporate finance in the best interests of the health needs of the Nation.

My bill is based on principles that are probably as well understood by economists as the principles upon which national health insurance plans are based; however, my application of these principles to the health care problem may well be considered too innovative. It is for this reason that I am introducing my bill at this time—at the end of the session. I am hopeful that after the general public and those particularly concerned with health care problems have had the opportunity to reflect upon the merits of my plan, they might be more ready to accept it and provide me with suggestions for improvement when I introduce it again in the next session of Congress.

I also am introducing my bill at this time in order that it will come within the reporting provisions of my study amendment to the recently enacted Health Improvement Act of 1970. My amendment requires the Secretary of the Department of Health, Education, and Welfare to report by March 1971, on national health care proposals introduced in this Congress and to complete a detailed systems analysis of alternative approaches to national health care, such as my own, before September 1971. I look forward to the Department's analysis of my bill.

MINIMUM HEALTH BENEFITS

The first key feature of my bill is my method of providing health benefits. I do not call for another tax on the workingman. I do not call for the Federal Government to make large payments to pay for health benefits. I do not call for a heavy tax on businesses. I simply ask that an employee be guaranteed a minimum level of health benefits by his employer, just as he is guaranteed a minimum wage. I use this minimum wage approach for a number of reasons.

*Senator Pell has reintroduced an identical proposal, S.703, into the 92nd Congress.

Anyone who examines the present Federal budgetary situation from a national priorities point of view cannot help but to come to two basic conclusions. First, even with the ending of the Vietnam war, there will not be a large amount of additional funds available for major new initiatives for some time; and second, if new funds are to become available, new general taxes are going to have to be levied to provide for those additional funds, and neither business nor labor wants to pay more taxes. This I avoid in my plan.

Presently the average workingman pays about a third of his overall income for Federal, State, and local taxes. If additional Federal income taxes are levied, and if a national health insurance tax is added to the present employment taxes paid for social security, the workingman's tax burden may well become unbearable. Moreover, many small businesses would also have financial difficulty with an additional employment tax for national health insurance.

This tax situation and the limited Federal budgetary situation has lead me to search for a more reasonable alternative for the financing of health care than a national health insurance scheme which is dependent on more taxes on employee wages, on more taxes on employers, and on more money from the Federal Treasury.

Thus, I am proposing making a minimum level of health care services a direct cost of producing the country's gross national product. I am suggesting an "in kind" tax.

I am suggesting that every wage earner should not only be entitled to a minimum level of wages adequate to support his family as consideration for his labors, but he should also be entitled to a minimum level of health care benefits for himself and his family.

These minimum benefits would be primarily preventive in character and emphasize annual medical examinations and the use of ambulatory medical facilities care, which is the most economical and sensible way of approaching the problem. These benefits would emphasize walking care rather than death bed care. Curative benefits would be scaled to the employee's pocketbook and his medical condition. He would have to pay for the first 2 days of direct care, but the next 12 days of care would be provided as benefits. If the employee is simply recuperating rather than actually receiving direct medical treatment, he will be entitled to 10 days in a long-term care facility if a doctor so recommends. Costs of catastrophic illness exceeding one fourth of a worker's annual income is also provided as a benefit.

Most employees have already some coverage of curative benefits, such as hospitalization coverage, so the minimum benefits provided would be complimentary to those policies and would thus tend to reduce the pressure on the use of more expensive hospital care, which is now where most high cost reimbursable care is obtained under health insurance.

This approach would have the twin anti-inflationary effects of, one, reducing the use of expensive care facilities, and two, of the increasing of the bargaining power of the health consumer through the bargaining power of an employer who would, of course, have the incentive to contract for low cost health coverage for his employees. To reduce his costs the employer would be expected to contract for a prepaid health plan or to provide the health services directly himself as some industries, such as Kaiser, presently do.

For those businesses which might face unusual financial difficulties in providing benefits to their employees, I allow the Secretary of Health, Education, and Welfare to exempt them for a period up to 5 years or to provide matching per capita grants on prepaid health insurance plans for the cost of employees' benefits.

The exemption period would allow for a period of adjustment and planning for those businesses that may have long-term wage contracts or which may be facing unusual financial hardships.

AREA HEALTH SERVICES AND HEALTH EDUCATION CORPORATIONS

The second key feature of my bill is the means by which I would make health services available to all persons and the means by which I would provide for the education of necessary health personnel. I propose the creation of federally chartered corporations which would have all the advantages of modern business organizations plus all the advantages of a monopolistic public service agency. These corporations would be a means of getting the health care that people need to them and a means of supplying health manpower where it is lacking.

These corporations would be partially modeled upon the health maintenance organizations recommended by the Department of Health, Education, and Welfare, the area health education centers recommended by the Carnegie Commission on Medical Education, the health care corporation suggested by a study group of the American Hospital Association, and upon the form of a federally chartered corporation as encompassed in Public Law 91-518, the Rail Passenger Service Act of 1970, which has existing providers of service exchanging their assets for stock in a Federal corporation.

Areas of the country would have a number of incentives for supporting the incorporation of area health service and health education corporations.

Most areas of the country now lack the facilities and medical manpower needed to provide comprehensive health services to their citizens. Area corporations could fill this need.

Most areas of the country now lack the means for educating the health manpower they need. The Carnegie Commission on Higher Education has listed 126 areas where area health education centers should be established. Area corporations could provide for the balanced distribution of medical manpower among all regions.

Corporations could provide a means for an area to organize all its fragmented health services under one umbrella. Health providers would have a number of incentives for coming under a Federal corporate umbrella.

Existing providers of health services, such as doctors, hospitals, and medical schools could exchange their assets for stock in the corporation and receive the numerous financial and organizational benefits to which the corporation is entitled, including the ability to issue tax-exempted bonds guaranteed by the Government, including priority consideration in existing Federal grant programs and including eligibility for new Federal grants and loans provided for the initial operation of new corporations. Also, doctors would be able to reduce their medical liability and receive tax benefits by becoming corporate employees.

For employers in an area, corporations would be a low cost option for the provision of health benefits to their employees.

For State governments, corporations would be a low cost provider of medicaid services.

For the Federal Government, corporations would be a low cost provider of medicare services.

For a region's economy, the existence of an area health corporation would have a competitive effect on other providers of health services in the region and would tend to force down the price of health care.

After incorporation, the Secretary would appoint eight members of a corporation's 15-member board of directors; common stockholders—who would be those hospitals, medical schools, and doctors who have exchanged their assets for stock—would elect three directors, and preferred stockholders—such as health insurance companies—would elect four directors.

The majority of the board of directors would be weighed toward public interest representation. Of the eight members appointed by the Secretary, two members would be representative of qualified medical personnel, one member would be representative of medical education personnel, one member would represent the Secretary, one member would represent the State and local political subdivisions, and one member would represent health consumers.

The primary purpose of the corporations would be to provide an area with comprehensive health services on a prepaid basis and to educate the health personnel an area needs.

Through the corporate structure the cost of medical education would be merged into the cost of delivering health services. Over the long run, the demand for health services in an area would be expected to pay the full cost for the supply of health services and for health manpower in an area through the use of a corporation.

Corporations would be expected to operate neighborhood health centers within their areas of services and be able to provide either directly or by contract all levels of medical care from the level of intensive care down to the level of long-term care. They would be expected to handle medicaid and medicare beneficiaries.

Corporation health services would be provided primarily on a prepared per capita contract basis rather than on the more costly, and inefficient, traditional "fee for service" and "reimbursement for cost" method.

Since area corporations would have the power to raise funds through federally guaranteed tax-exempted bonds, since they would have a steady program of income from employers paying for the minimum health benefits due to employees, they should only require a minimum of Federal grants and loans for the initiation of their services.

Thus, in order to put the corporations on their feet, the Secretary of Health, Education, and Welfare is authorized to provide grants and loans under existing public health legislation or provide assistance through the new loans and grants authorized in the bill.

If an area lacks health personnel, the Secretary can assign, temporarily, Public Health Service personnel until sufficient area health personnel is trained.

For services which corporations provide to indigent persons or to persons employed by small businesses and charitable organizations not capable of paying for their health benefits, they would be reimbursed by the Secretary on percentage per capita basis depending upon the ability of the corporation to absorb those costs.

Corporations would be required to maintain high standards of medical quality and medical education and financial accountability. Each corporation would be required to submit on an annual basis a 5-year program financial plan to a regional planning agency in order that their operations and financing plans be coordinated within their State health plans and their regional health plans.

As a general rule, given all the corporate and public advantages provided in my bill, area health services and health education corporations might be expected to become completely self-sufficient economic entities within, at most, 25 years. Given the benefits of preventive care and comprehensive health care services provided by health corporations, the standards of good health for the population within a corporation's service area could be expected to improve significantly after, at most, 10 years of coverage.

I would add with a note of pride, that my own State of Rhode Island—the home of Aime Forand, the father of medicare, and the home of the late John Fogarty, a long-time crusader for health research—has been moving ahead with the ideas I have suggested. The AFL-CIO in Providence is establishing a prepaid group health care plan. A statewide public corporation to do health care demonstrations is being formed by the State department of health in conjunction with the hospitals in the State, the Brown University medical education faculty, and other interested health personnel. Hopefully, with the assistance of a Federal grant coming under a program I helped make law, this public corporation will make my State a model health care State.

REGIONAL HEALTH PLANNING COUNCILS

Mr. President, the third key feature of my bill is the method of providing for the rational allocation of health resources within the country.

I propose the establishment of regional health planning councils in each major geographic region of the country. These councils will have the responsibility of insuring that adequate plans are being made for the provisions of health services to each citizen and that adequate plans are being made for the education of needed health personnel and for the construction of needed health facilities.

Members of the regional planning councils would include representatives of State Governors, medical societies, and area health corporations. Regional planning councils would have the responsibility of approving State health plans and the program financial plans of area corporations. They would be responsible for submitting on an annual basis regional health care plans to the Secretary of Health, Education, and Welfare for his approval. Federal funds would not be sent on projects not included within an approved regional plan.

ADVANTAGES OVER THE NATIONAL HEALTH INSURANCE APPROACH

Mr. President, a fourth key feature of my bill is that it is, on the one hand, complementary to a national health insurance approach and it has, on the other hand, a number of advantages over the national health insurance approach.

It is complementary to a national health approach in that, if a national health insurance program were to be enacted, it would still require mechanisms, such as my bill's area health services and health education corporations, to supply the health services and health manpower that would be required to meet demand.

However, my bill has a number of distinct advantages over the national health insurance approach.

It not only provides health benefits for people, but it provides a method of getting those benefits to people.

My bill does not eliminate market forces as a regulator of health prices, but it creates a planned and balanced marketplace regulated for quality and providing a role for private enterprise.

By making employers the health consumers, the bargaining power of health consumers is increased. By making area health corporations provide health services on a comprehensive prepaid basis, an economical supply of health services is created. My bill, thus, creates a balance between supply and demand which has a built-in anti-inflationary tendency.

Also, my bill does not have a burdensome employment tax on workers or on businesses.

Rather my bill provides that, while a minimum standard of health benefits be provided employees, employers have up to 2 years to provide them, and, if any economic hardship is involved, up to 5 years. This means that, when wage agreements are being negotiated, employers would be able to include the cost of meeting these minimum health equipments as part of all of any new wage agreements.

Moreover, along that same line, my bill does not force employers to pay for health services for their employees through a Federal tax which is based upon costs over which they have no control and through a tax set according to national health care prices which might be higher than the actual prices of providing care in an employer's own particular area.

My bill provides a means for partially solving the financial crisis faced by our Nation's medical schools and provides a means of reducing the tremendous shortage of health manpower that exists in the country today.

And, finally, it creates a decentralized system of health care which can become, eventually, economically self-sufficient and independent of any future need for extensive Federal appropriations.

Mr. President, in sum, the failure of this country to provide adequate health services to its citizens is a most serious matter.

I offer a suggestion, for all to consider, as to a means of remedying our national health care crisis.

Today, I offer a bill to make health care our first national priority.

I offer a bill not only to guarantee health benefits to every citizen, but also to provide a means for getting those benefits to the people.

I offer a bill designed to make medical care a matter of "walking care" not "death bed care."

I offer a bill designed to take health care out of the Federal budget and make it self-supporting.

I offer a bill designed to halt inflation in health care costs by balancing health care supply and demand.

I am hopeful that my bill will meet these expectations, and I look forward to receiving the comments of interested persons on my bill.

Mr. President, I ask unanimous consent that the text of my bill be printed in the RECORD at this point.

The PRESIDING OFFICER (Mr. COOK). The bill will be received and appropriately referred; and, without objection, the bill will be printed in the RECORD.

The bill (S. 4594) to provide minimum health benefits to employees and their immediate families and to provide for the distribution of health benefits, for medical education, and for other purposes, introduced by Mr. PELL, for himself and Mr. COOK, was received, read twice by its title, referred to the Committee on Labor and Public Welfare, and ordered to be printed in the RECORD, as follows:

S. 4594

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as "The Minimum Health Benefits and Health Services Distribution and Education Act of 1970."

The "AETNA PLAN," as outlined by Daniel W. Pettengil, Vice President Group Division, Aetna Life and Casualty, during hearings on Social Security and Welfare Proposals, House Committee on Ways and Means, 91st Congress, 1st Session, November 6, 1969.*

Aetna is the largest private health insurer in the United States. It therefore has a vital interest in health care, its problems and its future. Aetna and other insurance companies recognize that the increasing complexity of the skills and equipment needed to perform the modern miracles of medical science and the increasing shortage of health-care manpower have created an upward spiral of medical-care costs. That spiral threatens the economic security of virtually every family in America.

As an aside, I would point out that in drafting testimony for today, we have avoided urging the cause of private health insurance, which has contributed so much to the field of health care. We have tried instead to reach for a constructive set of solutions to a major national problem.

Our proposals do, however, envision a continuing role for private health insurance companies, because we believe competition among them will provide the efficiency and flexibility essential for a sound solution.

I realize that the Committee on Ways and Means is basically concerned with financing and taxing. However, while financing health care is a serious problem, the fundamental health problem facing the Nation today is the inaccessibility of quality health care for much of the population and the unacceptability of some of the care that is available. The adoption of any plan that seeks to solve the financing problem—without at the same time seeking to solve the fundamental problem of the availability of quality medical care—not only will not be a solution but will make matters far worse.

Underscoring this view are statements made last week by Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, and John W. Gardner, former Secretary of HEW. Dr. Egeberg said that it would be a mistake to introduce any unitary national system for health-care payments before the Nation had reformed its system of medical care. The extra burden of demand would swamp an already overtaxed system of medical care.

Mr. Gardner said that while the medicare and medicaid programs have gone far to relieve the elderly and the poor of the financial burden of health care, the programs have brought only a small increase in the availability of health-care services. He added:

> The billions of dollars they (Medicare and Medicade) have place in the hands of the health-services consumer—pressing against a system incapable of providing these services on an adequate scale—have produced a terrifying inflation of the cost of medical care.

Our Nation must adopt a coordinated set of programs to improve for all citizens the availability and acceptability of health care as well as the means of financing it. These programs should make maximum use of the private sector and judicious use of Government funds. To achieve those goals, Aetna Life & Casualty recommends the adoption of the programs which I shall highlight now.

In brief, these programs would:

(1) Strengthen both the responsibilities and the financing of comprehensive health planning agencies.

(2) Provide additional funds for meeting specific and growing health manpower needs.

*You will note that many of the provisions of the "Aetna Plan," outlined above were incorporated in H.R. 19935, introduced in December 1970 by Representative Burleson; information on H.R. 19935 is contained in another section of this report.

(3) Promote the development and use of comprehensive ambulatory care.

(4) Improve cost controls while assuring quality care.

(5) Extend the availability of health insurance to all and provide a new plan of catastrophe coverage.

(6) Establish a National Advisory Health Council.

I. STRENGTHEN COMPREHENSIVE HEALTH PLANNING

Comprehensive health planning is essential if we are to use our large but not unlimited resources for the greatest good of both present and future generations. Planning is needed to identify unmet needs and to establish a rational order for meeting them. Planning is also needed to avoid unnecessary and costly duplication of facilities and services. Although some needs are common to all communities, others are not, and the priorities differ considerably. For example, some communities need to plan for additional hospital beds while others need to plan for elimination of excess hospital beds. Because local health needs are involved, planning must be done at the local level with support and coordination at the State and National levels.

For those reasons, Aetna Life & Casualty proposes that comprehensive health-planning agencies be assigned at least the following specific responsibilities:

(1) To determine and assign priorities for the health needs of the community on a continuing basis and to publicize them.

(2) To review all proposals for constructing new health-care facilities, for remodeling existing facilities, or for offering new health services that would require either significant capital outlays for equipment or hiring substantial numbers of scarce health manpower—and to certify the degree of need that the community has for the facility or service.

(3) To review requests for Government loans or grants for health-care facilities, manpower, or services, and to advise the appropriate government agency whether the project for which the loan or grant is requested is one for which the community has an essential need—and, in the case of a grant request, whether that need has a high priority.

We also propose that the Federal Government give greater guidance and financial support to comprehensive health planning.

II. PROVIDE ADDITIONAL HEALTH MANPOWER

The shortage of health manpower is widespread, acute, and worsening. Until this shortage is relieved, health-care costs will continue to rise much faster than the overall cost of living. More important, until this manpower shortage is overcome, our Nation cannot hope to make quality health-care available to all.

In solving the health manpower problem, particular attention should be paid to training physicians who will provide primary care for families and to developing allied health personnel who will assist physicians in this work. Also needed are doctors trained in the special skill of managing teams of physicians and allied health personnel in health centers. Indeed, in some instances, it will be necessary first to

develop curriculum and secure the necessary faculty before it will be possible to train students.

Accordingly, Aetna Life & Casualty proposes:

A. That the Federal Government consolidate its various loan-grant programs for health manpower into a single program.

B. That this new program provide:

(1) That a student may borrow up to the full cost of tuition, room and board for such medical, dental, nursing, or other allied health professional training as the Secretary of Health, Education, and Welfare specifies as essential to relieve the health manpower shortage; and

(2) That, upon completion of his training, the student will have one-tenth of the total loan waived for each year of service within an area—rural or inner city—which is certified as needful of his service by the appropriate comprehensive health-planning agency and authorized by the Secretary of Health, Education, and Welfare.

C. That Federal grants be made to medical schools for devising curricula and securing faculty to train additional physicians skilled either in providing primary care or in managing teams of doctors and allied health personnel in health centers.

III. PROMOTE AMBULATORY CARE

Much diagnosis and treatment currently provided hospital in-patients could be more economically rendered on an ambulatory basis if adequate facilities and personnel were available. Thus, provision of comprehensive ambulatory care services is another urgent national need.

In some communities an existing group practice could be expanded to meet this need. In others, the hospital out-patient department could be reorganized, while in still others a brand-new facility may have to be established by the community. Properly-equipped ambulatory care centers could probably perform 25 percent of all the surgery now done on an in-patient basis as well as much of the diagnostic X-ray and laboratory testing.

The potential reductions in the total cost of care are substantial, even though the initial cost of establishing these centers will be considerable.

Accordingly, Aetna Life & Casualty proposes:

A. That a Federal program of loan guarantees be established to encourage construction of ambulatory care centers.

B. That Federal loans be made available to cover setup costs, with grants made in place of loans for centers established in poverty areas.

C. That benefits for ambulatory care be included in all governmental health insurance programs.

D. And that employers be urged to include ambulatory care coverage in group medical expense plans—with a proviso that an employer who has not done so within a reasonable period, say 5 years, could deduct for Federal income tax purposes only 50 percent of the money spent to provide medical expense benefits for employees and dependents.

IV. IMPROVE COST CONTROLS

Strengthening comprehensive health planning, providing additional health manpower, and promoting ambulatory care are all essential ingredients for improving the availability of health care and doing so at a lower overall cost. It is also essential that cost controls be introduced in order to slow the upward spiral of health-care costs.

Accordingly, Aetna Life & Casualty proposes:

A. That no Federal loan or grant for a specific health facility or service be made unless the project is certified by the appropriate comprehensive health-planning agency as an essential need, and, in the case of a grant, that the need is of high priority.

B. That reimbursement of health-care services under all Federal programs be subject to the following conditions:

(1) That care will be covered only in those health-care institutions which have a review committee of qualified physicians that effectively check whether the services rendered are of good quality and are necessary for the proper treatment of the patient, and whose management takes effective action with respect to adverse findings of the review committee.

(2) That the professional services of physicians and allied health personnel be subject to effective peer review and that no payment shall be made for any professional service which is found to be unnecessary.

(3) That no payment be made for that portion of a fee charged by a physician or allied health personnel which exceeds the prevailing level of fees in the community.

(4) And that the services of a health-care institution be paid for on a "controlled charges" basis and that no payment shall be made unless the institution uses controlled charges for all its patients.

Under the controlled-charges system, each institution would budget its expenses for the fiscal year and establish charges for services that should produce the income assumed by the budget. The cost of capital would be includable in the budget, and hence in the charges to patients, only to the extent that the capital expenditure had been approved by the applicable comprehensive health planning agency. The institution would file its budget and its charges with a reviewing agency composed of representatives of consumers, insurers, and health-care institutions.

Should the budget reveal that the institution apparently would not operate efficiently, in comparison with comparable institutions providing comparable services, or the charges appear out of line, the reviewing agency would request a revised budget and revised charges. Filed charges would be deemed to be acceptable by the reviewing agency unless it acted to the contrary within 60 days of the filing. The reviewing agency would be able, however, to request a prospective change at a later date. For valid reasons, budgets and charges could be revised during the year in accordance with the foregoing procedures.

V. EXTEND AVAILABILITY OF COVERAGE TO ALL

I have emphasized that our major problem is to improve the availability of acceptable health care. We must not, lose sight, however, of

the fact that at least 11 percent of the population under age 65 has no health insurance at all and that the poor need assistance with financing and adequate level of health-care coverage. Solving this latter problem need not be as costly to the Government as it might appear.

At least 60 percent of the population under 65 is covered under employer-sponsored group medical-expense insurance programs, some quite rich in scope. It is logical to build on this private health insurance in extending the availability of health insurance to all. For example, group plans could cover permanent part-time employees and even temporary employees where the temporary employment is expected to be at least a calendar quarter. When employment is suspended due to layoff or labor dispute, some provision for continuation of the group coverage could be made. Most important of all, when an employee becomes totally disabled, he could be permitted to continue his coverage until becoming eligible for medicare.

A. *Minimum standards for group medical-expense plans*

Accordingly, Aetna Life & Casualty proposes that the Federal Government limit the deductibility of an employer's expenditure for medical-expense benefits for employees and their dependents to 50 percent instead of the present 100 percent if the plan does not include all of the following features:

(1) That eligibility for coverage include all full-time and all part-time employees working at least 20 hours a week for at least 13 weeks of the year. Inclusion of the insurance industry's model coordination-of-benefits clause is recommended to avoid costly over-insurance.

(2) That coverage continue for at least 1 month during a layoff or labor dispute with no increase in required employee contributions, with provision for continuation for up to 11 more months during such layoff or labor dispute subject to the employee's paying the full cost of the coverage.

(3) That coverage continue during a period of illness or injury up to a maximum of 6 months with no greater employee contributions being required than would have been had the employee remained actively at work. If at the end of the 6-month period the employee were totally disabled, coverage would be continued for as long as total disability continued but not beyond the date he first becomes eligible for benefits under title XVIII of the Social Security Act. The employee would not be required to contribute more for such continued coverage than he would have paid had he remained a healthy, active employee.

(4) That coverage continue for dependent children who are totally disabled, provided the child were insured under the plan prior to age 19 and became disabled prior to that age. This continuation would remain in effect until the child recovered or became eligible for benefits under title XVIII of the Social Security Act. The employee would not be required to contribute more for such coverage than would have been required were the child a dependent under age 19.

Admittedly, the foregoing does nothing to help the hardcore unemployed, the near-poor whose employers do not provide group medical-expense insurance, and the self-employed who are uninsurable because of poor health. These three classes of people need Government assistance in financing their health care. This assistance would be more

acceptable if it were in the form of a subsidy for private health insurance rather than the present welfare type of payment.

B. *Uniform insured plan for poor, near-poor, and uninsurables*

According, Aetna Life & Casualty proposes:

(1) That the Federal Government encourage each State to make available, through a reinsurance pool underwritten by all carriers, a uniform plan of health-insurance benefits to the poor, near-poor, and uninsurables.

(2) That the uniform plan be operated like a group plan with all the administration being performed by one carrier or a set of carriers chosen by the State with the concurrence of the Secretary of Health, Education, and Welfare.

(3) That the benefits provided by the plan be at least the minimum benefits specified by the Federal legislation creating the program. (See exhibit I.)

(4) That poor families would be defined in the law as those whose adjusted income for the preceding calendar year was less than a specified dollar amount, which would be uniform for all States. The adjusted income would be gross earnings less the sum of the $600 personal exemptions allowed in the income tax law. This would avoid the rigorous means tests which some States have applied in administering the medicaid program and simplify and reduce the cost of administration.

(5) That the upper income limit for the poor be the lower income limit for the near poor and that there be an upper income limit for the near poor specified in the law and uniform for all States. The near poor would be required to make a contribution towards the cost of their coverage, which would be a percentage of the adjusted income for the calendar year on which their eligibility for coverage was based. The percentage would range from a very nominal figure for those who are just above the lower income limit to an amount which approximated the full cost of the premium for those just below the upper income limit for the near poor.

(6) That an uninsurable person would be defined in the law as one who had attempted to purchase private health insurance providing the minimum benefits prescribed by law for State uniform plans and who had either been completely rejected or offered the coverage at a premium rate in excess of that required by the State's uniform plan for uninsurable people. Each uninsurable person electing to participate in the State's uniform plan would be required to pay a contribution reflecting in part his very high claim costs with the balance being borne by the pool as a whole. If the uninsurable individual were a member of a family, the insurable members of the family would secure whatever private coverage they desired for themselves from the carrier of their choice.

(7) That participation in the uniform plan would be voluntary except that the State would be obligated to include any family to whom cash assistance is provided.

(8) That the policy year of the pool program would run from July 1 of one year through June 30 of the following year. Premiums, contributions, and coverage would be provided for the entire policy year regardless of when the individual actually applied for coverage

during that year. (This provision is necessary since some people will not apply for coverage until after they become sick.)

(9) That all carriers, profit and nonprofit, licensed in the State to write medical expense benefits would share any losses suffered by the pool and would be allowed an appropriate risk charge for assuming this risk.

(10) That the administering carrier or carriers would set the premium rates for the uniform plan for each year with the advice and consent of a non-man actuarial committee appointed by the Governor of the State from among actuaries recommended by the other carriers.

(11) That the State's cost of the program would be the excess of the premiums charged by the pool over the contributions made by the near poor and the uninsurables. This cost would be shared by the Federal Government on a basis related to the difference between the per capita income of the states and the per capita income of the Nation, with a minimum Federal contribution of 65 percent for all States whose average per capita income was higher than the national average and with a maximum Federal participation of 90 percent. To the extent that a State wished to provide more than the minimum benefits required by the law, it would be permitted to do so. However, the extra premium required for the additional benefits would be shared by the Federal Government at a rate equal to 75 percent of its sharing rate for the minimum benefits.

We believe that each family is responsible for insuring its own medical expenses with assistance, where appropriate, from the Government. At the same time, we recognize that no insured plan can soundly provide benefits for every single dollar of medical expense that a family might incur. Thus, the Nation needs a catastrophe medical program under which each family would be responsible for its own medical expenses up to a portion of its income, or up to the amount of its insurance, if greater. The State would pay any medical expenses incurred in any given year in excess of the family's responsibility.

Obviously, such a program could not be instituted overnight by any State, even with Federal assistance. Instead, the program should be phased in gradually, starting with the poor, then the near poor, and finally the balance of the population.

Before embarking on an open end medical expense program of this type, Congress should be aware of the tremendous cost of providing room and board for those people, primarily the elderly, who are not physically able to feed and clothe themselves or take care of their daily personal needs. Congress should determine whether this is a medical problem, the cost of which should be covered under the State catastrophe programs, or a social problem which could more effectively be met through some other means. The problem exists. It is an enormous one. The question is how best to solve it.

C. *Catastrophe medical expense program*

Specifically, Aetna Life & Casualty proposes:

(1) That the Federal Government encourage each State to set up a catastrophe medical program by agreeing to share the cost at a rate equal to 75 percent of the sharing rate applicable in that State for a pool program of minimum benefits as described in section B above.

(2) That the Federal Government specify that its sharing would initially be available only with respect to the poor and would specify

a time schedule under which its sharing would become available for the near poor and finally the entire population.

(3) That the Federal Government would specify the types of medical expenses eligible for inclusion for purposes of Federal sharing initially, and provide a time schedule for including additional expenses.

(4) That the amount of the annual deductible under the catastrophe program—the amount of medical expenses the family would be responsible for before it would be eligible to have the balance of its expenses paid for by the catastrophe program—would be set by Congress in the enabling legislation. The deductible would be such as to be zero for the poor and then rapidly increase to give the average worker ample incentive to secure adequate health insurance which would at least cover his deductible. An illustrative scale of deductibles is attached hereto as Exhibit II.

VI. ESTABLISH A NATIONAL ADVISORY HEALTH COUNCIL

Health care and health-care problems are so complex today that no President and his Cabinet can be fully informed. It seems desirable, therefore, that the President and his Cabinet have available the advice of a group of experts in the provision and insuring of health care who would be independent of political pressures.

Accordingly, Aetna Life & Casualty proposes:

(1) That a National Health Advisory Council be appointed by the President of the United States.

(2) That the council be of limited size, say nine members, each serving for a 3-year term with the initial terms on a staggered basis.

(3) That the council encompass a broad spectrum of those associated with the delivery, financing and receipt of medical care, including in particular a consumer representative and a State administrator of health programs.

(4) That the council be responsible for keeping the President and his Cabinet advised about the major problems in the field of health care and for recommending: the priorities that should be established for allocating available funds or manpower to solve such problems, the agency that should administer any given governmental health-care program, and the governmental health-care programs that should be revised or discontinued because they are ineffective or no longer serve an essential need of the Nation.

Our present health-care system is not working as well as it should. Some people do not have access to acceptable care because of income or place of residence. All find that good medical care is becoming increasingly expensive. The shortage of health-care personnel grows more critical daily. Catastrophe looms behind the approaching crisis.

We are confident that these problems can be solved by bold, imaginative action. The comprehensive and interrelated programs proposed by Aetna Life & Casualty build on the strengths of all the elements of our present system. They combine the unsurpassed flexibility, innovativeness and managerial skills of the private sector with the unique economic capacity of the public sector. Out of this cooperative endeavor would arise a new partnership of unprecedented scale and potential.

We are prepared to enter such a partnership. We invite Federal, State and local governments, our fellow insurance companies and all other interested parties from the private sector to join us in this partnership.

"Ameriplan," from a report of the Special Committee on the Provision of Health Services, American Hospital Association, November 1970.

I

AMERIPLAN: ITS GOALS AND PROGRAMS

1-001 The importance of providing good health care for all should be self-evident. Although we have done much in the United States to create outstanding health care institutions, to educate and train competent physicians and hospital administrators, and to provide excellent care for many of our citizens–accomplishments of which we may be justly proud–much remains to be done, and urgently.

1-002 As a nation we must provide better quality, more convenient health care for all the people, at reasonable cost, and in a manner in keeping with human dignity. This must be done because we accept one basic, irreducible principle:

1-003 Health care is an inherent legal right of each individual and of all the people of the United States.

1-004 From this principle four corollaries follow:

1-005 (1) it is a function of health care to enhance the dignity of the individual and to promote better community life for all;

1-006 (2) it is a function of government to assure the preservation and maintenance of the health of all the people;

1-007 (3) health care must be available without regard to any person's ability to pay and without regard to race, creed, color, sex, or age;

1-008 (4) health services must be so organized and located that they are readily accessible to all.

1-009 This basic principle and its corollaries can be best and most rapidly implemented through a new nationwide system for the delivery of

health services, to be known as AMERIPLAN to symbolize the uniting of all the health resources of the United States for better care.

Goals

1-010 To be truly effective and relevant to the problems and opportunities before us, the AMERIPLAN system for the delivery of health services must have the potential to meet the goals which follow. Some of these goals may be relatively easy to attain. Others are more difficult, calling for long-range planning and large investments of money and manpower. Some require little change from the present manner in which health services are delivered; others require considerable changing of habits, commitments and even laws. And some are goals that will become more sharply defined in coming years.

1-011 1. A system for the delivery of health services must be developed which has as a primary objective the optimum health care of each and every person. Untreated illness in the community must be sought out and treated.

1-012 2. The system for the delivery of health services must focus on individual needs, must be personalized through the skills and humanity of health personnel, and must preserve the dignity of the individual.

1-013 3. The system for the delivery of health services must assure that no person becomes financially dependent or suffers loss of dignity as a result of illness or accident.

1-014 4. The system must assure that all children are provided with preventive health care and that no child suffers from untreated illness.

1-015 5. The system for the delivery of health services must provide comprehensive health care. It must be able to provide the following components of care to each individual as needed: health maintenance, primary care, specialty care, restorative care, and health-related custodial care. Comprehensive health care must be developed as rapidly as possible.

1-016 6. The system must be provided financial incentives for en-

couraging utilization of ambulatory facilities, extended care and nursing home facilities, and home care programs, rather than the present incentives which encourage reliance predominantly on hospitalization.

1-017 7. The system must be oriented to the maintenance of personal good health and to the prevention of illness, in contrast with the present system which is primarily oriented to the treatment of illness after it becomes acute.

1-018 The system must be provided financial incentives for keeping people well and, if they are ill, for making them well as soon as possible.

1-019 8. The system must support only those providers that meet standards of effectiveness, quality, and efficiency.

1-020 Health care institutions providing quality care in the most economic manner must be continued and developed; institutions not providing such care must be assisted to do so; and institutions unwilling or incapable of providing such care must not be supported.

1-021 9. The system for the delivery of health services must include the private as well as the public sector of the health field.

1-022 The predominant concern and mission of all health care institutions must be the public interest even though their ownership may be private.

1-023 In order to maximize innovation and preserve the benefits of alternative choice, the system must consist of a multiplicity of organizations with varied types of ownership and organizational forms.

1-024 10. The system must be designed so that at the outset it provides care for persons suffering from alcoholism, drug abuse, and acute mental illness.

1-025 The system must also be designed so that long-term mental health care, non-health-related custodial care, and institutional care provided by all federal, state and

local governmental hospital systems will be integrated into the total system within a reasonable time.

I-026 11. Programs to resolve those sociological and environmental problems that affect the health of individuals must be coordinated and integrated with the system for the delivery of health care.

I-027 The failure to resolve acute sociological and environmental problems such as poverty, drug abuse, and air pollution adds to the cost and amount of necessary health care of individuals. It must be realized that the pace at which these problems are addressed and solved directly affects the organizational burdens and total effectiveness of the health care system.

I-028 To accomplish these goals, the existing system for the delivery of health services must be substantially restructured, including both the methods of delivering health services and the methods of financing health services, so that all available resources may be utilized to provide better health care to all at a reasonable cost.

I-029 Therefore, AMERIPLAN has been formulated with priorities given to the accomplishment of these goals, and with the hard choices made of where scarce fiscal, organizational, and manpower resources should be allocated.

I-030 AMERIPLAN incorporates methods of financing as one component of restructuring the system for the delivery of health care. Thus it differs significantly from many current proposals that deal only with the financing of health services and fail to provide a solution to the problem of establishing necessary standards and an organized system for the delivery of health services throughout the nation.

The Health Care Corporation

I-031 The basic innovation of AMERIPLAN is an organization called a Health Care Corporation having the resources necessary to provide truly comprehensive health care to a defined population. The establishment of Health Care Corporations would allow the health field to move from what some have called a cottage industry to a modern,

coordinated and comprehensive system for the delivery of health care.

1-032 To permit the establishment and growth of Health Care Corporations, and to assure uniform availability of adequate health services throughout the country, legislation would be enacted by the federal government which would require the adoption of federal regulations defining the scope, standards of quality, and comprehensiveness of health services and stating the benefits to be provided for all of the people. These regulations would be administered at the state level with care being provided locally by Health Care Corporations.

1-033 Health Care Corporations would have the following characteristics:

1-034 (1) Each Health Care Corporation would synthesize management, personnel, and facilities into a corporate structure with the capacity and responsibility to deliver the five components of comprehensive health care to the community: health maintenance, primary care, specialty care, restorative care, and health-related custodial care.

1-035 (2) Health Care Corporations would cover the comprehensive health needs of every geographic area and of all of the population, with some Health Care Corporations spanning geographic and political boundaries where necessary to assure that all persons have access to care. All persons would have the opportunity and be encouraged to join Health Care Corporations.

1-036 (3) The Health Care Corporation would assure optimum service to the community by physicians. Every practicing physician would have the opportunity to be affiliated with a Health Care Corporation, and physicians would have the opportunity and could accept the responsibility of participating in the management of Health Care Corporations.

1-037 Various forms of medical practice, including group practice, would be permitted within the Health Care Corporation.

1-038 (4) The Health Care Corporation would be responsible for providing professional peer review and other mech-

anisms to evaluate the quality of all health care on a continuing basis. Such evaluation of quality would be an integral part of AMERIPLAN and a basic responsibility of the Health Care Corporation.

1-039 (5) The Health Care Corporation would identify its manpower needs, and be responsible for the inservice education and training of its health manpower and the recruitment of all health personnel for its providers.

1-040 (6) The proper growth of Health Care Corporations would only occur through the most appropriate, economical use of all resources. Enforceable regulatory controls would be established by legislation in each state to assure that needs would be met without unnecessary construction or duplication of facilities and services.

1-041 (7) Each Health Care Corporation would develop a suitable mechanism by which the community could express its health needs and through which the Corporation could actively respond. All persons in the community would have a role in identifying how health services would be provided, in determining how care could be made more accessible, and how the delivery of care could best support the dignity of the individual and his family.

AMERIPLAN Health Benefits

1-042 Constructive change in any system occurs only when those using the system, those financing the system and those delivering care within the system are motivated to change. The health care system is no exception. Therefore levers must be supplied to motivate change.

1-043 The lever to motivate change by those using the system and those financing the system would be the better quality and greater accessibility of health care, and the new health maintenance benefits that would be created at reasonable cost by establishing Health Care Corporations. The lever to motivate health care providers to establish Health Care Corporations would be the strong demand for these changes by those who use and finance health care.

1-044 AMERIPLAN would utilize both federal government and private fi-

nancing. All health care benefits that are tax-supported would be financed at the federal level, and all present federal and private sources of financing, including prepayment plans and health insurance companies would be utilized. The broader AMERIPLAN benefit packages would make Medicare and Medicaid no longer necessary.

1-045 Under benefits proposed for AMERIPLAN, for the first time in the history of our country all of the people would be secure from becoming financially dependent or suffering loss of dignity as a result of illness or accident. The total benefit packages of AMERIPLAN, when interrelated and delivered through Health Care Corporations, would encompass a scope of benefits never before available to any individual or group and at a cost this nation could afford.

1-046 (1) Health Maintenance and Catastrophic Illness Benefits Package: This package would be the keystone of AMERIPLAN. It would consist of benefits for health maintenance and benefits to protect every person in the United States against the major costs of catastrophic illness or accident. These benefits would be paid for by the federal government in whole for the poor, and in part for the near-poor through general federal revenues, and for the aged and all others by a tax collected through the Social Security mechanism.

