NATIONAL HEALTH INSURANCE
(A Collection of Articles and Congressional Record Excerpts Describing Pending Proposals and Major Policy Issues)

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and
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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 noted and was
given permission to address the House
for 1 minute, to revise and extend her
remarks, and include extraneous
material.)

Mrs. GRIFFITHS, Mr. Speaker, I am
introducing today a bill which will es-

tablish a national health insurance
program under the social security

system, and which will give to middle Americans
those health and medical benefits pres-

ently 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 bur-
dens, currently estimated to be about $7
billion annually. In addition, since this
bill would eliminate medicaid and medica-

laid, the $16 billion supporting these pro-
grams would become available for the
comprehensive national health program.

My bill would also preserve free choice
of physicians; preserve traditional profes-
sional freedom of practice and meth-

ods of payment; and maintain, indeed,
utilize the authority of local medical and
dental associations and societies.

At the same time, my bill would make
possible for doctors and dentists to
to bypass time-consuming business-admin-
istration and bookkeeping functions and
permit them to concentrate on the prac-
tice of medicine and dentistry. It recog-
nizes that the business of doctors is ad-
ministering health and medical care. They
should not have to be bookkeepers or credit collection agents.

Mr. Speaker, most Americans who

have incurred or serious illnesses and
mishap 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 cost of care without
severe economic sacrifice. Health expendi-
tures now amount to $564 for every-


ducation, and whom will give to middle Americans.

The cost of a medical illness is such
that 9 out of 10 Americans are medically
indigent right now. They can not afford
to pay the high cost of care without
severe economic sacrifice. Health expendi-
tures now amount to $564 for every-

men, women, and child in the Nation.

For some middle Americans, this means
spending from 10 to 25 percent of their
incomes on uncontrolled health and
medical services. For some middle Amer-

can 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. Cur-

rent tax deductions for medical expenses
favor the rich, simply because they can
afford large expenditures for health care
and therefore receive huge tax deduc-
tions for them. The facts, the more they
spend, the more they get back. Middle

Americans, though, find that while their
medical expenses consume a proportion-

ately large share of their income, a tax
deduction, while welcome, is still an un-
affordable 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 women and children, who are
paying for health care at all costs, for

all people.

It is widely acknowledged that we face
a crisis in health care. Symptoms 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. I.ago Goldstein; "Ferment in Medi-
cine" by Dr. Richard Megrav; "The

Coming Revolution in Medicine" by Dr.

David Rutstein; "Professional Power
and Amedica Medicine" by Alton Tay-

lack; and "Hospital Regulation: Dilemma
of Public Policy" by Anne R. Somers.

More and more articles are being pub-
lished in magazines and periodicals about
the crisis. On July 10, 1969, Secretary
Finch and the Assistant Secretary for
Health and Scientific Affairs of the De-
partment of Health, Education, and Wel-
fare stated:

"The Nation is faced with a breakdown in
the delivery of health care unless immediate
concrete action is taken by government and
the private sector."

So there is little dispute, today, as to
the 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 financ-
ing system that will permit equal oppor-
tunity of access to the system. The result
has been fragmentation of services and
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 escal-
tion of health care costs.

The inflationary facets of health serv-
ices are astonishing. The Nation's spend-
ing for health reached $60.3 billion in
fiscal 1968.

H. R. 15779, the original "Griffiths Bill," received
the public endorsement of the AFL-CIO. During hear-
ing 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 organiza-
tions, 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 Edwad 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
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 1972. 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, 1962, issue of "Medical Economics" predicted that gross receipts of private physicians will average "at least 10 percent higher" for calendar year 1969 as compared to 1968.

Small payments with other health care has absorbed an increasing proportion of the gross national product. In 1950, health expenditures accounted for 4.6 percent of the gross national product; in 1965, 3.3 percent; and in 1966, 6.7 percent. In fact, if health expenditures continue to absorb an increasing proportion of the gross national product at this rate, the year 2077, 108 years from now, health expenditures will consume the entire gross national product at an end. In 1958, gross receipts of private financial support have declined. In 1964, the United States ranked 18th for males and 11th for females.

Maternal mortality rates—the percentage of women who die in childbirth—should be of first 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 its 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 1966, 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 for health care was 10 percent of the GNP.

The question we must ask is: Why has American medicine failed to live up to its potential?

Why is our relative position in the world?

The crux of the problem is that we have a system of 20th century technology saddled to a first 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. If there 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 doctors heard recently: "I'm 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 which manner will reward efficiency and penalize inefficiency and out-}

right fee-inflationary practices.

Under the present system, the physician is financially rewarded in proportion to his patient's immediate misery. 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 programs has demonstrated that 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 36 million Americans. This bill would not only contain the rising costs of health care within the limits of the 0.7 percent of the gross national product we are now spending, but it also has the potential of actually reducing costs 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, hospitals, and dental practitioners. 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 practice plans—which might be regarded as mini-national plans—such as the Kaiser Foundation health plan have contracted with medical groups to provide 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 achievable 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 medical cost. In addition to Kaiser, all other prepaid group practice plans have demonstrated the capability of reducing hospitalization and the number of hospital days. A recent study of the Federal employees health benefits program showed the group practice prepayment plans had but one-half the number of nonnursing 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 45 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 desire 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 running their own medical payments in the Federal Government to provide services. The physician-members of the medical society would, therefore, be running their own medical payments in the Federal Government to provide services. The physician-members of the medical society would, therefore, be running their own medical payments in the Federal Government to provide services. The physician-members of the medical society would, therefore, be running their own medical payments in the Federal Government to provide services. The physician-members of the medical society would, therefore, be running their own medical payments in the Federal Government to provide services. The physician-members of the medical society would, therefore, be running their own medical payments in the Federal Government to provide services.

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 to regulations dealing with compensation of individual physicians.

My bill does, however, require that where a medical society does assume responsibility for delivering health services, it must establish a system of peer review and administration procedures to assure 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 1963 and makes good use of the self-paying concept. Last year the San Joaquin Medical Foundation contracted with the State of California to provide medical services to medical 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 carried unnecessary hospitalization, unnecessary surgery, and use paramedical personnel more effectively, I feel they should be rewarded for their efforts. From the standpoint of Government and 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 Oakland County in Oregon. Here the medical society 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 patient pays 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 hospital 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, community health councils, 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, prepare 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 no urban-rural imbalance in the practice of doctor care. In the country-wide, over 412,000 people in 43 counties scattered through 25 States do not have access to a physician at all. One out of 50 Americans cannot get a doctor under any circumstances. There is also a doctor imbalance inside our large cities. New York City, for example, has an overall physician-population ratio of 756 doctors per 100,000 residents. We call it a well-decorated community. Yet, in the shadow of the city's suburbs, the ratio is only 10 doctors per 100,000 residents in poor areas and shanties.

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 "overstocked" areas to the "understocked" areas of the United States, simply because the money will be available. 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 or on the basis of the people's 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 correct 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 encourage and promote free choice of health delivery systems—state or group practice.

Moreover, beneficiaries would choose their personal physician when they were well and perhaps in the years 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 could have the greatest professional freedom they have ever known. Within the framework of a budget, they would be able to establish their own guidelines of compensation. They could, if they so choose, eliminate all paperwork in connection with claims and contemplate on that which they were so magnificently trained to do: Practice medicine. In my opinion, this bill will enlist significant numbers 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 deductible payment and without limits; physician services, including surgery, subject to a small deductible payment 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 18 subject to a $2 deductible 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 contributions from general revenue. Employee taxes are lower than employee taxes to take into account that the employers are now paying the entire cost of most employee health insurance benefit programs. If the employer contributions are lower than 3 percent, some employers would enjoy a windfall, in the sense that their contribution would be less than their average premiums into voluntary health benefit programs. The Federal contribution would not be much more than today's 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 care 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. The individual rights of American medicare guaranteed.

National health insurance is an old idea, but a "new" solution. Its hour has arrived.
S. 371—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 such reforms as the Social Security Act, the Civil Rights Act, the tax laws, the Medicare Program, the Consumer Credit Act, the consumer interests, the tremendous Civil Rights Act of 1964, the war on poverty, the Economic Opportunity Act, and other recognitions by the Congress 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 developed and universally incorporated into our governmental system as is public education. The returns are a thousand-fold in economic terms 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 similarly as it is not self-financed, this requires a resent in 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 takes, because of the millions of people whom it will enable to do more and better work.