1-047 Benefits to protect against the cost of catastrophic illness or accident would become operative depending upon annual family income level, size of family, and amount of health care expenditures. Accordingly, the poor would receive the benefits immediately after exhausting the benefits of the Standard Benefits Package, whereas persons with higher incomes would have to expend a predetermined amount before becoming eligible for these benefits.

1-048 To be eligible for the Health Maintenance and Catastrophic Illness Benefits Package, to which all persons would be entitled, each person would have to demonstrate that he has purchased or been provided with the Standard Benefits Package and has registered with a Health Care Corporation.

1-048 (2) Standard Benefits Package: All persons would be uniformly covered by this package, offered by prepayment plans and private health insurance companies. Its benefits would consist of four components of care–primary, specialty, restorative, and health-related custodial care. These four components of care would provide all of the care most frequently required, such as physicians' services and acute hospital care, and would emphasize ambulatory services.

1-050 This Standard Benefits Package would be paid for in whole for the poor and in part for the near-poor through general federal revenues. For the aged, the Standard Benefits Package would be paid for by a tax collected through the Social Security mechanism. All other persons would purchase the Standard Benefits Package from prepayment plans and private insurance companies.

1-051 (3) Supplemental Benefits: One of the basic precepts of AMERIPLAN would be that within reasonable limits those who are able to pay for their care should do so. Accordingly, for those persons there would be a gap between the benefits provided under the Standard Benefits Package and the benefits for protection against the cost of catastrophic illness or accident, provided in the Health Maintenance and Catastrophic Illness Benefits Package. Various packages of supplemental benefits to fill this gap would be available through prepayment plans and private health insurance for those who wish to purchase them.

The Concept of AMERIPLAN

1-052 A unique characteristic of AMERIPLAN is that it provides a blueprint of a nationwide system for the delivery of health services that can be implemented today by the health field. Often a field of endeavor waits until change is thrust upon it from the outside. However, it is possible for the health field to use AMERIPLAN to make changes now, before the enactment of legislation, and thus play a central role in shaping the future course of AMERIPLAN.

AMERIPLAN: ITS GOALS AND PROGRAMS

1-053 AMERIPLAN would be implemented upon passage of federal legislation stating the benefits to be provided all the people and permitting the adoption of federal regulations for the scope, standards of quality, and comprehensiveness of health services.

1-054 The federal legislation would result in the establishment by each state legislature of State Health Commissions to regulate Health Care Corporations and be responsible for the approval of these Corporations and their operation.

1-055 Federal and state legislation should be passed as soon as possible so that the system could be fully implemented within several years. AMERIPLAN could develop rapidly–within the decade of the 70's–and should within that time embrace the entire health field and cover all the people.

1-056 Most significantly, the implementation of AMERIPLAN could hasten commitments by all health professionals, especially physicians, to join with health care institutions in a corporate responsibility to provide good health care for all. And AMERIPLAN would provide the primary method through which the public could participate responsibly in determining the future of the nation's health care system.

1-057 Many segments of the health care field such as medical schools, governmental hospitals, and professional groups would contribute markedly toward the development of AMERIPLAN. Because of the constraints of time, details of their participation are omitted from this report, in favor of spelling out in greater detail the participation of one group, the physicians, as leaders in determining the quality of care. But in formulating the concept of AMERIPLAN, due consideration has been given to the impact of the system on all such groups. It is hoped that the many committees currently studying the roles of health professionals, organization of institutions and services, and standards of quality of health care will join in an effort to develop AMERIPLAN and contribute to its concept so that all of the best thinking of the health field may be used in the public interest.

1-058 In summary, many details of AMERIPLAN remain for delineation at some future time. The recommendations of this report are intentionally flexible to permit the widest range of alternative solutions and to encourage an immediate beginning to the restructuring of the nation's health care system.

NATIONAL HEALTH INSURANCE—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 92-49)

The SPEAKER laid before the House the following message from the President of the United States; which was read and referred to the Committee of the Whole House on the State of the Union and ordered to be printed:

To the Congress of the United States:

In the last twelve months alone, America's medical bill went up eleven percent, from $63 to $70 billion. In the last *ten* years, it has climbed 170 percent, from the $26 billion level in 1960. Then we were spending 5.3 percent of our Gross National Product on health; today we devote almost 7% of our GNP to health expenditures.

This growing investment in health has been led by the Federal Government. In 1960, Washington spent $3.5 billion on medical needs—13 percent of the total. This year it will spend $21 billion—or about 30 percent of the nation's spending in this area.

But what are we getting for all this money?

For most Americans, the result of our expanded investment has been more medical care and care of higher quality. A profession of impressive new techniques, powerful new drugs, and splendid new facilities has developed over the past decade. During that same time, there has been a six percent drop in the number of days each year that Americans are disabled. Clearly there is much that is *right* with American medicine.

But there is also much that is wrong.

One of the biggest problems is that fully 60 percent of the growth in medical expenditures in the last ten years has gone not for additional services but merely to meet price inflation. Since 1960, medical costs have gone up twice as fast as the cost of living. Hospital costs have risen five times as fast as other prices. For growing numbers of Americans, the cost of care is becoming prohibitive. And even those who can afford most care may find themselves impoverished by a catastrophic medical expenditure.

The shortcomings of our health care system are manifested in other ways as well. For some Americans—especially those who live in remote rural areas or in the inner city—care is simply not available. The quality of medicine varies widely with geography and income. Primary care physicians and outpatient facilities are in short supply in many areas, and most of our people have trouble obtaining medical attention on short notice. Because we pay so little attention to preventing disease and treating it early, too many people get sick and need intensive treatment.

Our record, then, is not as good as it should be. Costs have skyrocketed but values have not kept pace. We are investing more of our nation's resources in the health of our people but we are *not* getting a full return on our investment.

BUILDING A NATIONAL HEALTH STRATEGY

Things do not have to be this way. We can change these conditions—indeed, we must change them if we are to fulfill our promise as a nation. Good health care should be readily available to all of our citizens.

It will not be easy for our nation to achieve this goal. It will be impossible to achieve it without a new sense of purpose and a new spirit of discipline. That is why I am calling today not only for new programs and not merely for more money but for something more—for a *new approach* which is equal to the complexity of our challenges. I am calling today for a new National Health Strategy that will marshal a variety of forces in a coordinated assault on a variety of problems.

This new strategy should be built on four basic principles.

1. Assuring Equal Access. Although the Federal Government should be viewed as only one of several partners in this reforming effort, it does bear a special responsibility to help all citizens achieve equal access to our health care system. Just as our National Government has moved to provide equal opportunity in areas such as education, employment and voting, so we must now work to expand the opportunity for all citizens to obtain a decent standard of medical care. We must do all we can to remove any racial, economic, social or geographic barriers which now prevent any of our citizens from obtaining adequate health protection. For without good health, no man can fully utilize his other opportunities.

2. Balancing Supply and Demand. It does little good, however, to increase the demand for care unless we also increase the supply. Helping more people pay for more care does little good unless more care is available. This axiom was ignored when Medicaid and Medicare were created—and the nation paid a high price for that error. The expectations of many beneficiaries were not met and a severe inflation in medical costs was compounded.

Rising demand should not be a source of anxiety in our country. It is, after all, a sign of our success in achieving equal opportunity, a measure of our effectiveness in reducing the barriers to care. But since the Federal Government is helping to remove those barriers, it also has a responsibility for what happens after they are reduced. We must see to it that our approach to health problems is a balanced approach. We must be sure that our health care system is ready and able to welcome its new clients.

3. Organizing for Efficiency. As we move toward these goals, we must recognize that we *cannot* simply *buy* our way to better medicine. We have already been trying that too long. We have been persuaded, too often, that the plan that *costs* the most will *help* the most—and too often we have been disappointed.

We cannot be accused of having underfinanced our medical system—not by a long shot. We have, however, spent this money poorly—reenforcing inequities and rewarding inefficiencies and placing the burden of greater new demands on the same old system which could not meet the old ones.

The toughest question we face then is not *how much* we should spend but *how* we should spend it. It must be our goal not merely to finance a more expensive medical system but to organize a more efficient one.

There are two particularly useful ways of doing this:

A. Emphasizing Health Maintenance. In most cases our present medical system operates episodically—people come to it in moments of distress—when they require its most expensive services. Yet both the system and those it serves would be better off if less expensive services could be delivered on a more regular basis.

If more of our resources were invested in preventing sickness and accidents, fewer would have to be spent on costly cures. If we gave more attention to treating illness in its early stages, then we would be less troubled by acute disease. In short, we should build a true "health" system—and not a "sickness" system alone. We should work to maintain health and not merely to restore it.

B. Preserving Cost Consciousness. As we determine just who should bear the various costs of health care, we should remember that only as people are aware of those costs will they be motivated to reduce them. When consumers pay virtually nothing for services and when, at the same time, those who provide services know that all *their* costs will also be met, then neither the consumer nor the provider has an incentive to use the system efficiently. When that happens, unnecessary demand can multiply, scarce resources can be squandered and the shortage of services can become even more acute.

Those who are hurt the most by such developments are often those whose medical needs are most pressing. While costs should never be a barrier to providing needed care, it is important that we pre-

serve some element of cost consciousness within our medical system.

4. Building on Strengths. We should also avoid holding the whole of our health care system responsible for failures in some of its parts. There is a natural temptation in dealing with any complex problem to say: "Let us wipe the slate clean and start from scratch." But to do this—to dismantle our entire health insurance system, for example—would be to ignore those important parts of the system which have provided useful service. While it would be wrong to ignore any weaknesses in our present system, it would be equally wrong to sacrifice its strengths.

One of those strengths is the diversity of our system—and the range of choice it therefore provides to doctors and patients alike. I believe the public will always be better served by a pluralistic system than by a monolithic one, by a system which creates many effective centers of responsibility—both public and private—rather than one that concentrates authority in a single governmental source.

This does not mean that we must allow each part of the system to go its own independent way, with no sense of common purpose. We must encourage greater cooperation and build better coordination—but not by fostering uniformity and eliminating choice. One effective way of influencing the system is by structuring *incentives* which reward people for helping to achieve national goals without forcing their decisions or dictating the way they are carried out. The American people have always shown a unique capacity to move toward common goals in varied ways. Our efforts to reform health care in America will be more effective if they build on this strength.

These, then, are certain cardinal principles on which our National Health Strategy should be built. To implement this strategy, I now propose for the consideration of the Congress the following six point program. It begins with measures designed to increase and improve the supply of medical care and concludes with a program which will help people pay for the care they require.

A. REORGANIZING THE DELIVERY OF SERVICE

In recent years, a new method for delivering health services has achieved growing respect. This new approach has two essential attributes. It brings together a comprehensive range of medical services in a single organization so that a patient is assured of convenient access to all of them. And it provides needed services for a fixed contract fee which is paid in advance by all subscribers.

Such an organization can have a variety of forms and names and sponsors. One of the strengths of this new concept, in fact, is its great flexibility. The general term which has been applied to all of these units is "HMO"—"Health Maintenance Organization."

The most important advantage of Health Maintenance Organization is that they increase the value of the services a consumer receives for each health dollar. This happens, first because such organizations provide a strong financial incentive for better preventive care and for greater efficiency.

Under traditional systems, doctors and hospitals are paid, in effect, on a piece work basis. The more illnesses they treat—and the more service they render—the more their income rises. This does not mean, of course, that they do any less than their very best to *make* people well. But it does mean that there is no economic incentive for them to concentrate on *keeping* people healthy.

A fixed-price contract for comprehensive care reverses this illogical incentive. Under this arrangement, income grows not with the number of days a person is sick but with the number of days he is well. HMO's therefore have a strong financial interest in preventing illness, or, failing that, in treating it in its early stages, promoting a thorough recovery, and preventing any reoccurrence. Like doctors in ancient China, they are paid to keep their clients healthy. For them, economic interests work to reenforce their professional interests.

At the same time, HMO's are motivated to function more efficiently. When providers are paid retroactively for each of their services, inefficiencies can often be subsidized. Sometimes, in fact, inefficiency is rewarded—as when a patient who does not need to be hospitalized is treated in a hospital so that he can collect on his insurance. On the other hand, if an HMO is wasteful of time or talent or facilities, it cannot pass those extra costs on to the consumer or to an insurance company. Its budget for the year is determined in advance by the number of its subscribers. From that point on it is penalized for going over its budget and rewarded for staying under it.

In an HMO, in other words, cost consciousness is fostered. Such an organization cannot afford to waste resources—that costs more money in the short run. But neither can it afford to economize in ways which hurt patients—for that increases long-run expenses.

The HMO also organizes medical resources in a way that is more convenient for patients and more responsive to their needs. There was a time when every housewife had to go to a variety of shops and markets and pushcarts to buy her family's groceries. Then along came the supermarket—making her shopping chores much easier and also giving her a wider range of choice and lower prices. The HMO provides similar advantages in the medical field. Rather than forcing the consumer to thread his way through a complex maze of separate services and specialists, it makes a full range of resources available through a single organization—often at a single stop—and makes it more likely that the right combination of resources will be utilized.

Because a team can often work more efficiently than isolated individuals, each doctor's energies go further in a Health Maintenance Organization—twice as far according to some studies. At the same time, each patient retains the freedom to choose his own personal doctor. In addition, services can more easily be made available at night and on weekends in an HMO. Because many doctors often use the same facilities and equipment and can share the expense of medical assistants and business personnel, overhead costs can be sharply curtailed. Physicians benefit from the stimulation that comes from working with fellow professionals who can share their problems, appreciate their accomplishments and readily offer their counsel and assistance. HMO's offer doctors other advantages as well, including a more regular work schedule, better opportunities for continuing education, lesser financial risks upon first entering practice, and generally lower rates for malpractice insurance.

Some seven million Americans are now enrolled in HMO's—and the number is growing. Studies show that they are receiving high quality care at a significantly lower cost—as much as one-fourth to one-third lower than traditional care in some areas. They go to hospitals less often and they spend less time there when they go. Days spent in the hospital each year for those who belong to HMO's are only three-fourths of the national average.

Patients and practitioners alike are enthusiastic about this organizational concept. So is this administration. That is why we proposed legislation last March to enable Medicare recipients to join such programs. That is why I am now making the following additional recommendations:

1. We should require public and private health insurance plans to allow beneficiaries to use their plan to purchase membership in a Health Maintenance Organization when one is available. When, for example, a union and an employer negotiate a contract which includes health insurance for all workers, each worker should have the right to apply the actuarial value of his coverage toward the purchase of a fixed-price, health maintenance program. Similarly, both Medicare and the new Family Health Insurance Plan for the poor which I will set out later in this message should provide an HMO option.

2. To help new HMO's get started—an expensive and complicated task—we should establish a new $23 million program of planning grants to aid potential sponsors—in both the private and public sector.

3. At the same time, we should provide additional support to help sponsors raise the necessary capital, construct needed facilities, and sustain initial operating deficits until they achieve an enrollment which allows them to pay their own way. For this purpose, I propose a program of Federal loan guarantees which will enable private sponsors to raise some $300 million in private loans during the first year of the program.

4. Other barriers to the development of HMO's include archaic laws in 22 States which prohibit or limit the group practice of medicine and laws in most States which prevent doctors from delegating certain responsibilities (like giving injections) to their assistants. To help remove such barriers, I am instructing the Secretary of Health, Education, and Welfare to develop a model statute which the States themselves can adopt to correct these anomalies. In addition,

the Federal Government will facilitate the development of HMO's in all States by entering into contracts with them to provide service to medicare recipients and other Federal beneficiaries who elect such programs. Under the supremacy clause of the Constitution, these contracts will operate to preempt any inconsistent State statutes.

Our program to promote the use of HMO's is only one of the efforts we will be making to encourage a more efficient organization of our health care system. We will take other steps in this direction, including stronger efforts to capitalize on new technological developments.

In recent years medical scientists, engineers, industrialists, and management experts have developed many new techniques for improving the efficiency and effectiveness of health care. These advances include automated devices for measuring and recording body functions such as blood flow and the electrical activity of the heart, for performing laboratory tests and making the results readily available to the doctor, and for reducing the time required to obtain a patient's medical history. Methods have also been devised for using computers in diagnosing diseases, for monitoring and diagnosing patients from remote locations, for keeping medical records and generally for restructuring the layout and administration of hospitals and other care centers. The results of early tests for such techniques have been most promising. If new developments can be widely implemented, they can help us deliver more effective, more efficient care at lower prices.

The hospital and outpatient clinic of tomorrow may well bear little resemblance to today's facility. We must make every effort to see that its full promise is realized. I am therefore directing the Secretary of Health, Education, and Welfare to focus research in the field of health care services on new techniques for improving the productivity of our medical system. The Department will establish pilot experiments and demonstration projects in this area, disseminate the results of this work, and encourage the health industry and the medical profession to bring such techniques into full and effective use in the health care centers of the nation.

B. MEETING THE SPECIAL NEEDS OF SCARCITY AREAS

Americans who live in remote rural areas or in urban poverty neighborhoods often have special difficulty obtaining adequate medical care. On the average, there is now one doctor for every 630 persons in America. But in over one-third of our counties the number of doctors per capita is less than one-third that high. In over 130 counties, comprising over eight percent of our land area, there are no private doctors at all—and the number of such counties is growing.

A similar problem exists in our center cities. In some areas of New York for example, there is one private doctor for every 200 persons but in other areas the ratio is one to 12,000. Chicago's inner city neighborhoods have some 1,700 fewer physicians today than they had ten years ago.

How can we attract more doctors—and better facilities—into these scarcity areas? I propose the following actions:

1. We should encourage Health Maintenance Organizations to locate in scarcity areas. To this end, I propose a $32 million program of direct Federal grants and loans to help offset the special risks and special costs which such projects would entail.

2. When necessary, the Federal Government should supplement these efforts by supporting out-patient clinics in areas which still are underserved. These units can build on the experience of the Neighborhood Health Centers experiment which has now been operating for several years. These facilities would serve as a base on which full HMO's—operating under other public or private direction—could later be established.

I have also asked the Administrator of Veterans Affairs and the Secretary of Health, Education, and Welfare to develop ways in which the Veterans Administration medical system can be used to supplement local medical resources in scarcity areas.

3. A series of new area Health Education Centers should also be established in places which are medically underserved—as the Carnegie Commission on Higher Education has recommended. These centers would be satellites of existing medical and other health science schools; typically, they could be built around a community hospital, a clinic or an HMO which is already in existense. Each would provide a valuable teaching center for new health professionals, a focal point for the continuing education of experienced personnel, and a base for providing sophisticated medical services which would not otherwise be available in these areas. I am requesting that up to $40 million be made available for this program in Fiscal Year 1972.

4. We should also find ways of compensating—and even rewarding—doctors and nurses who move to scarcity areas, despite disadvantages such as lower income and poorer facilities.

As one important step in this direction, I am proposing that our expanding loan programs for medical students include a new forgiveness provision for graduates who practice in a scarcity area, especially those who specialize in primary care skills that are in short supply.

In addition, I will request $10 million to implement the Emergency Health Personnel Act. Such funds will enable us to mobilize a new National Health Service Corps, made up largely of dedicated and public-spirited young health professionals who will serve in areas which are now plagued by critical manpower shortages.

C. MEETING THE PERSONNEL NEEDS OF OUR GROWING MEDICAL SYSTEM

Our proposals for encouraging HMO's and for serving scarcity areas will help us use medical manpower more effectively. But it is also important that we *produce* more health professionals and that we educate more of them to perform critically needed services. I am recommending a number of measures to accomplish these purposes.

1. First, we must use new methods for helping to finance medical education. In the past year, over half of the nation's medical schools have declared that they are in "financial distress" and have applied for special Federal assistance to meet operating deficits.

More money is needed—but it is also important that this money be spent in new ways. Rather than treating the symptoms of distress in a piecemeal and erratic fashion, we must rationalize our system of financial aid for medical education so that the schools can make intelligent plans for regaining a sound financial position.

I am recommending, therefore, that much of our present aid to schools of medicine, dentistry and osteopathy—along with $60 million in new money—be provided in the form of so-called "capitation grants," the size of which would be determined by the number of students the school graduates. I recommend that the capitation grant level be set at $6,000 per graduate.

A capitation grant system would mean that a school would know in advance how much Federal money it could count on. It would allow an institution to make its own long-range plans as to how it would use these monies. It would mean that we could eventually phase out our emergency assistance programs.

By rewarding *output*—rather than subsidizing *input*—this new aid system would encourage schools to educate more students and to educate them more efficiently. Unlike formulas which are geared to the annual number of enrollees, capitation grants would provide a strong incentive for schools to shorten their curriculum from four years to three—in line with another sound recommendation of the Carnegie Commission on Higher Education. For then, the same sized school would qualify for as much as one-third *more* money each year, since each of its graduating classes would be one-third larger.

This capitation grant program should be supplemented by a program of special project grants to help achieve special goals. These grants would support efforts such as improving planning and management, shortening curriculums, expanding enrollments, team training of physicians and allied health personnel, and starting HMO's for local populations.

In addition, I believe that Federal support dollars for the construction of medical education facilities can be used more effectively. I recommend that the five current programs in this area be consolidated into a single, more flexible grant authority and that a new program of guaranteed loans and other financial aids be made available to generate over $500 million in private construction loans in the coming Fiscal Year—five times the level of our current construction grant program.

Altogether, these efforts to encourage and facilitate the expansion of our medical schools should produce a 50 percent increase in medical school graduates by 1975. We must set that as our goal and we must see that it is accomplished.

2. The Federal Government should also establish special support programs

to help low income students enter medical and dental schools. I propose that our scholarship grant program for these students be almost doubled—from $15 to $29 million. At the same time, this administration would modify its proposed student loan programs to meet better the needs of medical students. To help alleviate the concern of low income students that such a loan might become an impossible burden if they fail to graduate from medical school, we will request authority to forgive loans where such action is appropriate.

3. One of the most promising ways to expand the supply of medical care and to reduce its costs is through a greater use of allied health personnel, especially those who work as physicians' and dentists' assistants, nurse pediatric practitioners, and nurse midwives. Such persons are trained to perform tasks which must otherwise be performed by doctors themselves, even though they do not require the skills of a doctor. Such assistance frees a physician to focus his skills where they are most needed and often allows him to treat many additional patients.

I recommend that our allied health personnel training programs be expanded by 50% over 1971 levels, to $29 million, and that $15 million of this amount be devoted to training physicians' assistants. We will also encourage medical schools to train future doctors in the proper use of such assistants and we will take the steps I described earlier to eliminate barriers to their use in the laws of certain States.

In addition, this administration will expand nationwide the current MEDIHC program—an experimental effort to encourage servicemen and women with medical training to enter civilian medical professions when they leave military duty. Of the more than 30,000 such persons who leave military service each year, two-thirds express an interest in staying in the health field but only about one-third finally do so. Our goal is to increase the number who enter civilian health employment by 2,500 per year for the next five years. At the same time, the Veterans Administration will expand the number of health trainees in VA facilities from 49,000 in 1970 to over 53,000 in 1972.

D. A SPECIAL PROBLEM: MALPRACTICE SUITS AND MALPRACTICE INSURANCE

One reason consumers must pay more for health care and health insurance these days is the fact that most doctors are paying much more for the insurance *they* must buy to protect themselves against claims of malpractice. For the past five years, malpractice insurance rates have gone up an average of 10 percent a year—a fact which reflects both the growing number of malpractice claims and the growing size of settlements. Many doctors are having trouble obtaining *any* malpractice insurance.

The climate of fear which is created by the growing menace of malpractice suits also affects the quality of medical treatment. Often it forces doctors to practice inefficient, defensive medicine—ordering unnecessary tests and treatments solely for the sake of appearance. It discourages the use of physicians' assistants, inhibits that free discussion of cases which can contribute so much to better care, and makes it harder to establish a relationship of trust between doctors and patients.

The consequences of the malpractice problem are profound. It must be confronted soon and it must be confronted effectively—but that will be no simple matter. For one thing, we need to know far more than we presently do about this complex problem.

I am therefore directing—as a first step in dealing with this danger—that the Secretary of Health, Education, and Welfare promptly appoint and convene a Commission on Medical Malpractice to undertake an intensive program of research and analysis in this area. The Commission membership should represent the health professions and health institutions, the legal profession, the insurance industry, and the general public. Its report—which should include specific recommendations for dealing with this problem—should be submitted by March 1, 1972.

E. NEW ACTIONS TO PREVENT ILLNESSES AND ACCIDENTS

We often invest our medical resources as if an ounce of cure were worth a pound of prevention. We spend vast sums to treat illnesses and accidents that could be avoided for a fraction of those expenditures. We focus our attention on *making* people well rather than *keeping* people well, and—as a result—both our health and our pocketbooks are poorer. A new National Health Strategy should assign a much higher priority to the work of prevention.

As we have already seen, Health Maintenance Organizations can do a great deal to help in this effort. In addition to encouraging their growth, I am also recommending a number of further measures through which we can take the offensive against the long-range causes of illnesses and accidents.

1. To begin with, we must reaffirm—and expand—the Federal commitment to biomedical research. Our approach to research support should be balanced—with strong efforts in a variety of fields. Two critical areas, however, deserve special attention.

The first of these is cancer. In the next year alone, 650,000 new cases of cancer will be diagnosed in this country and 340,000 of our people will die of this disease. Incredible as it may seem, one out of every four Americans who are now alive will someday develop cancer unless we can reduce the present rates of incidence.

In the last seven years we spent more than 30 billion dollars on space research and technology and about one-twenty-fifth of that amount to find a cure for cancer. The time has now come to put more of our resources into cancer research and—learning an important lesson from our space program—to organize those resources as effectively as possible.

When we began our space program we were fairly confident that our goals could be reached if only we made a great enough effort. The challenge was technological; it did not require new theoretical breakthroughs. Unfortunately, this is not the case in most biomedical research at the present time; scientific breakthroughs are still required and they often cannot be forced—no matter how much money and energy is expended.

We should not forget this caution. At the same time, we should recognize that of all our research endeavors, cancer research may now be in the best position to benefit from a great infusion of resources. For there are moments in biomedical research when problems begin to break open and results begin to pour in, opening many new lines of inquiry and many new opportunities for breakthrough.

We believe that cancer research has reached such a point. This administration is therefore requesting an additional $100 million for cancer research in its new budget. And—as I said in my State of the Union Message—"I will ask later for whatever additional funds can effectively be used" in this effort.

Because this project will require the coordination of scientists in many fields—drawing on many projects now in existence but cutting across established organizational lines—I am directing the Secretary of Health, Education, and Welfare to establish a new Cancer Conquest Program in the Office of the Director of the National Institutes of Health. This program will operate under its own Director who will be appointed by the Secretary and supported by a new management group. To advise that group in establishing priorities and allocating funds—and to advise other officials, including me, concerning this effort—I will also establish a new Advisory Committee on the Conquest of Cancer.

A second targeted disease for concentrated research should be sickle cell anemia—a most serious childhood disease which almost always occurs in the black population. It is estimated that one out of every 500 black babies actually develops sickle cell disease.

It is a sad and shameful fact that the causes of this disease have been largely neglected throughout our history. We cannot rewrite this record of neglect, but we can reverse it. To this end, this administration is increasing its budget for research and treatment of sickle cell disease fivefold, to a new total of $6 million.

2. A second major area of emphasis should be that of health education.

In the final analysis, each individual bears the major responsibility for his own health. Unfortunately, too many of us fail to meet that responsibility. Too many Americans eat too much, drink too much, work too hard, and exercise too little. Too many are careless drivers.

These are personal questions, to be sure, but they are also public questions. For the whole society has a stake in the health of the individual. Ultimately, everyone shares in the cost of his illnesses or accidents. Through tax payments and through insurance premiums, the careful subsidize the careless, the nonsmokers subsidize those who smoke, the physically fit subsidize the rundown and the overweight, the knowledgeable subsidize the ignorant and vulnerable.

It is in the interest of our entire country, therefore, to educate and encourage each of our citizens to develop sensible health practices. Yet we have given remarkably little attention to the health education of our people. Most of our current efforts in this area are fragmented and haphazard—a public service advertisement one week, a newspaper article another, a short lecture now and then from the doctor. There is no national instrument, no central force to stimulate and coordinate a comprehensive health education program.

I have therefore been working to create such an instrument. It will be called the National Health Education Foundation. It will be a private, non-profit group which will receive no Federal money. Its membership will include representatives of business, labor, the medical profession, the insurance industry, health and welfare organizations, and various governmental units. Leaders from these fields have already agreed to proceed with such an organization and are well on the way toward reaching an initial goal of $1 million in pledges for its budget.

This independent project will be complemented by other Federal efforts to promote health education. For example, expenditures to provide family planning assistance have been increased, rising fourfold since 1969. And I am asking that the great potential of our nation's day care centers to provide health education be better utilized.

3. We should also expand Federal programs to help prevent accidents—the leading cause of death between the ages of one and 37 and the fourth leading cause of death for persons of all ages.

Our highway death toll—56,000 fatalities last year—is a tragedy and an outrage of unspeakable proportions. It is all the more shameful since half these deaths involved drivers or pedestrians under the influence of alcohol. We have therefore increased funding for the Department of Transportation's auto accident and alcohol program from $3 million in Fiscal Year 1971 to $35 million in Fiscal Year 1972. I am also requesting that the budget for alcoholism programs be doubled, from $7 million to $14 million. This will permit an expansion of our research efforts into better ways of treating this disease.

I am also requesting a supplemental appropriation of $5 million this year and an addition of $8 million over amounts already in the 1972 budget to implement aggressively the new Occupational Safety and Health Act I signed last December. We must begin immediately to cut down on the 14,000 deaths and more than two million disabling injuries which result each year from occupational illnesses and accidents.

The conditions which affect health are almost unlimited. A man's income, his daily diet, the place he lives, the quality of his air and water—all of these factors have a greater impact on his physical well being than does the family doctor. When we talk about our health program, therefore, we should not forget our efforts to protect the nation's food and drug supply, to control narcotics, to restore and renew the environment, to build better housing and transportation systems, to end hunger in America, and—above all—to place a floor under the income of every family with children. In a sense this special message on health is one of many health messages which this administration is sending to the Congress.

F. A. NATIONAL HEALTH INSURANCE PARTNERSHIP

In my State of the Union Message, I pledged to present a program "to ensure that no American family will be prevented from obtaining basic medical care by inability to pay." I am announcing that program today. It is a comprehensive national health insurance program, one in which the public and the private sectors would join in a new partnership to provide adequate health insurance for the American people.

In the last twenty years, the segment of our population owning health insurance has grown from 50 percent to 87 percent and the portion of medical bills paid for by insurance has gone from 35 percent to 60 percent. But despite this impressive growth, there are still serious gaps in present health insurance coverage. Four such gaps deserve particular attention.

First—too many health insurance policies focus on hospital and surgical costs and leave critical outpatient services uncovered. While some 80 percent of our people have some hospitalization insurance, for example, only about half are covered for outpatient and laboratory services and less than half are insured for treatment in the physician's office or the home. Because demand goes where the dollars are, the result is an unnecessary—and expensive—overutilization of acute care facilities. The average hospital stay today is a full day longer than it was eight years ago. Studies show that over one-fourth of hospital beds in some areas are occupied by patients who do not really need them and could have received equivalent or better care outside the hospital.

A second problem is the failure of most private insurance policies to protect against the catastrophic costs of major illnesses and accidents. Only 40 percent of our people have catastrophic cost insurance of any sort and most of that insurance has upper limits of $10,000 or $15,000. This means that insurance often runs out while expenses are still mounting. For many of our families, the anguish of a serious illness is thus compounded by acute financial anxiety. Even the joy of recovery can often be clouded by the burden of debt—and even by the threat of bankruptcy.

A third problem with much of our insurance at the present time is that it cannot be applied to membership in a Health Maintenance Organization—and thus effectively precludes such membership. No employee will pay to join such a plan, no matter how attractive it might seem to him, when deductions from his paycheck—along with contributions from his employer—are being used to purchase another health insurance policy.

The fourth deficiency we must correct in present insurance coverage is its failure to help the poor gain sufficient access to our medical system. Just one index of this failure is the fact that fifty percent of poor children are not even immunized against common childhood diseases. The disability rate for families below the poverty line is at least 50 percent higher than for families with incomes above $10,000.

Those who need care most often get care least. And even when the poor do get service, it is often second rate. A vicious cycle is thus reinforced—poverty breeds illness and illness breeds greater poverty. This situation will be corrected only when the poor have sufficient purchasing power to enter the medical marketplace on equal terms with those who are more affluent.

Our National Health Insurance Partnership is designed to correct these inadequacies—not by *destroying* our present insurance system but by *improving* it. Rather than giving up on a system which has been developing impressively, we should work to bring about further growth which will fill in the gaps we have identified. To this end, I am recommending the following combination of public and private efforts.

1. I am proposing that a National Health Insurance Standards Act be adopted which will require employers to provide basic health insurance coverage for their employees.

In the past, we have taken similar actions to assure workers a minimum wage, to provide them with disability and retirement benefits, and to set occupational health and safety standards. Now we should go one step further and guarantee that all workers will receive adequate health insurance protection.

The minimum program we would require under this law would pay for hospital services, for physicians' services—both in the hospital and outside of it, for full maternity care, well-baby care (including immunizations), laboratory services and certain other medical expenses. To protect against catastrophic costs, benefits would have to include not less than $50,000 in coverage for each family member during the life of the policy contract. The minimum package would include certain deductible and coinsurance features. As an alternative to paying separate fees for separate services, workers could use this program to purchase membership in a Health Maintenance Organization.

The Federal Government would pay nothing for this program; the costs would be shared by employers and employees, much as they are today under most collective bargaining agreements. A ceiling on how much employee could be asked to contribute would be set at 35 percent during the first two and one-half years of operation and 25 percent thereafter. To give each employer time to plan for this additional cost of doing business—a cost which would be shared, of course, by all of his competitors—this program would not go into effect until July 1, 1973. This schedule would also allow time for expanding and reorganizing our health system to handle the new requirements.

As the number of enrollees rises under this plan, the costs per enrollee can be expected to fall. The fact that employees

and unions will have an even higher stake in the system will add additional pressures to keep quality up and costs down. And since the range within which benefits can vary will be somewhat narrower than it has been, competition between insurance companies will be more likely to focus on the overall price at which the contract is offered. This means that insurance companies will themselves have a greater motivation to keep medical costs from soaring.

I am still considering what further legislative steps may be desirable for regulating private health insurance, including the introduction of sufficient disincentive measures to reinforce the objective of creating cost consciousness on the part of consumers and providers. I will make such recommendations to the Congress at a later time.

2. I am also proposing that a new Family Health Insurance Plan be established to meet the special needs of poor families who would not be covered by the proposed National Health Insurance Standards Act—those that are headed by unemployed, intermittently employed or self-employed persons.

The Medicaid program was designed to help these people, but—for many reasons—it has not accomplished its goals. Because it is not a truly national program, its benefits vary widely from State to State. Sixteen States now get 80 percent of all Medicaid money and two States, California and New York, get 30 percent of Federal funds though they have only 20 percent of the poverty population. Two States have no Medicaid program at all.

In addition, Medicaid suffers from other defects that now plague our failing welfare system. It largely excludes the working poor—which means that all benefits can suddenly be cut off when family income rises ever so slightly—from just under the eligibility barrier to just over it. Coverage is provided when husbands desert their families, but is often eliminated when they come back home and work. The program thus provides an incentive for poor families to stay on the welfare rolls.

Some of these problems would be corrected by my proposal to require employers to offer adequate insurance coverage to their employees. No longer, for example, would a workingman receive poorer insurance coverage than a welfare client—a condition which exists today in many States. But we also need an additional program for much of the welfare population.

Accordingly, I propose that the part of Medicaid which covers most welfare families be eliminated. The new Family Health Insurance Plan that takes its place would be fully financed and administered by the Federal Government. It would provide health insurance to all poor families with children headed by self-employed or unemployed persons whose income is below a certain level. For a family of four persons, the eligibility ceiling would be $5,000.

For the poorest of eligible families, this program would make no charges and would pay for basic medical costs. As family income increased beyond a certain level ($3,000 in the case of a four-person family) the family itself would begin to assume a greater share of the costs—through a graduated schedule of premium charges, deductibles, and co-insurance payments. This provision would induce some cost consciousness as income rises. But unlike Medicaid—with its abrupt cutoff of benefits when family income reaches a certain point—this arrangement would provide an incentive for families to improve their economic position.

The Family Health Insurance Plan would also go into effect on July 1, 1973. In its first full year of operation, it would cost approximately $1.2 billion in additional Federal funds—assuming that all eligible families participate. Since States would no longer bear any share of this cost, they would be relieved of a considerable burden. In order to encourage States to use part of these savings to supplement Federal benefits, the Federal Government would agree to bear the costs of administering a consolidated Federal-State benefit package. The Federal Government would also contract with local committees—to review local practices and to ensure that adequate care is being provided in exchange for Federal payments. Private insurers, unions and employees would be invited to use these same committees to review the utilization of their benefits if they wished to do so.

This, then, is how the National Health Insurance Partnership would work: The Family Health Insurance Plan would meet the needs of most welfare families—though Medicaid would continue for the aged poor, the blind and the disabled. The National Health Insurance Standards Act would help the working population. Members of the Armed Forces and civilian Federal employees would continue to have their own insurance programs and our older citizens would continue to have Medicare.

Our program would also require the establishment in each State of special insurance pools which would offer insurance at reasonable group rates to people who did not qualify for other programs: the self-employed, for example, and poor risk individuals who often cannot get insurance.

I also urge the Congress to take further steps to improve Medicare. For one thing, beneficiaries should be allowed to use the program to join Health Maintenance Organizations. In addition, we should consolidate the financing of Part A of Medicare—which pays for hospital care—and Part B—which pays for outpatient services, provided the elderly person himself pays a monthly fee to qualify for this protection. I propose that this charge—which is scheduled to rise to $5.60 per month in July of this year—be paid for instead by increasing the Social Security wage base. Removing this admission cost will save our older citizens some $1.3 billion annually and will give them greater access to preventive and ambulatory services.

WHY IS A NATIONAL HEALTH INSURANCE PARTNERSHIP BETTER THAN NATIONALIZED HEALTH INSURANCE?

I believe that our government and our people, business and labor, the insurance industry and the health profession can work together in a *national partnership* to achieve our health objectives. I do *not* believe that the achievement of these objectives requires the *nationalization* of our health insurance industry.

To begin with, there simply is no *need* to eliminate an entire segment of our private economy and at the same time add a multi-billion dollar responsibility to the Federal budget. Such a step should not be taken unless all other steps have failed.

More than that, such action would be dangerous. It would deny people the right to choose how they will pay for their health care. It would remove competition from the insurance system—and with it an incentive to experiment and innovate.

Under a nationalized system, only the Federal Government would lose when inefficiency crept in or when prices escalated; neither the consumer himself, nor his employer, nor his union, nor his insurance company would have any further stake in controlling prices. The only way that utilization could be effectively regulated and costs effectively restrained, therefore, would be if the Federal Government made a forceful, tenacious effort to do so. This would mean—as proponents of a nationalized insurance program have admitted—that Federal personnel would inevitably be approving the budgets of local hospitals, setting fee schedules for local doctors, and taking other steps which could easily lead to the complete Federal domination of all of American medicine. That is an enormous risk—and there is no need for us to take it. There is a better way—a more practical, more effective, less expensive, and less dangerous way—to reform and renew our Nation's health system.

Nineteen months ago I said that America's medical system faced a "massive crisis." Since that statement was made, that crisis has deepened. All of us must now join together in a common effort to meet this crisis—each doing his own part to mobilize more effectively the enormous potential of our health care system.

RICHARD NIXON.

THE WHITE HOUSE, *February 18, 1971.*

SPECIAL ARTICLE

WHY DOES MEDICAL CARE COST SO MUCH?*

WALTER J. MCNERNEY

Abstract The major element in medical-care costs is manpower. The production of more doctors and allied personnel is often promoted as an effective way of reducing unit costs and improving distribution. Expansion of manpower, however, under the present delivery and financing systems would not lower price, improve distribution or have any measurable impact on the health of the population. Analysis of the present health system, furthermore, shows that it has relatively little to do with health and that it is tangential to many health problems. More necessary than mere increases in manpower are broader concepts of health services, clearly enunciated health goals, more consumer involvement in policy formulation, greater exploitation of the process of organization, more sophisticated management, the striking down of various artificial impediments to change and more imaginative methods of payment.

MEDICAL care costs as much as it does for both good and bad reasons. Effective demand for it is high and growing substantially — a compliment to the expanding services provided. And like most services, the labor component in production is appreciable, affording the field relatively few opportunities to guard against inflation through mechanization. On the other hand, the institutional and financial arrangements through which service is obtained are badly out of date, and the resultant costs from this point of view are excessive. At the nub of the problem is manpower, with specific reference to its magnitude, distribution and use. In fact, over 60 per cent of health-care costs are attributable directly to manpower. It must be the prime target for reform, if costs are to be moderated.

My thesis is that we have enough health man-

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Address reprint requests to Mr. McNerney at the Blue Cross Association, 840 N. Lake Shore Dr., Chicago, Ill. 60611.

power and, in some specialties, too much. Furthermore, expansion of our manpower under the present delivery and financing systems would not lower prices, improve distribution or within reasonable limits have any measurable effect on the health of the population. It is not too strong to state that the present health system has relatively little to do with health and that it is tangential to many health problems.

The reform proposed by many public figures and health professionals is production of more doctors and more allied personnel. For example, Illinois Congressman Edward J. Derwinski is quoted in the May 1, 1969, *Congressional Record* as stating that "America had a crash program in World War II which doubled the annual output of doctors. We need the same thing now."[1] The American Medical Association and the Association of American Medical Colleges issued joint statements in 1968 calling for accelerated efforts to produce more physicians.[2]

The reasoning behind such calls has various accents, but, in general terms, it pursues the following course: more doctors (for example), trained domestically, will result in lower fees, better distribution, more effective primary care, less use of the hospital (our most expensive service) and the use of fewer foreign doctors.* All this will happen through the interacting forces of supply and demand. Contemplated is the need for more medical schools, the enlargement of others, the creation of new schools for training allied skills and the initiation of new grant and loan programs among other efforts.

The magnitude of this task can be seen in the fact that a new medical school and its attendant parts can cost up to $150,000,000. The fact that medical schools are expensive to operate needs no elaboration. Currently, at least five well known schools are on the verge of bankruptcy. Furthermore, we know that approximately 10 years must elapse between the time of decision to increase physician output and its realization as output of graduates of four-year medical schools plus internship, military service and two or more years of residency training. In proposals to increase physician supply there seems to be an implied expectation that once more physicians graduate, there will be an early demonstrated effect on total supply. Such a result, of course, is not likely. If we double the output of American medical schools today and keep all other factors constant, it will be 30 years before we double the total number of physicians in the country. And, of course, total population served, physician hours worked and use of physicians will not stay constant.

The Real Problem

It is my contention that we do not suffer from a shortage of doctors, our key resources. Also, the supply of supporting skills varies with the skill — and not all are in short supply. Of course, from any reasonable base line, there is a need to adjust the supply of manpower over time, as population and medical science changes, but to call for an increase now is unwise, if not economically unsound.

The major problem we face is not numbers; it is how to use manpower properly. The increase in physician productivity (approximately 2.5 per cent annually between 1959 and 1965) and productivity of dentists through the use of substitute skills, better equipment and other developments has not been sufficient to meet the increased demand for service. In the face of sharply rising costs of medical care, it is totally unreasonable to ask the public to pay for new medical schools, hospitals and allied institutions without better exploitation of what we know about improving delivery of care. In essence, the recurrent theme reflecting the need for more manpower not only has lacked relevance but, of equal importance, has prevented a clear focus on the real problem and thus has been of double disservice.

What Is the Evidence?

There are a number of indications — in effect, circumstantial evidence — that our present health care is less than efficient. These telltale signs include not only sharply rising costs but the often wide variations found in both input and output among health services. By any measure, medical-care costs have risen rapidly over the past decade. For example, medical-care prices rose 22.2 per cent over the three-year period ending June, 1969. The Consumer Price Index, excluding its medical component, increased only 12.4 per cent. There were concomitant increases in per capita (disposable) income for the working population, but the average consumer of health services found himself paying relatively more each year for the same health service than for almost any other goods or service in our economy. Only the cost of education, among major goods and services, was close. Today, both health and education find themselves in the uncomfortable position of having had half or more of new expenditures absorbed by price increases as opposed to service or population increases over the past five years. Thus, although medical care is becoming more highly valued by the public, it is, at the same time, harder to purchase.

Wide variation in use of resources for a given result is indicative. Hospital bed-population ratios and patient-day-population ratios vary two to one by state across the country. Ratios of active nonfederal physicians to population vary on a scale of three to one. For example, whereas New York State has 200 physicians for every 100,000 people, Mississippi has only 69. For nurses, the ratio nationwide is four to one. Eighteen states had five or less psychiatrists per 100,000 population, whereas Massachusetts had

*In some major cities, large hospitals have intern and resident staffs in which more than half the doctors are from foreign medical schools. We are a debtor country despite the magnitude of our resources (or, perhaps, because of it)

22, in 1967. Within a given area the trend is toward practice in metropolitan areas at the expense of rural areas, and within metropolitan areas a shift in concentration is measurable from central city to outlying, suburban localities. In reporting on the Medex demonstration jointly sponsored by the University of Washington and the Washington State Medical Association, Dr. Richard A. Smith pointed out that it is increasingly difficult to attract physicians to rural areas. Those that remain are aging rapidly, and there are frequent complaints of overwork. No physician seems to complain about economic rewards. In addition, Dr. Smith reported that it is becoming more and more difficult to recruit nurses and laboratory technicians in rural areas.[3]

In hospitals, there are widely varying staffing patterns among comparable institutions (size, scope of services and accreditation status) in the same area. In a more clinical vein, Lewis, reporting in the New England Journal of Medicine,[4] pointed up a curious variation (three to four times) in the rates of common surgical procedures by region. He attributed some of the differences to variations in incidence of disease, but identified other significant contributing factors, including number of hospital beds available, number of board-certified surgeons in the area, and number of other doctors who performed surgery.

Variation is also marked on the output side, when the results are related to manpower and other factors such as income and family integrity. Such key indexes as life expectancy (63.6 to 70.2 years), maternal mortality (22.4 to 90.2 per 1000 live births), infant mortality (21.5 to 40.3 per 1000 live births), from tuberculosis mortality in all forms (3.4 to 12.8 per 100,000 population) and mortality from influenza and pneumonia (24.4 to 55.4 per 100,000 population) varied substantially between the white and nonwhite population in 1965. That these differences are not genetically determined is indicated by the fact that they were more economically than racially related. Similarly, there was wide variation in the prevalence of chronic conditions that limited activity (29 per cent versus 4.2 per cent) between families with income under $2,000 and those over $7,000.[5]

My purpose is not to document the weaknesses of an essentially strong health-care system but, rather, to point up the fact that there are strong indicators of mismanagement of the resources that we have. These resources, incidentally, are considerable on a world scale. The United States has the third highest concentration of physicians among civilized countries in the world. In total, more than 4,000,000 people worked in health occupations or in a health-related industry in 1967; 3,400,000 were in health occupations, per se, constituting some 4 per cent of the civilian labor force. Currently, we are spending approximately $60,000,000,000 annually on health care, which is nearly 7 per cent of our gross national product, in contrast to 5 per cent or less in countries whose populations are equally healthy.

Underlying and Contributing Factors

If we have a relatively impressive concentration of physicians overall, and a growing array of supporting helpers, why does health care cost so much, and why are we not doing a better job? Several factors are involved.

Perhaps the most basic reason is that the market is aberrant in free-enterprise terms, as has been pointed out frequently in recent years. There is a lack of true competition among providers of care. Consumers are highly compromised. They are faced with no choice but to get care if ill enough, and they are guided through services by principals, on whom they are emotionally dependent, and who have a vested interest in the services delivered. Furthermore, there is a lack of consensus on the relative force, if not desirability, of demand versus need or how to measure either. As a result, the market deals permissively with the weak while rewarding the strong. Resources are not allocated forcefully in response to the dictates of knowledgeable consumers, nor is price a reliable index of efficiency. In fact, the word "efficiency" is used generally with great caution and guarded generally by an allied reference to effectiveness that is indicative of the relative force of need as a motive power.

No market operates in pure classic terms, but the degree of compromise in the health-services market is appreciable and strongly suggests the compensating steps that must be taken. It is unlikely that demand will diminish appreciably, if at all, in the decade ahead. The odds are that it will continue to grow, even if slowed by reduced federal spending resulting from a tight federal budget and a widespread concern with the problem of inflation. Medicare and Medicaid, for example, have certain types of escalation built in, unless benefits or eligibility or both are considerably changed. Prepayment and insurance continue to grow in both extent and depth in the private market. Approximately 85 per cent of the civilian population has some coverage, but of the average medical-care dollar spent, only 35 to 40 per cent goes to prepayment or insurance, leaving considerable room for expansion ahead. With growth in prepayment or insurance inevitable, a growth in effective demand follows. Demand will, in turn, inspire and be inspired by the availability of better service. A reasonable cure for cancer, for example, will inevitably elicit a strong response.

In addition, and in quite a subtle way, society's interest in the value of human capital is growing. As the average income and educational levels rise in this country, a greater proportion of the population will adopt a middle-class life style. This includes a high value on medical care.

When one steps back and takes a hard, detached view of the health system, one sees a system rela-

tively unchecked by the lash of competition on the one hand and financed largely on a cost-plus or charge basis on the other. To a large extent then, the system is motivated by the self-esteem of the provider, and one can only hope that the professional connotations in the word "esteem" balance reasonably well the more materialistic or narcissistic connotations. Many are reluctant to assume that much.

Possible Solutions

Although progress has been slow, an encouraging note is that the tools of intervention are becoming increasingly clear, and a small amount of experimentation is getting under way. Promising interventions include corporate and areawide planning for health facilities and programs, incentive reimbursement (as opposed to paying simply costs or charges), organization of medical practice (outside the hospital as well as within), utilization review (to detect inappropriate use) and implementation of professional standards. None of these in themselves hold the total answer to better delivery of care or access, but each used within a reasonable framework of public policy could have a definite impact.

Impediments

What holds us back from using the tools we have?

First of all, demand for health care is not synonymous with need, and much care now given by physicians does not require a physician's level of education and training. In time past, many illnesses were endured and survived without benefit of medical help, largely because it was not available or could not be afforded. Today, persons seek medical care for many of these illnesses because it is available, and they can afford it, and because they are convinced they need it. The United States public has been told over the years by health educators, organized medicine, public-health authorities and others that any illness is dangerous and that it is extremely unwise for the patient to assume any responsibility for its diagnosis and specific treatment. Only a physician can do this. Thus, there is a high demand for physician services, particularly when purchasing power is available, and anxiety and anger when these are not available, among poor and rich alike. Yet many physicians and a number of studies have confirmed the fact that nonphysicians can safely and satisfactorily give many health-care services now given by physicians.

Perhaps one of the reasons that the limited number of programs using nonphysicians to do physicians' duties have worked so well is that many of the disorders cared for in the usual office practice are self-limited or unmodifiable. Primary care of upper respiratory infections — the reason for a large number of physician-patient encounters — is largely a ritual whose chief product is some solace of the patient. Under such circumstances, it may not make much difference whether he gets chicken soup, a Navajo healing ceremony, aspirin or antibiotics with laboratory tests. All can comfort the patient and relieve his anxiety. They are not specific for the illness, which takes care of itself or continues to progress.

Secondly, both the public and the health professions have chosen to define health and health care in very restricted and distorted terms, so that measures that might have greater effectiveness on health are not undertaken. If our society's concern were truly with health (that is, postponement of death and preservation of maximum function), we could achieve gains much more effectively than by pouring more money into the health-care system. We would develop as national goals, for example, the following: elimination of cigarette smoking or development of a nonhazardous substitute; development and promotion of foods low in sucrose and saturated animal fats and regulation of diet to keep body fat low; regular, vigorous, physician-supervised exercise for all age groups; production of motor vehicles capable of withstanding 35 g or better decelerative forces; and better control of air pollution. Institution of these measures would surely decrease disability and death among adults. That we do not choose to pursue these achievable goals but continue to focus on health services, as presently given, suggests that this commitment is not based on logic and scientific knowledge but on complex psychosocial and economic needs and demands.

Furthermore, when we talk about health problems, we are talking largely about disorders that physicians and dentists have designated as falling within their area of professional responsibility. Often, we do not include drug abuse, alcoholism, mental illness or social illness (war, crime, apathy, underproductiveness or dissatisfaction). And if we talk about these problems at all, it is usually with respect to treatment rather than prevention.

Yet we know through study of animal and human colonies that the social health and well-being of the colony has profound effects upon its physical status — that is, growth, development and physical disease. The major determinants of health appear to relate more to general living conditions than to medical care. Provision of middle-class medical care to disadvantaged populations will not necessarily produce middle-class health. Health is a product of life style, and demand for and utilization of health care are characteristics of a given way of life. If a person is raised to the middle class, he will adopt values and practices concerning health and health care, just as he does concerning food, clothing and religion.

The third circumstance holding back development of a more efficient health-care system is that the internal needs of the system seem to have higher priority than the enunciated purposes it is designed to serve. More than 75 and as many as 200 skills

depending on one's reference, have developed to assist the physician in his task. Many have become preoccupied with emulating the physician. We see a vast network of white coats, diplomas, certification, societies and the like. Each justifies its quest for specialization, as medicine does, in terms of higher quality and better skills. In fact, too often the quest is more for form than substance. A great deal of sensitivity about professionalism and status develops. And high wages and work restrictions become part of status. The resulting array of skills is difficult to administer both because the average physician is not accustomed to getting things done through other people and because the sheer number and variety takes more co-ordinating pressure than even the hospital framework can muster. A real question that we face is whether the average physician can accept the challenge of leading a team and of reorienting away from crisis medicine. He tends to fear that there will be a sin of commission if a less trained person takes responsibility. And, often, he has a liability orientation that leads to a greater concern with never being wrong than with being right.

The average medical center shows a similar preoccupation with its own interests as opposed to its impact on the health problems of the communities that it serves. The institutionalization process involved is understandable. In the absence of widely accepted qualitative measures of performance, which we see in the health field, one could expect high stress on specialization. Also, teaching hospitals need to compartmentalize for teaching and research purposes. But balance, especially in the centers of medicine, is important. Knowledge and skills must be improved, but not at undue expense to effective communication among special interests or to a co-ordinating effort among them, serving community goals and objectives. If any other point of view is adopted, medical centers may not be asked to participate in many public-policy issues and their resolution, which, ironically, will have a greater impact on health than the most advanced technics at hand. Dr. John H. Knowles's study in 1968 of the attitudes of professional specialty societies toward manpower supply and use was hardly encouraging. Few of the specialty groups surveyed considered the problem within their field of interest or responsibility, despite the fact that specialty boards, as Dr. Knowles points out, "have been given the power to protect the public interest."[6]

The manner in which the states license health practitioners complicates the proper utilization of manpower. Licensure laws were passed years ago, when conditions were more primitive, to protect the public against uneducated, incompetent or unscientific practitioners. Today, each state has its own regulatory apparatus, although reciprocity arrangements have been worked out among several states for some disciplines. Overall, the states license between 12 and 21 occupations. The administration of licensure laws is most commonly vested in a separate board for each discipline — for example, physicians, dentists and nurses. Across the country, 794 statutes are involved. Half the laws require that all board members be licensed in the occupations regulated by the boards on which they serve. Few public members are involved.

The system stands squarely in the way of progress. Separate laws with varying requirements slow the mobility of manpower unduly among states. Outmoded requirements discourage innovations in medical education. The delegation of tasks to persons with lesser skills has been frustrated by superficial regulations. In one instance, in fact, such delegation has been held to be negligence, unless authorized by statute.[7]

Licensure also makes career ladders very complicated. Getting ahead involves innumerable side trips, to the extent where most health workers end up where they started (for example, as a pharmacist or physical therapist) despite their ability to assume broader and higher-level responsibilities over the years. What makes the situation particularly galling is the fact that the licensure programs have failed miserably to control cultism or so-called unscientific practices. Several cults, sanctified by licensure and protected by effective lobbies, still bilk the American public. To be meaningful, licensure must take into account the need for innovation as well as protection. Both serve the public.

To what does this all add up? Most physicians are now delivering services that do not require their level of education and skill but are considered necessary by the public as well as themselves. Health needs are narrowly defined, and only the present health-care methods are considered in the search for solutions. The health professionals and institutions are self-serving and self-perpetuating, and the state has complicated matters by making ossification self-respecting. The result is that the present health-care system has relatively little to do with health. It is tangential, often parallel, to health problems. Thus, it is possible to expand or contract many health-care efforts with little effect on health.

What Is the Lesson?

Given the current nature of the health market, here is little reason to believe that an increase in the number of doctors would result in lower prices. Such is the excess of demand over supply and the distortion in the supply process. Furthermore, it is unlikely that distribution would improve measurably with increased numbers, just as it is unreasonable to assume that effective delivery of care would follow perfect distribution. In the absence of better organized and financed care, the odds are that the wealthy would outbid the poor for services they desired, and prices would, if anything, go up. Finally, there is little evidence that increasing physician

supply, by itself, would have a discernible influence on the health of the nation.

The strategy of manpower development and the search for better productivity and access to care must be planned in this light. In broad terms, the system can be manipulated by demand or supply pressures. How money is spent can shape the course of events among providers of care, although any infusion of new money always creates the chance that prices will rise. Controls worked out on the supply side in the name of effectiveness can, if inexpertly devised, backfire and damage initiative or innovation. As each side is managed, we must be alert to where the burdens fall. Introduced changes have reverberative effects. It is not like replacing one part without affecting the whole. The going will be tricky because there is a great deal we do not know about how to improve perfect markets. But, at least, we will be on the right track.

Eloquent testimony to the need to be on the right track is seen in the second thoughts now being expressed about national health insurance. Early in 1969, strong campaigns started from several quarters, although with different concepts of what national insurance should be. Each would have increased purchasing power. More recently, a close examination of the impacts of Title XVIII and Title XIX on health-care costs in concert with new minimum-wage legislation, strikes for higher pay among professionals and nonprofessionals alike, and growing prepayment and insurance in the private sector, has caused most thinking people to dwell more on the delivery of care problems. There is an increasing conviction that unless delivery of care is improved, new money will be misspent, or worse, that a monolithic financing system will rigidify present practices. Also, the fact that health costs in Canada, Sweden and other countries are rising as rapidly as ours tends to discourage any flip reference to "let Uncle Sam do it."

Where Do We Go from Here?

The consumer must play a stronger part in establishing policy and making major decisions affecting the financing and delivery of health care. The health professional left to his own prejudices tends to develop programs and institutions that are to a measurable degree self-serving. And in the last analysis important value judgments must be made beyond the limited point where the science of medicine is definitive. They are best made by consumers. This is not to imply that the health professional should not have a voice. He must. And he must have enough of an audience to guard against moves detrimental to the quality of care. But as between quality and effectiveness (both important), the second must prevail, and this is the realm of the consumer.

Although consumers have served on the boards of hospitals and of allied voluntary agencies for years, their input has been below potential. One reason may be that ordinarily only the wealthy or prestigious section of the community is represented. More importantly, however, the management of health-care institutions has not learned to harness the potential. Schooled in the idea that intervening in medical affairs is presumptuous, too many boards and administrators deal in trivia rather than policy — means rather than ends. As a result, the community suffers. Admittedly, many consumers have a high capacity for lethargy when serving on health-institution boards. However, this is a challenge faced by management in all walks of life. It is not confined to the health field.

Of parallel importance is the employment of more sophisticated management in both the public and private sectors. This does not suggest that physicians and other professionals should be downgraded. Quite the contrary, they must become more involved in the larger affairs faced by individual institutions and the system as a whole. It does mean greater attention to such familiar concepts as goal determination, organization, program, control, system and efficiency. I should like to touch on a few relevant areas of many that could be mentioned.

We are lacking enunciated health goals at all levels and the mechanisms to support them. HEW has a prime obligation, as the converging point of our governmental process, that it is not discharging. Without preconceived and clearly stated goals relevance is hard to establish, and progress difficult to evaluate. State and local planning agencies also have a long way to go.

Organizationally, we are facing up to several challenges. For example, federal, state and local governments are wrestling with the problems of how to organize health services within and among programs and between levels of government. The organization and reorganization of HEW and of several state departments of health or welfare (or both) bears testimony to this fact. Also, the organizational ties between the public and private sectors are being subjected to renewed definition as the intercourse between the public and private sectors increases. Suffice it to say that the problems, many of which go back to an easygoing assumption that agencies are largely facilitators in a free-market context, have considerably slowed our response as a country and as neighborhoods to the cost, access and productivity problems of the day.

A major structural issue is how to organize health services at the areawide and local levels. At a state or local level, how do the forces of clinical medicine, teaching, research, environmental sanitation, public health and the like converge? Is it through a process of areawide planning that capital structure and program is controlled, as it is in New York? Is it through a process of outreach on the part of medical centers? Should we conceive of new public-service corporations to administer a wide span of

health institutions, such as Mayor Lindsay is establishing in New York City? We should experiment with several models. It is likely that no one model will fit all areas, given the diversity of our traditions and problems. But experiment we must.

Locally, the time for greater exploitation of organized medical practice is ripe. Physicians need to formalize their relations with one another and with hospitals. Given organized working relations, it is then possible to work more effectively toward economies. For example, in such a setting it is possible to relegate safely to allied help many technical skills now performed by doctors, and, importantly, to train doctor assistants who can master several skills now excessively fragmented in the zealous pursuit of specialization, to which previous reference was made. Permanente in California has experimented successfully with multidisciplined assistants. It has made co-ordination of services easier and more certain. Organized efforts among physicians create enough patient volume to capitalize on first-rate assistant generalists, who need only selective supplementation by specialists. Furthermore, it is found that many technicians of today's schools, like the physicians, can give up many lower-order tasks to less expensive personnel without jeopardy to quality, given a structure that gives the process predictability and direction. An impressive number of schools and universities are now training doctor assistants as generalists, and the prospects, at least conceptually, are bright.

Organized efforts among physicians hold out other advantages. The growing problems of doctor supply in rural and depressed areas will never be solved on a solo-practice basis. More and more doctors are becoming specialists, leaving few in the ranks of primary care. And a 365-day schedule devoid of professional stimulation is more than most good men can bear. The concept of strategically placed groups of physicians able to support and stimulate one another, aided by itinerant assistants, holds promise. Incentives will be needed selectively to achieve this goal — perhaps in the form of forgiveness of student loans or even outright scholarships to young people of the area who agree to return and practice after they receive their degree. Once care is organized through groups, it is possible to devise payment schemes that bear on continuity of care and preventive care as well as treatment for episodes of acute illness. Currently, too many payment systems reward the bed patient and not the ambulatory patient, or reward the surgical intervention and not early detection or better prevention. One example of improvement is per capita payment.

In Boston the Massachusetts Blue Cross is working in partnership with the newly formed Harvard Community Health Plan. Members of a Blue Cross Plan are offered, under "dual-choice" enrollment procedures, the advantages of membership in a prepaid group practice. Several other Blue Cross Plans are on the same course.

In conjunction with greater consumer involvement and fuller use of organized effort, it is essential to strike down artificial impediments to intelligent use of labor. Some states literally prohibit consumer-sponsored group practice. The inhibiting effects of licensure has been pointed out. Increasingly, we see malpractice suits becoming so prevalent that surgical specialists in California are paying premiums for malpractice insurance as high as $15,000 a year.

There is no better way to deal with antigroup-practice laws than to strike them down through whatever legal means are available locally. In my view, licensure should be delegated to one Board in each state with broad consumer participation, and it should seek reciprocity with other states. Flexible criteria that do not discourage medical schools from teaching and program innovations are needed. Many supporting skills could well be "licensed" through attainment of reasonable education and through working in licensed institutions whose use of manpower is subject to periodic review. Soaring malpractice insurance costs will ultimately drive the average physician to a level of conservatism that works at cross-purposes with good care for the patient. What it connotes, in terms of either doctor effort or his ability to delegate work, is in need of immediate review. Finally, employees enrolled in group prepayment plans must be given a choice of several contracts. Ordinarily, they are bound to one negotiated method of payment for services. Autoworkers, for example, can select a fee-for-service or salaried-physician scheme with equal support from the employer. In this manner, unjustified resistance on the part of the professions is broken down.

What we come to, then, is a new phase in medical care in which more alternative solutions should be available, greater resort is made to basic tenets of management in achieving more defensible costs and effectiveness, and the consumer is put in a reasonable position vis-à-vis the professional. In a sense, it calls for more and less structure at the same time: more in the sense of management, less in the sense of guilds or fiefdoms. Given the nature of health, ample room for — and positive encouragement to — innovation and experimentation is needed as well as new ways of using manpower and financing care.

Although the mood of the new phase will rest on a great deal of local initiative, some bold interventions from Washington will be needed to solve depressed-area problems with reasonable dispatch (for example, through selective-service assignments or domestic-peace-corps programs built around neighborhood health centers liberally supported by federal money). The accumulated deficit is that great.

Finally

Up to and shortly after World War II, there was a great deal of concern with undersupply of hospitals, doctors and allied personnel and institutions. To correct this, we set upon a course involving massive infusions of money from taxes, prepayment and insurance. In solving many of the supply problems in numerical terms, we uncovered the hard facts of our unique market and its lack of management sophistication. Before much new money is spent, or while it is spent, this lack must be corrected. To act otherwise would price care out of reach of those who need it and simultaneously contribute to inflation in the economy in general.

Recently, John Gardner called for ferment among young health professionals and a "massive assault" to correct what he called an "out-worn, expensive and outrageously inefficient" system. He assailed Congress and the Administration for "a failure in leadership" and said that Americans at all levels are "seized by a kind of paralysis of will."[8]

I have watched the young idealists in the professions attack the present system and seen too many of them absorbed by it. No one can fault the need for leadership. But let us hope that the "massive assault" faces up finally to the gut issues involved in effective delivery of care, and not give in to the tempting thought that because the delivery system is not what it should be, let's staff it according to the way it should not be.

I am indebted to Kenneth D. Rogers, M.D., professor and chairman, Department of Preventive and Social Medicine, School of Medicine, University of Pittsburgh, who provided, through an interchange of correspondence, many thoughts regarding professional attitudes and actions and who made several helpful suggestions in the preparation of the final draft of this paper.

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THE GROWING PAINS OF MEDICAL CARE

Mr. KENNEDY. Mr. President, we are all well aware of the increasingly serious crisis in the Nation's health care system. In recent weeks and months, a number of useful and informative articles have appeared in the press detailing the facts of the crisis and proposing possible new approaches and solutions.

One of the most perceptive discussions was published recently in the New Republic. In a series of three articles entitled "The Growing Pains of Medical Care," Mr. Fred Anderson deals extensively with the issue. In the first article, Mr. Anderson, who is a staff associate of the National Academy of Engineering, describes the Nation's existing health care system and the paradox that allows the best care in the world in some parts of the country to exist alongside some of the worst care in other parts of the country.

In the second article, he discusses the need for a reorganization of the Nation's health delivery system, with particular emphasis on more effective use of group practice, comprehensive preventive care and community medicine, and prepayment of the costs of health care.

In the third article, he discusses the possible methods by which better health care should be financed, and the various alternative ways in which a comprehensive national health insurance program might be phased in. Here, he stresses the point that the financing mechanism should contain special incentives to encourage the reorganization of the health delivery system.

Mr. President, I believe that Mr. Anderson's articles will be of interest to all of us concerned with the quality and equality of health care in the Nation. I ask unanimous consent that they be printed in the RECORD.

There being no objection, the articles were ordered to be printed in the RECORD, as follows:

[From the New Republic, Jan. 17, 1970]

THE GROWING PAINS OF MEDICAL CARE (I): PAYING MORE, GETTING LESS

(By Fred Anderson)

Several months ago President Nixon, Secretary Finch and the Assistant Secretary for Health and Scientific Affairs, Dr. Roger Egeberg, gathered at the White House to tell the nation that it is about to face a complete breakdown in the delivery of health services. Many think the breakdown has already occurred. Long waits for an appointment with a physician, poor service, and astronomical medical bills have gradually become the rule, rather than the exception. The public does not understand how this state of affairs came about, nor why physicians, hospitals and insurers have not done something about it. Particularly irritating is the federal government's failure, though it paid 29.6 percent of the $53.1 billion spent on health in 1969. Long hours in the "waiting room," hurried and impersonal attention, difficulty in obtaining night and weekend care, reduction of services because staff is not available, high drug and treatment costs, loopholes in insurance coverage, and the like, tell only part of the story. The rest is told by statistics which smash any remaining confidence that we lead the world in health care. Fifteen other countries have longer average life expectancies. (Ten-year-old females have a longer life expectancy in twelve other countries, while the American male child of ten years is bested in 31 countries.) Infant mortality is less in 14 other nations. Five countries have better maternal mortality rates. Twelve have better records for ulcers, diabetes, cirrhosis of the liver, hypertension without heart involvement. Twenty have less heart disease.

Whatever life expectancy a white American has, subtract seven years from the life of his nonwhite counterpart. Infant mortality rates are two times as great for nonwhites as for whites. Infant mortality rates for Negro children in Mississippi or a Northern city are comparable to Ecuador's; nationwide, to Costa Rica's. Nonwhite maternal mortality is four times as great as the white rate. (The disparity in maternal death rates has grown from twofold to fourfold since the end of World War II.) In the city slums there is three times as much heart disease, five times as much mental disease, four times as much high blood pressure, and four times as many deaths before age thirty-five than there is nationwide.

The National Advisory Commission on Health Manpower (1967) reviewed 15 representative studies of the quality of health care services in the United States. Here are the findings in three of the studies: (1) a survey of medical laboratories sponsored by the National Center for Communicable Diseases (US Public Health Service) found that 25 percent of reported laboratory results on known samples were erroneous; (2) an evaluation of all major female pelvic surgery performed during a six-month period in a community hospital revealed that 70 percent of the operations which resulted in castration or sterilization were unjustified in the opinion of expert consultants; (3) the medical records of a random sample of 430 patients admitted to 98 different hospitals in New York City during May 1962 were reviewed by expert clinicians. In their opinion only 57 percent of all patients, and only 31 percent of the general medical cases, received "optimal" care.

Organized medicine attributes deterioration in health care to our failure to produce enough physicians for the growing demands for services. That's correct, to a point. Over the decade 1955–1965 "physician-directed services" rose 81 percent and hospital services 65 percent, although the increased output of physicians (22 percent) barely exceeded population growth (17 percent). In fact, the increase in physicians who went into patient care (12 percent) was *less* than population growth. Thus the availability of direct personal treatment by a physician has diminished at a time when demand for medical care is going up rapidly. Demand has been so great that the expected undersupply of physicians should have occurred years ago. What happened? Physicians learned to delegate many tasks to other medical professionals, a practice which should be encouraged. Between 1955 and 1965, professional nurses increased by 44 percent, nonprofessional nurses 63 percent, x-ray technologists 56 percent, and clinical laboratory personnel 70 percent. Nevertheless, in the opinion of the National Advisory Commission on Health Manpower, the existing organization of medical care will soon require more physicians than the medical schools are capable of producing. "If additional personnel are employed in the present manner and within present patterns and 'systems' of care," said the Commission, "they will not avert, or even perhaps alleviate, the crisis." That seems to say that no number of additional physicians will be sufficient unless medical care is reorganized. But the Commission did not say how reorganization should be carried out.

What is so unsatisfactory about the organization of our present medical care system? It consists by and large of physicians in practice alone, or in small groups, on a fee-for-service basis. The model is the independent business entrepreneur, and a strong sense of nineteenth century individualism still guides professional conduct. (About 60 percent of physicians in direct care of patients are solo practitioners, even though less than two percent of current graduates go into general practice. Of physicians in office practice, about 72 percent still work on a fee-for-service basis.) The "nonsystem" of separate practitioners and few hospitals which grew up in the last century has somehow managed to underpin the vast array of interlocking referrals, specialties, clinics, hospital services and financial arrangements which exists today. That foundation is crumbling.

We cannot allow the further duplication of services, equipment and personnel, not only because of the high cost of redundancy, but because fee-for-service medicine is medically one-sided. It is adequate for episodic care for patients with a specific complaint. But such care, though good, is delivered in sporadic bursts. It is not the personalized, lifelong program of prevention, diagnosis, treatment and rehabilitation that it should be. Patients very rarely receive preventive screening or treatment. How could a fee-for-service bill be written for "diagnosing" and publicizing a dangerous playground? Who would be billed? The city? Parents? Fixing up several broken arms is a medical "service," with a going rate per arm. Getting embroiled with nonmedical "playground" issues is not, even though the expense of an ounce of prevention may be less than that for a pound of cure.

It is not quite fair to lay all the ills of the health care system at the feet of the practitioners who favor the fee-for-service system. The American Medical Association, as chief defender of fee-for-service, is almost a caricature of an Establishment, an easy target. But medicine has two Establishments, both of which contribute to our troubles. The second Establishment, hostile to the first, is based in urban hospitals. It is research and technology oriented, often salaried, and provides the world's best surgery and treatment for complex illnesses. The result is that though this is the best country in the world in which to have a serious illness, it is one of the worst countries in the world in which to have a non-serious illness. That part of medicine which most people encounter most often is mediocre. At the same time, we have outstanding open heart surgery, plastic surgery, surgical organ transplantation, and diagnostic skills. It is this paradox which makes it possible for a patient to read in the waiting room literature of America's latest triumph of medical technology, while failing to receive quick, effective and inexpensive treatment for a sore throat.

The strength of the new hospital-based Establishment is in its domination of the medical schools. Dr. Charles E. Lewis of Harvard's Center for Comunity Medicine and Medical Care believes that the inertia of medical schools and their affiliated teaching hospitals is the health care delivery system's chief problem. The schools and their hospitals turn out excellent clinicians, scientifically imaginative researchers, who appear more concerned with a patient's interesting electrolytes than with his humdrum good health. A department chairman, selected perhaps, because he discovered subtle mechanisms of kidney function, makes the school's reputation (and much of its money) by his work and by the grants which he gets for research. No one can tell the collection of department chairmen who run a medical school, or their granting agencies, that the funds which they collect should go to teach

students how to care for whole patients in the environment in which patients live.

The fee-for-service system has not adapted well to third-party payments, whether from insurance companies or from government. The public finds this awkward welter of insurance plans and complex federal programs confusing and vexing.

Picking one's way through the medical maze requires, in the words of Dr. Sidney Lee of Harvard Medical School, "the flexibility of a worm, the dexterity of a locksmith, and the hairsplitting ability of a Philadelphia lawyer." For instance, new employees at the Lawrence Radiation Laboratories in California are handed a chart which folds out like a roadmap into a description of eight programs and benefits for 21 selected services. In the 168 separate boxes of fine print are detailed the conditions of coverage and exclusions of each of the eight plans. Making sense of health insurance is a problem for all of us, even if we are not given "helpful" charts. With approximately 1800 separate plans in existence to choose from, what are we to do?

Perhaps it would be worth working through the maze *if* private insurance provided complete coverage. It does not. *All* third-party payments, including federal programs and philanthropy as well as private insurance, accounted for only *half* of personal health care expenditures by 1966. The private health insurers make quite a fuss over how extensive their coverages are. They point out that about three-fourths of the population has some kind of hospitalization or surgical coverage and that the number is growing, but the important point is not that the number of persons covered is going up; it is that the insured are not getting much for their money. The insured three-fourths of the population has about one-third of its medical bills paid through insurance. Large categories of medical expenses, such as drugs, dental care, and non-hospital "ambulatory" office visits, are excluded from most policies. These exclusions are critical at a time when consumers spend about 20 percent of their health dollars on drugs, about 10 percent on dental care, and, according to a recent MIT study, another 25 percent to 50 percent for ambulatory care.

Government, principally through Medicare and Medicaid, has ventured into paying some of the medical bills of those least able to pay—the elderly and the poor. Medicare includes two related programs for insuring persons over 65 against the costs of hospitalization, physicians' services and related health care. There is no means test. Part A, Hospital Insurance Benefits, covers practically all persons over age 65. It draws its money from a special hospital insurance trust fund, in the case of social security beneficiaries, and general revenues, in the case of those not currently covered by Social Security. Part B, medical insurance for some (but nothing like all) physicians' fees and related costs, is financed by voluntary individual monthly payments, although the federal government also contributes from general revenues. Medicare functions quite smoothly, though hospitals complain of the paperwork and restrictions, and patients complain that in some hospitals they are discriminated against as Medicare patients. Lastly, and contrary to general belief, Medicare covers only about 35 percent of the total health bill of persons over 65.

Medicaid is more complicated. The primary recipients here are, in the bureaucratic phrase, the indigent "categorically needy": the aged, the blind, the disabled, and families with dependent children. Each participating state must submit a plan, and the categorically needy must be included. States are permitted, but not required, to include persons who are self-supporting but have no reserves to meet medical expenses. These are (again, their phrase) the "medically needy." States may also extend Medicaid to those whose only qualification is poverty. But the federal government will pay only the administrative costs of providing them with medical care. State Medicaid plans must offer five basic services: inpatient hospital care, outpatient hospital care, other lab and x-ray services, nursing home services, and physicians' services. States may elect to provide five additional services for a comprehensive program.

We constantly hear that Medicaid was ill-conceived, that it slipped by Congress while its attention was on Medicare. It certainly was not ill-conceived. Medicaid is a ten-year plan designed to gently badger the states into providing comprehensive medical coverage for all medically and economically deprived persons by 1975. Inflation aside, one reason why Medicaid now gobbles up the dollars is because it is growing, exactly according to the plan set out in the original legislation. After four years of varying degrees of state acceptance, the plan does, however, seem to be a shambles: Medicaid currently serves limited categories of the poor and sick, through benefits of Byzantine complexity, which vary astonishingly from state to state (under Medicaid, New York averages $57 per inhabitant for medical assistance; New Hampshire, $5). The states abuse Medicaid, about a dozen of the states have rejected it altogether, and it is underadministered in Washington.