In addition, this bill draws very heavily on the present enterprise system. This has always characterized the health services that we 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, however, despite the enormous growth of governmental programs and private health insurance plans, despite the $36 billion in private expenditures for health care, despite the $100 billion health insurance industry—the fastest growing unsuccessful big business in America—that goal remains.

My relationship to this problem goes back a very long time. Twenty-one years ago, in 1949, I introduced H.R. 4419 in the 81st Congress, a bill for a system of national health insurance. One of its co-sponsors was the then Congressmen, now President, Richard M. Nixon, and others included the late very distinguished Senator from Colorado, Mr. Knowland, and the late Senator from Missouri, Mr. Morse, who served with such distinction in this body.

Since then, I have talked with many Members of the Senate. I have been actively engaged in the long struggle to provide health insurance to this 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 XVII—public program—nor the then little-noticed title XIX—enacted at the same time—medicaid—has proven adequate to meet the expanding demand for quality health care 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 percent 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 backward 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-1968, President Nixon, Secretary Finch, and the Assistant Secretary for Health and Scientific Affairs, Dr. Roger E. Zemke, 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 wasted, utilized, and nearly are not adding to them fast enough to keep pace with rising demand. Our health priorities are criticized out of balance."

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

And it is 1 year ago to this day when the introduction of a national health insurance bill. Since then, public awareness and support for this concept has 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 oil-embattled hospital—the public symbol of modern medicine—national health insurance legislation will serve as the focal point of controversy and debate. However, I am confident that this national health insurance bill will come to be a part of our basic social system, and to confront 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, which might be extended to all Americans to the exclusion of none.

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 realignment 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. 5836.
the interim—that is, beginning now and in the course of the next 2-4 years—the disabled, the unemployed, and the poor may be placed into the system some time in the extended to all Americans by the date specified—to wit, July 1, 1973.

Second. Before health insurance is extended to all, the following improvements should be made in the present medicare system: Merger of parts A and B of that system; a single tax would provide for hospital and physician benefits for the elderly; and extension of these benefits to the disabled under age 65. These changes would become effective July 1, 1973.

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 would be authorized to conduct studies relating to maintenance drug utilization, efficacy, and cost, and to establish a committee to assist with these studies.

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, Medicare and medicaid 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 extended the system by 1975 or 1979 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 exams. Of course, there is a risk of abuse of this benefit, but so crucial is its role in preventing more serious and costly illnesses and hospitalization, that it is essential to be included in the benefit package. A recent national conference on multiphase screening noted that technology has not caught up with our needs to control serious conditions 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 constitute the possible base 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 on 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.
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.

Fourth. The Secretary of Health, Education, and Welfare is authorized to establish a National Health Insurance Corporation to administer national health insurance programs. This is a very important point to me because there must be a recognition of something that took place in regard to medicine which I deplore very greatly.

When the Senator from New Mexico (Mr. Andrews) and I 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 companies, their 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 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 the sun follows night. To provide against that contingency, either nationally or regionally, and to provide for an autonomous Government corporation which can in a given area—I hope it will not be necessary nationally—function if the insurance companies will not.

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 enterprises willing to pitch in on this problem.

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 program. 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 to 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. But we 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. It is needed 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 effective approach to the problem of health care. But not only must insurance increase purchasing power and thereby equate access, but it must also bring about a 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 'pennywise' philosophies 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 shield for funds which reinforces existing inequities of the present health care. The system which is one of the big things that I am pointing out about 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 will do to improve the delivery and availability of health care.

The health-insurance industry should undertake to foster better organization of health care, to reshape insurance mechanisms to facilitate progressive change. It cannot stand aside and reap the benefits of a health system which it is funding. It is a very heavy developmental job. To our dismay, the testimony before the hearings was that the health-insurance industry was not willing to do it. The companies, if they put into this plan, will find that many of us feel that way. There is no provision here not to understand that making inefficient insurance businesses do to serve 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 bargaining and trying to establish the industry out of business. But this is what would happen if we bypassed the insurance carriers in establishing a national health insurance system. Unless we make very heavy gains, 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 come 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 operate, then I will consider bypassing the carriers with the alternative of establishing a Federal Corporation or corporations to administer the program, as authorized by title 8 of my bill.

This bill is designed to establish a system of health insurance suffering 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 Federal programs and from private third-party programs can be a force of change. That is the very essence of my bill.

We must seek to ston the inflationary cost spiral which now view the heart of the health crisis and which is a big factor in overall price increase. There has been a fantastic increase in the cost of many services. While the general cost of living index rose 70 percent between 1948 and 1967, medical care costs increased almost twice as much—133 percent. The average cost of a day in a hospital in New York State, for example, went up from $19.72 in 1953 to $21 in 1960 to $38 in 1967. In the city of New York, the average cost is now $56.47.

According to the American Hospital Association, by the year 2000 we will have treat patients in a community hospital. In many hospitals in the United States the daily charge is now well in excess of $100 and one hospital is $350. It is of great importance that the ELS cost of living index.

Although we spend more money than any other in the world on health care, America remains uneven—and by many—particularly. It is abysmally low, if not nonexistent.

The United States leads the world in many branches of medical science. Yet a national disparity in the United States between rich and poor is mirrored by New York City figures. In 1964, Bedford-Stuyvesant contained 34 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 1955 and 1961. In 1964 a New York City child from a family earning less than $1,000 a year was half as likely to be immunized as a child from a family earning over $5,000. A former New York City health commissioner has rated poverty as the third leading cause of death 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 hospitals. Accordingly, my bill proposes that the level of benefits previously discussed be phased-in to the system, with a priority to the need, 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 should allocate sufficient resources to establish a Federal commitment to assist in the development of the newest and safest in quality health care, for the health personnel and facilities.

In the event we services, 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 the feasibility of setting aside a package of health services.

If there are children who die whose lives can be saved; if there are adults who are handicapped from a medical standpoint, then we must have the capacity to treat them. If the life expectancy of a nonwhite American is 7 years less than that of his white counterpart; if infant mortality rates are twice as great; if nonwhites as a group are still so much behind the group, 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 dedicate and participate in such a system. Increasingly, leading medical schools have begun to emphasize community health and the delivery of medical care; 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 coming decade is one of 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 too many, many American, quality health care—indeed almost any health care—is still unavailable.

The eminent British statesman, Benjamin Disraeli, said:

"The advancement of the people is really the foundation upon which all their happiness and all their powers as the state, depend." We are at the beginning of a new century. For the first time in our history, we have the opportunity to shape the health care system for this century in a way that will be beneficial to all Americans.

Mr. President, I wish to make a few additional observations. I would like to read to the Congress a telegram that I have received from Governor Nelson Rockefeller of my State, who has been one of the leading spokesmen for the "universal" health plan and for the right to basic health care services 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 those services. It is also important that the remaining and the maintenance of the private insurance industry be utilized.

I am pleased that you are introducing legislation to achieve those objective. 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 all the cancer population and would stimulate the establishment of prepaid comprehensive health care.

We can both hearten that the national dialogue on universal health insurance is now underway and I congratulate you for introducing pioneering health insurance legislation.

With appreciation,

Sincerely,

Gov. Nelson A. Rockefeller

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

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

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

Congratulations on introduction of national health insurance. The bill is an important contribution to Congressional and public consideration. Your bill will do much to advance on 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.

William 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 William 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 which have been 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 medical and medical which would result from national health insurance. I ex-
S. 3—INTRODUCTION OF A BILL TO CREATE A NATIONAL SYSTEM OF HEALTH SECURITY

Mr. KENNEDY. Mr. President, on behalf of Senator COOPER, Senator DAVES, and myself, together with Senators BYRD, CASE, CHAMREY, CAMPBELL, HARRIS, HAYES, HUMPHREY, JORDAN, MAHJUNSON, McCOY, MOORE, MONTAGUE, Money, MUSSEY, PASSOVER, PELZ, RANKIN, 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 comprehensiveness, 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 tool of the Health Security program is to enable each of us to make that right a continuing reality, not just the empty promise it is today. Just as Social Security programs of the decade of the 1930's brought hope and our faith to a nation mired in the social crisis of that great depression, so do the Health Security program in the decade of the 1970's can guaranteed high quality health care and lead us out of the current crisis of confidence in our health system.

We know from recent experiences that without the organization and delivery of health care in the United States will come only by an exhausting national effort. Throughout our society today, there are no solutions that require us to change the health care system. Indeed, because the changes in the delivery of health care are so great, are many who argue that we must make improvements in the organization and delivery of health care 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 of the time has come for national health insurance makes it all the more urgent to join now, before it is too late, into remaking our present system. The existing organization and delivery of health care are so obviously inadequate to deal with the health care needs of America in the 21st century. The only catalyst of national health in-
burden of worry, frustration, and disappointment that mark our search for better health care. The average American lives in direct contrast to the idea of health insurance or a national health service. Indeed, we have placed our prime reliance on private enterprise and private health insurance to provide medical care.

I believe that the private health insurance industry has failed us. It fails to control costs. It fails to control quality. It allows 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 government growth, despite massive subsidies of health insurance by thousands of private companies competing with each other for the health dollar of millions of citizens, health insurance benefits today may only produce part of the total cost of private health care, leaving two-thirds to be paid out of pocket by the patient at the time of treatment. It is so after, at the very time when he can least afford them.

Nearly all private health insurance is partial. Thus the best source of their health insurance coverage is mere initiation or protection. In 1958, of the 160 million Americans under 65:

- Twenty percent, or 39 million, had no hospital insurance;
- Twenty-five percent, or 39 million, had no surgical insurance;
- Thirty-four percent, or 61 million, had no in-patient medical insurance;
- Fifty percent, or 80 million, had no out-patient X-ray and laboratory insurance;
- Fifty-seven percent, or 162 million, had no insurance for doctors' office visits or home visits;
- Sixty-four percent, or 168 million, had no insurance for prescription drugs;
- Ninety-seven percent, or 175 million, had no dental insurance.

As a result, the figures show that private health insurance today is a major part of our current crisis in health care. Nearly all private health insurance pays only about one-third of the total cost of personal health services in the Nation. Commercial carriers spend only 30 cents of the young and healthy, leaving the old and ill to Blue Cross, vulnerable to escalating rates they cannot possibly afford.

Too often, these carriers pay only the cost of hospital care. They force doctors and patients alike to resort to wasteful and inefficient use of hospital facilities. To this already soaring cost of hospital care and unnecessary admission on health insurance.

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 health care system would be conducted on an out-patient basis.

Unnecessary surgery is encouraged. We know that one-fifth of all patients face surgery, and that the vast majority is unnecessary. We know that under the Federal Employees Health Benefits program, more than twice as much surgery takes place as by the purely surgical service.

We believe that the Federal Employees Health Benefits program, more than twice as much surgery takes place as by the purely surgical service.

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

THE REASON OF OUR HEALTH CARE

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, but we are among the poorest nations of the world in our ability to translate the tremendous advances in medical science into the reality of a 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 burdened under our dominant industries of medical research. We have allowed ourselves to become so preoccupied with developing techniques to treat diseases that we have ignored the delivery of health care. To be sure, the delivery of health care has been evolving, but it has evolved too slowly. As one well-known critic has said, the crisis in health care is not due to the need for more medical research, but rather to the need for more medical care.

We know that there is a vast unmet need for medical care, and we know that the demand for medical care is growing at an unprecedented rate. As a result, specialization in medicine has become necessary, and a number of specialists have emerged to develop in medicine in the United States.

The family physician began to disappear, replaced by an increasing variety of specialists, according to age of life, categories of disease, organs of the body, and medical specialties.

Medical care became increasingly fragmented. No adequate resources were developed to take the place of the disappearing family physician, to provide...
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primary medical care, or to coordinate services of the emerging specialties. The quality and effectiveness of medical care began to noticeably wane.

The specialization of physicians was accompanied by an increasing variety and number of allied practitioners. And, 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 liability in the United States had developed over the centuries when medical care was simple and uncomplicated—became increasingly rigid and irremediable. It became necessary to develop 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 dimensions. We are now experiencing increasing unavailability of medical care while increasing public expectation and demand for better medical care; and, simultaneously, the system resulted in the development of systems for the delivery of medical care, and it resisted organizational improvements to moderate the cost rise in costs.

These developments and pressures 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 tended to deal with the situation. Some countries developed national health insurance programs. Others developed national health services. They sought their problems as best they could, according to their own needs and resources.

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

The crisis today reflects the fact that professional leadership alone was not able to meet the national needs and that the demands and needs of medical care did 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 medicare extensions of private health insurance could not resolve the crisis of disorganization and the spiraling cost of health care. Walter Reuther also had the foresight that the United States needed a new approach to health care delivery and financing. To this end, he arranged for a national health insurance program to be developed and presented to the country.

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The crisis today is the result of these shortcomings, which was evident in the recommendations of the two previous bills. The new bill it is that the health care system is developing. We believed that a system of health care for America should rest upon the positive motivation and just interests of both the consumers and providers of health services. They believed that the system could succeed if it were imposed by fiat through the Federal legislation and administrative regulations.

Through its deliberations, the committee has been guided by the work of its subcommittees on the Commission on health care, chaired by Dr. J. B. Pook, professor emeritus of public health at 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, health care unions, business groups, and many other interested organizations. The Health Security program is the result of these discussions and reflects the consensus of the recommendations of all these groups.

Late August, Senators Cooper, Russell, Humphrey, and 11 other Senators, introduced the original version of the Health Security program as S. 1461. In the 92d Congress, in September, the Committee on Labor and Public Welfare held 5 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 were first brought to the attention of the Congress. 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 93d Congress.

At the time the bill was originally introduced last year, Congresswoman Mooney Conyers and representatives of Michigan had already introduced legislation in the House of Representatives to create a national health insurance program similar. In each 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 pursue our efforts and introduce a common bill in the 92d Congress. One of the differences between the two previous bills have already been referred and the debate over the re-entry of the 92d Congress was led to the stronger Health Security program we introduce today.

As some other developments make clear, we are now among the major American institutions to support the goal of Health Security. It is an issue destined to grow and remain before the American people until we can adequately 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:

1. The basic principle is to establish a system of comprehensive national health insurance that is capable of bringing the 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 runs the facilities, employs the personnel, and manages all the finances of the health care system. On the contrary, the programs provide certain partnerships 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. Individuals 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, or of Social Security, or a means test, as in Medicaid.
Third, starting date for benefits—July 1, 1974. The 5-year running-up period prior to which will be used to prepare the health care system for the program.

Fourth, covered benefits—with certain specific limitations, the program will provide comprehensive health benefits for every eligible citizen. The benefits available under the program will cover the entire range of normal health care services, including the prevention and early detection of disease, the care and treatment of illness, and medical rehabilitation.

There are no co-payments, no co-insurance, no deductibles, and no waiting periods.

For example, the program will provide full coverage for professional physicians, 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.

Specific limitations in the otherwise unlimited scope of benefits are dictated by inadequacies in existing health resources or in management potentials.

Third, covering home care, psychiatric care, dental care, and prescription drugs, as follows:

- Eligible home care: home care is limited to covered beneficiaries. 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 25 visits during a benefit period. These lengths do not apply, however, when benefits are provided through comprehensive mental health care organizations.
- Dental care is restricted to children through age 15 or the covered group increasing annually until persons through age 25 are covered. Persons eligible for coverage through age 25 will be 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.

Structure of the program—The program will be administered by the 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.

Membership on the Board will provide representatives of both providers and consumers of health care.

Field administration of the program will be based on the 18 existing REA regions, as well as through the approximately 100 health councils that now exist as rural medical marketplaces. Each of these councils will be responsible for reviewing and recommending policy. The Board, in turn, will be responsible for the overall administration of the program. It will coordinate its functions with local and regional planning agencies, and it will accept its activities to Congress.

Financing the program—the program will be financed through a Health Security Trust Fund, and, similar to the Social Security Trust Fund, income to the Fund will derive from three sources: federal tax revenues; annual taxes on employers' wages and unearned income; and, annual taxes from individuals. The tax rate, for example, will be 2.5 percent from total earnings income up to $15,000 a year.

In addition, direct services and community treatment centers are specifically included as eligible providers of services under the program.

Resources Development Fund—An essential feature of the Resources Development Fund, which will come into operation 2 years before the health benefit begins, is that the Board of Trustees will be able to carry on and, in time, take over, and implement the program, and to use the resources of the system. In every area of our economic life, the health care system will be changed 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 one financial binge in which health care has had a signed 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 made among different types of services in the health system. Advance estimates, constituting the program budgets, will be subject to adjustments in accordance with midyear or other changes in the allocations to regions and to subregions which are guided initially by the available data on current levels of expenditure. Therefore, they will be prepared by the program's own experience in the field and in the membership 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. Indirect charges will not be charged for covered services.