Skyrocketing costs under Medicaid have led to a well-publicized campaign to economize through administrative reforms. The Administration may actually believe that such tinkering with Medicaid, including November's frantic efforts of yet another Task Force, are the kind of "revolutionary change" which the President said he wanted when he drew attention to the crisis in health care. It would appear so, since the Administration's July report, billed as a major interagency study requiring five months to complete, spent most of its shot on administrative reforms. For instance, the government pins great hopes on the strict limits it recently set on fees of physicians participating in Medicaid. But physicians, angered by this effrontery, are likely to respond either by dropping out of Medicaid entirely, or raising their fees to the new legal maximum, causing costs to escalate further.

This sort of reform is worthless. All large institutional funds such as Medicaid, whether public or private in origin, are uncontrollably inflationary in the present *entrepreneurial fee-for-service system*. There is no effective way to police this vast undertaking. Through their right to determine "reasonable" fees, and behind the screen of the simple physician-patient contract for services, hospitals and practitioners are tempted to take what large third-party funds will allow. Proof is not hard to find. Medical costs were already increasing at twice the rate of increase in the Consumer Price Index when Medicaid and Medicare went into effect. But in that year physicians' fees shot up at almost three times the rate of general prices, while hospital charges, incredibly, increased at five times the rate of general prices! Small wonder that the Senate Finance Committee felt obligated to inquire into possible fraudulent behavior among the 10,000 physicians who in 1968 "earned" $25,000 or more apiece from Medicaid and Medicare.

Federal bureaucratic inefficiency is not particularly to blame, as a recent experience of a private insurer shows. Blue Cross of Kansas, a comparatively simple, modestly financed scheme, recently made $250,000 available to its subscribers for walk-in care at the physician's office. Ten percent of the physicians participating used 50 percent of the fund, and $50,000 was paid out by Blue Cross for simple hypodermic injections alone. Four physicians gave most of the injections, collecting remarkably "reasonable" fees. Patients did not need the injections any more than they did before Blue Cross acted, nor did they request injections. Nevertheless, their physicians prescribed them, and patients, because they were not paying or because they had no idea what an injection should cost, did not object to the artificially high prices charged back to Blue Cross.

It is not going to be easy to change all this, to modernize medical care. With $2.5 million of campaign contributions, the AMA was able in 1968 to control the political forces which shape a health care system costing the public $53.1 billion annually. The AMA pattern is clear: first a survey, a recommendation, a legislative proposal for change, supported by physicians and laymen alike, which speaks up for the public, attempting to head off health care crises like the one we're in. The retaliation of organized medicine is always swift and defensive, reaching an emotional crest on the editorial pages of the *Journal* of the AMA. So it was in 1948 when the recommendations of the President's National Health Assembly provoked a $25 assessment on AMA members for a war chest to fight socialized medicine. So it was in 1951 when the President's Commission on the Health Needs of the Nation was called "another flagrant proposal to play politics with the medical welfare of the American people." So it was, for eight years, with the battle for Medicare which ended in 1965.

[From the New Republic, Jan. 24, 1970]

THE GROWING PAINS OF MEDICAL CARE (II): WE CAN DO IT BETTER, CHEAPER

(By Fred Anderson)

When the President told the nation last July that its health services were about to break down, he based his conclusion on a major, five-month interagency study. Considering the gravity of the news and the President's call for "revolutionary change," it's astonishing that the study hardly mentioned the one way that we might avoid a crisis—reorganization of the nation's entire health care system. Nothing else could rescue a system where physicians' fees are increasing at twice the rate of general prices, hospital costs are increasing at three times the rate of general prices, and scarce physicians provide fewer services, limited to episodic illnesses, for patients; patients that is, who are not overlooked entirely because of race or class.

Reorganization, if effective, must include three components: group practice, comprehensive preventive care, and prepayment.

Group practice is not a new idea. Physicians learned quite some time ago to cut duplication of office expenses by going into business together. Decreasing overhead increases profits. Comprehensive preventive care, on the other hand, is a new idea. It reduces the present overemphasis on episodic, crisis medicine by requiring that physicians provide for prevention of illness, as well as for its cure, on a family and community basis. Prepayment is also a relatively new idea; it helps pass the savings of group practice on to patients. By paying in advance for total care, patients eliminate the itemized doctor's bill which lists a highly inflatable array of fees for each separate service.

These three concepts, when put together, would foster urban and rural group practices, with a variety of health professionals rendering comprehensive medical services, including family and community-centered preventive care, for a prepaid annual fee per group or person. Hospitals would be integrated with the group practices in a regional plan and would be expected to provide types

of specialized or intensive care now unavailable to most people.

Solo practitioners, who may number as many as 175,000, have their own fully equipped offices and pay for them by passing the costs on to their patients. But when it is properly set up, a group practice cuts overhead by finding an optimal size for sharing underused resources, such as receptionists, record maintenance, instruments and buildings. Group practice has other benefits. It relieves the medical graduate of the burden of establishing an office and building up a practice. It facilitates collaborative treatment among physicians who know each other well. It makes possible regular hours, time off for vacation, "sabbaticals" for continuing and updating the physician's medical education, and other benefits of a collegial practice. These advantages probably account for the 26,000 physicians who by 1965 had chosen to go into groups, although very few of the 5450 practices had prepayment plans and almost none passed savings along to consumers.

The second component of reorganization, preventive medicine, poses a philosophical challenge to current medical thought about health care. Today, we must wait until we are ill (preferably *very* ill) before modern medicine can bring its sophisticated techniques into play. Hospitals, medical researchers, and, to a surprising extent, private practitioners prefer it this way: illness is impersonal, isolatable, scientific. People, thought of in terms of what's needed to *prevent* illness, are not nearly as tractable. Experimentation now taking place in the urban ghetto in a special kind of group practice may reverse this unfortunate trend.

Not only are these experimental urban neighborhood practices efficient (Dr. Harold Wise, Director of the Office of Economic Opportunity's South Bronx project, says that in his clinic 35 physicians do what normally would require 60); they are a new approach to health services as well. The urban clinics are staffed with a variety of professionals, including the usual complement of pediatricians, internists, and other specialists. But community health nurses, social workers, nutritionists and psychologists are added, in order to give preventive—as well as episodic—care to families. The neighborhood practitioners are critical of the fragmented care which hospitals provide in outpatient departments or emergency wards at night, or in clinics organized around organ systems and diseases—ear, nose and throat clinics, cancer clinics, burn clinics, chest clinics, medical clinics. The patient is critial, too. He sees this array as frustrating, senseless. Need we be told that diseased organs are found in people, people in families, and families in communities, and that overemphasizing the pathology of tissues may underemphasize simple good health? Good health may require intervention in the social, as well as medical, aspects of a patient's problem. As small as the clinics' impact is, they seem to be gaining: several medical schools have started pilot projects; OEO has 40 clinics in operation; Senator Percy and 22 colleagues have introduced legislation for a $295 million program similar to OEO's; and young health professionals, many through the Student Health Organization, intend to make the clinics work.

Oddly, the communities have not always accepted community medicine with unclouded gratitude, from which an important fact can be learned. Community leaders want control of the health programs and a larger say in what services they will deliver. Thus, Harvard University, which claims the first university-sponsored prepaid group practice plan, has had to contend with community suspicion that Harvard will provide services only so long as the community is content to do no more than provide plenty of illnesses. Tufts University, also in Boston, found that the community's Columbia Point Health Association had ideas about community health which went well beyond the "programmed" level. These "people difficulties" show that medicine is not nearly in close enough touch with its consumers, even in the inner city where medicine has tried very hard. It leads one to wonder what middle-class patients might learn and say if they, too, had a voice in health care. Preventive family medicine, through dietetics, early screening, and broader consultation, could have a great effect on middle-class maladies: ulcers, diabetes, obesity, dental caries, cirrhosis of the liver, hypertension, heart disease, cancer, neurosis. It does not take a physician to realize that each of these can be prevented or detected quite early, and that families and communities contribute to cause and cure.

The last component in reorganization, prepayment, shifts attention once again to economy. Having agreed to a set lump sum to cover comprehensive care, physicians increase their income through internal savings below their predetermined annual income, not by gradually raising fees, here and there, for the uncountable number of separate services now available. Physicians in a prepayment plan must also give their time to patients whose health needs are greatest. This is a healthy contrast to the present situation, where all too often money determines what patients get. If Warbucks chooses to pay the prevailing rate, he can buy two hours of a Menninger's time for little Annie's sniffles. A prepayment group practice, in theory, must be more economical and apportion its talent and time on a health-oriented basis if it is to make money.

The Group Health Association of America estimates that almost eight million people are served, in part or in whole, by group health prepayment practices. About 25 of these are community plans, the largest of which are the Kaiser Foundation Health Plan (Western states), the Health Insurance Plan of Greater New York, the Community Health Association of Detroit, the Group Health Association of Washington, D.C., and the Group Health Cooperative of Puget Sound. Together, they care for up to four million people. The Longshoremen, the Hotel Union (New York), the Teamsters, the Mineworkers and other labor groups support a variety of plans with checkered coverages for another 3.5 to 4 million people. The collective experience of these plans has revealed some interesting facts: our outmoded system typically requires four hospital beds for every 1000 of population served; in the plans, half as many beds are enough, because office visits and outpatient care are more intelligently used, and because there is no built-in incentive to overutilize hospitals in order for the patient "to get his money back" from insurance plans (which usually provide generous benefits for hospitalization but almost nothing for outpatient care). The plans also keep drug costs down. For example, drugs for subscribers to the Seattle plan cost 50 percent less than the national average. The plans, then, are making dramatic savings in just those areas of health finance which are the most expensive, and usually they do it with substantial improvement in the quality of care rendered.

The Kaiser Foundation Health Plan, which now serves almost two million subscribers, has been particularly successful. Kaiser has saved its California subscribers 20 to 30 percent of the costs which Californians must meet if they are not in Kaiser's program. Further, under the terms of Medicare, Medicaid, and private insurance plans, many services are not reimbursable unless delivered in hospitals, causing a tremendous overuse of hospitals and consequently lower uninsured expenditures for early detection and preventive care. By reversing the incentive Kaiser has cut hospitalization 30 percent and costs even more, and without higher outpatient costs.

But group practices *alone* will not get us better medicine at lower cost. Especially when organized by physicians themselves, they rarely pass savings on to patients. Community and labor plans like the ones above are exceptional, in spite of their successes in some parts of the country. Nor will adding the prepayment device to group practice cut into medical consumers' huge bills unless a way can be found to keep down the initial lump sum payments. The purchasers of medical care need to be able to find effective representation for themselves and to challenge abuses when there is an increase in annual prepayments. What is needed in fact, is countervailing "patient power."

Although prepayment cannot do the whole job, it does lay a foundation for effective patient representation. National norms for what a medical consumer should pay for comprehensive care are already evolving, since a prepaid group practice is a manageable unit for quality review. (The plans mentioned have begun to develop a figure, leaving age differences aside, of around $130 a person a year.) With the evolution of standard costs for comprehensive services for individuals in various age groups, one is able to inquire why any particular group practice cannot hold its rates down to the norm. And given patients, services and profits, it is possible to develop a set of facts with which a group, an insurer, a consumer's representative or a government agency can criticize the quality of care rendered. For instance: the cost of *my* minor respiratory disorder is almost impossible to estimate. But the cost of 2000 of them can be estimated, and that information used for more rational health pricing, or, if need be, as a weapon in the consumer's battle for better care and reduced costs. Furthermore, united consumers can afford physicians, and economists, who are hired to protect *their* interests.

As matters now stand, no one really knows how to challenge physicians' fee scales. (There is much talk and some effort directed to "quality control and review" under the federal programs, but review depends upon statistical analysis, and the needed data cannot be produced under the present organization of health care.) To make things easier, relevant statutes can be amended or passed to require annual reports to subscribers, where statutes do not already require this disclosure as part of corporation or partnership law. There is no good reason why the financing of health (the second largest of all our private industries, second only to education), should not be openly reported. Participants can negotiate collectively for coverage and for items of preventive care from which the community or group as such can benefit. Prepayment can make available additional kinds of health benefits which are unmanageable in a fee-for-service system. The large institutional funds may even do it for them. For instance, state Medicaid agencies have already bargained with the Clackamas County, Oregon, Physicians' Association and with 290 physicians in California's San Joaquin Valley to pay fixed per capita premiums for total care for Medicaid recipients. A private insurer, if it had to, could do the same.

The success of groups like Kaiser in cutting consumers' costs by 20 to 30 percent is encouraging. Similar savings nationwide could save $7.5 billion in hospital bills by 1975. But without being overly cynical one may ask why physicians, who are in short supply, would want to respond to the pressures of patients, who are in large supply, even if annual set rates are charged. There is no final guarantee that physicians would not keep the annual rates as high as they possibly can. But if they attempt to do so

they will meet informed opposition where virtually none had existed before. They will have to push prices up under the scrutiny of consumers' representatives who know facts formerly unavailable—facts showing how much increase is due to real costs, normal inflation, waste, or higher incomes for physicians.

Either physicians will see the wisdom of economies in the financing of health care and in reorganization or they will risk their prestige to demand even larger incomes and the continuation of wasteful practices which make life easier for the physician and harder for everyone else. Even if blinded sometimes by the preeminence which they enjoy in American society, physicians know that they are wide open to every kind of regulation and control once they lose the prestige that has made them so effective in Congress. Many of them believe that group practice and prepayment, combined as described here, or in another way, are a means of preserving the private practice of medicine.

The medical profession may not go gently into reorganization, however, and for reasons other than its desire to continue to receive large incomes and practice fee-for-service medicine. Early efforts to get group practice accepted showed that the profession can be quite effective in opposition. Organized medicine, working determinedly in the forties, has left 20 states with laws that pose barriers to group practice, voluntary care plans, or consumer control of the business and financial aspects of these activities. Of course they want to increase their earnings, but physicians also say that entrusting more than one physician with a single patient's care destroys the crucial "doctor-patient relationship" of trust and continuity. They believe this even though the experience of large hospitals with team treatment has been excellent, even though neighborhood centers have actually expanded the scope of meaningful doctor-patient relationships, even though continuity of care is mainly important in episodic, not chronic or preventive, care, and even though it has been demonstrated that a succession of new faces and fresh interest is better for some patients.

Accustomed as they are to autonomy, many physicians rankle at the thought of quality review, or peer review of a partner's contribution to the practice. Nor are they comfortable with the social side of preventive, comprehensive care. Prevention is vague, frustrating, not scientific; they prefer detective work on tissues, which is more "satisfying" to them. At the same time, they are unwilling to accept other health professionals as colleagues who can give valuable advice and initiate some care. This is particularly unfortunate since supporting staffs now are doing much of the actual work, with physicians spending more and more time just supervising them. Over the decade 1955–1965 "physician-directed services" rose 81 percent and hospital services 65 percent, although the increased output of physicians (22 percent) barely exceeded population growth (17 percent). Tasks were taken over by nurses and medical auxiliary personnel. Lastly, physicians' frustrations are compounded because their expertise in crisis medicine (surgery, cures for infectious disease, treatment for various trauma) is receding as it becomes more important to provide continuing care for children and the elderly, both of whom make up increasingly larger proportions of the population.

Nevertheless, the medical profession is not by any means close-minded. The three-part reorganization discussed here is palatable, I believe, because it does not run head-on into the charge of medical socialism which other plans face. When led away from politics, where emotions run high, practicing physicians may actually suggest reorganization to improve cooperation and efficiency. Robert Sigmond reported to the National Conference on Health Costs that in a year-long study, he had asked physicians whether, in the event of war or other national emergency, they could reorganize their areas' health facilities so as to free staff and equipment for the emergency without substantial impairment of preexisting care. They said they could, through an efficient regional group practice plan. Many physicians, especially the younger ones, while not sure about family-centered preventive care, are interested in prepaid group practice because of the collegiality, security, regular vacations and regular hours that group practice makes possible. In a sense they have stopped admiring the nineteenth century independent entrepreneur and have started imitating his successors in modern corporations and partnerships.

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THE GROWING PAINS OF MEDICAL CARE (III): PAYING FOR HEALTH

(By Fred Anderson)

If it were not for the financial squeeze on the Middle American, President Nixon, Secretary Finch and Dr. Egeberg probably would never have gathered at the White House last summer to admit that the nation's health care system is in very bad shape. Politicians are pretty shrewd diagnosticians themselves. They see where the public hurts—in the region of the pocketbook. And so they prescribe "reform." Rep. John Dingell has a plan; so do Sen. Jacob Javits, Governor Rockefeller and the AFL-CIO. Even the AMA suggests a tax credit proposal which is being advanced by Rep. Richard Fulton and Sen. Paul Fannin. For the most part, all these "reforms" are after short-run savings and avoid "revolutionary change," which is what the President said we should have.

The AMA recommends that the cost of purchasing health insurance be a credit against income tax. These benefits would be graduated, so that those with higher incomes get correspondingly less benefit; persons whose incomes are so low that they got little or no benefit from the proposal would have part or all of their insurance premiums paid by federal, state or local government. A tax credit rather than deduction at least tends to give lower income groups as much of a break as the rich. But the AMA plan doesn't reach the cause of the crisis. Wasted resources, inflation, limited episodic care, and exclusion from insurance coverage of high risk patients would continue, except that insurance premiums would quickly surpass physicians' fees as inflationary items. Helping the taxpayer pay for inflation is no substitute for better care at less real cost. Where Medicaid waste occurs in exorbitant hospital bills and physicians' fees, the waste in a tax credit plan would come when private insurers got the breathtaking boon of indirect federal payment of a large share of the nation's insurance premiums. Congress ought to think twice before subsidizing a health insurance industry which imposes ever higher premiums, excludes more and more costs and treatments from coverage, and fails to insure more than about one-third of the poor. I hope my first two articles made clear that reorganizing health care is far more important than merely refinancing it. Yet refinancing is really all that the AMA plans, and most of the various national health insurance plans, would accomplish.

I am for national health insurance. But if enacted today, *with no change in the underlying system*, national health insurance would feed inflation for the same reasons that Medicare, Medicaid and private insurance feed it now. The physician's right to self-determined "reasonable" fees and the present physician-patient contract for services shields hospitals and practitioners from scrutiny and tempts them to take what they can get from large third-party funds, principally the federal programs and the private Blues. We saw this happen in the abrupt tripling of the rate of increase in physicians' fees and the quintupling of the rate of increase in hospital fees in the first year Medicaid and Medicare were in effect.

How then should health care be paid for? Two weeks ago I suggested that in return for a regular, set prepayment, each medical consumer ought to be able to receive comprehensive care, largely from group practices adept at family and community-centered preventive medicine. I also suggested that hospital care, and its financing, be coordinated with the group practices. Suppose, for instance, that Congress were to authorize the Social Security Administration to increase payroll taxes on a sliding scale, thus creating a large fund out of which the public's medical expenses could be paid. No one would be exempt from this tax; on the other hand, no citizen could be denied its benefits. Suppose also that in order to pay the public's medical bills, Congress added to this fund from general revenues. This National Health Insurance fund would cover as many medical services as Congress could be convinced to include. Patients would be entitled to receive these services without additional charge, and physicians and health care institutions would receive payment for them from federal National Health Insurance. Gradually, other services would be added, until there is comprehensive health care for all.

The critical step comes when physicians or institutions ask National Health Insurance for reimbursement. They will, of course, be entitled to their fees, whether or not they practice in groups, participate in regional hospitalization plans, economize, accept annual lump-sum payments rather than fees-for-service, or practice preventive medicine. In fact, the only thing that might keep physicians or hospitals from being reimbursed is their refusal to submit information on health care delivery in sufficient detail to permit review by panels of physicians. But if physicians and health care institutions actually did move toward regionalized, prepaid group practice, they would be entitled to extra payments from National Health Insurance. Their less progressive, fee-for-service colleagues would have an incentive to do likewise.

The kind of special financial incentive I have in mind would reward pediatricians, internists and other specialists for forming group practices, with a bias toward preventive medicine. But incentives would do more than that. A key concept in reorganization is the sharing of total health responsibility among a team of health professionals. To foster the development of such teams, National Health Insurance might initially pay the entire salary, or a large fraction of it, for a consulting dietitian, or a community health nurse. Thus group practice, preventive medicine and shared responsibility would be made financially attractive to physicians, reducing their changeover costs substantially.

A variety of diseases can be headed off before they do their damage (e.g., glaucoma, high blood pressure, cancer, tuberculosis). Californians in the Kaiser Plan have been delighted that it offers screening (smears, x-rays, etc.) for as low as $1 per test. Prevention is cheaper than cure, and Kaiser is a *prepaid plan*. National Health Insurance, by offering to buy the necessary screening equipment and pay part of the operating costs, would be offering a further incentive to physicians to set up Multiphasic Health Screening (MHS) throughout the nation. The federal government has already supported MHS on an experimental basis in New Orleans, Milwaukee, Brooklyn and

Providence.

The success of National Health Insurance, then, depends on a comprehensive plan which handles the medical care system with the right sticks and carrots. Such a plan is being drawn up by the Committee for National Health Insurance, which exists largely through the efforts of Walter Reuther and the UAW. Its membership includes Senators Yarborough, Cooper and Kennedy, Dr. Michael DeBakey, Whitney Young, Dean Robert Ebert of Harvard Medical School, Arthur J. Goldberg, Dr. Charles Mayo II, and Mayor Carl Stokes. A capable Technical Committee, headed by Dr. I. S. Falk, who has retired from teaching at Yale Medical School, is working on details which will be made public in mid-March. There are still some difficult questions. Will ceilings be set on the physicians' fees and insurance premiums charged during the transition period? (There seems to be no other way to curb inflation until the plan has a chance to take hold.) Should fee-for-service medicine be strongly discouraged right from the start? How long should the reorganizational changeover be expected to take?

Almost $20 billion of federal and state funds currently goes to medical education, health facilities construction and medical research. The money is not being wisely spent. Not only have we too few physicians; there is an imbalance in the distribution of physicians among the specialties as well. Take surgery. According to economist Victor Fuchs of New York University, surgeons averaged only 220 operations each in 1966, well below most surgeons' capacity for competent care. National Health Insurance would try to alter the career choices of medical students by supporting medical school training programs in undersupplied specialties (particularly those needed for family-centered health care teams), by funding internships and residencies in those specialties, by supplementing the salaries of young physicians who choose these careers, and by helping in critical regions and neighborhoods to build the facilities needed for group practice.

I mentioned earlier that National Health Insurance would gradually replace out-of-pocket expenditures, private insurance, Medicare and Medicaid. Thus, in its first year, NHI might pay the total costs of basic services (outpatient and inpatient hospital care, physicians' services, etc.), adding new services each year thereafter (laboratory and x-ray, nursing home, etc.), until comprehensive care is reached. I favor this approach. Others, however, think National Health Insurance should pay an escalating percentage of *all* personal medical costs until comprehensive prepaid care is attained. Senator Kennedy disagrees with both these approaches and argues that infants, preschool and school-age children up to age 15 should receive total coverage the first year (1971), since preventive medicine would help them the most, and that the rest of the population should be added in ten-year steps (age 25 in 1972, age 35 in 1973, etc.) until National Health Insurance links up with an expanded Medicare program at age 65.

All these alternatives are reasonable ones; the only unreasonable one calls for immediate assumption of the entire $40–45 billion personal health care bill by National Health Insurance. It's unreasonable because it would perpetuate wasteful practices that might be eliminated through incentive payments and reviews. Also, while it is important that patients be able to make set prepayments to National Health Insurance (so that they can budget ahead for health care), it is more important for physicians to be paid in advance for care. Such a system will take time to build. A rapid takeover of the $40–45 billion health bill now paid for care *after* it is rendered would actually protect the fee-for-service pricing mechanism.

The success of National Health Insurance will depend very much upon how physicians react to it. Many have said they favor it; young physicians are not likely to oppose it as strenuously as their older colleagues. Nevertheless, the recalcitrance of physicians could throw health care into chaos. Nowhere in the world have physicians had the prestige, organizational muscle and resources that they do in the US; and nowhere else has there been a professional group more grimly determined to resist "socialized medicine." It is not just the AMA, which draws on dwindling but fervent support from the 20 percent of physicians in patient care who are general practitioners. Most specialists, salaried hospital doctors and medical school teaching staff are not interested in "national" health plans.

The resistance of some physicians to National Health Insurance is predictable; what is not predictable is how public opinion will form in the coming months. There are good reasons to think that the public is more receptive to National Health Insurance than is generally believed. Over the past few months politicians have flocked to the medical care issue, which gives support to this view. At the same time, organized medicine's image has been tarnished. The public did not think much of the AMA's victory last spring when it kept Dr. John Knowles from becoming Assistant Secretary for Health and Scientific Affairs, even though Dr. Knowles was Secretary Finch's choice (and the President's too, it appeared, for a few hours). The press used the incident as a short seminar on power politics, self-interest, and the shortsightedness of organized medicine. A 1967 Harris poll found that a majority of the American people favored a federal medical care insurance plan modeled on Medicare for the entire population. Indeed, most Americans were receptive to a federal role a decade ago. During the 1960 Presidential elections the Inter-University Consortium for Political Research at the University of Michigan found that 59 percent thought that "government ought to help people get doctors and hospital care at low cost." Early public support for a federal role in medical care also helps explain the 1965 passage of Medicare and Medicaid, despite frantic opposition by the AMA.

The Nixon Administration's opposition to National Health Insurance is based on the argument that it would be uncontrollably inflationary. This puts the Administration in something of a quandary. If inflation is running amok, reform of the kind I have described is necessary. And yet such far-reaching reform will be fought by the AMA with all its political resources, and the multi-billion dollar health insurance industry, threatened with extinction, would not be far behind.

The Administration thinks it has a way out through a proposal the AMA advanced in 1968: more medical services and manpower. True, in classic economic theory and increase in supply slow down inflationary demand. But more MDs and support personnel are wasted in a system which quickly loses marginal gains in its general inefficient operation, in population growth, and in increased demand. The most recent confirmation of this was offered in 1966 by the National Advisory Commission on Health Manpower, which concluded that we should not continue to expend vast sums, simply to get marginally more services of the same kind. We *will* need more physicians and other health professionals, but added numbers will not get the American people the care they need at prices they—all of them—can afford.

The Committee for National Health Insurance will soon publish figures on the money we have lost through inefficiency in our health care system—not from inflation, not from poor financing mechanisms, but from plain waste. Taking insurance alone, medical consumers are being squeezed to death by both private and federal insurers. When costs become too great for insurance companies, they raise premiums, refuse to insure for more and more kinds of illnesses and costs, and turn down high-risk applicants. After a while the federal government begins to pay a share, principally through Medicare and Medicaid. Yet government too can apply the squeeze in our present system. Congress has limited the categories of the medically needy and cut funds; the Administration has cut health budgets and talks of ineffectual administrative reform. Congress could end the squeeze entirely by enacting a compulsory National Health Insurance plan, but one which commits government to add, not subtract, benefits, and which includes carefully worked out incentives for the reorganization of our entire health care system.

HEALTH SERVICES FOR ALL: IS HEALTH INSURANCE THE ANSWER?

Eveline M. Burns, Ph.D.

ONE must assume, in view of the interests and contributions of the man we are honoring today, that the words "health insurance" must refer to governmental contributory health insurance. The term itself is, as so often pointed out, misleading. The systems which have been developed all over the world certainly do not insure health. Some have suggested "sickness insurance" as being more accurate, but even that is ambiguous. What most of them do is to insure against the costs of medical treatment and one is tempted to think that a more accurate name for our own venture into health insurance would be "Medicost," rather than "Medicare."

Essentially, health insurance is a method of spreading the costs of medical care, broadly or narrowly interpreted, over as large a proportion of the group at risk as possible. It is one device for removing all, or part, of the financial barrier to the receipt of medical care and health services. One would have thought that the case for using this device would have been so obvious that the United States would have long ago followed the example of other countries and instituted a health insurance system.[1] I still remember my astonishment when I arrived in this country in 1926, a wide-eyed student eager to learn about the social institutions of the United States, to find that apart from workmen's compensation there was no form of social insurance in effect, and that any such institution was regarded as something possibly appropriate for effete and unprogressive Europeans but certainly not needed by self-reliant and wealthy Americans. Even with the onset of the depression, which turned men's minds to consideration of ways of assuring income maintenance, it was unemployment insurance, and to a lesser degree old-age insurance—but not health insurance —that attracted professional discussion and attention.

In fact, of course, there had been earlier interest in health insurance. In 1912, National Health Insurance had been one of the major planks in Theodore Roosevelt's Progressive Party; organized social workers had made studies and proposals; several states had introduced and debated compulsory health insurance bills, and even the AMA had appeared to approve the principles embodied in some of these bills. Anne and Herman Somers have reminded us that as late as 1917 the AMA, when adopting a resolution concerning the principles that a proper health insurance system should include, stated "the time is present when the profession should study earnestly to solve the questions of medical care that will arise under various forms of social insurance. Blind opposition, indignant repudiation, bitter denunciation of these laws is worse than useless: it leads nowhere and it leaves the profession in a position of helplessness as the rising tide of social development sweeps over it."[2] One can only say "Amen!"

And "amen" in another sense it was! The war came, and when it was over the AMA, responding to the adverse reactions of state medical societies, de-

cleared its formal opposition to any plan of compulsory contributory insurance operated or controlled by government. The social workers turned their attention to the acquisition of professional status, stressed clinical service and casework and spent their energies on the absorption of Freudian principles that seemed to offer a basis for a unique, identifiable professional service. Until the Depression, social policy in general was neglected by them. Nor were matters helped by the stance of organized labor, which might have been expected to lead a movement for social insurance. For it was not until 1932 that the AFL formally withdrew its opposition to social insurance, and then only on condition that the costs be carried by the employer. Interest in the subject was kept alive only through the work of a few scholars (such as Rubinow or Armstrong), and the individuals associated with both the American Association for Social Security and the American Association for Labor Legislation.

Even the farsighted Committee on the Costs of Medical Care, 1927-1932 (with which I. S. Falk was prominently associated), while it recommended, in its majority report, financing through comprehensive group payment, placed its reliance on voluntary action and refrained from recommending compulsory public health insurance. In subsequent years the spectacular growth of private (profit and nonprofit) health insurance seemed to promise that voluntary action might indeed be the answer.

The next opportunity for action came in 1934-1935 but the Committee on Economic Security did not include any proposals for health insurance in the proposed social security legislation, reportedly because it was felt by the Administration that to include so controversial a plan would have endangered the other, extremely important, old-age and unemployment-insurance provisions. I am hopeful that Dr. Falk, who was deeply involved in that part of the committee's work, will tell us more about that missed opportunity.

We are all familiar with the subsequent story: the efforts to enact federal health insurance (especially in the immediate postwar years), the gradual whittling down of the objectives—until we find ourselves, in 1965, regarding the passage of a limited health insurance measure for the aged as a great victory. To the extent that it is the *premier pas qui coute*, the 1965 legislation is of course an important milestone, the more important because of the very violence of the opposition. And yet from a broader perspective there may be less cause for rejoicing, for some of the price that was paid involved compromises that may make future progress more difficult.[8]

I have always been a great proponent of social insurance, and regard it as one of the major social inventions. It effected the transition from reliance on charity or grudging, and often degrading, public aid to a system of rights to socially assured income in the event of specific occurrences. It did so by linking the bestowal of rights to the concept of insurance, a thoroughly respectable and respected institution. So successfully was this done that today it is difficult to get students to realize that before 1935 in this country, not only was it a problem of getting the voters, as a group, to accept the fact that giving old or unemployed people the right to cash payments without undergoing a means test would not undermine the very basis of our capitalist free enterprise system, but it was also necessary to persuade the potential beneficiaries that there was nothing wrong or shameful about accepting such payments. The word "insurance" performed a very useful social function.

But social insurance has done more than this. In has proved to be a very effective method of raising money to finance welfare programs. People seem much more willing to pay taxes if they

feel that they are going to benefit personally and directly from the expenditures. There is another side to this coin, of course, for we must never forget that it was the social insurance tax systems with their provision for employer withholding and their acceptability to workers which opened the eyes of Treasuries to the fact that it was indeed possible to tax low-income receivers. Politicians have not been blind to this fiscal advantage of social insurance. In 1925, contributory old-age pensions in England were enacted by a Conservative government that was under great pressure to liberalize the noncontributory income-tested old-age pension system. Similarly it is not, I think, by accident that recently the governor of New York, faced with mounting costs of Medicaid, has become a most active proponent of compulsory health insurance.

In somewhat broader terms, contributory insurance also appears to provide some check on irresponsible liberalizations. The linkage of benefits and taxes has undoubtedly served up to now as a useful control in a world where competition for the taxpayers dollar is intense. Finally, as its scope has widened (and coverage in terms of people had to be fairly broad even initially, in the interests of spreading the risk) social insurance has served as a socially cohesive force. It is not a program solely for "the poor." From the first a cross section of wage earners has been covered, thereby including the upper working-class groups, and increasingly the middle classes have also been included. Involvement of the direct interest of the middle classes has prevented social insurance from deteriorating into a program for the poor, for whom, alas, it often seems to be felt that anything is good enough. In a world that is increasingly subject to divisive forces, social insurance has stressed solidarity and mutuality of interest.

So long as it was confined to dealing with loss or interruption of income, and to the making of cash payments, this instrument performed remarkably well. It has been essentially a mechanism for collecting funds and paying them out in specified contingencies. There have of course been problems and troublesome policy issues but they have proved manageable. There have been administrative problems in determining the occurrence of the risk insured against: what is involuntary unemployment?, when has a man retired?, how to assess the degree of disability that is held to prevent a man from working?, and the like. And there have been policy issues: who should be covered?, what level of benefits should be payable?, how should the costs be allocated among the covered population, their employers, and the general taxpayer?

These problems have been difficult enough but they are simple in comparison to those faced when social insurance is used to deal with the financial barriers to the receipt of services. Services have to be rendered by professionals whose responsible cooperation with the program is essential. When cash payments are made, it has proved possible to hire mainly non-professional staffs and use machines to check eligibility and calculate payments, even when the benefit formulae and the rules governing eligibility are extremely complicated. The criteria and formulae are highly objective, call for the exercise of minimal discretion, and their application rests in the hands of the public administrator. Where payment for services is the objective, organized professionals must first be induced to render these services to the insured. This is a matter partly of determining rates of remuneration acceptable to both the profession and the wider community, and partly of determining other conditions of employment to which professionals attach importance. The extent to which services were in fact rendered is attested to by

the professionals or purveyors of service rather than by the administrator who, in effect, is underwriting all or part of a bill whose size is out of his direct control, and who depends on the professionals' competence and integrity.

Again, when making cash payments in the event of interruption of income, a dollar is a dollar. At any given time every dollar received by a beneficiary buys as much as that received by any other. Even changes over time in the value of the dollar have not proved impossible to adjust to; with services, however, the problem of variable quality arises. One then has to face the question whether the government, as operator of the system, has any responsibility for ensuring that the services received by its insured, for which it is paying, are indeed of minimally acceptable quality. In some cases the services may not be available at all and the system may be charged with deception for collecting contributions to pay for services that do not exist.

There is yet a third complication. In social insurance systems dealing with income maintenance, the question of how much of the taxpayer's income is to be devoted to this end (income transfers) can be openly debated and controlled by legislative decisions on eligibility rules and benefit formulae. The global costs of any given combination of these can be estimated with a high degree of reliability so that rational choices are possible and, once made, the administrator can control them. When it is a matter of paying for services, cost (i.e., the taxpayer's bill) is affected not only by the decisions of individual practitioners and purveyors of care as to how much service is to be rendered but also by the prices charged by professionals and institutional suppliers, and by the efficiency or inefficiency of the organizational arrangements for the delivery of services.

There is one final difference in the application of social insurance to the problem of income maintenance and its application to the problem of health services. All social insurance systems contain eligibility criteria. Only those persons who have been "covered" for some specified period, or have paid some specified amount of taxes, or are related in some defined way to the insured person are eligible for benefits. This limitation of access to the program may make sense in a cash payment system, although we often carry the exclusions too far. As an example, if the system exists to replace income from work, then one needs some proof that the claimant was indeed normally working and the eligibility rules aim to test this and to eliminate the voluntarily unemployed. But once it is realized that the function of eligibility rules is to keep people out (i.e., to exclude), one may ask whether this concept is appropriate to a health service system where surely one wishes to exclude nobody who is in need of health services.

It is perhaps not surprising that most countries, notably including our own, have first conceived of the problem in the health services as being one of removing the financial barrier. Even so, it has proved impossible to escape the problem of ensuring professional cooperation; in most countries the history of health insurance is replete with disputes between the authorities and the medical professions as to rates and methods of pay, and conditions of employment.[4]

So far, we have not been very effective in using health insurance to remove the financial barrier. In the first place the coverage, in terms of population, is very restricted. The history of the postwar movement for health insurance is one of gradual retreat from the goal of almost universal coverage, as embodied in the early Wagner-Murray-Dingell Bills, to coverage of the narrower group of the aged. Given the strength of the

opposition, the 1951 decision to concentrate on the aged was probably inevitable. Their plight, in terms of need for health services and limited income with which to pay for them, could be demonstrated. The inability of private insurance to deal with the problem was becoming daily more evident, even to the insurance companies themselves. An effectively operating instrument, namely OASDI, was available, and the aged were numerous and had votes.

From a longer range point of view, of course, this concentration on the aged makes no sense. If the nation is unwilling to open the doors to needed health services for everyone, a different priority would seem obvious. A powerful case could be made for beginning at the other end of the life span and removing the barriers to health services for children. The national interest in having a healthy and productive labor force would alone argue for this, quite apart from other considerations. Perhaps even now we may hope that some ingenious mind will invent some way to reverse the concept of paid-up insurance as now applied to the aged and to provide postpaid insurance so that children can have health insurance protection *before* they enter what is now an almost universal coverage system. Assuming certain changes in our present health insurance system, which I shall later suggest, this would surely be a better way of ensuring at least minimal health care for children rather than, as now, leaving them to the uncertain outcome of Medicaid developments.

I also suggest that we should not be too surprised at the recent reaction against Medicaid on the part of both Congress and the states. In my judgment, Title 19 attempted to achieve too much, too fast. To my knowledge, no other grant-in-aid program has ever been so completely open-ended or left the federal taxpayer so strongly committed to pay a bill the size of which he could in no way control. No other federal grant-in-aid program has ever contained so many standards and requirements for state programs; all these standards and requirements aimed at wider coverage and increased service, and carried the penalty of loss of existing federal grants if the states did not conform by specified dates. In any case, the objective of providing needed health services for all children through Medicaid will always be thwarted by the fact that everything depends on state action and whatever service is provided will reflect differences in states' resources and interests. If we are serious about providing for children with at least minimal adequacy, we shall have to look to federal action.

The inclusion of children and aged in federal health insurance would leave the productive age groups unprovided for. It is difficult to forecast the extent to which they will be able to meet the problem of health costs through private insurance. My own guess is that we shall increasingly find, as medical care costs rise, that private insurance will have a harder and harder selling job, and will find it difficult to cover an acceptable percentage of the ever-increasing medical bill. If this is so, we must expect pressure to extend federal health insurance to other adult groups. It seems obvious that Medicare will soon be extended to additional social security beneficiaries. The same arguments that were compelling for the age-65-and-over group apply equally to the disabled and to early retirees. Nor will it be easy in the years ahead to resist the claims of survivor beneficiaries whose incomes are, for the most part, limited.

I said earlier that we have not been very effective in using social insurance to remove the financial barrier to health care, in part because we limit coverage. However, in the immediate future the task of making health insurance more adequate (in the sense of doing the job it was devised to do more effectively)

will be more important than extending coverage to more people. As a method of removing the financial barrier to access to needed health services, Medicare has two gross defects.