Hospitals and other institutional providers will be paid on the basis of appropriate budget, determined by patients, including physicians, dentists, pharmacists, and optometrists, may be paid by various methods which they may elect, by fixed periode by subscription periodic, or in some cases by some combination of these methods. Comprehensive health care organization or companies may be paid by any method, or by a combination of these methods. Comprehensive health care organizations may be paid by capitation, or by a combination of capitation and methods appropriate to payments to hospitals and other institutional providers. Other independent providers, such as pathology laboratories, radiology services, pharmacies, and providers of services, will be paid by methods and in their own cost.
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is authorized to require prior consultation with an appropriately qualified professional to determine if performance of designated nonemergency surgery is warranted. In order to allow administrative streamlining of surgical procedures that are frequently abused.

Tendees—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 local ongoing primary health care program in urban and rural areas.

Relation to existing programs—Various Federal health programs will be supported, 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 program will be incorporated. Federal aid to the States for medical 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. Moreover, the bill does not affect the current provisions for personal health services in the Veterans Administration, disability benefits, or veterans' compensation programs.

Cost of the program and Federal revenue raising—On the basis of data available for the fiscal year 1970 a total of $21 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 $21 billion. The $21 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 $3.8 billion in private health insurance payments and private out-of-pocket payments, $2 billion in payments by the Federal Government, and $5 billion in payments by States 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 $21 billion price tag for the health security program represent government 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 tax on Federal expenditures or on top of existing public and private spending for health care. Instead, the health security program simply redistributes the health expenditures that are already made through the system. Federal expenditures in 1970 would have been $2 billion if the health security program had been in effect, and the individuals and organizations throughout the Nation would have been relieved of $33 billion of private health insurance expenses and out-of-pocket payments for health care, and State and local governments would have been relieved of $2 billion, representing costs incurred largely in medical 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 $2 billion in substantial and immediate Federal financial relief to State and local governments, thereby releasing 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 Federal outlays. The savings achieved by the program will be sufficient to offset the cost of the increased services. In effect, from the day the Health Security program begins, we will guarantee our citizens better value for their health dollars, and achieve a substantial moderation of the current excessive inflation in health costs. Even in the first year of the Health Security program, the comprehensive health care 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 $80 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 over-stimulated and overburdened medical system 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, those 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 (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 Committee on Finance, and ordered to be printed in the Record, as follows:

Sec. 1. 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 crisis 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 $58 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 watching—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 when 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 doubling 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 have the most careful scrutiny, Mr. Speaker, as will the alternatives they are certain to generate. For no sooner does one confront us with the domestic scene than cries cry out for a workable solution with more urgency than any other. And this poses a greater need for hard, original thinking.

As Victor Hugo once wrote:

Great problems of mighty nations is an idea who's 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 10 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 participation 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 or family's income in excess 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 debate.

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 swallowing 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 colleagues, Representatives Josi. 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 physician 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 paid. 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 pre-payment plan.

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

A Health Insurance Advisory Board, to...
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, medicaid requires 30 days of inpatient hospital services, including inpatient 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 18, we have been saying—even to the health-conscious—can afford, and feed themselves—spend yourselves to the point of insolvency, and then we will move in to help.”

Medicaid 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 insolvency.

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, medicaid would have been an administrative nightmare. In fact it becomes increasingly clear that the private sector should be involved even further in the medicaid 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 that already the construction of the marketplace to operate in maintaining cost control and insuring quality of care. Medicated would be unaffected by this bill’s passage, for only those under 65 years of age would be covered by medicaid.

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. Nor do I think I have yet seen includes—such as the magnitude—a mechanism which promises effective cost control of the taxpayers’ money.

This brings us to an essential element of medicaid—for 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, whenever performed; review hospitals and skilled nursing home admissions; review the length of stay 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 provisions of services, thereby cutting down on the occasional or intentional abuses that would otherwise occur.

Pathways of abuse would be detected, and the abuses either suspended from or excluded from the program. Exclusion could be requested 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 functioning, 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 medicaid 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; medicaid will cost a third as much, or a half as much, as some of the alternatives we have heard proposed. And its total is now will reflect far more to the Federal and State Government of the money spent on medicaid—about $6 billion a year presently, about $1 billion in projected increases.
PROPOSED NATIONAL HEALTH-CARE ACT

Mr. BURLESON of Texas, Mr. Speaker, I today introduce 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 insurance, including all types of health costs prepayment mechanisms, would insure these unable to pay for or secure health insurance. These state pools would be supplied by Federal and State funds and contributions by individuals, scaled to income.

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

Mr. Speaker, I wish to be recorded 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 proposal.

GENERAL STATEMENT ON NATIONAL HEALTHCARE ACT OF 1970

It is agreed that every American should have access to quality health care. There is an 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 remedy this situation. These proposals range from those 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 United States 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 strengths 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 $200 billion a year in Federal tax dollars to fund this national health insurance program. 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 tend to assure 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, innovation, efficiency, and financial goals of private enterprise, the scientific and technical competence of the medical and allied health professions, the fiscal and legislative capability 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 solving the nation's health care problems on an economically sound basis, with the communities served participating in developing and maintaining the proposed program.

There has been considerable criticism of our present health care system. Excesses, abuses, nursing homes, health insurance, government plans, have all come under attack from one quarter or another. Our present system obviously has its shortcomings. However, it has much to recommend it. Our system is one of a health care system on the scale. It is a growing system and it has growing pains. What must be provided now is the wherewithal to assure that the growth is continued and that the benefits of the system are extended to all men, women, and children regardless of their inability 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 allocations for training in the health professions, grants for the planning and establishment of curricula for training in comprehensive ambulatory health care; and grants to personnel in the health professions, allied health professions, and nursing for service in areas of critical need.

2. Promoting universal development of comprehensive ambulatory health care centers to provide a trend of care of all beneficiaries, including check-ups, diagnosis and treatment of most/emergency admissions, rehabilitation, family planning, maternal health care and vision and dental care.

3. Creating a Council of Health Policy Advisers in the Executive Office of the President. The three-member Council, appointed by the President, would formulate and recommend national policies to improve the quality of health care. Each year, beginning in 1973, 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 Advisers would assist the President in preparing this report.

4. Strengthening health planning in order to create a system that is comprehensive and services 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.
and changes unless these fell within professionally established guidelines.

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

In 1965, we enacted Medicare, Medicaid brought health, blossoming and reassurance to millions of Americans. But it complicated the problem. It provided more dollars— but not more service—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 provide high-quality, high-cost hospital care to lower-cost types of institutional care and in particular, more easily accessible ambulatory 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 more 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 creation of health care benefits to all employer-employee groups and to economically self-sufficent individuals not in such groups. All employer plans would have a minimum national standard 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 needs, 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 federally 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 1974 tax year. It would cover charges for all physicians' 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. Wellbaby care, including immunizations during the first six months after birth, the first 90 days of semiprivate or general or psychiatric hospital care per illness, the first 60-days of confinement in a skilled nursing home and the first 60-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 subsequent tax years, the benefits would be improved and others added, including dental care for children under 12, prescription drugs for all people, rehabilitation services and maternal 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 $25,000 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 emissions of this bill.
The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Maryland (Mr. HOGAN) is recognized to conclude his remarks on the National Catastrophic Illness Protection Act of 1970.

Mr. HOGAN. Mr. Speaker, I have today introduced a bill (H.R. 18059) on which I have been working for several months and which I consider to be an extremely important piece of legislation.

The bill is known as the National Catastrophic Illness Protection Act of 1970, which, if enacted, would 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, as defined, 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 $30 and $100 a day after your normal hospital 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 think about our Federal expenditure, 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 become incapacitated and perhaps rendered 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 means that the afflicted member of the family is transferred to what is called a public facility to treat patients under such circumstances. Unfortunately, these public institutions are often understaffed, under-equipped, and horrifically overcrowded. All too often they become depots 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 to the common coronary. It is the fall from a step into a hole, a highway accident, or even the unlikely sting of a bee, which costs one family over $57,000.

It is anything that happens to any of us that causes medical expense in excess of what the actuary tells us we should expect. Virtually every family becomes medically destitute when that point is reached. And yet, 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 plunged into such an abyss, there is—currently—no hope.

While catastrophic illness is indiscriminately in whom it attacks, when it attacks and where it attacks, it seems that a basically small number of these cases involve children. When a child is the victim, the parents are often young marrieds who find themselves deserted by 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 couple must wash their dreams down the drain as all present and future planning is marred toward the single goal of finding the money to pay for child's health care. While nearly all of the pediatric diseases that are catastrophic are individually rare, in the aggregate they affect more families than most of us would imagine. The list of obscure diseases such as sickle cell disease, Noonan's disease, sickle-cell anemia, kidney disease, muscular dystrophy, mental retardation, and the scores and scores of other maladies that destroy our people at enormous emotional and financial cost to their families seems endless.

Obtaining and maintaining catastrophic insurance 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 vitiated 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 alleviating 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 must be required to promote the plan aggressively, and because we would be dealing, statistically, with a small minority of all claims, the costs per policy would 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 reimbursing against losses in those instances where insurance companies paid out more in benefits than they took 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 the health care administration and the fiscally sound, non-profit, education, and welfare to participate in the actual audit of the policy rate structure in order to ensure that the rates charged for these new policies are of the utmost concern.

Perhaps the most attractive feature of this legislation is that it would be free of all of the constraints that are plaguing existing Federal health care programs. We would not be overburdened by an already overburdened social security system in order to finance the plan. Families who 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 calculate each family's contribution to such protection for their insured member. It would only be when this deductible amount had been exceeded that the catastrophic insurance protection plan would be utilized. For 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 80 percent of their family insurance protection to offset the deductible requirement.

Catastrophic insurance for 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 otherwise 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:

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

October 7, 1970

INTRODUCTION OF "EXTRA CARE" HEALTH PLAN *

The SPEAKER pro tempore (Mr. HOTTENBERGER). Under a previous order of the House, the gentleman from Missouri (Mr. Hall) is recognized for 3 minutes.

Mr. HALL. Mr. Speaker, I am today introducing a bill that translates into legislative form an idea that has been germinating in my mind for nearly 6 years. Our distinguished chairman, the gentleman from Arizona (Mr. William Martin) of the Committee on Ways and Means, was kind enough to allow me to present the concept 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 to every American citizen—rich or poor—nearly ever going 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.

It is well to 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.

I freely acknowledge that this is conveniently overlooked by some of my friends who back the various entries in the national health insurance debate, regardless of the price they carry. I would remind them, Mr. Speaker, of our brief experience with medicaid and medigap—the costs of which were patricially underwritten by the proponents—and assure 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, 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 variable, that is national across America. But we are so rich as to allow, with financial equilibrium, the prolonged illness requiring hospitalization, continuing medical care, and the mastering of those formidable, but enormously expensive, processes of modern medical science in all places.

I have had considerable experience with catastrophic illness, in my own family, as a practicing physician, 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 home town.

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 want but they do not have the way they exit this earth at this time.

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

It was my privilege to do the first bilateral thrombectomy operation south of the Missouri River in our State for high blood pressure. One of the criteria for selecting or allowing people to undergo this surgery was that they be young and that they have exhausted the three of suicide for the pounding and intractable headaches before the devastating two-stage enlarging surgery, if you please, but prior to the discovery of reserpine, which is very effective. I am happy to say no say of those people are still alive and working after having been snatched back from blindness, severe headaches, and, yet, very recently.

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 of the haunting becomes of catastrophic disease. Such cases are fortunately statistically rare, not that this is of any comfort to the bankrupt parent whose son must perhaps 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 go 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 excess of this measure would serve a twofold purpose besides resolving existing situations and ways and means. It would provide for those who are unable to provide for themselves, and it would assist those who care for their own needs and yet in the risk of being wiped out in the event of extensive and prolonged medical expenses.

Let us examine the first of these 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 of some 18.5 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 amount is now Federal, according to the social security actuarial own figures. The bill I propose would replace the present Title XXI program. Under those provisions the State's are presently covered would be provided with the basic health insurance policy purchased by the Federal Government. This policy would be bought from regularly established gold concerned with private health insurance companies, including the Blue Cross and Blue Shield—or any commensurate carrier. The premium would be paid for by the Federal Government.

It would be an annual needed and appropriately sent directly from the Treasury. In order to present 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 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 these 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...
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 on their taxable earnings, based on their income tax return, up to the maximum social security base, which is now $1,000 a year. Fourth, all persons with gross non-
earned 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 provision 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 93 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 $2,000, 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 those 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 higher administrative costs, for it requires that many small claims be processed. Thereby the contents 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.
V. CATASTROPHIC HEALTH INSURANCE PROGRAM

The Committee on Finance is concerned about the devastating effects 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 giant 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 dialysis 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 fiercer 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. Those 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 (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 Secretary. 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 Secretary, 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 would amount to $13 a day for inpatient hospital services and $7.60 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 $8,000 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, 1973.
December 18, 1970

CONGRESSIONAL RECORD--SENATE

S. 20683

A NEW APPROACH

Mr. President, I believe that the time is now at hand to act. I believe, as I mentioned in my opening remarks, that, in the 92nd 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.

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

My bill is based on principles that are probably as well understood by economists as the principles on which national health insurance plans are based; however, my application of these principles in the health care problem may well be different yet. 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 may be more ready to accept it and provide the recommendations 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 be available for the reporting provisions of my study amendment to the recently enacted Health Improvement Act of 1976. 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 and I do not call for government to make large payments to pay for health benefits. I do not call for a heavy tax on businesses. I simply ask that the employer guarantee 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.
CONGRESSIONAL RECORD — SENATE December 18, 1970

S 20664

Anyone who examines the present Federal health policy from a national priorities point of view cannot help but come to two basic conclusions. First, even with the ending of the Vietnam war, there is an enormous amount of additional funds available for anti-inflationary initiatives for some time; and second, if new funds are to become available, new general taxes to be levied to provide for these additional funds, and neither business nor labor wants to pay more taxes. This I avoid in 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 umbrella is added to the present employment taxes paid for social security, the workingman's tax burden may well become unendurable. Moreover, many small businesses would also have financial difficulties 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 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. The most economical and sensible way of approaching the problem. These benefits would also be emphasis walking care rather than death bed care. Curative benefits would be covered to the employee's pocketbook and medical condition. He would have to pay for the first 12 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 complementary to those policies and would thus tend to reduce the pressure on the use of in-patient hospital care, which is now where most high cost reimbursable care is obtained under health insurance.

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

For these 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 to provide health benefits on a prepaid health plan for the costs 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 CORPORA TIONS

The second part 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 and registration of all health personnel. I propose the creation of federally chartered corporations which would have all the advantages of modern business organizations while at the same time being a low cost provider of medical services.

These corporations would be means of getting the health care that people need to them and at an affordable medical manpower wherever 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 the non-profit, non-profit corporations. These corporations would be a means of getting the health care that people need to them and at a reasonable medical manpower wherever it is lacking.

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Areas of the country would have a number of incentives for supporting the incorporation of the 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.

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

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 on a 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 an annual plan, to a regional planning agency in order that their operations and financings be coordinated within the State health plans and their regional health plans.

As a general rule, given all the corporate 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 quality of health for the population within a corporation's service area would 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, the home of SUNY, and the home of the late John Fogarty, a long-time crusader for health care—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.

REGIONSAL 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 assuring 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 Commissions on medical education, 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 budgets 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, a complementary 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 is 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 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 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 become bankrupt, up to this time. This means that, when wage agreements are being negotiated, employers would be able to include the cost of meeting these minimum health equipment 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 remediating our national health 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 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 PRESIDENT PRO Tempore. (Mr. Cooke). 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, as medical care, and for other purposes, introduced by Mr. Paul, for himself and Mr. Cooke, was received, read, 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 "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, envisage 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 unacceptable 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 Medicaid) have placed 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 these 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.

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 these 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 20 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. 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 age 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 includes 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 so 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 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 he would have paid had he remained a healthy, active employee.

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 1.)

(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 uninsurables. 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.

1

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.

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

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. 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.

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.

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.

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

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.

6. The system must be provided financial incentives for en-
AMERIPLAN: ITS GOALS AND PROGRAMS

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.

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.

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

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.

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

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

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.

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.

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.

1. 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.

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.

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.

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.

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

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,
AMERIPLAN: ITS GOALS AND PROGRAMS

coordinated and comprehensive system for the delivery of health care.

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.

Health Care Corporations would have the following characteristics:

(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.

(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.

(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.

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

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

anisms to evaluate the quality of all health care on a con-
tinuing basis. Such evaluation of quality would be an in-
tegral part of AMERIPLAN and a basic responsibility of
the Health Care Corporation.