First, it still leaves the insured person with a sizable medical bill over and above his annual premium, because of the provisions for deductibles and co-insurance, and because of the leeway in Title 18B which permits doctors to charge what they think the traffic will bear over and above the reimbursable "reasonable and customary" charges. So far as deductibles and co-insurance are concerned, justification is apparently based on the assumption that people have an inordinate appetite for medical care and hospitalization, and this appetite must be checked. It is evidently also assumed that one cannot trust the professionals whose decisions govern whether a patient shall go to hospital or undergo specific tests or procedures. These assumptions need to be tested by research.

Admittedly there is a real problem of ensuring responsible use of a service that, apart from the premium, would be free. But an intelligent society would surely seek controls that do not have the undesirable consequences of forcing the patient to bear a sizable share of the bill over and above what he pays by way of a premium. Increasing efforts must be made to enlist more professional cooperation and self-policing. The experiences of nongovernmental prepaid comprehensive health plans with such controls must be more carefully studied, especially because these lend themselves to experimentation more readily than does a national program.

The limited financial protection of the patient, due to the physician's freedom to collect from him more than he will be reimbursed for, will be especially difficult to change. It was presumably part of the price paid for physicians' participation in the program. Perhaps we have to await a new generation of doctors whose professional training, we may hope, will include a far broader and more socially oriented concept of professional ethics.

The second shortcoming of contemporary health insurance is its selectivity about the reimbursable types of treatment and the places where treatment is received. This unfortunate item-by-item approach to the payment of medical costs is further complicated by the existence of two separate and confusing reimbursement systems, Parts A and B. From the financial point of view, this policy of reimbursing for some items only, again leaves some patients with sizable bills and limits the extent to which health insurance removes the financial barrier.

The major thrust of reform should be directed to removal of this selective reimbursement system for even more compelling reasons than the financial one. The present reimbursement system interposes an unnecessary barrier to the planning of appropriate courses of treatment, distorts professional advice by considerations of finance, and influences the extent to which patients can or will act on the advice given. Above all, this item-by-item method of meeting the costs of medical care, coupled with the exclusion of some items, fosters fragmentation of service, which is the outstanding weakness of our present system for the delivery of health services.

Thus I would urge that the first priority for effective utilization of health insurance is insistence on comprehensiveness of service coverage. This is even more crucial than removal of deductibles and co-insurance, and it is more important than extending coverage to additional population groups, even though the latter is desirable and politically feasible.

I said earlier that the dimensions of the problem of assuring health services for all are broader than the mere re-

moval of the financial barrier. Availability of facilities, supporting services and personnel, assurance of high quality of service, and economy in the use of funds and resources—all call for urgent attention. To what extent may we expect the health insurance system as such to grapple with them? Certainly not all health insurance systems have accepted responsibility in these areas. Between 1911 and 1948 the British Health Insurance system limited itself essentially to paying bills. Availability, quality, and use of resources were none of its concern. Health insurance systems in other countries either have been slow to act in these difficult areas or have done so only with reluctance. Nor is it surprising that initially the question of availability and quality of care should have been relatively neglected by the health insurance authorities. For in the 1880's when Germany began to develop its system, and the early 1900's when Britain and other countries were developing their systems, the scientific revolution in medicine had scarcely begun. What passed for acceptable medicine in those days was less highly skilled and less scientific than now. Probably there was also more uniformity in the more limited professional service then available. Probably people in general were less aware of the potentials of good health services and of the difference between good and poor quality service. We live today in a scientific and technological era, and people's sights have been raised. Today, people will not be satisfied with the mere removal of the financial barrier, and we can no longer neglect the organizational and related problems that have been brought about by the scientific and technological revolutions.

Some health insurance authorities have, however, made efforts to deal with problems of supply, availability, and quality by building and operating their own hospitals, clinics, convalescent homes, and other facilities in which their own staffs provide group care. I do not see us following this pattern, at least not until the population coverage of health insurance is much wider than it now is. Parallel delivery systems, one for the limited group of the aged that is insured and another for the noninsured, would perpetuate and strengthen our already undesirable two-class health-service system. Such a policy would be met by insistence by the medical profession on free choice of doctor, a demand which appears to have considerable support from the population at large. We here may recognize that realistically—even when the financial barrier is removed—free choice of doctor is largely an illusion because choice is restricted to the selection of the primary physician, and free choice of institution is limited by the availability of beds and the admission policies of individual hospitals. However, the idea of free choice has broad popular appeal. Our hope is that the health insurance system will prove flexible enough to give full support to groups providing comprehensive high quality care and that in time the superiority of this method will become evident and win out in competition. But here again there will be need for both careful evaluative studies and wide dissemination of the results.

Other countries such as Sweden have responded to the problem of supply and availability by direct provision by government, rather than by the health insurance system, of certain types of institutions such as hospitals. These are open to all on either a free or a nominal charge basis and when charges are made, the health insurance authorities purchase service on behalf of their members. I suspect that this will be the more probable trend in the United States. The health insurance system will remain largely a financing mechanism but government will be heavily involved in the construction of facilities that are either

publicly operated (directly or through public corporations) or privately operated under increasingly close public supervision. Government will also play a large role in assuring an adequate supply of needed personnel through subsidizing education and training.

It already seems evident that the health insurance administrators in the United States cannot escape some degree of involvement in our second major area of concern, quality of care. A major step in this direction has been taken in the formal Conditions of Participation laid down for certain types of institutions and providers of technical services. Quality control will, however, be easier to achieve for institutional care than for practitioner services. In both cases, two needs are apparent. To the extent that the instrument used is accreditation (or licensing) and consultation, we must develop stronger and better staffed state (and even local) health departments. There is also a need for much more research into measures of, and methods of control over, quality.

On the the third major problem, economical use of health resources, we may indeed expect major leadership to come from the health insurance authorities. Inefficient or uneconomic resource use by a health insurance system shows up immediately in increased costs that at once become visible and onerous through increased contributions or taxes. We may therefore expect that the administrators of Medicare will increasingly chafe under the restrictions imposed by the preamble to Title 18, whereby there is a disclaimer of any effort by government to interfere in the methods by which health services are delivered and administered. I am also sure that the Congress will look with increasing favor on investigations into the extent to which the methods of rendering services, and the organization and administration of medical institutions, involve unnecessary costs. There is already an awareness of the extent to which reimbursement formulae can affect costs. The amendments of 1967 authorize the Secretary of HEW to experiment with various methods of reimbursement to physicians and organizations "that would provide incentives for limiting costs of the programs while maintaining quality care." Once again a vast new field for demonstration and research has opened up. The Medicare administrators will also possess a rich store of data which will facilitate sophisticated statistical comparisons of the performance of both institutions and practitioners. As the arrangements for determining reasonable costs and charges are renegotiated, the purveyors of health services will have to be prepared to answer some awkward questions.

At the same time there is a danger in sole reliance on the health insurance authorities to press for more efficient methods of delivery, for their main concern will be financial. It is not always the case that the method which saves money is the one that renders service in the most desirable way. Many of the changes that one might envisage, such as a central data bank or a centralized community-operated ambulance or laboratory service, would meet the demands of both economy and better service. But from such reading as I have done, it does not seem indisputably clear that group practice, although it renders better service, is necessarily cheaper than solo practice. The need therefore is for vigilance, a vigilance that must come from two sources. On the one hand we need more knowledge from nonofficial sources about what is happening; here the responsibility is clearly on the universities, medical schools, and research centers. On the other hand, we need to make more provision for representation of the consumers in the administrative structure of our health insurance sys-

tem. Up to now we have been extraordinarily fortunate in the caliber and sense of public interest of the federal administrators, but they are in a difficult position and are subject to heavy pressure from the organized purveyors of health services. The administrators need an organized constituency on the other side, if only as a countervailing force. It is neither fair nor reasonable to expect them to carry the entire responsibility for protecting the interests of the consumers of health services. High on my agenda for making health insurance a more effective instrument in this country is provision for more effective user representation and influence.

Like Dr. Falk,[5] I do not see us moving rapidly toward a national health service. I still believe a free national health service to be the most effective instrument yet devised for assuring universal access to the full range of comprehensive health services; even while saying this, I recognize that national services also have some unsolved problems. However, the very size and diversity of this country suggest that such a system would be difficult for us to organize and administer. At the same time we must not forget that we do in fact have a national health service—for veterans. Perhaps we could start by developing a national health service for children.

It took Great Britain over 30 years of experience with a much more extensive health insurance system than ours to get to the point of switching to a free health service; even then the change might not have come had not the war and the blitz thrown the inefficiencies and inadequacies of the existing system into relief.[6] The rising costs of health care may propel us faster than I now anticipate into a radical reorganization of our health delivery systems. However, unlike the British, we are affluent and can afford a lot of waste. Organized medicine in this country is more resistant to change, but even here there are some faint signs of recognition of the changed world.

Much depends too, on what happens under Medicaid. The current adverse reactions should not blind us to the potential of this program. Because it is a state- (and even a locally-) influenced program it will lend itself to experimentation. It will be of the utmost importance that these experiments be recorded and evaluated. We may indeed find that here and there Medicaid programs are developing which offer comprehensive care under nonoffensive conditions that may compare very favorably with what the health insurance system has been able to deliver. The important thing will be to make effective use of the much vaunted experimentation potential offered by our numerous states and political subdivisions—"effective use" means capturing and recording the results and disseminating widely the knowledge thus gained.

As he looks back on his long and richly productive professional career, Isidore Falk must have many reasons for satisfaction. Health insurance, for which he fought so long and so valiantly, is no longer a dirty word but an established institution. I have no doubt that in a few years young students will be describing it as "the American way" of handling a problem, as they now do with OASI! Both the changing public attitude about what is expected from a health system and the vast scientific and technological changes that have affected the health services have created new problems that are more complicated than can be dealt with by a health insurance system alone. Today we have to ask what the role of health insurance is in a complex of institutions and arrangements for the provision of health services to all. Even now we can foresee a considerably larger role for health insurance than it now plays.

Perhaps even more than in the enact-

ment of a health insurance system, Falk must feel a deep satisfaction in the increasing attention paid by scholars (medical and nonmedical experts alike) to research in the health services field. Once almost a lone wolf, at any rate a member of a tiny pack, he is today one of the outstanding leaders of a sizable and ever-growing group of men and women whose work—and this is the important point—is directed toward the solution of the health service problems of the real world. When one asks in which direction we should move, one finds the first essential is to know more about what is happening and about what works and what does not.

Despite disturbing signs of growing irrationality in the world I still believe, as does Myrdal,[7] that knowledge is a powerful force for bringing about change and reform. I believe this is Dr. Falk's credo, too. It is because he has asked questions of relevance to the functioning of our health services and because he has helped to find some of the answers, either directly or through those he has influenced, that we honor him today—a scholar whose work has affected public policy.

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Dr. Burns is Professor Emeritus, Columbia University School of Social Work (2 East 91st Street), New York, N. Y., and currently Professor of Social Work at the Graduate School of Social Work, New York University (One Fifth Avenue), New York, N. Y.

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NATIONAL HEALTH INSURANCE: MAJOR PROPOSALS, ISSUES AND GOALS

Anne Somers

Vice-Chairman, New Jersey Medical Assistance Advisory Council for the New Jersey Medicaid Program

Mrs. Somers is well known in the field of health care economics because of her many professional articles and books. Following are excerpts from her remarks made at the Council's August 12, 1970 meeting which serve to describe the arena in which New Jersey's Medicaid Program is operating. New Jersey's Medicaid Program is administered by the Division of Medical Assistance and Health Services in the Department of Institutions and Agencies.

Mrs. Somers deals fully with the question of health care in her forthcoming book, THE DYNAMICS OF HEALTH CARE: FROM PARADOX TO NEW PROGRESS, soon to be published by the American Hospital Association.

Debate on the subject of national health insurance for the American people has ebbed and flowed for nearly sixty years. With the passage of Medicare in 1965, probably the majority of both proponents and opponents of national health insurance believed that the issue had been settled, at least for a decade or so.

On the contrary, the issue became livelier in 1969 than at any time in the past. The principal reasons are evident: the apparently uncontrollable rise in health care costs—a rise that is threatening the viability of many of our major health care institutions as well as the access of many consumers to needed health services, the difficulties faced by many private health insurance carriers in maintaining the present level of benefits let alone improving benefit coverage, the general popularity of Medicare, the crisis in Medicaid and its implications for state, local, and even national politics.

Perhaps the most significant aspect of the current debate, however, is that this time, the major provider organizations are not in opposition—at least not to the general idea. The American Medical Association (AMA) has been on record with its own brand of national health insurance—known as "Medicredit"—since 1968.* In 1969, Representative Fulton of Tennessee and Senator Fannin of Arizona introduced companion bills embodying major features of Medicredit (H. R. 9835 and S. 2705).

In September 1969, Dr. Edwin Crosby, Executive Vice-President of the American Hospital Association (AHA), announced that a Special Committee on Provision of Health Services (Perloff Committee) would undertake a study of national health insurance, along with related issues. The Perloff Committee has not yet reported.

The Nixon Administration, apparently, has not decided what position to take. In September 1969, former HEW Secretary Finch instructed the McNerney

*For the 1970 version see, for example, Russell B. Roth, M.D., Speaker, AMA House of Delegates, "Medicredit—A National Health Services Financing Proposal," paper prepared for National Health Forum, Washington, D.C., February 1970. Also periodic reports in American Medical News.

Task Force on Medicaid and Related Programs to also study the problem of "long-terms methods of financing the Nation's medical care" and to develop recommendations. Even before the Task Force reported, however, in response to Senate criticism that it had not considered the relation between Medicaid and the proposed Family Assistance Plan (FAP), Secretary Finch suggested a program of compulsory health insurance for all those who would receive aid under this program.

By the time the Task Force turned in its report, June 1970, Secretary Finch had departed from HEW and the new Secretary Richardson had just arrived. The Task Force made numerous recommendations, including one that the cost of the basic Medicaid benefits be completely federalized. On the question of national health insurance, however, it made no commitment, although some commentators are so interpreting its guarded call for "a new national policy for health-care financing" for "the existing and potentially eligible" Medicaid population. The Report did urge that HEW "develop a policy position on this critical and controversial health-care issue." It urged the Secretary to appoint another high-level body "to undertake promptly a study directed toward development of a health-care financing policy for the nation" and "to present recommendations to the Secretary in time for consideration during the 1971 session of the Congress."

The Task Force's own contribution to the national debate was embodied in a set of "central and necessary objectives against which long-range financing proposals should be evaluated," and a long list of specific issues and questions, arising out of the previously stated objectives, which—the Task Force said—should be considered in evaluating all financing proposals. The new committee has not been appointed.

Thus it appears that the great debate over national health insurance is still far from its climax. Until the new Administration study is completed, the Congressional sponsors will probably not push too hard. More important, the House Ways and Means Committee, which claims the right to initiate all such legislation, has given no indication that it is ready for any decisive action.

How long this period of indecision will last no one knows. The chief factor will be the extent to which the inflation in health care costs is, or is not, brought under control. The course of the war in Vietnam, the crisis in the Middle East, and their effect on domestic policies are also factors. The growing deficits in many of the nation's leading hospitals, especially in the East, and in private health insurance operations, combined with the Medicaid cost crisis could force the issue sooner than even many partisans of national health insurance expect. In order to get FAP—the welfare reform program—through Congress, the Administration may have to come up with a Medicaid replacement before it is really ready.

The time has come to move on from the usual litany of criticism of existing financing programs—public and private—and to make a serious effort to assess the probable results, both good and bad, of the various proposals that are being advanced and then tot up the balance.

Three Broad Approaches

It is essential to define what we mean by "national health insurance" by sorting out and classifying the major current proposals. Broadly speaking, there are three general categories:

1) A federal program, with compulsory

coverage of all or most of the civilian population, with broad and explicitly defined benefits, financed by a combination of payroll taxes and general federal tax revenues, and administered by the federal government without any use of private carriers.

2) A voluntary federal program of income-tax credits to taxpayers and vouchers to non-taxpayers, to help them purchase private health insurance, with minimal benefit standards, and administration by the Internal Revenue Service.

3) A middle-of-the road program somewhere between these two extremes.

Category One: The Labor Proposals

There are two major proposals in Category One—both supported by organized labor—the Griffiths Bill, sponsored primarily by the AFL–CIO, and the Health Security Program of the UAW–sponsored Committee for National Health Insurance (CNHI). The latter has not yet been reduced to legislative language and is therefore less precise in some details.

Both aim for universal coverage. The CNHI proposal specifies that every resident of the U.S. will be covered. The Griffiths Bill covers all citizens (except active-duty members of the uniformed services) and aliens who have been resident for at least a year or come from a country with reciprocal health benefits. The CNH proposal specifically states that Medicare would be terminated and its benefits absorbed into Health Security. This would also be true of the personal health components of the Office of Economic Opportunity (OEO), Vocational Rehabilitation, maternal and child health, and crippled childrens' programs. Medicaid and CHAMPUS—(Civilian Health and Medical Program of the Uniformed Services)—would continue only as residual programs, providing such benefits as exceed the broad Health Security limits. On the other hand, workmen's compensation medical benefits would remain intact. The Giffiths bill is silent on these points but presumably it would have approximately the same effect. Private health insurance has no role in either bill. The Federal Employee Program (FEP) would be terminated.

With respect to benefits, both provide a broad range, including all necessary physicians' services and hospitalization. Both specify certain limits on most other services. For example, both limit dental benefits: the CNHI to children under 15 and exclusive of most orthodontia; Griffiths to children under 16 and others "who meet eligibility requirements for Medicaid or financial or other requirements set by the Board."

Outpatient psychiatric care is covered in full by CNHI if provided in a hospital, community mental health center, or other approved institution. Private care is limited to 25 consultations during a spell of illness and inpatient care to 45 days per spell of illness. Griffiths appears to impose no limits in this respect. In the case of skilled nursing home care, CNHI has a limit of 120 days per spell of illness; Griffiths, no limit. As to prescribed drugs, Griffiths is unlimited; CNHI is unlimited for inpatients and for persons enrolled in comprehensive group practice plans. For others, drug coverage applies only for chronic diseases and conditions requiring especially long or costly drug therapy.

The Griffiths bill's more liberal provisions with respect to several of the minor services is presumably balanced by a $2.00 copay charge for all physician and dental visits, after the first, and for home health services. Copayments are limited, however, to a yearly maximum of $50 per person or $100 per family.

Both proposals would be financed on a tri-partite basis—general federal tax revenues, employers, employees and other individuals—although the proportion coming from the three sources would be somewhat different. CNHI proposes 40 percent federal, 35 percent from employers, 25 percent from employees and other individuals. Griffiths requires the federal contribution to equal ¾ of the tax on employers and employees—43 percent of the total. The tax rate specified in Griffiths is 3 percent of payroll for employers, 1 percent of wages for employees, and 4 percent of self-employment income.

Under the CNHI proposal, the contribution rates are described as both tentative and flexible. To fulfill the 40-35-25 ratios in FY 1969, the tax would have been 2.8 percent on employers, 1.8 percent on individuals. (The CNHI third source appears to be an individual tax—on wages, salaries, and other adjusted gross income—rather than an employee payroll tax.) Both plans propose a cut-off point of $15,000 a year on payroll and individual taxes. Both propose that funds be deposited in a special federal fund, from which benefit payments would be made.

Both programs call for total administration by the federal government—HEW and regional units. Private intermediaries are excluded. At the national level, CNHI calls for a five-man, full time Health Security Board, appointed by the President, and serving under the Secretary of HEW, to establish policy and regulations, and an executive director appointed by the Board. The Board would also be assisted by an advisory council with consumers holding majority memberships, and technical advisory committees. The Griffiths bill proposes a nine-man board, six full-time, with three top HEW officials *ex officio*. This Board would be advised both by a consumer council and a professional council.

Both programs provide that their national boards shall establish standards for participating providers. The Griffiths bill spells out specific standards for hospitals and other institutions. Among other more conventional requirements, the hospital is required to have a full-time medical director.

The national administration would be assisted by a number of regional offices; the CNHI speaks of the 10 existing HEW regions and a network of area—perhaps 100—and local offices. The CN HI regional offices would be responsible for coordinating the program in their regions, approving providers for participation, as well as the annual budget of all institutional providers as the basis for payment, and acting as payment authorities.

In the Griffiths plan, each region would have its own consumer and professional advisory council, would enter into contracts with the providers, and generally supervise the program.

CNHI envisions a nation-wide budgeting system.

> "This means that each year an advance determination will be made of the total amount to be spent in the various regions on physicians' services, institutional services, and other categories of services provided in local communities. The cost of each kind of service and the overall cost of the Health Security Program will be allowed to increase only on a controlled and predictable basis. . .
>
> "The size of the annual Health Security Trust Fund will be determined by the health insurance taxes and the federal general revenue contributions. . .After an appropriate percentage of the Fund

is set aside for contingency reserves and for the Resources Development Fund, the remaining money will be divided among the ten regions, with regard for recent and current patterns of utilization of, and expenditures for, personal health services of the kinds covered by the program. In FY 1969 figures, this would have represented a national per capita allocation of approximately $200 (adding up to a total of $37 billion), but with higher and lower per capita amounts in the several regions."

Under this plan, institutional providers would be paid exclusively on an approved budget basis. Money for payment of physicians and other practitioners would be distributed to local areas within the region on a per capita basis with some adjustments. From the physicians' allotment, first priority would be made to those on salaries, those working in comprehensive group practice prepayment organizations, and others who agree to accept capitation payments for the care of a defined population. The remainder of the local fund available for physicians' services would be used for payment of fee-for-service bills on the basis of negotiated fee schedules. "If the amount available for fee-for-service payments is in danger of being exceeded, payment of bills will be prorated." Providers would not be permitted to charge anything over and above the official fee. All payments would be made directly to providers; there would be no billing or indemnification of patients.

The Griffiths plan provides more flexibility with respect to payments. Hospitals could be paid on the basis of capitation, budgeted costs, or any other basis approved by the regional director "which shall provide incentives for improving the quality of care and the efficiency by which hospital services are delivered." With respect to practitioner services, the regional offices are expected to enter into agreements with state or local medical societies, medical groups, or other nonprofit organizations. In turn, the latter may reimburse the individual practitioner on the basis of capitation, salary, fee-for-service, contract, or any combination thereof. An additional allowance of up to 5 percent would be made to such organizations for certain innovations, including quality review, improving efficiency, and continuing education.

Both programs provide that a portion of their total revenues should be set aside for development purposes. CNHI establishes a separate Resources Development Fund. A percentage of the trust fund's annual income—starting at 2 percent, rising to 5 would be used "to increase health personnel and facilities and strengthen the health care system. Priority will be given to stimulating the development and growth of group practice programs and other innovative and productive health care alternatives." The Griffiths bill also provides a revolving fund aimed at development of comprehensive health delivery systems.

Category Two: The Tax-Credit Bills

The Fulton Bill—H.R. 9835* differs from the labor proposals in every essential respect. It is completely voluntary. Neither Medicare nor any other public health care program would be di-

*On July 21, 1970, Representative Fulton and Broyhill of Virginia introduced a new version of Medicredit—H.R. 18567—incorporating several significant changes. The tax credit is based on net taxable income rather than gross income; eligibility for a voucher is broadened and the table of tax credits is changed; minimum benefit standards, including 60 days of hospitalization, are specified; a national health insurance advisory board is provided, and a peer review mechanism to be operated by the state medical societies, as a cost and quality control, is included (American Medical News, July 27, 1970).

rectly affected although presumably the Medicaid load would be reduced. The purpose is to assist individuals and families to purchase private health insurance through a system of graduated federal income-tax credits on gross income. The credits vary from 25 to 100 percent, depending on the taxpayer's income, marital status, and type of income tax return, up to prescribed limits. The limits are $150 a year for an unmarried person filing a separte return, $200 for a married person filing a separate return, $400 for a family unit. Existing medical expense deductions are disallowed. Individuals whose tax liability is less than the prescribed limits would be eligible for a voucher or "premium certificate" worth up to $150 for an individual, $400 for a family, to be issued by the federal government to be used to purchase insurance.

There are only two specific benefit standards—the policy must be offered without regard to any pre-existing condition and must be guaranteed renewable. Nor are there any special taxes. It would be financed entirely from federal general taxes and would be administered by the Internal Revenue Service.

Category Three: The Middle-of-the-Road

The bills and proposals that fall into this category are so diverse that a case could be made for listing each separately. However, the similarities are more important than the differences. All represent a middle-of-the-road between the extreme centralization of Category One and the extreme permissiveness of Category Two.

Although it is the most recent, the most fully-developed proposal in this class is Senator Javit's bill—S.3711, introduced in April 1970. He starts with improvement and extension of medicare to the entire population. The first step involves coverage of disabled Social Security beneficiaries and merger of parts A and B—both financed through payroll taxes. The second step would cover all remaining citizens, and some aliens, effective July 1, 1973. The benefits would be those of the present Medicare plus some drug and dental benefits and annual physical examinations.

Financing would be tri-partite but the federal share would be limited to that necessary to pay for the unemployed and public assistance recipients. Employers and employees would pay equal amounts —starting at 0.7 percent of the first $15,000 of wages or salary in 1971, up to 3.3 percent in 1975 and after.

Like Medicare, the new program would be administered by the Secretary of HEW, but below the federal level administration would be highly pluralistic with numerous options. Private intermediaries would be continued as under Medicare except that in areas where the Secretary cannot find an efficient private intermediary he is authorized to set up a federal health insurance corporation or to contract with a state for this purpose. Private carriers may also sell plans, which provide equivalent benefits at a cost equivalent to the national program. And employer-employee plans may be continued provided their benefits are superior to the national program, and the employer pays at least 75 percent of the cost.

No specific method is spelled out for payment of providers. The secretary is instructed to study and promulgate a new reimbursement method by 1973. The new method:

> "will be designed to control, and if possible reduce costs and utilization, to improve the organization and delivery of health services, yet assure that such control and

improvement will not deprive providers or suppliers of care of 'fair and reasonable compensation.'"

The Javits bill also aims to encourage development of more effective delivery systems, provides special grants for group practice plans, and authorizes contracts with "comprehensive service systems" on a basis that will enable them to share in any savings.

Governor Rockefeller, who came out for a national insurance scheme early in 1969, was the first to sponsor legislation of this general type. Bills providing for state-wide compulsory health insurance have been introduced, unsuccessfully, into the last four New York State Legislatures. In general, these bills have provided that all employees of firms with more than a specified number of workers—usually 2 or 3—must be covered by health insurance, to be paid for jointly by employer and employee. Minimum premium rates, as a percentage of payroll, and minimum benefit standards were specified but the insurance could be purchased from any approved carrier. The government would contribute on behalf of low-income employee groups, the short-term unemployed, and welfare recipients.

The program would have been administered by a New York State Health Insurance Corporation and a series of regional councils, responsible for recommending medical fees schedules. In its 1970 version, the Rockefeller proposal would also have authorized creation of nonprofit medical corporations to encourage physicians and hospitals "to unite under a common management for the purpose of providing efficient, comprehensive health services on a prepayment basis." Such corporations would have been given preferred tax status.

J. Douglas Colman, President, Associated Hospital Service of New York, endorsed the Rockefeller approach in testimony before the New York Joint Legislative Committee on the Problems of Public Health.

The most constructive proposal from the commercial insurance industry has come from Daniel W. Pettengill, Vice President, Aetna Life and Casualty, the company which has long administered the Federal Employees Program on behalf of an industry-wide consortium. Mr. Pettengill's plan is two-fold: 1) federal standards for private group health insurance, enforced by means of reduced income-tax deductions from employers in case of non-compliance, and 2) federal promotion of "a uniform plan of health insurance benefits to the poor, near-poor, and uninsurable" by means of state-wide "reinsurance pools" operated like a group, underwritten by all carriers in the state, administered by a single carrier, and with statutory benefit standards. The "near-poor" and "uninsurables" would be required to pay something toward their insurance. Federal-state subsides would make up the difference as well as the total cost for "the poor."

Speaking to a special meeting of the United Hospial Fund of New York, January 1970, I suggested extension of a modified version of the Federal Employees Health Benefits Plan (FEP) to all the population not now covered by Medicare.

What distinguishes ths group of proposals from those in Category Two is their insistence on compulsory or "mandated" coverage, compulsory or required minimum benefits, financing through a combination of payroll taxes and general tax revenues, and an identifiable and accountable administration. What distinguishes them from Category One is their continued use of private health insurance, in one form or another, and administrative decentralization.

Narrowing the Range of Choice: The Vital Center

Our aim is to clarify the major problems involved in the development of a viable national insurance system for this huge country, to delineate the desirable goals of such a system, and to establish guidelines for evaluation of the proposals that have been made and others that are sure to follow. In so doing, it should at least be possible to narrow the range of choice.

No effort will be made to compare the different proposals on the basis of estimated costs. In the first place, no reliable estimates are available for most—and cannot be. The particulars of all the proposals are still in extreme flux and any estimate at this stage is inevitably ephemeral. Moveover, the experience of Medicare—where the most careful actuarial projectons fell so far short of the mark—suggests that any evaluation keyed primarily to the dollar sign is likely to be misleading.

Secondly, what really matters from an economic point of view is not the gross cost of any specific new program but the net cost; i.e., what it adds to the nation's total health care expenditures. Thus the net cost of a program which absorbed Medicare would, in 1970, be $7 billion or so less than its gross. Similarly, the extent to which it absorbed all or part of Medicaid would have to be taken into account.

Third, with respect to social utility, it is not the dollar cost of the program that is vital but the degree of protection, in terms of actual coverage of family health care costs—that those dollars would buy. The CNHI proposal, which they themselves set at $37 billion, could be a better buy for the nation than the theoretically much less expensive Fulton Bill.

Medicaid: Pros and Cons

This discussion is aimed primarily at social value and workability. Measured by this yardstick, the Fulton-Fannin version of Medicredit must be faulted. It offers no chance of approaching universality of coverage. Income tax payers who do not participate would be penalized by losing their potential tax credits but that is not the same thing as mandatory coverage. There is no penalty on the poor who do not take advantage of the government vouchers. Consider this possibility. Vouchers are issued to millions of poor people who, for one reason or another, do not use them, or if they do, the insurance they buy is inadequate. They get sick and need help. What happens? Is the Internal Revenue Service expected to go into the ghettos and take care of them? Medicaid would obviously have to be continued as a major, rather than a residual, program.

Benefit coverage would be no better than it is today; that is, only about 36 percent of the average family health care expenditures could be covered. Indeed, it might even deteriorate since the federal "mark of approval," inherent in the federal subsidy, would be available for policies below the current national average. The $400 limit on the family subsidy could, of course, be raised—or even eliminated—but that is not the point. Something like $400 bought reasonably good coverage for a family of four under FEP in 1969. But if we have learned anything from the bitter experience of the past two decades, it is that simply pumping more money into an already imbalanced supply-demand situation, without any administrative controls, does not buy better benefits but only more inflation.

Totally lacking in such controls, the 1969 Fulton bill makes no contribution to increased efficiency and economy but would, almost surely, result in the reverse. Since it subsidizes existing inappropriate patterns of coverage it would run counter to new organizational trends which seek to encourage more primary care. And, ironically, since the results are so thoroughly unpredictable, it would provide little or no financial relief to the hospitals or any other hard-pressed providers. On the contrary, it would contribute to the general fiscal instability which is the source of so much of the present difficulty throughout the industry.

Since funding is entirely out of the general federal revenues, the impact is not regressive as it would be if totally funded out of payroll taxes. But, by the same token, the funding is probably less stable and less immune to political pressures of one type or another than if based, at least partly, on payroll taxes and administered through a trust fund.

The chief plusses to be cited for this proposal are: 1) it does not interfere with free choice for those who now have a choice; 2) it would offer some measure of relief—a few hundred dollars a year whose real value would almost certainly be reduced by the accompanying inflation as well as loss of the existing income-tax medical deduction to middle-class families, especially the self-employed who pay all of their own insurance premiums, and 3) it would establish at least the principle of federal regulation of health insurance. Some years ago, these might have been real contributions. Today, they are conspicuously too little and too late.

This is obviously not the only possible version of Medicredit. Instead, the AMA has already formulated a somewhat more liberal proposal, specifyng certain benefits—60 days of hospital care and payment for physicians services—basing the test for eligibility not on gross income but on actual tax liability, and raising the upper limits of eligibility. This process of liberalization can and probably will be continued in the effort to win more public support. But it does not touch the basic flaw in the Medicredit approach. It is simply not possible, in the present condition of the health care economy, to provide anything like universal coverage, comprehensive benefits, and stable provider income, without an effective administrative control mechanism. The income tax-voucher combination is an ingenious effort to circumvent this basic fact but it cannot succeed and, if tried, the results will, almost surely, do more harm than good.

The Labor Bills

The labor proposals are better bills. They aim to provide something approaching comprehensive coverage to nearly all Americans and at the same time to do something about the basic dysfunctions in the health care economy and the rampant inflation. Nevertheless, they, too, must be faulted on many counts. Their universality and comprehensiveness are self-evident. The claim to universality is particularly true of the CNHI proposal which flatly states its intention of replacing nearly all existing financing programs.

This is the opposite fallacy from Medicredit. Whereas the latter is too limited, this is too broad and all-encompassing. Whereas Medicredit makes no effort to correct, indeed underwrites, existing shortcomings of the private health insurance system, the labor bills tend to throw out the baby with the bathwater. Private health insurance has many achievements to its credit. There are many excellent programs of various types, for example,

FEP, Kaiser, GHI, San Joaquin, some of the Blue Cross programs, and some of the insurance company programs. Medicare has not only an impressive record of satisfied customers but, over a painful five-year period, has built up a body of administrative expertise probably second to none in the health insurance world. To think of dismantling most of these programs overnight without the assurance of anything better to put in their place except a well-motivated dream of universality and comprehensiveness is both irresponsible and politically unthinkable.

In other respects too, the labor bills provide a sort of mirror image of the Medicredit faults. Whereas Medicredit is at great pains to try not to interfere with the evisting delivery system, the CNHI and Griffiths proposals—especially the former—quite candidly seek to restructure the system, primarily toward prepaid group practice. The short-shrift given to fee-for-service doctors with respect to payment and the discrimination against patients of fee-for-service doctors in respect to drugs are illustrative. This effort to manipulate both providers and consumers into a form of health care which—regardless of its appeal to the experts—is still distinctly a minority pattern is as unacceptable in a democracy as the AMA's traditional effort to strait-jacket everyone into fee-for-service.

With respect to hospitals, CNHI provides only one method of payment—approved budgets. Agan, this is as bad as the Fulton bill's simply ignoring the problem of controls over provider payments.

The administrative structure of both labor proposals appears, on the surface, as if it weren't meant to be taken seriously. Here are proposals that would inevitably involve in the order of $50 billion as year or more if their goals of universality and near-comprehensiveness are to be achieved. Some 200 million consumer-patients would be almost totally dependent upon the program for services of life-and-death importance. Some 300,000 physicians, and perhaps three million additional health workers, over 7000 hospitals, 20,000 long-term care institutions, and probably thousands of other health care facilities and programs would be almost totally dependent upon the program for their income.

Yet it is proposed that a program of this magnitude, dealing in an area of such complexity, sensitivity, and controversy, should be administered out of one federal and ten regional offices. The CNHI indicates the need for additional area and local offices, with not-clearly-defined duties, but it is the ten regional offices that would be responsible for reviewing and approving, *every year*, the budgets of *all* institutional providers as the *only* basis for their payment! This is as patently unsatisfactory as the Medicredit "no administration" proposal.

On one point, however, the two approaches appear to be in some sort of agreement—the downgraded role of the hospital. Both CNHI and Griffiths rightly seek to promote more primary and ambulatory care. But in so doing they would build up power centers outside the hospitals. Griffiths specifically offers to negotiate payment contracts with medical societies as well as medical groups. This could result in driving a new wedge between hospitals and doctors and thus lead to further fractionation of the community health care system and impede development of the desperately-needed integrated institutional responsibility for community-wide comprehensive care.

The extent to which the CNHI's Resources Development Fund would displace Hill-Burton and

other current sources of capital funds is not indicated but a fundamental shift in priorities clearly is. The AMA proposals, not included in the 1969 Fulton-Fannin bills, but now being vigorously pushed and probably to be added to later versions of Medicredit, for "peer review" and "cost controls" to be delegated to the medical societies would probably represent a further break-up of existing hospital controls without any assurance of equal effectiveness.

Finally, the labor bills are overly rigid, would almost certainly affect adversely the income of many providers—the uncertainty and Medicaid-type delays resulting from the overly bureaucratic administration would probably be worse than any actual reductions in amounts, would probably interfere in some cases with consumer free choice, and while appearing to offer incentives to efficiency and economy in the short-run would probably in the long-run have the opposite result.

The chief merit of these bills, aside from the well-motivated concern with universality and comprehensiveness, is their financing. The progressive-regressive tax argument has been nicely resolved through tri-partite funding. The small differences in the government proportions and in the employer/employee proportions need not be argued here. The CNHI proposal is easier on the self-employed; apparently they would be taxed at the same rate as employees. On the other hand, the Griffiths bill is to be commended for its $2.00 physicians' fee visit—another way of spreading the cost. The logic of imposing this on home-care visits is less evident.

All in all, however, it appears that these bills, especially the CNHI proposal, are as undesirable in their way as the tax-credit approach. Where the latter was much too timid, these are too heavy-handed. Ironically, both would probably be self-defeating even in terms of their owned aims. The inflation and confusion likely to result from Medicredit would, almost certainly, lead to more stringent government controls than would be necessary if moderate controls were applied now. On the other hand, the monolithic labor bills would, almost certainly, lead to a large amount of health care being sought and being given totally outside the system and its controls. Since the ability to opt out of the system is, in practice, more readily available to the rich than to the poor, we could move again to a two-tier situation. Only this time the resulting political furor would understandably be far more bitter. In short, while the labor sponsors aim for innovation and change in the delivery system they have not yet designed machinery that apears promising for those objectives.

Bargaining Toward the Center

But, just as the 1969 Fulton-Fannin bills will not be the last word on Medicredit so we may anticipate numerous revisions of the labor proposals—what may be called for lack of a better word "the universalist approach." As it nears the legislative hopper it will probably become more limited and less global, less restrictive and more flexible. There is obviously a great deal of room for negotiation and compromise in these proposals. Perhaps that was the mood in which they were presented.

Indeed, this may be true of the AMA proposals as well. Perhaps we are witnessing a classic example of collective bargaining on a national scale. There is much to be said for the bargaining approach to resolution of difficult social

problems. But it is all the more reason to focus major attention not on these extremes, which are certain to be modified, but on the vital center—the middle-of-the-road—where the acceptable compromise is almost sure to emerge.

So we turn to the four major proposals in this broad center area. A decade ago, the two-pronged Pettengill proposal, with its call for federal standards for private health insurance combined with publicly-subsidized state reinsurance pools to enable private insurance to care for the indigent and medically indigent, might have saved the day for private insurance; it might have averted the need for Medicaid, as well as national health insurance. Today, it too, is too little and too late. Medicare exists; so does Medicaid. Medical care costs are over 100 percent higher than they were ten years ago; hospital costs nearly 300 percent. Labor's disenchantment with private health insurance has reached the point that it would never accept such a scheme.