(5) The Health Care Corporation would identify its man-
power needs, and be responsible for the inservice educa-
tion and training of its health manpower and the recruit-
ment of all health personnel for its providers.

(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 as-
sure that needs would be met without unnecessary con-
struction or duplication of facilities and services.

(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 sup-
port the dignity of the individual and his family.

AMERIPLAN Health Benefits

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 ex-
ception. Therefore levers must be supplied to motivate change.

The lever to motivate change by those using the system and those fi-
nancing the system would be the better quality and greater accessi-
bility of health care, and the new health maintenance benefits that
would be created at reasonable cost by establishing Health Care Cor-
porations. 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.

AMERIPLAN would utilize both federal government and private fi-
AMERIPLAN: ITS GOALS AND PROGRAMS

Financing. 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.

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) 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.

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.

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.
(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.

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.

(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

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

1453 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.

1454 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.

1455 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.

1456 Most significantly, the implementation of AMERIPLAN could hasten commitments by all health professionals, especially physicians, to join with health care institutions in 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.

1457 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.

1458 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, American medical bills went up fourteen percent, from $53 to $70 billion. In the last five years, it has climbed 170 percent, from the $20 billion level in 1959. Then we were spending 5.3 percent of our Gross National Product on health; today we devote almost 7.5 percent of our GNP to health expenditures.

This growing investment in health has been led by the Federal Government. In 1959, Washington spent $5.5 billion on medical needs—13 percent of the total. This year it will spend $21 billion—or about 38 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

1959, 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 medical care has become prohibitive. And even those who can afford more 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 health 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 when their needs are not urgent. 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, but not necessarily 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 this condition—indeed, we should—by changing the way we use our resources.

This new strategy should be built on four basic principles:

1. Access. 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 ensure that all citizens achieve 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 achieve 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 achieve access to our health care system.

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. When Medicare and Medicaid 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 cost should not be a source of anxiety to 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 now the Federal Government is deciding to remove those barriers, it also has a responsibility for what happens after they are reduced. We must ensure that any resulting 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 out of our problems. 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 undermined our medical system—not by a long shot. We have, however, spent this year poorly—relying on incentives 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 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 emergency services. Yet both the system and those services 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 care. If we gave more thought 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, not just a "medical" system alone. We should work to maintain health and not merely to restore it.

B. Preserving Cost Consciousness. As we did in organizing to reduce 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 their provider has an incentive to use the system efficiently. When that happens, unnecessarily demand can multiply, scarce resources can be squandered and the shortage of services can become even more acute.

Those who are hurt by the most by such developments are those whose medical needs are most pressing. While costs should never be a barrier to providing needed care, it is important that we pro-
serve some element of cost consciousness within our medical system.

Most importantly, we should also avoid holding the whole of our health care system responsible for failures in some of its parts. There is a natural tendency to place blame in an effort to place responsibility for shortcomings where it does not belong. This is a 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 these strengths is the diversity of our system—and the range of choice it therefore provides to doctors and patients alike. I believe the public well 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 do its own thing without any 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 one another. National goals will then be given their due, but dictated in 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 Congress the following six point program. It begins with measures designed to increase and improve the delivery 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 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."

One of the most important advantages 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 higher the fees. 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 little motivation for them to avoid ailments that lead to the complications and recurrences. HMO's pay doctors and hospitals a fixed contract fee which will enable private sponsors to enable private sponsors to provide better services to their clients, including preventive care.

Those who work in the HMO's—physicians, surgeons, nurses, therapists—will be paid a fee for each service they render. On the average, HMO's pay doctors and hospitals about 20% less than they do in the traditional fee-for-service system. This difference is then used to keep in the hospital, pay for preventive services, and generally lower rates for continuing education, lesser financial risks upon first entering practice, and generally lower employee benefits.

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 illnesses, or failing that, in treating them in early stages, preventing a thorough recovery, and preventing any recurrences. Like doctors in a group practice, they are paid to keep their clients healthy. For them, economic interests work to reinforce their professional goals.

At the same time, HMO's are motivated to function more efficiently. When providers are paid retroactively for each of their services, they can 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. The other hand, if an HMO is wasteful of talent or facilities, it cannot pass these costs on to its subscribers. Instead, it must find a way to economize. It may sell off assets, cut staff, or close entire hospitals.

And if an HMO is wasteful of money, it loses money. Such organizations, therefore, work to keep their clients healthy. For them, economic interests work to reinforce their professional goals.

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 manner which is convenient for patients and more responsive to their needs. There was a time when every housewife used to go to a variety of shops and butchers and grocers to buy her family's groceries. Then came along the supermarket—which made her shopping chores much easier and also gave 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-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, as is the case with our family doctors. Because many doctors often use the same facilities and equipment and can share the expense of medical assistance and business personnel, overhead costs can be sharply curtailed. Hospitals and other health facilities that come from working with fellow professionals who can share their professional achievements and readily offer their 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 employee benefits.

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 the 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 I propose legislation this spring which will 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 $25 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 $500 million in private loans during the first year of the program.

4. Other barriers to the development of HMO's include barriers to the 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 adapt to remove such barriers.
the Federal Government will facilitate the development of HMO's in all States by entering into contracts with them to provide care for the disadvantaged and other Federal beneficiaries who elect such programs. Under the supremacy clause of the Constitution, these contracts will obligate us to comply with any incumbent State statutes.

Our program to promote the use of HMO's is one of the efforts we will be making to encourage a more expanded organization of our health care system. We will take other steps in this direction, including stronger efforts to develop 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 doctors for reducing the time required to obtain a patient's medical history. Methods have also been devised for using computers in health care, for recording and diagnosing patients from remote locations, for keeping medical records and generally for restructuring the layout and functions of hospitals and other care centers. The results of early tests for such techniques have been most promising. If new developments can be wisely deployed, they can help us deliver more effective, more efficient care at lower prices.

The hospital and outpatient clinics of tomorrow will be free of those recurrences of 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 systems. The Department will establish demonstration and experimentation projects in this area, disseminate the results of this work, and encourage the medical industry and the medical profession to take advantage of such technology into full and effective use in the health care centers of the nation.

**B. MEETING THE SPECIAL NEEDS OF SCARCEY 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 750 persons in America. But in over one-third of our counties the number of doctors per capita is less than one-third that of urban areas. In 430 counties, comprising over eight percent of our land area, there are no private doctors at all—and the number of such counties is growing.

This 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 12,500, Chicago's inner city has fewer physicians today than it had ten years ago.

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

1. **WE SHOULD ENCOURAGE HEALTH MAINTENANCE ORGANIZATIONS TO LOCATE IN SCARCEY AREAS.** 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 UNDERPROVIDED.** These units can build on the experience of the Neighborhood Health Centers experiment which has now been operating for several years. Amendments would serve as a base on which full HMO's—operating under other public or private direction—could later be established.

3. **A SERIES OF NEW AREA HEALTH EDUCATION CORPS SHOULD ALSO BE ESTABLISHED IN PLACES WHICH ARE MEDICALLY UNDERDESERVED—AS THE CARNEGIE COMMISSION ON HIGHER EDUCATION HAS RECOMMENDED.** To be satisfactory, the facilities of existing medical and other health science schools; typically, they could be built around a community hospital, a clinic which is already in existence. 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 otherwise not be available in these areas. I am requesting that up to $40 million be made available for this program in Fiscal Year 1973.

4. **WE SHOULD ALSO FIND WAYS OF COMPENSATING AND EVEN REWARDING—DOCTORS AND NURSES WHO MOVE TO SCARCEY AREAS, DESPITE DISADVANTAGES SUCH AS LOWER INCOME AND POORER FACILITIES.** As one important step in this direction, I am proposing that our existing capitation grant programs for medical students include a new forgiveness provision for graduates who practice in a scarcity area, as long as they specialize in primary care skills that are in short supply.

5. **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 CORP., MADE UP LARGELY OF DEDICATED AND PUBLIC-SPRITTED 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 care more effectively. But it is also important that we produce more health professionals and that we educate more of them to perform crucially 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 acquiring a sound financial position.

I am recommending, therefore, that much of our present aid to schools of medicine, dentistry and osteopathy—along with $50 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 program 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 also mean that we could eventually phase out our emergency assistance programs.

We are, of course—rather than subsidies falsipr—this would lead not only to greater incentive for schools to educate more students and to educate them more efficiently but also to a substantial reduction in the number of school grants which are geared to the annual number of enrollments, capitation grants would provide a strong incentive for schools to shorten their curriculum. For example, the same sized school would have one-third more money each year if it phased by another sound recommendation of the Carnegie Commission on Higher Education. For them, the same sized school would have one-third more money each year for the next ten years.

In order to use new methods for compensating and even rewarding—doctors and nurses who move to scarcity areas, despite disadvantages such as lower income and poorer facilities.

2. **THE FEDERAL GOVERNMENT SHOULD ALSO ESTABLISH SPECIAL SUPPORT PROGRAMS FOR MEDICAL SCHOOL GRADUATES WHO WISH TO SERVE IN SCARCEY AREAS.** These grants would support efforts such as improving planning and management, shortening curriculums, expanding enrollments, teaching of physicians and allied health personnel, and starting HMO's for local populations.

In addition, I believe that Federal support money, rather than the usual method of providing Federal support money, would encourage medical students to enter medical education facilities can be used more effectively. I recommend that the five national programs in this area be consolidated into a single, more flexible grant authority and that a new program of guaranteed loans and other financial aid be made available to generate over $300 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 60 percent increase in the number of medical school graduates by 1975, 850. We must set that as our goal and we must see that it is accomplished.

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to help low income students enter medical and dental school. I propose that our scholarship grant program for these students be almost doubled—from $15 to $30 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 crowding 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 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 personal training programs be expanded by 50% over 1971 levels, to $79 million, and that the $84 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 MEDUC 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 20,000 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 over the next five years. At the same time, the Veterans Administration will expand the number of health training in VA facilities from 14,000 in 1970 to over 30,000 in 1972.

D. A SPECIAL PROJECT: 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 for an average practicing doctor increased 16 percent a year—a fact which reflects both the growing number of malpractice claims and the growing size of settlement payments. 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, inhibitsthat free discussion of care 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 and 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 reports should include specific recommendations for dealing with this problem. They should be submitted by March 1, 1972.

II. NEW ACTIONS TO PREVENT DISEASES AND ACCIDENTS

We often invest our medical resources as if an cure were worth a point of prevention. We spend vast sums to treat illnesses and accidents that could be avoided for a fraction of these expenditures. We focus our attention on making people well rather than keeping people well—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 for the long-term. Such 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 240,000 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 rely on cancer unless we can reduce the present rates of incidence.

In the last seven years we have spent more than $1.5 billion on cancer 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 money into cancer research and—learning an important lesson from our space program—to organize these resources as effectively as possible. It is my intention and my administration's to assign a much higher priority to the work of cancer research.

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 illnesses or accidents. Through tax payments and through insurance premiums, the carefree pay the bill. For the careless, the non-smokers subsidize those who smoke. Scientists have physically ly fit subsidize the rundown and the overweight, the knowledgeable subsidize the ignorant and the vulnerable. 
It is in the interest of our entire country, therefore, to educate and encourage each family to develop and practice healthy life habits. For we have given remarkably little attention to the health education of our people. Most of our current practices have been fragmented and haphazard—a public service advertisement one week, a newspaper article another, a short lecture now and then from the doctor. There is an urgent need to centralize forces 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 effort and are now working toward reaching an initial goal of $1 million in pledges for its budget.

This independent project will be complemented by certain Federal efforts to promote health education. For example, expenditures to provide family planning assistance have been increased, rising $1 million since 1962. And I am certain that the great potential of our nation's day care centers to provide health education is better utilized.

We should also expand Federal programs to help prevent accidents—the leading cause of death between the ages of one and 25 and the fourth leading cause of death for persons of all ages. Our highway death toll—60,000 fatalities last year—is a tragedy and an outrage of unacceptable proportions. It is all the more shameful since more than half of 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 $5 million in Fiscal Year 1971 to $35 million in 1972. I am also encouraging that the funds for alcoholism programs be doubled, from $7 million to $14 million. This will permit an expansion of our efforts into better ways of treating this disease.

I am also requesting a supplemental appropriation of $25 million this year and an increase of $75 million over amounts already in the 1973 budget to implement aggressively the new Occupational Safety and Health Act I signed last December. We must begin immediately to combat 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, the water he drinks—each of these 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 exaggerate the role of the doctor. We must not neglect the nation's food and drug supply, to control narcotics, to restructure the environment, to build better housing and transportation systems, to end hunger in America, and—let us not forget—do our share to improve the health 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.

I, therefore, request the following:

3. 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 their 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 carrying health insurance has grown from 20 percent to 57 percent and the portion of medical bills paid for by insurance has gone from two to four. Despite this impressive growth, there are still serious gaps in present health insurance coverage. For such gaps do not disappear. Unemployment, for example, has been a disturbing factor for some years. In addition, the cost of insurance is a continuing problem.

First—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 addition, we have taken action to improve our hospital services. In the next few months, the Government will make sure that the hospital beds in some areas are occupied by patients who do not really need them and could have been treated at home or better cared for outside the hospital.

A second problem is the failure of most private health insurance to cover the catastrophic costs of major illnesses and accidents. Only 49 percent of our people have catastrophic health insurance of one kind or another. Medicaid payments average $7 to $15 per person for one month's hospitalization. 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 been treated at home or have been given better care outside the hospital.

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and unions will have an even higher stake in the system will add additional pressures to keep quality up and wages down. And while there will be new opportunities for raising rents, consumer prices, and profits, these will be offset by the increased productivity and wages of the economy.

But there is a more fundamental reason why the system will be endangered: it is part of a larger system of social and economic relations that are being transformed by the forces of production.

The system of insurance will be increasingly threatened by the growing power of the working class. The increasing concentration of wealth and power in the hands of a few is leading to a growing demand for social change.

For the poorest of families, this program would make no changes and would pay for basic medical costs. As family income increased beyond a certain level ($3,000 in the case of a four-family family), the family would begin to pay a larger share of the costs. This would encourage premiums to be kept down to a reasonable level.

The Family Health Insurance Plan would also go into effect on July 1, 1972. In its first full year of operation, it would cost approximately $3.3 billion under federal programs. It is estimated that all eligible families participating in State programs would have no more than a 4% share of this cost, which would be reduced by 20% for families of the elderly.

This, then, is how the National Health Insurance Plan would work: The Family Health Insurance Plan would meet the needs of most welfare families—although Medicare would continue for the most part and the disabled. The National Health Insurance Standards Act would help make the population acceptable to the Federal Government. Medicare bills for most of the population. Members of the Armed Forces and civilian Federal employees would continue to have their own insurance programs and our other citizens would continue to have Medicare.

Our program would also require the establishment of each State of special insurance costs which would offer insurance at reasonable rates to people who do not occur to the Federal government, for example, poor and elderly individuals who often cannot get insurance.

I urge the Congress to take further steps to improve Medicare. Furthermore, beneficiaries should be allowed to use the program to help with Health Maintenance Organizations or other programs. The existing system of Medicare would be supported by the federal government and by state governments in the event that state governments cannot provide adequate coverage.
SPECIAL ARTICLE

WHY DOES MEDICAL CARE COST SO MUCH?

WALTER J. MCNEERNEY

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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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." The American Medical Association and the Association of American Medical Colleges issued joint statements in 1965 calling for accelerated efforts to produce more physicians.4

The reasoning behind such calls has various aspects, 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 intersecting 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 unwise.

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 include signs that 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 of 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 60. For nurses, the ratio nationwide is four to one. Eighteen states had five or less psychiatrists per 100,000 population, whereas Massachusetts had
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.

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, 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 indices 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 1955. 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.

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-care 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 extert 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 area-wide 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
depends 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 recouping away from crisis medicine. He tends to fear that there will be a sin of omission 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 techniques at hand. Dr. John H. Knowles' study 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."9

In 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, 7% 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 show the mobility of manpower similarly 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 collusion or so-called unscientific practices. Several cults, sanctified by licensure and protected by effective lobbies, still helm 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, there 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 payers of care, although any infusion of new money always creates the chance that prices will rise. Contests worked out on the supply side in the name of effectiveness can, if inexactly 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 sciences 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 presumptions, 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 primary 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. Sufice it to say that the problems, many of which go back to an everspiring 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 reallocate 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. Penmanne in California has experimented successfully with multidisciplinary assistants. It has made re-organization 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 private 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 anticompetitive 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. Suing 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. An alternative, for example, can be a fee-for-service or salary-physician scheme with equal support from the employer. In this manner, not only is resistance on the part of the profession is broken down...