There are, also, some basic shortcomings. Administratively it might prove almost as impossible as the Fulton Bill. Who would police all the hundreds of private carriers to make sure they lived up to the federal standards? If the standards were high enough to guarantee really comprehensive benefits to the non-poor, could they be sold, on a voluntary basis, and without government subsidy? If not, what would happen?

The Rockefeller proposal for compulsory coverage through private insurance seeks to deal with some of the weaknesses of the previous plan. Not only are public benefit standards spelled out but coverage is compulsory, at least for most persons who can be reached through the labor market. Employers and employees are required to make specified payments. Conceivably, labor and provider support could be mustered although up to now organized labor has consistently opposed the Rockefeller bills.

The major deficiencies in this approach involve lack of incentive to efficiency or economy, and the difficulty of administration. The workmen's compensation experience in this type of program is relevant. Would it be possible to supervise and police the hundreds of different carriers and hundreds of thousands of different policies? When coverage proves inadequate and people are still sick, who would take care of them? Would there not be continued danger of inflation and the continuation of existing inefficiencies and disincentives? The surest way to make such a plan work would be to limit the number of carriers permitted to participate and to require public approval of the policies they could sell.

But if this were done, we would, in effect, have made the step between mandated insurance and FEP's "controlled competition." Here, finally, in this area which includes the Somers proposal—improvement and extension of FEP to the entire population, and the Javits proposal—improvement and extension of Medicare to the entire population with the additional option of private insurance if it meets the benefit and price standards of the public program—lies the greatest hope for meeting all or most of the criteria of an acceptable national health insurance plan.

The Javits proposal is the more fully developed. It reflects a great deal of sophisticated thinking and effort. It has already been reduced to legislative form, a distinct advantage. It is particularly ingenious in combining comprehensiveness of benefits with flexibility of admini-

stration, in combining a gradualistic approach with a not-too-distant time-table for full coverage, in offering something for everybody and a minimum of offense to anyone. It is pragmatic in that it builds on a going program and its administrative expertise. It is idealistic in that it looks toward universality and comprehensiveness.

Of course, it finesses the toughest issue of all—provider payment—by leaving that up to a new HEW study. Its principal weakness, however, is in the overly-generous number of options which could turn out to be almost as difficult to monitor as mandated insurance. Thus, the difficulty of reviewing and passing on every policy in the nation which claims to be as good as the improved Medicare would in itself be formidable.

By contrast with this carefully-developed bill, the proposal to use the Federal Employees' Program (FEP) as a model for a universal program is still only an idea. There are, however, some important differences between this and the Javits bill which deserve careful study; 1) Under the FEP approach private carriers would be required to underwrite the new program rather than merely acting as fiscal intermediaries; 2) A basic comprehensive benefit package could be specified and the carriers encouraged to provide even broader benefits if they could do so at a saleable price; 3) The price too would be flexible. The price of the basic package would be covered by the basic tri-partite contribution (the present method of financing FEP would have to be changed and made tri-partite) but individuals could purchase broader coverage for an additional amount; 4) Only a limited number of carriers—in FEP there are currently 36 including two nationwide plans—would be permitted to compete for the business; 5) The administering agency would be responsible for approving both the benefits and the price of the various options; and 6) Consumer choice among the various options would be at specified times and on the basis of approved informational material; and 7) No single method of paying providers is decreed—either at the beginning or after a study. It is assumed that the different carriers would use different formulas in the effort to compete and that some of these would prove to be more efficient and viable than others.

There are many advantages in the FEP approach—suitably modified to take into account the vastly larger and more heterogeneous population involved in a national undertaking. Consumer free choice is retained but on a controlled and meaningful basis. Coverage could be made compulsory and as nearly universal as desired. Satisfactory existing programs could be assimilated or continued with varying degrees of autonomy. Benefits could and should be broad but the basic package would not seek to approach 100 percent. Individuals willing to pay for complete coverage, especially for more optional services, could do so by paying for higher options, within the system, which would have the additional virtue of making them more conscious of the price and the relation between benefit and price. Medicaid would be continued as a residual program, especially for long-term care, with some basis for predictability as to probable need and cost. Carrier competition is retained as an incentive to efficiency but on a controlled basis. Thanks also to the use of private carriers, administration should be greatly simplified.

With respect to the delivery system, FEP is neutral. It does not aim to restructure it, but it does not impede such restructuring. It assumes that most capital funding goes on outside the insur-

no prejudice against inclusion of an apance program although there would be propriate capital factor in the various payment formulas. On the basis of the record, Kaiser and most other comprehensive plans have more than held their own under FEP's controlled competition. Contrary to the opinion frequently expressed, a program of this type would probably lead to more meaningful changes in the overall delivery system than a less flexible one. The larger and more monolithic a program becomes, the more people and interests it affects, the more likely it is to be legislatively keyed to the least common denominator, and the less it is able to espouse minority or experimental patterns.

Both these plans have an important attribute in common. They are highly flexible. If, for example, it should turn out that private carriers, operating under an FEP-type program, are unable to exert effective cost pressures on providers and the necessary adjustments in delivery are not shortcoming, the decision is not irrevocable. Private underwriting could be terminated—a potent argument for maintaining Medicare as the core of the system—and the voluntary programs assimilated into a governmental program far more easily than the reverse. In short, such an approach provides maximum flexibility and maneuverability to enable the nation to meet future developments without giving irretrievable hostages to fate.

It is often forgotten that spokesmen for the Kaiser plan urged the FEP approach, in 1965, when Medicare was being debated. For example, Dr. Clifford Keene, now President, Kaiser Foundation Health Plan, urged that the proposed bill be amended along FEP lines.

Even assuming agreement on the desirability of this general middle-of-the-road, a great deal more study will be needed. Many specific issues remain to to be hammered out: the relation of the new program to Medicare; the manner and rate at which it would assimilate (or not assimilate) other public and private programs; benefit levels, premium rates, and the actuarial computations that tie them together; the precise technique for exercise of consumer choice; the administrative set-up which will be complex in any case; etc. Better to take a little longer making the decision than to stumble into another half-baked plan as we did with Medicaid.

On the other hand, we cannot wait too long. There is real urgency—a financial crisis that threatens the lives and well-being of many Americans as well as the viability of important segments of the health care economy. To say that a plan is not "perfect" is no excuse for inaction. We will never achieve a "perfect" plan just by studying it or talking about it. We have to start moving.

THE CASE FOR NATIONAL HEALTH INSURANCE

by RASHI FEIN

Foreign observers visiting the United States to examine the method of payment for medical services would find it difficult to conduct their inquiry. They would discover that in health, as in a variety of other fields, answers they receive to questions would depend on where and of whom the questions were asked. Some individuals pay or purchase insurance for medical care out of their own incomes. Various levels of government pay for some kinds of care for some people. Private charity provides certain services to certain groups. Not only do different sources pay for medical expenses for different persons, but multiple sources often pay for different parts of the care for an individual and family. Eligibility for payment by the various systems depends on the person's age, income, health condition, and on standards set by different levels of government, place of residence, and sundry other variables.

Only a discreet and diplomatic observer would say the situation is confused. A less tactful person might simply say, "It is a mess." He would be correct.

In general, the medical care delivery and payment system is based on a philosophy that medical care is a private matter: Providers of care have the right to select the individuals to whom they render care, and the consumer has the responsibility to pay for the care he seeks. Government is only a "court of last resort." It intervenes when help is sorely needed and, generally, only when the normal market has demonstrated its inadequacy. In recent years, such help has become increasingly necessary, as evidenced by two major medical care financing programs: Medicare and Medicaid. Yet, even Medicare and Medicaid can hardly be considered adequate to meet the payment needs of the population they serve, let alone of all those who need help.

In earlier years, there were many who felt that the payment for services problem could be solved by voluntary health insurance. They drew an analogy to fire or theft insurance, which protects the individual against a high-cost catastrophe with a very low probability of occurrence. Thus, if all individuals contributed small amounts, protection would be available for the few who were hit by a disaster not of their own making. Health insurance, however, turned out to be different. The probabilities were not so low (and for, say, physicians' visits, were quite high); some events against which protection was sought did not have catastrophic monetary consequences (again physicians' visits, for example); and utilization of services and therefore of coverage was controlled to some extent by the individual and to a large extent by the provider, making the probabilities in part dependent on whether the individual had coverage. Consequently, voluntary health insurance came to look more and more like a budgeting system for health expenditures rather than insurance.

Nevertheless voluntary health insurance is an important mechanism for payment for medical services. At the end of 1968, 77 per cent of the civilian population had some protection against hospital costs; 75 per cent were to some extent protected against surgical costs; and 65 per cent had some coverage of in-hospital physician visits. Only 43 per cent, however, had some protection against the costs of physician office and home visits. Moreover, although almost 88 per cent of the $12.9-billion paid by Americans to private health insurance organizations in 1968 was paid out in claims or benefits, private insurance met only 36 per cent of total consumer expenditures and only 23 per cent of national (including government) expenditures for personal health care. Despite failure to provide comprehensive coverage for all types of services, this limited protection was expensive, especially for families with modest incomes.

The problem of financing insurance coverage is becoming more severe. Although family income in the United States has been rising, medical care prices have been increasing even more rapidly, and more and more families are finding it difficult to pay for insurance. Further, many individuals who need financial protection are viewed as "uninsurable," since their medical conditions make high expenditures predictable. Inclusion of "high-risk" persons with other subscribers means higher premiums; excluding them leaves those who are most vulnerable to fend for themselves.

The aged, for example, use many more health services than does the younger population. Therefore, commercial insurers developed premium structures for population groups that did not include the aged. This, in turn, led to a siphoning-off of persons likely to have the most favorable experience, and left those with likely unfavorable experience in a weak position. Blue Cross programs that had begun with "community rating" (everyone in a community paid the same rate) lost subscribers who could obtain lower rates from carriers that did not cover the old. As a higher and higher proportion of Blue Cross subscribers became persons likely to have an unfavorable experience, premiums rose. In the absence of a social insurance philosophy that requires compulsory coverage, this situation creates havoc.

The remaining difficulty with voluntary private insurance is that, as structured, it offers little incentive toward economy and efficiency in provision of health services, or toward substitution of less expensive services for more expensive ones. In medical care, a field controlled by professionals and one in which the consumer often lacks knowledge, private health insurers have tended to be nothing more than bill payers. They have watched prices rise, but have done little to exert leverage on behalf of subscribers. Furthermore, insurance has provided built-in incentives for use of high-cost hospital services rather than ambulatory services. Given the traditions of the voluntary private health insurance sector, it is doubtful that it could be a force toward rationalization of the health care system. Voluntary private insurance cannot be considered as the vehicle for financing medical care for the American people.

For these and other reasons, legislation has been introduced to create a system of national health insurance. Other industrialized Western countries, including West Germany, Great Britain, and Sweden, already have such a system. However, wide differences of opinion exist as to the essential characteristics national health insurance should have. How should government raise the money required? Should the system be voluntary or compulsory?

What services should be covered? What should be the role of the private insurance sector? How should providers of services be paid? Most importantly, should national health insurance represent only a funding mechanism, or should it be considered a force for change in the health delivery system itself?

A number of financing mechanisms are possible. One approach would make funds available from general revenues, which are derived in large measure from the progressive personal income tax. This approach, which thus far has limited political support, would reflect the existing income tax structure. Persons with more income would pay more; those with less would pay less (and a lower percentage of their income). In determining the tax due, account would be taken—as it is now in calculation of the personal income tax—of size of family and other considerations.

Desirable as it is, a comprehensive national health insurance program would be costly. Unless tax rates were increased, health insurance could be financed only by cutting other programs and by allocating to it major portions of available tax "dividends" from economic growth and the end of the war. Whether the American public is prepared for a tax increase—even if that increase provides for essentially free health care—is not clear. In my view, it is clear that without such an increase social priorities would be violated.

The provision of free medical care at the expense of housing, education, and antipoverty programs would represent a misallocation of resources. After all, many Americans can and do pay for part of their medical care out of income. To provide care without an increase in taxes would increase income available for nonmedical expenditures in the private sector and reduce revenues available for social programs in the government sector. Such a policy would fail to meet the country's needs. We should have a national health insurance program that pays through government for the costs of care; it is not desirable, however, that we be relieved of private health expenditures by cutting other socially useful programs.

A second approach to financing the program is through Social Security, a system through which Medicare (Part A, Hospital Insurance) is now financed. In this approach Social Security taxes would be increased to pay for all or part of the services consumed. Given national priorities, an increase in tax revenues should be viewed as desirable. But traditionally the Social Security system involves employee and employer contributions based on wages of the employee up to a maximum wage level, without taking account of family size or other obligations. Thus, the family earning $7,800 (the present wage base) is taxed the same amount as is the single individual earning $7,800 or $78,000 or $780,000. The tax, therefore, does not adequately reflect ability to pay.

Successive declines in personal income tax rates coupled with increases in Social Security rates represent an unfortunate shift in American tax policy. I see little reason to foster this development by financing a new—and expensive—national health program through this type of wage tax. We could, however, have a much higher wage base and contributions from general revenues as well as from employer and employee, approaches that are supported by Michigan Congresswoman Martha Griffiths and the Committee for National Health Insurance originally organized by Walter Reuther. We could, and should, also consider Social Security tax rates that increase with income, and refunds to persons below certain income lines. It is possible to design a more equitable financing system even while exploiting the virtues and strengths of the existing Social Security system.

Finally, there is a tax credit approach. That is, assistance would be given in purchase of private insurance by an offset against taxes. The American Medical Association and others have argued for this system with two important features: The amount of credit against taxes due would decline as the tax due increases, and persons who would not benefit fully because their tax is too low would receive the difference between the credit and tax due. Such a program is not a particularly efficient approach, but in progressivity and equity it can be made similar to a general revenue, funding mechanism. Whether such a program is progressive enough and offers sufficient assistance depends on the rates selected.

An example of the importance of rates—though not in a tax credit context—can be seen in the administration's proposed replacement for Medicaid. The administration tentatively suggests that a family of four earning only $4,500 pay $220 toward the cost of a health insurance policy with a $500 market price—a policy that would not cover all medical costs. Families earning $5,620 would pay 25 per cent of their additional earnings (an additional $280 out of their extra income of $1,120) to cover the policy's full cost. Similar rates for a tax credit program would be insufficient and little more than a cruel hoax. Rates must offer more meaningful and equitable assistance.

Apart from progressivity, it is difficult to evaluate a tax credit program solely as a financing mechanism, since many who favor it have coupled it with proposals to minimize government involvement in standard-setting and regulation. The deficiency of an approach that minimizes the possibility of change in the health care delivery system should be apparent to all who are concerned with the size of the health care bill and whether we are getting our money's worth. A tax credit scheme need not freeze the delivery system, be private sector-oriented, nor be permissive in nature. Yet, many proponents have cast it in that manner. As a result, whatever one's views on tax credits in general, specific programs now offered—such as the AMA's—should be rejected as falling far short of national needs.

Consideration of alternative financing mechanisms requires discussion of questions of equity, efficiency of alternative administrative procedures, and possible impacts on other national programs. Such matters often are left to technicians and "experts." The issues, however, are not only technical. They involve ideology and values. All of us should be participants in these debates.

There also will be controversy about such matters as breadth of coverage and comprehensiveness of benefits. Here, experience with voluntary health insurance should remind us that it is important that the scope of coverage not distort the choice among medical care services. Hospital coverage without ambulatory care coverage, for example, may appear tempting as a way to save money. But it is predictable that it will lead people into hospitals even if they do not require hospitalization, and will add to the cost of care. We dare not distort the medical care system in this way.

Also, we must focus on total costs—both public and private—and not be tempted to exclude certain coverages or have high deductibles or co-insurance provisions to reduce the impact on the government budget. If these should reduce costs to government, they would increase costs that the individual would have to bear. Such provisions entail high administrative and bookkeeping costs, their impact on utilization is frequently insignificant, and to the extent that they have an impact it is greater on the poor and on preventive services. Furthermore, physicians, not patients, determine the utilization of those medical care services that are most costly: the number

of days spent in the hospital, the number of laboratory tests performed. We need measures that have an impact on the physician's behavior; it is he who, in large measure, controls the situation.

Provision of health insurance coverage for all the population would bring substantial benefits to many persons. Such coverage, however, is not enough. In the absence of significant restructuring of the delivery system and of the method by which providers are paid, one can easily envision further escalation of costs, again demonstrating what we already know: that government cannot announce it will pay for services and permit providers to fill in a blank check. The absence of competition combined with traditions of the nonprofit sector strongly suggests the need to stimulate and reward efficiency and provide incentives for reorganization. We have learned this lesson with Medicare and Medicaid.

In many ways this part of the problem will be the most difficult to solve. The payment mechanism, even while meeting equity criteria, must recognize diversity in tastes, in geography, in population density, in health conditions. The tradition of American medicine is permissive, encouraging physicians to practice where they want, what they want, and for the people they want. Clearly, however, if national health insurance is to be fully meaningful, government must assume a responsibility for the health care of the population or delegate that responsibility to organizations such as medical schools, group practices, community hospitals, neighborhood health centers. It will have to make certain that resources are available and that the individual can find his way into the medical care system.

It is unlikely that we will legislate a changed system. Rather we will evolve it. To do so—to enable the delivery system to respond to pressures brought by consumers and by younger physicians now graduating from medical schools—the national health insurance payment mechanism must be designed to make change possible, to speed it along; above all, not to freeze what now exists.

Opposition to national health insurance will come from various sources. Some will suggest that, whatever its future merits, the nation is not yet prepared for it; that we must get ready for the increase in demand the program would bring; that we must first increase the supply of personnel and facilities and rationalize and reorganize the system to achieve greater productivity. I submit that if we choose to wait till we are better prepared, we will wait a very long time. What, after all, has the administration done, what is it proposing to do, to increase resources and rationalize the system during the "waiting period"? Little will happen to improve the situation, and we shall find ourselves no more ready for national health insurance six years from now than we are today.

There is little evidence to suggest that, as a nation, we do well in "getting ready" for the future. If we respond at all, we do so when the problem is upon us. We commit resources to increasing supply only when the demand has already been there; when the public has been frustrated in its ability to find services that have been promised. We must mobilize demand if we want to bring changes in supply.

Finally—and this lies at the center of the debate—to say that we are not yet ready to institute a national health program is to say that even today we cannot deliver the medical care that Americans need. If that is the case, if the system is unable to produce more services, shall we continue to ration the short supply on the basis of income and ability to pay for the services? Is this the basis on which medical care should be distributed? Should we not ration according to medical need?

I believe that we should commit ourselves to the concept of a national health insurance program and move forward to institute it as rapidly as it can be enacted. We must begin the debate. The submission of specific legislative proposals helps to focus the debate. Important as it is to enact national health insurance as rapidly as possible, it is also important that we not enter the political-bargaining stage before we examine the issues. It is important that all of us increase our understanding of the advantages and disadvantages of various options. Only in this way will we who are not part of the legislative process or members of organizations with links to the process make an impact on the design of an equitable program that protects against the financial burden of high medical costs and promotes development of a health care system that meets the needs of our population.

SOURCE: Saturday Review, Aug. 22, 1970.

The stunning price tag on national health insurance

By James A. Reynolds
Washington editor, MEDICAL ECONOMICS

Now that battle lines are being drawn for the coming fight over national health insurance, a new but related question is belatedly gripping the attention of official Washington: Can we afford the cost of such a program? Says one influential lawmaker, "That's a good question." Says a health economist, "I wish I knew."

Cost estimates put forward to date are suspect for one reason or another. Nonetheless, projections offered by sponsors of three of the front-running programs hint at the possible price tag:

¶ The A.M.A. tentatively figures its latest tax-credit scheme would cost about $15.4 billion a year—chicken feed compared with rival programs but still seven times the money cost of building and dropping the first two atomic bombs. Stated another way, the A.M.A.'s plan would cost more in one year than we'll pay in veterans' pensions in the next three years.

¶ Senator Jacob K. Javits (R., N.Y.) thinks the annual cost of his plan would reach $68 billion—about what we've handed out in nonmilitary foreign aid over the last 18 years.

¶ The program conceived by the heirs of the late Walter Reuther and sponsored by Senator Edward M. Kennedy (D., Mass.) would provide unmatched benefits while costing, its backers claim, no more than $50 billion or so a year. Even that relatively modest figure, which assumes controversial health-care changes, would be double the amount we spent to land a man on the moon.

Boxcar figures such as these invite pointed questions from lawmakers and taxpayers alike.

How can national health insurance be considered such a near-certainty, it seems reasonable to ask, yet have been the subject of so little hard thinking about its cost? Where will the money to pay for it come from? Can the economy generate enough cash to bring health care to all, even if we get out of Vietnam? Would a new health program undermine the fight against inflation? Do Americans want subsidized health care, or would they rather fight smog, clean up polluted rivers, rebuild decaying cities, and explore space? Where, indeed, does health fit into the scheme of national priorities?

I put just such questions recently to some three dozen health planners, Capitol Hill insiders, and Washington lobbyists. Their answers make clear that a lot of knotty problems remain to be solved. Those favoring national health insurance often seem guilty of wishful thinking. As one advocate puts it: "We need it. Therefore, we *have* to afford it." Even critics despair of derailing the health insurance juggernaut. A hardened health lobbyist offers this cynical prediction: "This will be another of those programs that we pass first and

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worry later about funding." A key Congressional staffer confides: "A lot of the members are scared of this one. They hope it'll go away."

But it won't go away, and those Congressmen had better begin steeling themselves for some agonizing decisions. To understand why, you need only plot the trends and weigh the pressures that shape health-care legislation.

On one side, you see a willingness to use Federal largesse to help ease health problems. Congressmen in this camp—you might call them the healthniks—claim they reflect a slow but significant shift in public attitudes since the 1930s. Thus they rarely hesitate to vote more money for health than the White House proposes, they tend to denounce any cutbacks in existing health programs, and they turn deaf ears toward warnings of socialized medicine. While many of these lawmakers have not yet endorsed any specific proposal for national health insurance, they can be counted on to back some version of it when the issue comes to a vote.

On the other side, you find the economizers. They claim that most middle-class voters get adequate health care and have no interest in paying higher taxes to bring better care to the needy. Pointing to the out-of-control costs of Medicare and Medicaid, they warn that bigger Federal health programs could lead to even bigger Federal deficits. This bloc wields immense power in the Senate Finance and House Ways and Means Committees, through which any proposal for national health insurance must pass.

The conflicting aims of these antagonists portend an epic confrontation in the halls of Congress. Hardly anyone in Washington thinks the clash can be avoided, and most observers predict the acrimony will slop over into the 1972 Presidential campaign.

No matter how fierce the fighting, Washington can visualize only one outcome: "The Kennedy wing will win, and doctors will lose," as a pharmaceutical lobbyist puts it. He thus voices the prevailing view that more and more Americans will be brought under the Federal health umbrella, with accompanying restraints—imposed in the name of cost control—tightening around doctors and hospitals. Indeed, soaring health costs pose a threat independent of the drive for national health insurance. From a health planner for one of the nation's most conservative organizations comes this prediction, "If health costs continue to mount, I foresee that there will be pressure in Congress to bring everyone under a tax-supported program."

This year health spending from all sources will come to around $64 billion—which explains why health is said to be the nation's biggest industry after defense. Costs have been climbing on a curve that shows no sign of flattening out; health spending has risen by more than $25 billion since 1965—and the general inflation accounted for less than one-fourth of this increase. If these trends continue, the spending curve for health care will pass $100 billion by 1976.

On the rise, too, has been government spending for health. This year Uncle Sam will pay 26 cents of every health dollar while states and localities will add 12 cents—a 38 per cent government share, compared with around 25 per cent just five years ago. The Mediplans account for much of the increase. The Federal expenditure for Medicare benefits has climbed to $6,437,000,000, up 103 per cent in four years. Medicaid will cost an estimated $6,275,000,000 this year (more than half paid by Uncle Sam), even though the program reaches only a third of the poor and near-poor. A recent report warns that the program's normal growth could outstrip existing Federal and state tax resources within the decade.

Would the advent of national health insurance speed up the rate of over-all health spending? The answer, which is anything but clear-cut, depends on whom you talk with. Would it demand bigger Federal outlays? The answer to that is an unequivocal Yes.

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Take that A.M.A. plan, for instance. It would have Uncle Sam shell out $15.4 billion in health insurance premiums for needy Americans, but it presupposes a saving of more than $5 billion by eliminating Medicaid. The probable result: Over-all spending for health as well as Federal spending would both rise, perhaps dramatically if the influx of new money led to further inflation in the cost of health services.

Or consider the Javits plan. It would amount to a step-by-step extension of Medicare to everybody. Within five years the cost would climb to $68 billion—two-thirds from payroll deductions shared by employes and employers, one-third from the Federal treasury. In theory, individuals would incur fewer out-of-pocket health costs as they came under the program. Nonetheless, there's reason to suspect that this program, too, would lead to a rise in health spending, certainly by the Federal Government and probably over-all.

The Kennedy plan takes a different tack—one that might appeal to Congressional economizers. It advocates more generous benefits than any other, yet its backers claim it would cost no more than we already pay for less comprehensive services. To accomplish this feat, it would undertake to lure doctors into prepayment groups, discourage fee-for-service practice, and generally restructure the health-care system. The cost, which might touch $50 billion by 1973 if present price trends continue, would be shared by employes, employers, and the Federal Government. This plan would bring a sharp boost in Federal outlays but, in theory, no increase at all in over-all health spending. To be sure, the consumer would face higher taxes to cover these outlays, but he'd be relieved of his present obligation to pay health insurance premiums, doctor bills, and the like—or so the theory goes.

All this amounts to so much pie in the sky in the eyes of some who've studied the Kennedy plan. Sniffs the director of a major health organization, "Nobody can document those cost projections." The spokesman for a prepayment organization warns, "There's a tendency to underestimate the number of services to be provided." An H.E.W. economist says skeptically, "I'm from Missouri." A lobbyist for a private health organization asserts, "The figures are too low." Not necessarily so, retorts Robert J. Myers, former chief actuary of the Social Security Administration. "Advocates say the money they'd use would be money we're already spending, and there's some truth to that," he explains. "To the extent that this plan would simply divide up the money that's available for health, it's soundly financed."

Skepticism isn't limited to the Kennedy plan. "All of the cost estimates look too low," one planner avers. A similar view comes from Martin E. Segal & Co., Inc., a New York consulting and actuarial firm, which observes that "the price tags put on these health insurance plans may be illusory." In the back of everyone's mind, of course, are the cost increases that have haunted the Medi-plans. Spending for the Medicare hospitalization plan over the next 25 years, for example, will run more than double the original estimates. Sighs a Congressional aide, "There hasn't been a government health program yet that didn't cost more than its sponsors predicted it would."

One program—the A.M.A.'s first tax-credit plan—has been subjected to an impartial outside analysis, with results that hardly surprised its critics. When H.E.W. economists studied the plan, they concluded it would cost about $18 billion—some $3 billion more than the A.M.A.'s own estimate. A new study has been aimed at the current A.M.A. plan, which even the A.M.A. says would cost a bit more than its predecessor. The first H.E.W. study prompts one insider to observe, "Some of these things are deliberately understated to sell the package."

Even unintentional underestimates could be aggravated by stepped-up demand for health services. An H.E.W. expert warns, "We know from bitter experience that you get more utilization when you remove

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fiscal barriers." To illustrate what could happen as national health insurance brings to light a lot of unmet health needs, a health lobbyist offers this example: "Just think of the number of youngsters in Washington, D.C., alone who'd need $200 or $300 worth of dental care to get their teeth in shape." There's no doubt about that, another man concedes, but he hastens to make this point: "By giving preventive care today, you might spare yourself the cost of giving crisis care later on."

To return, then, to some of the questions posed at the outset of this article:

How can national health insurance be considered such a near-certainty, yet have been the subject of so little hard thinking about its cost?

Some form of national health insurance will become law sooner or later; you can count on that. And there *has* been a lot of thinking about its cost. The trouble is, nobody can pin a precise price tag on any program until he knows whom it will cover, what benefits it will offer, and when it will start. It's a safe guess, though, that the cost of any program will outrun its original estimates. It's also reasonable to assume that the cost, high as it may prove to be, won't all be piled atop existing health spending; some of the billions that will be required to pay for the program will replace current expenditures.

Where will the money to pay for it come from?

To some extent, as just noted, it will come from a rechanneling of dollars that now go for health expenses—doctor bills, insurance premiums, and the like. New taxes will be needed—perhaps an income tax boost, probably some form of payroll deduction specifically earmarked for health insurance.

Can the economy generate enough cash to bring health care to all, even if we get out of Vietnam?

Yes, if that's what people really want. But it will come only at a high price—more taxes for Americans generally, probably more controls on physicians, more doing without other Federally financed benefits. Health already takes 7 per cent of the gross national product, and it won't be easy to boost that percentage. You can't count on the so-called fiscal dividend—the additional tax yield from growth of the economy; claims on that money have already been staked out through 1975. Nor can you count on the so-called peace dividend—the money to be freed for civilian use when the war ends. Other Federal planners have their eyes on that, and the Pentagon has no intention of sharply cutting back military spending.

Would a new health program undermine the fight against inflation?

It might, particularly if the health system remains unchanged. If Medicare and Medicaid have taught us anything, it's that pumping more money into the system doesn't increase the system's capacity to deliver more services. (Though it would if a substantial portion of the money were to go, as it has *not* been going in recent years, for training additional medical and paramedical manpower.) Thus any program espousing usual and customary fees is likely to come under fire from Congressional cost cutters. Present trends suggest that no plan will gain Congressional approval unless it includes new curbs on costs, new controls on doctors and hospitals, and new incentives to change the traditional ways health care is delivered.

Where does health fit into the scheme of national priorities?

Right now, health has a low priority, but change seems to be in the wind. Fiscal pressures have forced the White House to maintain the health status quo. Indeed, the Administration's proposed Medicaid reforms seem even less liberal than the A.M.A.'s. Health issues should come to the fore as the 1972 elections draw near; the next Administration, whether it be Democratic or Republican, will probably propose its own plan for national health insurance.

Any plan that's ultimately enacted will almost certainly reflect the influence of the A.M.A., Javits, Kennedy, and Griffiths (see page 198) proposals. Though the final price tag therefore remains a question, you can bet it'll be a stunner—as befitting the most ambitious Federal welfare program ever undertaken. □

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NATIONAL HEALTH INSURANCE

By: Robert J. Myers, F.S.A.
Professor of Actuarial Sciences, Temple University

(Mr. Myers recently retired as Chief Actuary of the Social Security Administration, a post he had held since 1947, after joining SSA in 1936. He has been named by the American Life Convention a consultant on social security legislation and administration, and currently is in Okinawa on an assignment from the Defense Department. This is the first of two articles analyzing the national health insurance and medicare crises.)

Let me first define what the term "national health insurance" means, since nowadays many people are using it with quite different meanings.

In my opinion, national health insurance means a program under which the entire population of the country, or virtually the entire population, would be provided all their medical care needs either directly by the Government through salaried physicians and other staff and through government-owned hospitals (socialized medicine), or else through private providers of service most of whose remuneration would come from government insurance programs (the medicare or social insurance approach).

Other types of proposals are currently being made that are called national health insurance plans, but, in my opinion, they should be categorized differently. Some proposals would completely change--or it might be said, scrap--present methods of providing medical care. It would seem to many people that these would be catastrophic in effect if put into operation in the near future, and I think that many of the advocates realize this but are merely using the proposals for talking purposes.

Other proposals instead would be harmonious with the present medical-care system, which, despite strident charges from some quarters, has not been remaining static but rather, in the desirable pattern of American democracy, has been gradually and steadily developing better and more efficient procedures as experience has indicated feasible.

The social insurance approach is taken in bills introduced by Senator Jacob K. Javits (R., N. Y.) and Congresswoman Martha W. Griffiths (D., Mich.) and the proposed plan of the Committee for National Health Insurance (founded by the late Walter Reuther). All these plans are truly national health insurance, since they would apply to virtually the entire population and would provide virtually complete medical care, with the financing being through payroll taxes on workers and employers, plus a substantial matching government subsidy.

The latter, of course, merely tends to hide some of the huge costs involved, since who else but workers and employers will provide the money for the general-revenues financing?

Within a few years, after the full range of comprehensive benefits are provided, the cost of the Javits and Griffiths bills will be at least 10% of payroll, regardless of how it is is divided up, and could well be as high as 15%. Actually, no precise cost estimates for these bills are possible--as they can be made for a cash-benefits program--because there are so many intangibles involved.

For instance, there could be no certainty in the cost estimating process as to how the remuneration of physicians will be determined once there is a monopolistic, monolithic health insurance program. Nor is there any way to know how much service will be provided in such areas as hospitalization and drugs once the financial restrictions on patients have been largely removed.

At the one extreme, a national health insurance system can have a low cost by fiat of the Government if it merely allots a certain amount of money for health

services and provides only what results thereform--which has been very much the case under the British National Health Service and which would be the case under the plan of the Committee for National Health Insurance. The latter plan provides that the financing would come from relatively low tax rates, with the proceeds to be paid first on a "cost" reimbursement to hospitals and group practice plans, and the remainder to be divided up among physicians on a pro-rata basis according to their aggregrate charges.

On the other hand, the financial sky would be the limit if a national health insurance plan provides all the services that people demand as readily and quickly available as possibly can be, without regard to whether this is medically necessary or desirable.

A quite different approach has been taken by New York Governor Nelson A. Rockefeller. He advocates, in essence, that employers must have insurance or other programs covering certain basic health needs of their employees and their families, with a separate governmentally-financed program of similar nature for non-employed persons. In many ways, this would change the existing system very little, since the vast majority of employees in the country already have reasonably adequate private health insurance.

Another type of proposal is to grant tax credits for those who purchase, on a voluntary basis, comprehensive health insurance coverage from private insurers. The amount of the tax credit would be inversely related to family income, so that the very low income groups would receive their insurance policies without cost to them. Then, there would be a gradual tapering off for higher incomes, until, after a certain point, there would be no government subsidy involved.

Such proposals, of course, would be financed from general revenues and would therefore mean higher taxes from one source or another for the general taxpayer. Proposals along these lines have been made by the American Medical Association and by Rep. Richard Fulton (D., Tenn.) and Sen. Paul J. Fannin (R., Ariz.).

A quite different approach has been suggested by Rep. Durward G. Hall (R., Mo.). One part of his proposal would be to provide private health insurance policies for the medically indigent and thus would replace the Medicaid program. The second part of his proposal would cover truly catastrophic illness for the entire population, defining "catastrophic" in relation to the family's income. Through the latter procedure, families would obtain the very necessary economic protection in those rare instances where medical costs run far in excess of the maximum limits in most health insurance policies.

The cost for this "catastrophic expense" plan would be met from general revenues, which seems a most desirable approach because of the relatively few cases involved--so that establishing any insurance system involving premium payments would be administratively inefficient.

One might well wonder why there is currently such a clamor for national health insurance or similar programs at this moment. Medical science has been making giant steps of progress, and the health and longevity of the American public is at an all-time high. Many different types of programs are being developed and put into effect to provide adequate health care for the very small minority of our population who are truly in poverty.

And yet the advocates of socialized medicine are raising their voices ever louder to denigrate the existing medical situation. In turn, this causes more moderate groups to examine the situation and to come up with alternative proposals of their own. Undoubtedly, this debate in our democratic society has certain advantages, but it does seem somewhat strange that it is now occurring.

I think that there is a rather simple explanation of this occurrence--namely, the general inflation that we have been having for the last five years. As you well know, the price level has been rising recently at an annual rate of about 5%, while at the same time the general level of earnings has been rising about 6% to 7% per year. At the same time, physician fees have also been rising at about 7% per year, while hospital costs have been increasing about 15% annually.

The much sharper rise in medical costs than in the general price level has been brought home strongly to the American public. For one thing, there is the natural tendency that people object most strongly to rising prices for things that do not give

them immediate personal pleasure--and most medical costs hardly fall in that category, even though over the long run they are primary in achieving personal enjoyment and satisfaction of living.

The advocates of socialized medicine have seized this particular opportunity to achieve their goals or advance toward them, since they believe that the public can be aroused by the sizable increases in medical-care costs. These advocates made a strong drive for national health insurance--preferably of the socialized medicine type--in the 1940's, but they failed to achieve their goal because of the general growth of private health insurance then (which they said could never achieve the success that it actually has).

After lying low for two decades, during which they sought to get the camel's nose in the tent through the enactment of medicare, these advocates of socialized medicine are again out in the open in full force, using as their appealing argument the recent large increases in medical-care costs. As propagandists, they are quite willing to ignore and leave unmentioned several significant and crucial facts.

First, the largest increases in medical care costs have been for hospitalization --an area that is considered sacrasanct, because 95% of the short-stay hospital beds are in "nonprofit" institutions. Second, the relative trend of physician fees in the past five years has been almost exactly the same as it was in the preceding two decades--namely, increasing at about the same rate as the general earnings level.

Third, the illusion is fostered that, somehow or other, insurance is magic and has the inevitable effect of reducing costs. Actually, insurance does not reduce costs in the aggregate, but rather merely, although desirably, it spreads the costs among the insured group. Thus, none have extremely high costs, while others have little or no cost at all, but rather all persons have a uniform low or moderate cost (i.e. the premium rate).

In summary, on this point, it seems that the advocates of socialized medicine are trying to deceive the general public and sell them their old line of goods under a new guise--sharply rising medical costs which are unfairly blamed on physicians, when instead they are much more due to the rising general price and wage level and to the trend of hospital costs.

UNIVERSAL AND COMPULSORY HEALTH INSURANCE: FULL SPEED AHEAD AND DAMN THE CONSEQUENCES

HON. DURWARD G. HALL
OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 7, 1970

Mr. HALL. Mr. Speaker, Odin W. Anderson, Ph. D., recently delivered a most profound speech before the annual congress of the American College of Hospital Administrators, in Chicago, Ill.

Professor Anderson is an associate director of the Center for Health Administration, in Chicago, Ill.

The information he has set forth in his remarks are conclusions drawn from a lifetime of teaching and study.

I was particularly intrigued by Professor Anderson's recognition of the need for long-term, or catastrophic type assistance in health care planning. This is the predominant feature in a new concept of health care that I plan to offer in the form of legislation for the approval of Congress in the near future.

I offer this most timely and interesting speech to all those interested in what could easily become this Nation's greatest area of concern for the 1970's.

The speech follows:

UNIVERSAL AND COMPULSORY HEALTH INSURANCE: FULL SPEED AHEAD AND DAMN THE CONSEQUENCES

(By Odin W. Anderson, Ph. D.)

I. THE BACKGROUND

The re-emergence of universal and compulsory health insurance as a visible political issue—and in a Republican administration—after being quiescent since 1952 bears some examination. This issue is for the first time cutting across parties, one of the early signs of consensus creation in our political process. Many of us in this audience are old enough to remember the proposed universal health insurance legislation which was left simmering on the back burner of the Congressional kitchen stove from 1939 to 1952. It is also of more than passing political interest that none of this legislation—the usual triumvirate of sponsors being the euphonious combination of Democrats Wagner-Murray-Dingell—was ever brought to the floor.

There were probably two main reasons, not to mention many lesser ones, for this political cryness. First, the Social Security Act (its public health sector notwithstanding) was primarily concerned with income maintenance and transfer payments, i.e., the income redistribution aspects to mitigate and prevent destitution. The second major reason was that Congress was frightened about raising taxes in a country where politicians are so directly and quickly responsive to the moods of the electorate—silent or noisy. As all politicians in democracies know, the tax issue is the exposed nerve of the political process, the painful balancing point between the private and public sectors or, if you will, between "private affluence and public squalor". Otherwise, in our recently passed tax bill there would not have been a reduction for everybody, rich and poor alike; to paraphrase Orwell, all reductions were unequal but some were more unequal than others.

Americans continue to have the reasonable belief that the chief problem of people is an adequate income; assure people money and they can in turn buy the goods and services they think they need and want—including personal health services through voluntary insurance. The usual and reasonable theory would have it that if people have the money, they can express choice within a range of goods and services, and supply will then rise to meet this choice, given no artificial restrictions on supply. The opposite of this is the willingness of people to have a restricted supply and accept rationing, queuing, and directed planning so as to restrain rising costs and expenditures of the health system. This would seem to be a reason why, so far, the various levels of government in the United States own and operate so little of the health services enterprise and intervene gently in the operation of the enterprise. When government has been given a mandate—notably Titles 18 and 19, better known as Medicare and Medicaid—it has had to buy services from the private sector, competing for scarce resources and thereby stimulating rising prices. Except for the Hospital Survey and Construction Act in 1946 (Hill-Burton), the Federal Government has been given little financial and legal resources to increase the supply commensurate with recent legislative mandates.

Nevertheless, in the face of impending universal health insurance legislation, the private sector will be plugged into a financial mechanism which inherently—certainly historically—sets quite arbitrary limits to funding much sooner than the private sector. Further, it is undoubtedly hoped not only that universal health insurance will set limits to funds but also that those who distribute the funds can have a large part in determining the restructuring of the delivery methods. Current prevailing judgment among the proponents of universal health insurance is that the present system (or nonsystem) is in a shambles and needs to be restructured. This is quite an undertaking in a society which still fundamentally uses the carrot rather than the stick in getting things done. The difficulties of this undertaking are compounded even more when there is legitimate disagreement about organizational structures, range of services to be covered and methods of paying vendors. Of if one wishes to take an even less sanguine view, there is no monopoly on confusion as to how to solve the problems in the health field. Several commission reports—with a proper mix of citizen and professional representatives—testify to that, and more recently the brand new experts on medical care in *Fortune* and *Business Week*, to whom the solutions are self-evident. Universal and compulsory health insurance is the last untried alternative in this country; and it appears to be believed that such an alternative will make it easier to solve the problems that are now besetting us—certainly it cannot possibly make us worse off.

I believe what is novel about the current interest in universal health insurance in this country in comparison with enactments of such insurance in other countries and previous justifications in this country is that the stimulus seems to stem from concern with rapidly rising expenditures, rather than the usual stimulus of sharing the risk of costly episodes of illness or to assist the low-income classes. Undoubtedly the stimulus of sharing risk is present in view of rather inadequate health insurance benefit levels, but there seems to be a belief that, once the government gets control of the funding, expenditures will be contained within whatever may be regarded as tolerable limits, in this context politically tolerable limits. By making a primary issue of rising costs, the support of the broad middle class is enlisted, the so-called vital center and the ultimate agent of political change. There are legitimate social and moral reasons for some form of universal and compulsory health insurance in keeping with the value of health care as a right rather than as a privilege. Nationalization of the system, i.e., according to some set of scientifically determined specifications, is not one of them, and to imply that universal health insurance can solve the problem of rising expenditures in any rational way is political mischief. It smacks of the continuing propensity of Americans to simplistic solutions for complicated problems.

The democratic political process—particularly the American variety—is a wonder to behold because of the tremendous range of interest groups and the very open nature of political and public policy debate. It is what an English economist called "riotous pluralism", in comparison with his own country and Sweden where respective parliaments are chiefly ratifying instruments after all parties at interest have had their day in closed sessions. Although royal commission reports and parliamentary debates are well publicized in the newspapers, it is virtually too late for unbridled pressure groups to have an effect. In our system, however—and I make no value judgment here—complicated issues become political tradeoffs right on the floor of Congress resulting in shooting-from-the-hip-policy making, and delicate enterprises such as health services go through a severe mangling. What I am simply pointing out is that our political process is responsive to the issues once enough people and pressure groups convince Congress that there is political pay-dirt in being for or against something. Both Medicare and Medicaid are illustrations of this process of exquisite political maneuvering resulting in medical administrative complexities. But I guess this is the way we like it; we are willing to live with the consequences of this political process. It would seem to be expensive both in terms of money and effort, but we are willing to endure such consequences rather than have no legislation at all. As observed picturesquely by the late Professor Morton Grodzins, Political Science, University of Chicago, access to the politicians and political interest groups in this country is so open that our system is a system of "multiple cracks" and legislation results in a "marble cake".

The political bargaining will be particularly intense because whenever Congress faces an issue of redistribution of resources, taking from one segment of society to give to others, as an egalitarian health insurance act does, the question then becomes who shares what with whom? Who contributes more than they get in return? Is there enough for everybody according to self-determined standards as to what is regarded as enough? Or will a large enough segment of the population buy services outside of the universal health insurance system as to vitiate the whole principle of "to each according to his need and from each according to his ability". As I hope I am making clear, I believe in the American political process—a process which is exceedingly well established, in any case—but my concern is rather directed to how this process can be manipulated for the improvement and expansion of the health services. In this respect, the emerging political strategies worry me.

After this rather long introduction, I wish to move in some detail on specific problems and issues which I believe universal and compulsory health insurance will solve completely, solve only in part or not solve at all. This means I must separate generic problems in any health service system from those which can be mitigated by some form of government intervention.

II. IDEOLOGICAL ISSUES

A. Compulsion

During the Forties the issue of compul-

sion, i.e., compulsory taxation of one kind or another for the financing of universal health insurance, seemed to be the keystone issue overarching all others, and, in fact, confusing them. Government was interfering with the freedom of the individual to spend his income as he wished; the patient would be compelled to go to a certain doctor; the doctor would be compelled to take all patients and compelled to practice for arbitrarily set fees, or possibly even a salary. Currently, this issue of compulsion seems not to be a politically viable one for a complex set of reasons.

First, foreign experience has shown that it is possible to have free choice of doctor, various methods of paying doctors, and some variety of practice, and doctors remain in strong bargaining positions regarding professional and financial prerogatives. Then there has been a rather complete acceptance of the method of compulsory taxation for collective purposes. The social security pensions, the Medicare Act for the Aged—Title 18, and the withholding system for personal income taxes have resolved this issue in practice. Further, enrollment in voluntary health insurance is so frequently a condition of employment that an employee has in many cases no choice of whether or not to join. For a while, the controversy seemed to be centered on good compulsion or bad compulsion, but now even this distinction has disappeared.

B. Sources of funds

I believe, however, that there are more important issues than that of compulsion, and they related mainly to sources and amount of funds and sources and methods of controls on quantity, quality, and organization. It is the power of the purse rather than the power over citizen financial participation which bears on the enormous influence that a source of funding has on the general operation of a health service when the amount of funds is increasingly centralized and becomes subject to political tradeoffs. In this connection, the term political is not a dirty word but rather a process of policy formulation and bargaining where many interests have high stakes. Historically, however, I have not been impressed with our government's generosity in financing health and welfare services—Medicare to the contrary because the honeymoon is over, but Medicaid not to the contrary, because the honeymoon did not even start in that program: the bride with her relatively small dowry from general tax revenue was found too demanding right from the start. I see government as an important and for certain purposes a strategic source of funds, but I do not see it as an ample source of funds if it becomes the main source.

C. Equalizing access

I place equalizing access regardless of income and residence under ideology because this is a value which does not lend itself to rational discussion. When society raises a certain value to a moral and now apparently legal right, the impact on implementation is incalculable. It means, in effect, that the possibility of legal recourse on the part of disaffected citizens is increased. The right to health services becomes a civil right parallel to the right to justice. I do not disagree with this noble principle, but I do wish to point out that, as in the case of justice, provision of health care becomes a utopian principle, and the necessary myth of equality is created without the compensatory mechanism of some sort of a tax-supported health confessional when we fall short of utopian objectives, as we always do. The people in the health field are very masochistic; they writhe with pleasure when they are scolded for not attaining utopian goals, and the only outlet for guilt is to get mad at other doctors, patients, and hospitals, and themselves.

You either accept the principle of equal access as part of a humane society or you don't. I gather, however, the principle is now generally accepted in this country. The controversy centers on level of attainment—i.e., short of perfection. I do not see universal and compulsory health insurance, in itself, necessarily equalizing access if all it does is help people pay for services when the supply is not assured. Any system I can conceive of or have seen can only approximate equalization of access. Further, currently underserviced areas must be given priority as target areas for planned introduction of services like health centers. An important aspect of equal access is that of access to services of at least certain standards, and an attempt to spread a certain standard more evenly over the population. Universal and compulsory health insurance, therefore, will no more assure the supply of services at a minimum quality than does our current voluntary health insurance and Medicare. Equalization of access will require a lot more than a mere financing mechanism. It will require a policy of what the British now call "positive discrimination," the government doing more for one segment of the population than another segment, as a form of over-compensation for past deprivations. Otherwise, the health services will gravitate toward a double standard, one for the poor and one for the well-to-do.

III. ISSUES OF IMPLEMENTATION

I now wish to deal with the practical issue of implementation and administration. It is at this stage that the technical experts move in and put together a plan to carry out the mandate. This is the stage of social engineering and, in the health services particularly, a stage which is characterized as one of drawing on informed opinion and best estimates and hoping for a minimum of inevitable unintended consequences. This is a charitable description; usually it is one mad scramble to meet legislative deadlines.

Once universal and compulsory health insurance is agreed to be the chief financing mechanism for health services and as a means of inducing organizational changes, there are a number of major policy issues which must be faced. In order to deal with them adequately there must be built into the legislation the power and the means to do so. The extent to which such power will be given, and, if given, to what degree major issues can be resolved even then, will be examined.

A. Supply

Even though the demand has increased tremendously since the Thirties—admission rates to general hospitals have more than doubled and the proportion of the population who see a physician at least once in a year has also almost doubled—the ratio of hospital beds and physicians to population has remained almost constant. In other words these resources relative to population have absorbed a tremendous increase in demand with only a slight increase in resources. Predictions are that this balance will not continue because of the increasing and shifting age-composition of the population and ever increasing demand. Resources will fall behind, necessitating a much tighter operation of the health services. There will be more people, more disease, more technology, and more money. Obviously, universal and compulsory health insurance will stimulate further demand without a commensurate increase—at least according to present plans—in the supply. The magic word is reorganization.

To those who say that we cannot increase the number of physicians and supporting personnel, but particularly physicians, fast enough, I can only say that we can do so if we want to. If there is anything this country is good at, it is production, from automobiles to babies, and a crash program to increase health personnel seems possible given the acceptance of the policy. Sweden, for example, is increasing its physician supply by 50 per cent in less than ten years through a deliberate public policy, and medical students are already in the pipeline.

B. The poor

Supply, obviously, has some bearing on our ability to equalize access, because the more generous the supply, the easier it should be to distribute resources to people in poverty and rural areas. The current thinking seems to be one of sharing the present resources with the poor and people in rural areas through universal health insurance. It would seem to me that universal health insurance would make it even worse for the poverty areas unless there is a policy of increasing the number of physicians and supporting personnel and of establishing many health centers as outreaches of the large hospitals and medical centers. It is unlikely that the self-supporting elements of the population—by far the larger segment—will tolerate a substantial sharing of the resources without an increase in these resources.

C. Sources of funds

Sources and methods of funding are to some degree a political issue and to some degree a matter of rational tax policy. Invariably, the two become intertwined with political considerations becoming dominant, i.e., a matter of national priorities. Already, as in the case of health services, there are two schools of thought: pay-roll deductions by means of the Social Security Act and/or general taxes. Of the two, the progressive income tax is quite obviously the more equitable from an egalitarian standpoint while the pay-roll tax is actually moderately regressive. Egalitarianism, however, must be balanced with the kind of sources of funds which are most responsive to the constantly changing and expanding needs of the health services. Of these two types, neither would be very responsive, for an act of Congress is required to change the rates of taxation. My own position in case of universal health insurance would favor the pay-roll tax because it is highly visible, can be easily earmarked, and is less likely to compete directly with other national priorities as would be true of the general tax funds. I believe it is plausible to assume that a diversity of sources of funds will result in more funds than will a highly centralized source. There is some evidence for this as well. A British health economist, Brian Abel-Smith, made such observation in a study of the expenditures for health services in 29 countries with a variety of taxing methods.[3] A pay-roll tax shared by employer and employees could still be a stimulus for collective bargaining between labor and management as to relative shares to be collected from each. The ultimate authority, of course, would be Congress. It is also conceivable that, no matter how the money is raised, there will still be employees who want better health insurance coverage than a universal health insurance program is prepared to provide, certainly at the beginning, and, as for the poor, they need a subsidized comprehensive health service. This leads me to the consideration of what is descriptively called the benefit-package in voluntary health insurance.

D. The Benefit package

The benefit-package is, of course, closely related to the total cost of health insurance. This country, more than others, seems to accept the concept of health insurance as the risk of incurring costs for unpredictable contingencies of medical care episodes. At the same time the concept of financial risk becomes diluted by the opposite concept of a health service. These polar concepts imply quite different philoso-

gnies of how people are to buy and receive health services, and, in turn, how services are to be organized and delivered. In the risk concept, the underlying philosophy is one of giving people the money so that they can pay for services as contingencies arise. In the health service concept, the philosophy is one of providing services to people in a highly structured and organized system.

It is highly unlikely that a universal health insurance program will move immediately into paying for the whole range of personal health services and with no deductible or co-insurance. The cost of such a benefit-package would be much greater than Congress is likely to authorize either through payroll deduction or general taxation, i.e., the personal income tax. Nor do I see the possibility of reorganizing substantially our current delivery methods into group-practice and salaried units. Group practice-salaried units are also costly in absolute terms, even though their proponents claim they cost less than the prevailing method of delivering services. Nor do I see Congress willing to harness the medical profession against its collective will.

The inherently high costs will dictate fragmentation of the total range of health services by limitations on length of stay, leaving out certain types of services, and the application of deductibles and co-insurance. Medicare is certainly a precedent here. All the limitations built into the Medicare program undoubtedly reflect the fear of costs, and the patient is asked to share part of them. As long as government does not own the facilities or hire the personnel, it has to think of benefit-packages in the terms described.

It is unlikely, however, that this will be done rationally under the best of circumstances. Short of a comprehensive health service—which I do not think is in the cards now—a relatively low-cost health insurance program in terms of an acceptable tax increase would be a major medical type of benefit-package to cover the now quite frequent high cost episodes, after the first $100 or whatever threshold is accepted and with arbitrary ceilings. Still the lure of first dollar coverage is always there and must be contended with because the public has become accustomed to it and seems to want it.

The term episode, however, suggests a short-term, acute and expensive illness. Health insurance to date has been geared to this limited concept. But there is also the long episode, if I may stretch a term, of long-term and, on average, more expensive care which is a heavy and constant drain on family finances. The first priority, then, should be expensive episodes or an intelligent application of the major medical concept. It would seem that is the major medical concept which is the most rational one in our affluent society for, say, 80 per cent of the population. For the other 20 per cent, other arrangements need to be made for fully-paid comprehensive health services.

E. Methods of payment

Universal health insurance does not solve the chronic problems of methods of paying providers of services.[4] Presumably, the negotiations between hospitals and the government take place within a narrower range of alternatives than in a voluntary context because the government becomes the primary source of funds, rather than one among several others. Perhaps a primarily governmental source of funds can hasten the standardization of reimbursement to hospitals, and the grouping of hospitals into some sort of logical categories as to size, equipment, and patient mix, but the problem of inherently high cost will remain. Workable concepts of efficiency are no more likely in a governmental system than in a voluntary system because a workable and systematic reimbursement method involving quantity, quality, and internal efficiency of arrangements and purchasing has not been invented yet. I even venture to guess that the nature of health services is such that it will never be invented in a sense satisfactory to those who have the responsibility for public accountability if I can judge from foreign experience. In this connection I read with some sympathetic amusement the remarks of the economist Victor Fuchs in an issue of *Hospitals* about devising incentives for hospital efficiency in order to reduce costs: "Well", he said, "it is difficult", but with muted optimism, he continued "I would contend that it is not impossible."[5] And only two paragraphs later he really gets himself into a bind by expressing the fear: "If the hospital management had an incentive to keep costs down, they might be tempted to compromise on the quality of care."[6] So, there is the dilemma—on which side should we err, on tightness or looseness, toward suspicion or trust? In the same issue of *Hospitals* Ray Brown took an aggressive administrator's viewpoint (and one with which I have a great deal of sympathy) about efficiency by saying: "People may talk about his cost, but he knows that providing too much care never got an administrator fired. He has to overcommit his resources."[7]

And, as for the medical profession, the long-term evolution is generally toward salaries, but the short-term and exclusive alternative—with some, but relatively minor exceptions in terms of the whole—is fee-for-service. In this country the fee-for-service concept is deeply entrenched. Even in Europe, however, the fee-for-service method has an awesome persistence outside of hospitals. For hospital-based physicians, the usual method is salary related to some sort of hierarchy. The salary method in Europe is largely based on historical conditions, since no European country could afford to sustain most physicians on a fee-for-service method of payment, as has been true in the United States since the beginning of modern medicine. The alternative in this country is either a fee system or relatively high salaries ($40,000 and up?) or more likely a mixture of both. There is no cheap way out, even in Great Britain and Scandinavia. The salary method provides an ostensible control over short-range cost increases, but in the long run salaries must eventually fall in line with an expanding economy and other occupations. The fee system would seem to be more responsive to short-range changes. Perhaps the best that can be expected in this country is some form of negotiated fee schedule for the segment of the population under, say, $10,000 a year and a cash indemnity for those above this income.

A realization I came to some time ago was that the American medical profession (and apparently the Canadian also) does not limit the concept of professional freedom to the freedom to diagnose and treat but also includes the prerogative to determine the method and amount of payment. It is not long ago that the profession believed it should be able to determine its *source* of payment as well—the individual instead of an insurance agency. When the insurance concept is accepted, it begins with the cash indemnity method of payment where there is no contractual arrangement between the insurance agency and the physician. This, incidentally, is still true in Sweden for physicians practicing outside of the hospital. I point out this concept of professional freedom in the American medical profession because there is going to be some tough bargaining ahead. I believe that because of the monopoly of skills accorded the physicians, their relative supply, and the mandate placed on the government to deliver in the event of a universal health insurance system, the medical profession is in an exceedingly strong position. There will be no simple way to hold down costs in this most important component of personal health services. It is more likely that the hospital facilities and capital funding will be squeezed. Physicians can react immediately. A deteriorating hospital physical plant will take longer to show. Great Britain is a good example of this.

F. Methods of organization and delivery

It is assumed that the government, through its control of the funds, can exercise enough leverage to move the health services toward a form which is "closer to the heart's desire". This will take a great deal of finesse considering the many parties at interest that need to be placated and accommodated, not the least of which is the general public. Referring again to an issue of *Hospitals* Alanson W. Willcox said: "It may be that it (the private sector) can persuade Congress and the public that it has better answers than the government has. This doesn't seem very likely to me. On the other hand, the government has no magic formula for doing things either."[8]

I would assume that the leverage will be financial rather than by legislative directives, because this country has not taken kindly to directives (even in time of war). Given the use of financial incentives, it would then seem that universal health insurance must necessarily be quite expensive so that the incentives can really induce change. It is conceivable, for example, that most physicians might respond much less reluctantly to a salaried service if the salaries were high enough, i.e., comparable to those for currently high income specialists. It is conceivable that in a fee system the fees need to be high enough to encourage physicians, particularly the best ones, to participate in the universal health insurance plan rather than opt out exclusively for the potentially lucrative upper middle class clientele who also carry private health insurance. I believe proponents of universal health insurance who think that they can rationalize health services by this means underestimate the middle and upper middle class desire for options and the effect this can have on the overall health services financed by such insurance. Unless financing is generous both as to supply and as to a relatively loose structure, and apparently wasteful according to some standards, the upper middle class may bypass the government system.

By means of reorganizing the methods of organization and delivery, there is hope of managing both volume of services and quality of services, not to mention price. The issue of quality is an interesting one because the moment a country enacts universal health insurance it can hardly exclude any licensed practitioners in good standing from practicing. Except for practitioners who are obviously and grossly inadequate or border on the unethical and fraudulent, a universal health insurance plan must deal with the facilities and personnel as they are at the moment. There is, then, a long hard road to overall improvement of the entire system, improvements which depend more on "inner-directed" professional standards nurtured by medical schools, the profession, and society at large than on direct regulation by a central authority with the power of the purse. Again, incentives rather than directives for continual improvement must be built into the system, and, again, an incentive system is expensive; it assumes a flush economy.

G. Fiscal and administrative intermediaries

Our form of government has too much respect for autonomous interest groups to ignore or abolish them if they can serve a purpose in carrying out a public mandate rapidly and with a minimum of inter-group friction. Private for-profit nursing homes are already a political force. They responded to demand much faster than did government or the non-profit sector. Universal health insurance will in all likelihood use current health insurance agencies, hospital associa-

tions, and medical associations as fiscal and administrative intermediaries in a pattern very similar to Medicare. Congress will conceivably not authorize the funds to set up the tremendous bureaucracy which would be necessary for the day-to-day operation of a service where physicians treat two-thirds of the people in this country annually. The government will, as usual, be a buyer rather than an owner and will prefer not to deal directly with the providers of service. Hence, the pluralism of sources of funds will be reduced but a form of organizational pluralism will persist. The current parties at interest in the health services will continue to have great countervailing leverage, since the spot light will then also be on the government to assure reasonable access to services.

IV. OBSERVATIONS AND CONCLUSIONS

After this rapid review—despite a long speech—of the implications of universal and compulsory health insurance, do I appear opposed in principle to the government intervening in the health services? I am less concerned with the principle; in fact, it is a noble principle given its humane objectives. But I am concerned with the promises that universal health insurance will necessarily contain costs, reorganize services, and assure equality of access to services. Since the primary emphasis seems to be on containing costs and reorganizing the services through some sort of financial leverage, these objectives will not be attained. My own concept—which, I might add, is not easy to specify either—is to expect the need for continuous expansion in money, facilities and personnel within which a variety of delivery methods can keep on evolving. A universal health insurance system will not afford this type of dynamism, but perhaps a combination of private and public effort will do so. It would seem that the current big buyers of services—labor, management, government—can bargain for certain delivery methods. If these big buyers feel they need a government monopoly of funds to contain costs and bring the health services to heel, then, I believe, they will be disappointed. Let me tell you briefly what has happened in countries since 1950; specifically this country, Great Britain (England and Wales) and Sweden.[5]

Recall that the sources of funds are very diversified in this country, almost completely centralized in Great Britain where the government owns all the facilities, and in Sweden somewhat diversified through the counties which own and finance the facilities.

From 1950 through 1966 the per capita increase in expenditures for all personal health services in the United States, Great Britain (England and Wales) and Sweden has been as follows:

Country	1950–66	
	Percent increase per capita	Percent increase in Consumer Price Index
United States	174	35
Great Britain	137	68
Sweden	614	100

It is apparent that central government ownership and financing can slow the pace of cost increases as seen in the figure from Great Britain; but we do not want the British problem of underfinancing either (despite Britain's disclaimers of being too poor to allocate resources to the health services adequately in view of other priorities). Sweden, on the other hand, with decentralized government funding and apparently with a policy of generous financing, has increased expenditures by 614 per cent. This startling increase compared with the American increase of 174 is not the result of a planned policy but the result of a loose concept of expansion. The Swedes are now alarmed, however, and are wondering how to slow the pace of increase by planning. At the same time they are in a quandary because they are increasing their physician supply by 50 per cent within ten years, a sure fire way to increase total expenditures. When I break out expenditures for hospital and physician services, the same magnitude of increases occurs. It does seem, however, that in Great Britain physicians have been less successful in maintaining their relative position in the increases than the other health service components. In view of the capitation and salary methods of payment this would seem to be reasonable, but still the profession has hardly been supine. Everywhere the profession is in a strong bargaining position both for money and to control their destiny in any organized setting.

As a per cent of gross national income the United States proportion spent for health services moved from 5.3 per cent in 1950 to 7.4 per cent in 1966; Great Britain remained at 5 per cent, and Sweden doubled its proportion from 3.2 to 6.1 per cent. Now for a final set of figures from these countries indicating the relationship of expenditure for health services to the national income from 1950 to 1966. In the United States expenditures for health services increased 1.6 times as fast as did the national income; in Great Britain 0.9 times as fast, and in Sweden 2.2 times as fast.

The increase in hospital expenditure from a neighbor, Canada, which has had compulsory hospital insurance since 1956 (British Columbia and Saskatchewan earlier) further emphasizes that such insurance is not a universal answer to cost control. Per diem hospital expenditures rose 213 per cent in Canada from 1950 to 1967 and in the United States 148 per cent.[10] There is obviously no easy road to cost controls.

It seems to me that universal and compulsory health insurance not only overpromises what it can deliver but it is also the wrong way to set priorities in the current context. In fact, its inauguration may well evade the severe problems, one of which is the poor, which I have mentioned earlier, a second of which is care for the long-term patient, most of them old, and, third, high cost episodes. Drawing on experienced and compassionate observers from Great Britain and Sweden, the present chief medical officer for Scotland wrote regarding the aged:

"Nothing will really flow smoothly in the (National) Health Service unless we reach an adequate stage of provision in our society for the elderly."[11]

Health authorities in Great Britain pride themselves on their observation that the National Health Service always finds hospital beds for real emergencies, a rather elementary achievement it would seem for any system. From Sweden in the person of a Professor of Medicine, Karolinska Institute, comes a related observation, which divides patients into privileged and underprivileged:

"Privileged . . . will become anyone suffering from a sufficiently interesting disease to warrant special investigation and the assemblage of technical experts for diagnosis or treatment. The underprivileged will be the aged, the worn out, the deteriorated and, perhaps still more, the psychologically maladapted—in short, the useless, the uninteresting, and the nuisance."[12]

Will the impending move toward universal and compulsory health insurance set priorities and allocate resources to cope with these needs adequately? The current drive stems, as in the voluntary health insurance movement, from a broad middle class consensus to contain costs and spread risk of acute episodes. These are worthy goals in themselves, but they risk overlooking less tractable problems unless our policies are clear in that respect.

What then seems to be emerging as a public policy recommendation from my attempt to think out loud is: increase the supply, allocate increasing resources of this increasing supply to the poor, the aged, and long-term illness and rehabilitation, induce voluntary health insurance and the self-sustaining element of the public to offer and pay for better health insurance benefits in the direction of high cost episodes, and the big buyers of services should bargain hard with the providers for certain types of delivery methods. If access becomes tight and care parsimonious, we will have a plush private system of medical care and a continuation of "private affluence and public squalor" in health services.

FOOTNOTES

[1] Andrew Shonfield, *Modern Capitalism: The Changing Balance of Public and Private Power*, London, Oxford University Press, 1969 (Reprinted with corrections, paper) p. 323.

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[3] Brian Abel-Smith, *An International Study of Health Expenditure and Its Relevance for Health Planning*, Public Health Papers No. 32, Geneva: World Health Organization, 1967.

[4] See William A. Glaser, *Paying the Doctor: Systems of Remuneration and Their Effects*, Baltimore, Md., Johns Hopkins University Press, 1970.

[5] Victor Fuchs, "The Economics of Health Care in the 70's", *Hospitals* 44: 70, Jan. 1, 1970.

[6] Ibid.

[7] Ray Brown, "Changing Management and Corporate Structure," *Hospitals* 44: 70, Jan. 1, 1970.

[8] Alanson W. Willcox, "Public Vs. Private Sectors: A Further Shift in Power?" *Hospitals* 44: 67, Jan. 1, 1970.

[9] Unpublished data from the Center for Health Administration Studies in preparation for a book by Odin W. Anderson comparing the health services in the three countries.

[10] Ronald Andersen and John T. Hull, "Hospital Utilization and Cost Trends in Canada and the United States," *Health Services Research*, Fall, 1969.

[11] J. H. F. Brotherston, "Change and the National Health Service," *Scottish Medical Journal* 14: 181, 1969. (Reprint.)

[12] Gunnar Biörck, "The Next Ten Years in Medicine: Attempts at Analysis of Factors Determining Medical and Social Development," *British Medical Journal* 2: 10, July 3, 1965. (Reprint.)

Administration Readies Vast Health-Care Plan To Rival Democrats'

Heavy Coverage for Needy Some Aid for Everyone Are Likely to Be Included

Outlook in Congress Unclear

By JONATHAN SPIVAK
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON—Nixon Administration planners, seeking to meet the nation's mounting health-care needs and to fend off a Democratic-proposed cure-all, are devising a major medical initiative of their own.

In competition with liberal Democrats' drive for all-encompassing national health insurance, the Administration will offer the new Congress a less sweeping, less costly plan. The main aims will be to improve medical care for the poor and to ease the health-cost strain on everyone.

Despite its relatively limited objective, the Nixon plan would significantly expand Government health responsibilities, and its cost surely would reach several billion dollars a year. Though key decisions still remain to be made, these are the probable highlights of the proposals now under consideration:

— A "family health insurance program" would replace the much-criticized Medicaid program for the needy. It would extend benefits to additional millions of poor people and would provide greater benefits per family than Medicaid offers. It might include dental care. It would sharply boost Federal medical outlays for the poor.

—More limited insurance benefits would go to middle-income and upper-income Americans to help them meet catastrophically large medical bills. But recipients would have to spend sizable sums out of their own pockets before getting Federal aid, and even then they would pay part of the additional expenses.

—The Government would offer incentives to promote use of more efficient, and presumably less costly, forms of health service, such as group medical practice. There would also be new stress on disease prevention, family planning and other long-range attempts to lighten the nation's medical-care burden.

—The private health insurance industry would retain a substantial role in furnishing coverage for persons under 65 who can afford medical care, But Federal standards requiring minimum benefits could be imposed on the private plans.

"This Year Is the Health Year"

Just how far to go in proposing new Government health coverage is a prickly question for Mr. Nixon, whose budget deficits are ballooning. Merely mounting a more effective health insurance program for the 10 million recipients of the President's proposed welfare-reform plan—a pledge made last summer—could cost $2 billion to $3 billion a year. Additional steps under study could double the price tag.

To ease the fiscal strain, the Administration's new health program wouldn't take effect until the fiscal year that begins in July 1972. Only small start-up costs would be required in the year starting in July 1971.

There is no doubt about the President's eagerness to go ahead. He talks increasingly of his "new program of health," and word that it will get heavy stress has been circulating through the Administration for months. "This year is the health year," insists one planner.

Predicting the Capitol Hill fate of the Nixon program is perilous. Congress has shown interest in adopting some form of health insurance extending beyond existing Medicare and Medicaid programs. Pressure is mounting not only from the poor but also from others feeling the pain of rising medical expenses. The Senate Finance Committee, led by Louisiana Democrat Russell Long, recently voted for a program of catastrophic medical insurance for all Americans under 65, at a cost of $2.5 billion a year.

The Chances In Congress

With the approach of the 1972 elections guaranteeing more partisan infighting, some Administration strategists fear the Nixon proposals will stand little chance in the new Congress, still controlled by Democrats. They note that the Senate fairly bristles with Presidential aspirants; Massachusetts' Ted Kennedy, still considered a strong White House possibility, is an outspoken advocate of comprehensive national health insurance. Thus, it's reasoned, the Administration's plan might merely open a broad debate on the desirability of more extensive health insurance. "I don't think anything will pass in the next Congress," worries one drafter of the Nixon program.

But other Administration specialists insist the Republicans' limited approach will have persuasive political appeal. It's less expensive than the Democrats' approach, more acceptable to professional medical groups and far easier to put into effect, given the shortages of health personnel and facilities.

The differences between the parties on health legislation are dramatic. The massive national health insurance favored by many Democrats would cost at least $37 billion a year, which is more than half the total national expenditures on health care from all sources. This would cover the medical expenses of most Americans, requiring them to pay little or nothing. It not only would eliminate economic barriers to medical care but also would seek to change the way health services are organized, delivered and paid for. Physicians fear they might lose much of their freedom to set fees and determine the way they work; the Government might decide the type and location of new medical facilities.

The Nixon approach is far more cautious. It would finance care only for particular groups, like the poor, or for specific types of medical problems, like catastrophic illness. "We start with the assumption that the commitment is not to displace private coverage," declares one Health, Education and Welfare Department specialist.

The Government would attempt to foster certain forms of medical care; the Administration is particularly enamored of "the health maintenance organization," a type of group practice that emphasizes preventive, nonhospi-

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tal care. But doctors would probably remain free to determine their own charges.

The Administration originally assumed that the planned health insurance for poor families would cost no more than the $1.7 billion in Federal funds now being spent for their medical care under welfare programs. But this estimate counted on stiff financial contributions from many individuals now receiving Medicaid benefits free; moreover, it threatened to reduce levels of medical assistance in many states. Now, with Secretary Elliot Richardson's support, HEW department technicians have apparently convinced the White House that more money must be spent in this area. "Otherwise we may be put in the peculiar position of providing a smaller benefit package and charging the family for it," worries one HEW specialist.

To keep the total cost down, some White House officials maintain that most patients—except the very poor—should pay part of their medical expenses. Thus there might be a provision requiring a patient to pay for the first 60 days of a hospital stay, and he would have to pay a share of all other expenses.

Harvard economist Martin Feldstein and others argue that partial payment by patients would produce advantages beyond savings for Uncle Sam: Medical consumers would shop for the least expensive care; would avoid unnecessary, costly hospitalization; and would pressure physicians, hospitals and health insurance organizations to develop more efficient forms of health service.

But some critics worry that partial-payment rules would discourage patients from obtaining needed medical attention, particularly early diagnosis and preventive care that could cut treatment costs later on. "The real issue is how much people should be encouraged to use medical care and how much you fear they will overuse it," explains one Government official.

The White House has been working on the new health program for several months. The Domestic Council, under Nixon assistant John Ehrlichman, asked the HEW department to make its recommendations for a Presidential message to Congress. The department responded with a massive survey of "health options," including plans for producing more medical manpower and other proposals. But it's the idea of broadened health insurance that has clearly caught the White House's fancy.

Now HEW officials are pushing for a generous insurance program for poor families paid for by general revenues; a modest "major medical" insurance program for other individuals below age 65, financed by Social Security taxes; and the establishment of Federal standards for voluntary health plans.

Here are details of the major proposals:

FAMILY HEALTH INSURANCE PROGRAM: The Administration is committed to an insurance program for all 3.7 million needy families, replacing Medicaid, which aids the 2.3 million needy families headed by women. HEW is pushing for a package of benefits worth $700 or $800 a year to a four-member family. This sum is slightly higher than the national average of $650 under Medicaid and far higher than levels in some Southern states.

The HEW proposal would cover limited hospital costs, plus surgical expenses, preventive medical care, family planning costs—and perhaps dental care. The White House might prefer a far less costly package of benefits. But because some states, notably New York and California, now are paying much more than the national average under Medicare, a stingy Federal program could require unpalatable cutbacks for many recipients.

HEW planners would like the program to reach well above the poverty line to include families with annual incomes of as much as $8,000. Many of these people have private health-insurance coverage, but Federal experts argue that the benefits are often inadequate. The White House would probably prefer a lower income cutoff.

CATASTROPHIC INSURANCE: HEW officials are pushing a program similar to but slightly less generous than that proposed by the Senate Finance Committee. It would require beneficiaries to pay the first $2,000 of medical costs and the first 60 days of hospitalization costs—an additional $4,100 at current rates. The Government would then pay 80% of the remaining expenses. But certain items would be excluded, such as long-term nursing care, treatment with expensive machines for chronically ill kidney patients and experimental organ transplants.

The first-year cost of this program would be $2.3 billion, but no specific increase in Social Security taxes would be required to finance it until 1974. The reason is that Medicare costs aren't rising now as rapidly as anticipated. In the long run, the catastrophic program would require an increase of two-tenths of a percentage point in the Social Security taxes that are paid by both employe and employer; these taxes are already scheduled to rise by 1987 to 11.8% of the first $7,800 of annual income.

STANDARDS FOR PRIVATE HEALTH INSURANCE: Perhaps the most radical departure of all would be an attempt to set Federal standards for private health insurance plans. These plans are financed mainly through union-management contracts and are regulated by state insurance authorities. Perplexing legal and Constitutional issues would confront any Federal intervention in this area.

Some Government planners would like, at a minimum, to require that the private insurers offer subscribers the option of joining group medical practice plans; provide out-patient as well as hospital benefits; and continue coverage for at least a limited period after employment ends.

The Federal income tax would be relied on to enforce such requirements. Employers would lose business tax deductions for payments to health plans that didn't meet Federal standards. There will probably be much Administration agonizing before such a bold move is proposed. One possibility is that the President will simply call for study of the idea.

SOURCE: Wall Street Journal, Jan. 7, 1971

National Health Insurance: Will It Lower Medical Costs--Or Raise Them?

By ALLAN C. BROWNFELD

One of the major arguments used by those who advocate a program of national health insurance is that such a governmental involvement will, somehow, reduce the costs of medical care.

> Yet, those few experts in the field who have studied the National Health Insurance proposals have found that instead of costing the average American less than he is now paying for medical care, such a program would cost him a great deal more. In addition, the experience of those countries in Western Europe which have adopted systems of socialized medicine confirms that this is the case.

Initially, the advocates of such a plan ignore the fact that our medical costs have risen not because of a selfish interest on the part of doctors, but for the very reasons that the cost of everything in our inflation-ridden society has increased. It would be unusual indeed if medical costs remained stable while all other costs skyrocketed.

Hospital workers have now become unionized and are demanding wage increases. Construction workers are among the most highly paid in the nation, and the sophisticated new equipment used in modern hospitals is expensive, even in non-inflationary periods. Nurses are demanding better pay and better working conditions, and the demand upon hospitals has increased notably because of government programs such as Medicare and Medicaid. All of this has driven medical costs up.

There are other reasons for the increase in malpractice suits against doctors, and the cooperation of the courts in granting inflationary settlements. This year about 10,000 persons are expected to file malpractice suits against doctors. Claims against physicians are rising 8 per cent to 10 per cent a year. During the past four years, nationwide increases in malpractice-insurance premiums have averaged 290 per cent, and surgeons in certain "high risk" specialties have been hit with much greater increases. Settlements against doctors have occasionally topped $1 million.

Some doctors say they have raised their fees as much as 20 per cent during the past year to cover their higher insurance costs. In addition, they are overly cautious in their treatment of patients, and this has become expensive—to the patients. Dr. Carl A. Hoffman, chairman of the American Medical Association's professional-liability committee, notes that "Many doctors will order procedures that actually they feel aren't necessary—tests they wouldn't order on their own family—but they're afraid of omitting a test or a detail which might be held against them in case of a later suit."

Hospital beds are in short supply because doctors are becoming increasingly quick to admit and slow to discharge patients. "A couple of years ago, I'd take off cysts in my office," says one Los Angeles general practitioner. "Now if I have to do any surgery, I send patients to the hospital. Of course, this adds to the cost of medical care."

Surgeons are perhaps the most frequent targets for litigation. One, on New York's Long Island, says that if he was performing an appendectomy and discovered an abdominal tumor, he wouldn't touch the tumor until he had first sewn up the patient, brought him out of anesthesia and obtained his signed consent to perform the necessary additional surgery. The result is increased risk for the patient and added medical costs.

Other doctors increase the cost of medical care to patients by frequent consultation with colleagues to verify their own diagnosis. "A doctor's greatest comfort during a suit is knowing that a colleague was consulted," says one doctor. Dr. William Quinn of Los Angeles notes that "Just the other day I saw a patient who needed breast surgery. Since she also had a heart condition, I had to call in a heart specialist to confirm that she'd be a reasonable

risk for surgery. It's important to have his statement on the record, but it cost the patient an extra consultation fee."

The fact is that medical costs, for all of these reasons as well as others, are high. *The question remains, what would a government health program cost, how would it lower such costs, or would it, in fact, increase them?*

Harvard's Prof. Rashi Fein believes that "at least 10 per cent of the $63 billion we spend on medical care is wasted." Howard Ennes of Equitable Life guesses that "we're losing 40 per cent of what we're putting in."

One benchmark of what good care ought to cost is provided by the Kaiser program [see HUMAN EVENTS, Dec. 26, 1970, page 8], whose services currently cost about $120 per year per person, counting the nominal fees paid by members when they receive treatment. Making allowance for services not provided, the Kaiser experience indicates that a good job could be done for the non-aged, non-poor population for about $175 per capita —or about one-third what this group currently spends.

What would a government plan cost —given the $175 figure as one which is now being used by the private practitioners of the Kaiser Plan?

The proposal introduced by Sen. Edward M. Kennedy would be financed from three sources, beginning Jan. 1, 1973—about 39 per cent by employer payroll taxes (on total payroll, without a maximum taxable earnings base); about 21 per cent by taxes on individuals, at a uniform rate on the first $15,000 of earnings and other income, and 40 per cent from general revenues.

Thus, the government subsidy is equal to two-thirds of the total employer and individual taxes. The tax rates for 1973 would be 3.5 per cent as the employer rate and 2.1 per cent as the individual rate. No future increases in either the tax rates or the maximum taxable base for individuals are mentioned.

Discussing real projected costs for this program, Robert J. Myers, professor of Actuarial Science at Temple University and formerly chief actuary of the Social Security Administration for 23 years, wrote in *Private Practice* magazine:

"For calendar year 1974, the first full calendar year of operation, I estimate that income to the system will amount to about $57 billion (from the specified taxes and the government subsidy.) The Social Security Administration has estimated that the total cost under the proposal for calendar year 1974, for both the benefits provided and the administrative expenses involved, would be about $77 billion if the reimbursements were made under the standards of reasonable costs and charges of Medicare."

"What this means," notes Prof. Myers, "is that the program's income would likely be somewhat insufficient to pay off the costs for hospitals and GPPPs, and there would be nothing left over for fee-for-service physicians."

What would the tax burden of $57 billion mean to an individual? Prof. Myers points out that "First, we should recognize that the government subsidy of two-thirds of the direct taxes must be paid by the taxpayers. It just does not represent money that comes down from Heaven or from Santa Claus. The $57 billion represents an average payment of about $265 per year from each person in the United States. It can be expressed as an average annual payment of about $660 from each worker in the population."

Thus, even working with the figures set forth by Sen. Kennedy and the supporters of National Health Insurance, we see that the cost would be approximately $265 per person per year, as opposed to the $120 to $175 figure now in force by such private plans as that of the Kaiser Program. The fact is, however, that estimated costs by sponsors of government programs are notoriously low, as such scandals as that surrounding the TFX airplane show so clearly.

But we need not go so far afield to make the presumption that a National Health Insurance plan, inflated at its very beginning in presuming that $265 per person is necessary to provide adequate medical care, will, by the time it is operational, cost far more. The experience we have had with the government's current medical programs, Medicare and Medicaid, shows this very clearly.

An article in the *New Republic*, a liberal proponent of government control of medicine, admits that cost overruns are to be expected. Health affairs writer Mel Schechter stated that Medicare alone, without any changes, needs more payroll taxes to meet a 25-year projected deficit of $236 billion in hospital related benefits. This is a shocking overrun of 100 per cent. In the voluntary doctor-payment plan (Part B) the original $3 monthly premium paid by the elderly

themselves reached $5.30 in June 1970 as the trust fund almost went dry. The hospitalization deductible, originally $40, now is $52. Co-insurance rates are up similarly.

When the initial estimates for the cost of a government program by its own sponsors are outrageously high, as are Sen. Kennedy's, the public can expect overruns of at least the 100 per cent experienced by Medicare. Thus, the cost per individual would be far more than $265, and plans such as the Kaiser Program would effectively be put out of business. Why, for example, would anyone voluntarily pay $120 to Kaiser if the government is taxing him $265 or more on a compulsory basis anyway? It seems clear that medical costs, rather than declining, will rise dramatically.

The experience of those countries which have instituted socialized medical systems indicates that costs have significantly risen. The financial fate of France's system of partly socialized medicine provides an important case in point.

The cradle-to-grave systems of social security started in its present form in France just after World War II and has become one of the touchiest political issues in the country.

The system runs three funds: one to cover health costs, one for old age pensions and one for family allowances. The family allowance system, designed to combat a low birth rate by giving families money in direct proportion to their size, has the only fund showing a surplus.

The health fund, on the other hand, will run a deficit of $165 million this year, which is expected to double next year and, according to experts of the Government Planning Commission, will rise to $1.8 billion in 1975 if left unchecked.

According to the New York *Times*, "As a result of all of the advantages which the system accords, its official noted with rising alarm but general helplessness, there is an overwhelming eagerness among Frenchmen to take good care of themselves. ... The doctors, the medical laboratories and the pharmaceutical industry, both manufacturers and retailers, are prospering as the deficit grows."

Figures show clearly that under socialized medical systems patients spent more time at higher costs in hospitals which were, as a result, overcrowded and difficult to enter, even in emergency cases.

While American patients stay in the hospital about six to eight days, on the average, in Germany, which has a system of National Health Insurance, there is an average 24-day hospital stay. Although Germany has more hospital beds per number of inhabitants than the United States, all hospitals are overcrowded throughout the year. Part of the reason is that there is a lack of interest by the patient in regaining health as soon as possible. In addition, doctors have no concrete feeling for the costs that could be avoided if the hospital stay were shortened.

A German physician, Dr. Klaus Rentzsch of Hamburg, who has compared the medical care systems in his own country and in the United States, discussed the differences in these terms:

"Under Germany's form of health insurance, every employe and industrial worker is obliged to contribute about 10 per cent of his income, with half of the contribution paid by the worker and the other half by the employer. The insurance covers payment for all medical care. The employer is also required to pay full wages for the first six weeks of sickness.... The insured gets exactly the same money when he is sick as when he is at work. All medical care is provided by the government without any direct payment by the patient himself. Nobody can say how many millions of dollars are wasted this way every year."

Dr. Rentzsch points out that there are those patients who take their sickness every year exactly for those six weeks during which the full payment is guaranteed. But, he notes, the greater loss comes from those who are sick for some time:

"According to our social insurance statistics, tonsillitis caused the average patient to be laid up for 21 days in 1927 —and in 1967. In those 40 years therapy developed from aspirin to sulfonamides to penicillin and the other antibiotics. Every medical process shortened the process of tonsillitis. But not one day cut off the time the average patient was out of work. This may show what happens when all the risk of a sickness, including the income loss, is completely covered. The will of the patient to take up his work as soon as possible is paralyzed.... The situation is comparable in every country with a total medical care program such as ours."

Dr. Rentzsch had the opportunity to visit the Joslin clinic in Boston several years ago. He made this comparison:

"Here in Hamburg I head a diabetic out-patient clinic, so I have some basis for comparison. I will never forget my astonishment when, in Boston, patients asked the doctor exactly what they should do for themselves, what diet to follow, etc. They were eager and interested, and asked again if they did not understand the instructions. My first impression was that these people must be much more intelligent than ours, but that was an error; the only difference was that they had to pay for the advice; therefore they concentrated and were eager to learn what they could do for themselves ....

"In a complete social security system, things run otherwise.... The general feeling is: I have paid my contribution to the insurance. Now I am sick. It's the doctor's task to repair my health.... My only interest is to get as much medical care and drugs as possible, without pay, of course."

Thus, a national health system such as the one which now is operative in Germany and which is being proposed for our own country has not seen an improvement in medical care or a decrease in costs. Instead, medical care has remained stagnant and costs have risen as facilities have been unable to accommodate the thousands who sought to use them, primarily because of the fact that they were available and were "free."

What those who speak of "free" medical care, either in Germany or in the United States, often forget is that nothing is "free." The real cost of the care remains the same whether it is paid for through taxes or directly by individuals. Through taxes, however, there is a tendency toward irresponsibility and inflation, and Germans, Englishmen and Swedes now suffer under such inflated medical care systems which, in addition, have made such care difficult to obtain.

Those considering what a National Health Insurance system would cost in the United States often overlook another inflationary factor, that of the creation of a new and huge federal bureaucracy to administer it.

Involving the federal government in direct control of medical care would, according to Ralph R. Rooke of the National Association of Retail Druggists, "produce an administrative nightmare, with federal officials...working out contracts with 6,000 hospitals, 25,000 nursing homes, 700 visiting nurse groups, and, later, with 208,000 doctors and 55,000 retail pharmacists." The paperwork involved in processing the millions of resulting claims "staggers the imagination. An extremely large force of government workers would undoubtedly be required to do the job."

Another factor ignored by the advocates of National Health Insurance is that most Americans under 65 are already covered by private insurance plans which are far cheaper than the projected government plan.

As of the end of 1969, the Health Insurance Institute estimates, 164 million persons under 65—89 per cent of the total—had some form of private protection against medical costs. About 140 million Americans, it is estimated, have some protection well above the minimum. They have Blue Cross extended coverage or private major medical insurance offering some help in the area of medical costs dealt with recently by the proposal for catastrophic health aid by the Senate Finance Committee.

If National Health Insurance were to become law, the government program would replace all of these private plans—at a much higher cost. Since 89 per cent of the group in whose behalf such socialized medical plans are being supported and advocated are already covered, Sen. Kennedy and his supporters have hardly met the burden of proving a "need" for the program at all.

It must be remembered that the supporters of National Health Insurance are motivated as much by the philosophy of government control and supervision of medical, as well as other, aspects of our lives as they are in meeting any "need" on the part of Americans for medical care.

What they are urging is a reorganization of medical practice and an emphasis on prepaid groups, rather than the current private practitioners charging fees for their services. In fact, many advocates of National Health Insurance would permit government payments *only* to such groups, rather than to individual doctors.

Here again, it is instructive to observe the European experience. Dr. Rentzsch puts it this way:

"In Germany, as in most other European countries, there is no chance any more to limit the influence of these pro-

grams to maintain personal freedoms. The more social security is guaranteed by the government, the greater becomes the control over social behavior. One danger of a social security system guaranteed by the state is that personal freedom may be limited because the institution that has to pay for all risks of health may demand that members avoid circumstances which may be a risk of health."

Yet, placing the arguments about individual freedom and the traditional doctor-patient relationship aside, the fact remains that all available evidence leads to the conclusion that a system of National Health Insurance would increase rather than decrease medical costs and would, in addition, provide a major source of inflation in an already inflation-ridden economy. This conclusion becomes inevitable by looking carefully at the figures presented not by the opponents of such a program, but by its *advocates*. In advancing the view that socialized medicine would in some way be less expensive, the burden of proof remains their own.

SOURCE: Human Events, Jan. 23, 1971.

What's Behind Those Proposals On Health Care

By Jim Hampton
FROM WASHINGTON, D.C.

The modern American doctor is traveling the same road to obsolescence as his predecessor, the kindly old doc who made house calls on horseback and accepted a chicken and two jars of grandma's kraut if grandpa had no money to pay him.

Social change and inefficiency did old doc in. But before he departed, he built a medical-care system that many health experts say is doing today's physician in. Immense pressure is building in Congress, at the White House, and within the medical profession to change that system radically.

The programs that President Nixon outlined in his State of the Union Address are a step toward achieving that change. Their main purpose, White House officials said, is to "fill in the gaps" in U.S. medical care. But there is a hopper full of other health-reform proposals that, taken together with the Administration's ideas, add up to radical change indeed.

The 92nd Congress will soon be given at least eight different plans for health-care reform, including the Administration's still-incomplete proposal. They would cost from $3.2 billion to $66.4 billion a year. Most embrace a new, different concept containing these ingredients that would redirect the delivery of U.S. health care by:

- Discouraging the present system, in which individual doctors treat individual patients whose bills (and whose doctors' income) depend on the extent of treatment.
- Creating a more efficient and less expensive system emphasizing group practice by doctors and prepaid, comprehensive group coverage for patients.
- Stressing preventive and ambulatory care, thereby helping people to stay healthy and avoiding the costliest form of care, hospitalization.
- Guaranteeing good medical care as a birthright to everyone, with the Government paying for group coverage for persons too poor to buy their own.

The President will present a separate health-care message to Congress in a few weeks, giving his health-care proposals in detail. He said last week his proposals would stress "improving America's health care and making it available more fairly to more people." In his address, Mr. Nixon said his proposal will be:

"A program to insure that no American family will be prevented from obtaining basic medical care by inability to pay.

"A major increase in and redirection of aid to medical schools, to greatly increase the number of doctors and other health personnel.

"Incentives to improve the delivery of health services, to get more medical care resources into those areas that have not been adequately served, to make greater use of medical assistants, and to slow the alarming rise in the costs of medical care.

"New programs to encourage better preventive medicine, by attacking the causes of disease and injury, and by providing incentives to doctors to keep people well rather than just to treat them when they are sick."

Planners in the Department of Health, Education, and Welfare (HEW) say the President will propose a new family health plan to replace Medicaid, the Federal-state program of medical care for the poor and near-poor. It will recommend full Federal financing, a politically attractive change because Medicaid has severely burdened many states' budgets.

Cancer is expected to kill 330,000 Americans this year, a toll exceeded only by heart disease. The President said he will ask Congress to appropriate an extra $100,000,000 "to launch an intensive campaign to find a cure for cancer."

No Doctor Shortage?

The U.S. Public Health Service estimates that the nation needs 50,000 more doctors now, and medical schools have sharply increased enrolments to supply them. But a concomitant near-freeze on Federal grants to medical schools has hurt most schools and put several in financial crisis. [The National Observer, Nov. 16, 1970]. Some health experts argue that there is no doctor shortage, only a maldistribution of those now practicing.

Americans spend more for medical care—$324.32 per person in fiscal 1970—than any people in the world. In fiscal 1970, which ended last June, the nation's medical bills totaled $67.2 billion, up $7.3 billion in a single year. The total was 7 per cent of the gross national product. It far exceeds, in both relative and absolute dollars, the spending of any other nation.

U.S. medical costs have thus nearly tripled since 1960. The Social Security Administration, which keeps the figures, estimates that last year's spending will more than double again by 1980. The nation's medical bill is expected to reach $111 billion in 1975 and $156 billion, or $630 for every man, woman, and child, in 1980.

Despite this immense health-care outlay, many indicators say that Americans aren't getting their money's worth. Several smaller and poorer nations—among them France, Germany, Holland, Sweden, and Great Britain—all outrank the United States in United Nations indices.

The United States ranks 13th among the world's nations in infant mortality, for example, and 12th in maternal mortality. In the past decade, America has actually dropped from 7th to 11th in female life expectancy and from 13th to 22nd in male life expectancy. Some critics, including the American Medical Association (AMA), challenge the value of these yardsticks because nations differ in their statistical methods.

Uneven at Best

The quarrel isn't with the quality of American medicine: at its best, it is unsurpassed anywhere in the world. The problem lies in the delivery of care, which is uneven at best. The suburbs are doctor-rich, the urban ghettos are doctor-poor. Until the Federal Government financed a clinic in Chicago's Mile Square area, for example, there was only one private physician for more than 20,000 residents. Rural areas are suffering too: An estimated 5,000 small U.S. towns and 115 rural counties have no doctors at all.

How to rectify this inequality is one of the major questions facing the 92nd Congress. Almost everyone agrees that the answer isn't "more money." Congress did that in 1965, when it pumped billions of Federal dollars into the health system in passing Medicare and Medicaid. That legislation didn't increase the supply of doctors, however.

The proposals for changing the system are spread all over the philosophical lot. They range from the AMA's Medicredit plan, which leaves the system essentially unchanged, to the sweeping restructuring of Human Security, the national health-insurance plan to be introduced jointly by Sen. Edward Kennedy, Massachusetts Democrat, and Rep. Martha Griffiths, Michigan Democrat.

The Administration will push hard for legislation authorizing health-maintenance organizations (HMOs), a health-delivery concept involving group practice and comprehensive, prepaid care to groups made up of Medicare recipients and younger persons [The National Observer, June 22, 1970]. Variants of the HMO idea are central to other proposed health-reform bills as well, including those of the American Hospital Association, the Health Insurance Association of America, and Sen. Claiborne Pell, Rhode Island Democrat.

HEW Secretary Elliot L. Richardson said recently that "the total health-care delivery system could be materially strengthened if this approach to the financing of health care were to become widely available to the American people. Not only would it provide strong incentives for preventive health services, it would encourage and reward the most efficient use of manpower and facilities, while at the same time aiming toward the highest levels of quality."

HMOs are the creation of the Institute for Interdisciplinary Studies, a think-tank branch of the American Rehabilitation Foundation in Minneapolis. The foundation's executive director, Dr. Paul Ellwood, Jr., says that "there doesn't seem to be any doubt that HEW is proceeding all-out with the HMO idea. Secretary Richardson has made it quite clear to those connected with it that he intends to push through the idea with or without a Medicare reform."

Dr. Ellwood says that most of the health-reform proposals that Congress will receive "all talk in dual terms: better financing and better health delivery. They tend to emphasize the delivery of service that ties together comprehensive care. They emphasize that these organizations should be responsible for groups of individuals. . . . With the exception of the AMA plan, they all emphasize prepayment of a fixed sum" so that the patient's bill doesn't depend on how much treatment he gets.

"Every single plan has got in it this basic new form of health-care organization," Dr. Ellwood adds. "If one were to try to forecast what's going to happen to the health-delivery system, and if these plans are any indication of what's going to happen to it, people are going to be getting their health care from an HMO or whatever the organization calls it."

Dr. John H. Knowles, general director of Massachusetts General Hospital in Boston, predicts that intensive care in a hospital will cost $1,000 a day by 1980 unless something is done now to reverse medical-care cost trends. "I don't think the public or the private sector can allow that."

Dr. Knowles, whose free-wheeling liberalism supposedly kept him from being appointed as HEW's top doctor early in the Nixon Administration, says: "These are the three major public issues in medicine: cost, quality, and now equality.

"You cannot have a country of 200,000,000 people where 20 per cent of that population is bereft of certain human rights, [such as] nutrition and health services."

Only a drastic change in the medical-care system will make care available to these medically disfranchised people, Dr. Knowles says. Moreover, he adds, the cost of care will drop only when doctors no longer have a financial stake in their patients' illness.

"When you tie a physician's income to what he does or doesn't do to a patient, you're asking for trouble," he says. "It's been shown time and again that if you prepay persons on a capitation basis—so much per person per year—the rate of surgery and unnecessary hospitalization drops. I'm not polemicizing or inflating the rhetoric: Those are facts. Therefore the system has got to change its method to more prepayment, more capitation, less reliance on high-cost acute treatment, less hospitalization."

Still, Dr. Knowles adds, "I think it would be a mistake to try to enact a massive health-reform package overnight. . . . I'm not willing to say let's leave it all to the politicians, all to the consumers, or all to the Government. If you did that, you wouldn't have any doctors left in this country.

"The trick is, how do you reach that honest middle ground where all sides are legitimately represented?" The answer, if there is a practical one, may lie ahead in the 92nd Congress.

Health-Care Bills Proliferate

♦ Here are the major provisions of the health-care bills that the 92nd Congress will be asked to pass:

Administration Plan

Family health insurance for the poor and near-poor, replacing Medicaid and providing preventive, hospital, and surgical care. Full Federal financing (states now share costs) and nationwide eligibility standards (states now determine eligibility). Initial cost: $2 billion to $3 billion from general revenues.

Catastrophic insurance covering all persons. Would pay hospital bills after 30-60 days' care, and 80 per cent of medical bills over $2,000. Cost: $2.3 billion a year from Social Security funds.

Ameriplan

Proposed by the American Hospital Association, it would create perhaps 400 HMO-like health-care corporations nationally, each to deliver comprehensive health care in a given area. Medicaid and Medicare would be eliminated; Federal funds would pay premiums for the poor and the aged; the nonpoor would buy their own coverage. Consumers would help decide scope and evaluate quality of care.

The Government would buy a standard-benefits package for the poor and the aged; everyone else would buy this basic coverage themselves. Those who did would be eligible along with the poor and aged, for a prepaid health-maintenance and catastrophic-illness package. Luxury care, such as private hospital rooms, would be available in an added-cost supplemental-benefits package.

The hospital group did not estimate Ameriplan's annual costs.

Healthcare

Drawn up by the Health Insurance Association of America, whose 308 member companies write 80 per cent of U.S. private health insurance. Would extend private health-insurance framework to all Americans. Would provide complete medical care, including dental care for children under 19 and prescription drugs. State and Federal governments would pay premiums for the poor and near-poor. Individuals and employers would buy private coverage. New Federal standards for insurance plans would assure nationwide uniformity; employers with substandard plans would lose half of their tax deductions for premiums until their plans met standards.

Estimated cost: $3.2 billion in first year.

Human Security

The most sweeping plan of all, this national health-insurance proposal is coauthored by Sen. Edward Kennedy and Rep. Martha Griffiths, both Democrats. It would emphasize group practice and comprehensive care and would cost $53 billion (the authors' estimate) to $77 billion (HEW's estimate) a year. Would eliminate Medicare, Medicaid, and private coverage. The President would name a five-member Health Security Board whose policies would be administered through HEW's 10 regions and 100 subregions. Everyone would get comprehensive, total care with few limits on services. Consumers would be in the majority on local health-care-policy boards. Care would be financed by a 3.5 per cent tax on employers' payrolls and 1 per cent levied on individual income up to $15,000; Federal funds would pay the rest.

Catastrophic Illness

Sen. Russell Long, Louisiana Democrat, will reintroduce this bill, approved by the Senate Finance Committee in the 91st Congress. It protects 95 per cent of all Americans —those under 65 who are covered by Social Security--against catastrophic illness. It would pay for hospital bills after the first 60 days of care, and for 80 per cent of an individual's medical bills exceeding $2,000.

Estimated cost: $2.2 billion, financed by extra Social Security taxes.

Medicredit

The AMA's plan would let individuals choose their own health coverage by giving them tax credits to buy insurance. Credits would be scaled to income, with the Federal Government buying insurance for families paying less than $300 Federal income tax a year.

The system of delivering care would not be changed. The extent and quality of care delivered, including doctors' fees, would be governed by peer-review procedures set up by local or county medical societies.

Estimated Federal cost: $16 billion annually.

Minimum Health Benefits

A blend of HMO, Ameriplan, and area health-education centers recommended by the Carnegie Commission on Medical Education, this bill is sponsored by Sen. Claiborne Pell, Rhode Island Democrat. It would create Federally chartered regional health corporations whose stock would be owned by doctors, hospitals, insurers, and other providers of care. The corporations would deliver comprehensive, prepaid care, emphasizing preventive and ambulatory services. They also would educate their own medical manpower, and could issue tax-exempt bonds to build facilities. Doctors would be salaried employes; fee-for-service would be eliminated. The corporations' educational and medical-care functions would be financed by a combination of individual, Federal, and employer group-insurance payments. No annual cost has been estimated.

Optional Extended Medicare

Prepared by Sen. Jacob K. Javits, New York Republican, this bill would extend Medicare benefits to all Americans under 65 who chose it. They could buy other private insurance if they wished. To be implemented in stages, the plan gradually would offer complete medical services to everyone, including some free medicine and dental care for children under 8. It emphasizes comprehensive care through prepaid groups, HMO-type plans, and private insurance plans. The Government would pay premiums for the poor. All others would pay through payroll taxes on individuals and employers.

Estimated costs when fully implemented: $65.4 billion a year.

SOURCE: The National Observer, Jan. 25, 1971.

Health Insurance Sparks Hill Fight

By Spencer Rich
Washington Post Staff Writer

Fueled by the "crisis of health care" in the United States, a major congressional battle is beginning over what may be one of the most bitterly fought domestic political issues of the next two years—comprehensive health benefits for the entire national population.

The struggle pits the Nixon administration against a bloc of Democrats which is led by Edward M. Kennedy (D.-Mass.) in the Senate and Martha W. Griffiths (D.-Mich.) and James Corman (D.-Calif.) in the House, and which includes every potential Democratic presidential nominee.

The Kennedy - Griffiths group is sponsoring a compulsory national health insurance measure covering every person in the country, financed by federal taxes and providing a generous benefit package with almost no deductibles for common illnesses.

It is backed by the AFL-CIO, the United Auto Workers, the Alliance for Labor Action and a citizens' action group called the Committee for National Health Insurance. The CNHI includes Baylor College of Medicine President Michael E. DeBakey, health philanthropist Mary Lasker, NAACP director Roy Wilkins, Radcliffe President Mary Bunting and other major public figures.

They contend NHI is the only way to provide good, low-cost health care to the entire population.

They also contend it is the only way to avert inefficiencies and losses due to poor administration and profit-making by health insurance companies; and to develop the social "leverage" needed to restructure health care and put a lid on the gross inflation of medical costs, which have risen 50 per cent over the past decade. They stress that the government would not itself go into the doctor business, but would simply provide methods of payment for private physicians and group practice.

Although others, including some Republicans, are cosponsors, Kennedy has clearly taken over the leadership on the national health insurance issue in the Senate. He plans to publicize the issue this year with subcommittee hearings all over the country, although he doesn't have direct jurisdiction.

The Nixon administration opposes national health insurance, as does the American Medical Association (which fears it would lead to excessive government supervision of medical practice) and the Health Insurance Association of America (which argues the NHI proposal would virtually wipe out the $10 billion-a-year private health insurance industry).

The AMA and the HIAA both have put forward proposals for general coverage based on private insurance. The Nixon administration is expected to come up shortly with something along the same lines—a plan to induce or require all employers to buy private health insurance, with a specified minimum package of benefits, for all their workers.

The issue is so complex, involves so much money ($50 to $75 billion a year), touches so many people (the whole population) and reaches into such a deep reservoir of public concern that no final action can be expected this year, and possibly not next year either.

At the very least, the fight will lap over into the 1972 session of Congress and could become one of the key issues of the 1972 campaign, as Medicare health benefits for the aged were for Kennedy's elder brother, John, in 1960.

In the opinion of many Democrats, the administration's reluctance to support national health insurance could help blast Mr. Nixon out of the White House two years hence.

"Clearly, we don't have the votes now to pass this bill in Congress," Kennedy told The Washington Post. But he added, "A major national debate is beginning and I look for it to build to a crescendo on the Senate floor before the 92nd Congress adjourns for the 1972 elections."

The National Health Insurance proposal has been around since at least the Roosevelt administration in the 1930s. President Truman championed it during his second term (1949-53) but was roundly beaten by the American Medical Association (which feared "socialized medicine), the insurance industry and conservatives generally.

Crisis Recognized

Now, however, the issue has been revived because of what, by common consent, has come to be recognized as a growing crisis of health care in this country.

Even those who oppose NHI agree that rises in medical costs and gaps in care make it imperative to find some way to help the average citizen pay for his medical and hospital costs, not just the very poor and the aged, who so far have been the exclusive beneficiaries of the special health care programs of Medicaid and Medicare.

Kennedy and the Committee for National Health Insurance, as well as administration spokesmen, have ticked off some of the indices of medical failure:

• Total medical expenditures in the U.S. have leaped from $26 billion ($145 per person) in fiscal 1960 to $67.2 billion ($324 per person) in 1970, but a substantial portion of the increase has produced little benefit because of a 50 per cent rise in costs.

• About 85 per cent of the population, according to administration spokesmen, have some form of health insurance but it is often entirely inadequate both in scope and in amount of benefits. Kennedy told the Senate a few weeks ago, in 1968, some 36 million persons had no hospital insurance, 39 million no surgical insurance.

The Massachusetts Democrat said 102 million people had no form of insurance to cover the costs of visits to the doctor's office, visits by the doctor to their homes, and 108 million had nothing to cover the costs of prescription drugs.

• According to UAW President Leonard Woodcock's testimony before a congressional committee last September, 150 U.S. counties didn't have a single doctor and another 150 had only one physician. Woodcock also said twice as many black infants die in the first year of life as whites, and poverty-level people suffer four times as many heart conditions, six times as much mental illness, arthritis and high blood pressure as their more affluent neighbors.

• The United States ranks behind a dozen other countries in infant mortality, behind 17 others in life expectancy for males, behind six others in the rate of women's deaths in childbirth.

Hill Battle on National Health Insurance Opens

• Even well-to-do families with insurance can be financially ruined by the enormous costs of a long-term illness. Public concern over such costs are providing an impetus for some form of universal medical insurance coverage, whether public or private.

"Medical coverage for the general population by some method or another is one of those famous ideas whose time has come," said Sen. Abraham A. Ribicoff (D-Conn.), a member of the Senate Finance committee which will handle the Kennedy bill. Ribicoff has not endorsed the Kennedy bill, but another Finance member, Fred R. Harris (D-Okla.), is one of the cosponsors.

The Kennedy-Griffiths bill (called the Health Security Act) would wipe out the need for both the existing Medicaid program for the indigent and the Medicare program for the aged. In their place, it would provide automatic benefits to every individual residing in the United States, regardless of income, need, past employment record.

With a few exceptions, benefits would include payment—without any deductible feature—of all doctor and hospital costs, fees for visits to a doctor's office, dental care for children, many drugs, up to 45 days of active psychiatric hospitalization treatment and up to 120 days of skilled nursing home care during a benefit period. The program would be financed 50 per cent from federal revenues, 36 per cent from a 3.5 per cent employer payroll tax, 12 per cent from a 1 per cent employee payroll tax, and the rest from a 2.5 per cent self - employment tax for persons running their own businesses.

Kennedy said that if it had been put into effect in 1970, this would have cost the federal government $41 billion a year—a figure which has led Finance Committee members like Paul J. Fannin (R-Ariz.) to charge "it would bankrupt our country."

But Kennedy says the $41 billion doesn't represent "new money" but is simply the same as is already being spent by government ($11 billion) and private persons about $30 billion). The only difference is that the $30 billion would now be shifted to the federal budget.

According to the National Committee for Health Insurance, the great advantages of the bill are not only that it provides a universal, comprehensive payment system for the whole population for the first time, with better benefits than can be provided by private insurance, but that it wipes out administration by often inefficient insurance companies which skim off from private insurance policies both profits and high administrative costs.

Kennedy and NCHI aides say an even greater advantage is that the federal government, with an NHI system, would have "leveraging power" to reorganize this country's delivery system for medical services.

The bill creates a fund that will eventually total $2 billion to encourage more group medical practices, eliminate overlapping of facilities and help train whole new categories of physicians, especially badly needed family doctors. At the same time, the plan would pay both hospitals and physicians fixed fees for specified services, eliminating the patient as financial middleman and precluding the possibility of fee gouging.

An NCHI spokesman claimed this would not be possible if, instead of national health insurance, Congress simply forced all employers to buy private health insurance for their employees.

The bill would give a big push to prepaid group health medical plans like Washington's Group Health Association, which, for a fixed annual fee, provide services directly to members.

Claims Listed

Kennedy aides say such plans are inherently more efficient because patients, not having any special fee for it, come for regular checkups, find illnesses early and are cured much more cheaply. An NCHI aide said it was contemplated that the number of persons using prepaid group medical plans would rise from 7 million now to nearly 70 million in the next five years.

The Nixon administration has not yet unveiled its own alternative to NHI. But sources said it would probably include these features:

• Retention of the existing Medicare Social Security health insurance program for the aged.

• Elimination of Medicaid for the needy and substitution of a new program under which the federal government would pay somewhere between $300 to $800 a year in premiums for private health insurance for needy families, with benefits specified. Needy families would be those with up to somewhere between $5,000 and $7,000 income for a family of four; those at the upper level would be required to make some contribution themselves.

• A requirement on every employer to purchase a "major medical insurance" or similar health policy for every employee, with the U.S. specifying the minimum benefit package. Whether the employer would actually simply be required to buy such policies, or merely "induced" with some tax break, is not yet clear. The benefit package would undoubtedly be smaller than under the Kennedy bill, but the costs to the federal budget would be almost nil.

Administration spokesmen claim their proposal is better because (1) the Kennedy bill will actually cost $77 billion a year by 1974, when it goes into effect (a point in dispute); (2) the Nixon version would not ruin the health insurance industry; and throw away its experience in administering benefits; (3) it would not, in effect, herd people into prepaid group plans against their will; (4) it would not put a monolithic national straitjacket on medicine; (5) NHI is not really necessary to give the government "leveraging power" to force better medical organization and practices."

A new national health program must start in the House Ways and Means Committee.

That committee is not likely to get to the health problem until late this year. When it does act, given its current composition, it will probably adopt something closer to the administration program than to the NHI bill.

The Senate Finance Committee, when the bill reaches the Senate, seems much more likely to approve something like Chairman Russell B. Long's "catastrophic illness" plan, as it did by a 13-to-2 vote last year. This is a Social Security "major medical" proposal, costing an estimated $2.5 billion a year, picking up to 80 per cent of hospital costs after the first 60 days and 60 per cent of family medical costs in excess of $2,000 a year.

This would put the Senate floor debate into the summer of 1972, and allow Kennedy and his allies—who include Sens. Edmund S. Muskie (D-Maine), Harris, Birch Bayh (D-Ind.), Hubert H. Humphrey (D-Minn.), George S. McGovern (D-S.D.) and Harold Hughes (D-Iowa), presidential possibilities all—to make national health insurance a major campaign issue as the nation moves toward the November 1972 presidential election.

SOURCE: Washington Post, Feb. 8, 1971.

APPENDIX I

NATIONAL HEALTH INSURANCE PROPOSALS AND THEIR ALTERNATIVES INTRODUCED INTO THE 91ST CONGRESS

Bill Number	Sponsored by	Date Introduced	Type of Proposal	Identical bills	Sponsored by	Date Introduced
H.R. 24	Dingell	1-3-69	National Health Insurance (NHI)	H.R. 15446	Matsunaga	1-19-70
H.R. 19	Fulton (Tenn.)	1-3-69	Tax credit			
H.R. 9835	Fulton (Tenn.)	4-2-69	" "	S. 2705	Fannin	7-28-69
H.R. 15779	Griffiths	2-9-70	National Health Insurance (NHI)	H.R. 15884	Helstoski	2-16-70
				H.R. 17806	Griffiths et al.	5-27-70
				H.R. 17454	Addabbo	5-6-70
				H.R. 17480	Gilbert	"
				H.R. 17563	Roybal	5-11-70
				H.R. 17858	Farbstein	6-1-70
				H.R. 18111	St. Germain	6-17-70
				H.R. 18351	Anderson (Cal.)	7-8-70
				H.R. 18692	O'Neill (Mass.)	7-29-70
				H.R. 19467	Nedzi	9-24-70
S. 3711	Javits	4-14-70	National Health Insurance (under Medicare)			
H.R. 18008	Hogan	6-10-70	Catastrophic Health Insurance	H.R. 18142	Hogan et al.	6-18-70
				H.R. 18233	Hogan/Pollock	6-26-70
				S. 4031	Boggs/Muskie	"
H.R. 18567	Fulton/Broyhill	7-21-70	Medicredit	H.R. 18587	Burleson/Jarman	7-22-70
				H.R. 18833	Zion	8-5-70
				H.R. 18915	Fulton et al.	8-11-70
				H.R. 18971	Fisher	8-13-70
				H.R. 19074	Burton (Utah)	9-9-70
				H.R. 19076	Derwinski	"
				H.R. 19083	Minshall	"
				H.R. 19096	Tiernan	"
				H.R. 19135	Lukens	9-10-70
				H.R. 19142	Tiernan	"
				H.R. 19248	Thompson (Ga.)	9-16-70
				H.R. 19451	Stanton	9-24-70
				H.R. 19486	Addabbo	9-29-70
				H.R. 19447	Bow	9-24-70

APPENDIX I (cont'd)

Bill Number	Sponsored by	Date Introduced	Type of Proposal	Identical bills	Sponsored by	Date Introduced
H.R. 18930	Landrum	8-12-70	Tax credit	S. 4381	Hansen	9-22-70
S. 4297	Kennedy et al.	8-27-70	Health Security	H.R. 19050	Annunzio	9-8-70
				H.R. 19063	Podell	9-9-70
				H.R. 19072	Bingham	"
				H.R. 19121	Dulski	9-10-70
				H.R. 19144	Vanik	"
				H.R. 19158	Corman et al.	9-14-70
				H.R. 19159	"	9-14-70
				H.R. 19193	Minish	9-15-70
				H.R. 19284	Kee	9-17-70
				H.R. 19341	Ottinger	"
S. 4323	Yarborough et al.	9-8-70	Health Security			
S. 4419	Fannin	9-30-70	Catastrophic Insurance and Tax Credit			
H.R. 19631	Hall(Mo.) et al.	10-7-70	Catastrophic Insurance	H.R. 19643	Hall et al.	10-7-70
				H.R. 19685	Ashbrook	10-13-70
				H.R. 19693	Derwinski	"
				H.R. 19704	Teague (Cal.)	"
				H.R. 19719	Stafford	"
H.R. 19935	Burleson (Tex.)	12-10-70	Tax Credit and health system reorganization			
S. 4594	Pell/Mondale	12-18-70	Health Care Corporations and minimum health insurance			

APPENDIX II

NATIONAL HEALTH INSURANCE PROPOSALS AND THEIR ALTERNATIVES INTRODUCED INTO THE 92ND CONGRESS

Bill Number	Sponsored by	Date Introduced	Type of Proposal	Identical bills	Sponsored by	Date Introduced
H.R. 22	Griffiths et al.	1-22-71	Health Security	H.R. 23	Griffiths et al.	1-22-71
				S. 3	Kennedy et al.	1-25-71
				H.R. 2162	Griffiths et al.	1-25-71
				H.R. 2163	" "	1-25-71
				H.R. 3124	" "	2-1-71
				H.R. 4124	" "	2-10-71
				H.R. 4396	Podell	2-17-71
H.R. 177	Hall et al.	1-22-71	Catastrophic Insurance	H.R. 178	Hall et al.	1-22-71
				H.R. 576	Ashbrook	1-25-71
H.R. 817	Hogan et al	1-25-71	Catastrophic Insurance	S. 191	Boggs et al	1-26-71
				H.R. 4133	Hogan et al	2-10-71
H.R. 1283	Fisher	1-25-71	Tax Credits	H.R. 3167	Tiernan	2-1-71
S. 703	Pell	2-10-71	Minimum Health Benefits			
H.R. 4349	Burleson et al	2-17-71	National Health Care			
S. 836	Javits	2-18-71	National Health Insurance through Medicare extension			
H.R. 48	Dingell	1-22-71	National Health Insurance	H.R. 211	Matsunaga	1-22-71