What we are seeing now, then, is a new phase in medical care in which more alternative solutions should be available, greater resort is made to basic tools of management in achieving more defensible costs and effectiveness, and the consumer is put in a reasonable position vis-a-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 sophisticated. 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."

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 stuff 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 problem of financing the health care system. In recent weeks and months, a number of useful and informative articles have appeared in the press detailing the crisis of the present system and suggesting 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 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 comprehensively planned 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.

Several months ago President Nixon, Secretary Finch and the Assistant Secretary for Health and Scientific Affairs, Dr. F. E. Fogelson, gathered at the White House to tell the nation that it is about to face a complete breakdown in the delivery of health services. This is not to be a point. Over the decade 1955-1965 "physician-directed services" rose 15 percent, hospital service 65 percent, although the increased output of physicians (22 percent) barely exceeded population increase (17 percent). In fact, the increase in physicians who went into patient care (12 percent) was less than population increase. The availability of direct, personal treatment by a physician has diminished at a time when demand for medical care is going up antibiotic, and demand has been so great that the expected undersupply of physicians should have occurred years ago. What happened? Physicians learning 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 workers by 34 percent, allied health technologists 56 percent, and clinical laboratory personnel 50 percent. Nevertheless, in the opinion of the National Commission on Health Manpower, the existing organization of medical care will soon require more physicians than our schools are capable of producing. "If additional personnel are employed in the present manner and within present systems of care," said the Commission, "they will not necessarily be used, even if there is a shortage, or even perhaps alleviate, the crisis. That seems to many of us, and it makes the problem of additional physicians will be sufficient unless medical care is reorganized. But the Commission did not show any reorganization should be carried out.

What is so unsatisfactory about the organization of our present system? It consists by and large of physicians in practice alone, or in small groups, on a fee-for-service basis. This independent business entrepreneur, and a strong sense of the 19th century individualism still guides professional conduct. About 70 percent of physicians in direct care of patients are not hospital employees, even though less than two percent of current graduates go into general practice. Of physicians in office practice, only about 52 percent still work on a fee-for-service basis. The "institutionalizing 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 unattractive. It is inadequate for periodic care for patients with a special interest. But such care, though good, is delivered in separate bits and pieces. The "crisis," that is the personal, lifelong program of prevention, diagnosis, treatment and rehabilitation that it should be, is still very rarely recognized, never mind being treated or even conceived of as an ounce of prevention may be less than that for a pound of cure.

It is not quite fair to lay all the ill of the health delivery system at the feet of the practitioners who work in the fee-for-service system. The American Medical Association, for its part, has been one of the major advocates of fee-for-service. In 1965, 1964, 1963, the AMA spent $531,000 and $37,159 on the "Physician-directed Services" program, which has the approval of the AMA. This is the same argument put forward by the AMA when it recommended a study of the "Physician-directed Services" program, which was approved by the AMA. This is the same argument put forward by the AMA when it recommended a study of the "Physician-directed Services" program, which was approved by the AMA.

In 1962, the AMA's "Physician-directed Services" program was rejected by the Senate Health, Education, Labor and Public Welfare Committee. The committee's report was presented to the Senate on February 3, 1962, and made available to the public. The report was received with great interest and was the subject of much public discussion.

The report, "The Growing Pains of Medical Care," was published in The New Republic on February 17, 1970. It was written by Mr. Fred Anderson, a staff associate of the National Academy of Engineering. The report was based on a survey of the nation's 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.

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students how to care for the elderly and the poor. Medicare in-\v\ncluded to all physicians' fees and related costs, such as drugs, dental care, and non-hospitalized care. There is no effective way to police this vast un-\vented system. If effective, must include a dozen of the major, five-month interagency study. Congress was in 1948 when the recommendations of the President's National Health Assembly was introduced in Washington. The insurance companies have not made any botch of the Medicare program in 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. Medicaid functions quite smoothly, though hou-\v\nstitutions can charge for certain medical services, and patients complain that in some hospitals they are discriminated against. Medicaid has served the population of all states, and provides a general benefit. Medicare covers only about 35 percent of the total health bill of persons over age 65.

Medicaid is more complicated. The primary recipients are low-income citizens, the aged, the blind, the disabled, and families with dependent children. Each partici-\v\npants signs a contract with its program, which states, in general, the services provided in Medicaid is the categorically needy are included. States are permitted, but not required, to include persons who are self-supporting but have no medical insurance. And, for the most part, these persons are covered by some form of health insurance at all.
of specialized or intensive care now unavailable to most people.

Solo practitioners, who may number as many as 250,000, have systems that are too poorly equipped on one hand and pay for them by passing the costs on to their patients. But when it comes to preventive medicine, they are really at a loss. Henry is overhead by finding an optimal size for staying underresourced. This is because the medical clinics of today's world do not provide the same level of care as those of yesterday. There appears to be a need to work with the community, in terms of what's been called "a community medicine." This includes the work of the physicians, nurses, and other health care providers, who are responsible for providing care. However, in order to make the clinics work, they will need to be adequately compensated for their services.

The second component of reorganization, preventive medicine, places a philosophical challenge to the traditional roles. This requires a shift away from the individualistic, self-interested, and self-sufficient role of the patient to a more collaborative practice. These advantages probably account for the 25,000 physicians who by 1975 had moved into group practices. Although very few of the 6500 practices had pay-per-visit plans and almost none passed savings along to consumers.

Not only are the experimental urban neighborhood practices inefficient. Dr. Harold Wise, Director of the Office of Economic Opportunity's South Bronx project, says that in his clinic 25 physicians do what normally would cost 700; they are a new approach to health services as well. The urban clinics are staffed with a wide range of personnel, including the usual complement of pediatricians, internists, and other specialists. But community health nurses, public health 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 to emergency wards at night, or in clinics organized around organ systems and diseases—ear, nose and throat clinics, cardiovascular, child health, medical clinics. The patient is critical, too. He sees this area as frustrating, unnecessary. National estimates that almost eight million people are served less than the national average. The Northeast, the Midwest, the South have found that more people are poor and have less access to health care. The urban clinic is staffed with a wide range of personnel, including the usual complement of pediatricians, internists, and other specialists. But community health nurses, public health 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 to emergency wards at night, or in clinics organized around organ systems and diseases—ear, nose and throat clinics, cardiovascular, child health, medical clinics. The patient is critical, too. He sees this area as frustrating, unnecessary. National estimates that almost eight million people are served less than the national average. The Northeast, the Midwest, the South have found that more people are poor and have less access to health care.

Oddly, the communities have not always responded favorably to the community's need for preventive medicine. There are several reasons for this. First, the community is not always aware of the need for preventive medicine. Second, the community may not have the resources to provide the necessary services. Third, the community may not have the ability to implement the services. Therefore, it may be necessary to work with the community, in terms of what's been called "a community medicine." This includes the work of the physicians, nurses, and other health care providers, who are responsible for providing care. However, in order to make the clinics work, they will need to be adequately compensated for their services.

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they will meet informed opposition when their projected savings, before they will have to pay prices rises under the influence of consumers' representatives who know how to use the rising cost of medical care to achieve much higher earnings due to real costs, normal inflation, wages, or higher incentives for physician participation.

Physicians will see the wisdom of economics in the financing of health care and are already ocurring that they will have the prestige to demand even larger incentives and the construction of wasteful practices which may be very attractive indeed, but are not necessary for everyone. Even if health benefits by the presentations 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 attractive in Congress. Many of them believe that group practice and pre-payment, combined as mentioned here, or in another way, are 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, many groups once in large numbers, accepted showed that the profession can be quite effective in opposition. Organized medicine still wants to experience this. The membership in the AAMA has left 20 states with laws that place barriers to group practice voluntary or group plans, or both, and in some states are still working on financial aspects of these activities. Of course, they want to increase their earnings, but physicians are not interested in the fact that one physician with a single patient's case deserves the crutall doctor-patient relationship, even though community of care is easily important in strict, not chronic or preventive. care, even though it has been demonstrated that a successful new focus and fresh interest is better for some patients.

Acclaimed as they are to autonomy, many physicians rank at the thought of quality review, or peer review of a partner's contribution to the practice. For are they compelled by the social side of medicine, accepted showed that the profession can be quite effective in opposition. Organized medicine still wants to experience this. The membership in the AAMA has left 20 states with laws that place barriers to group practice voluntary or group plans, or both, and in some states are still working on financial aspects of these activities. Of course, they want to increase their earnings, but physicians are not interested in the fact that one physician with a single patient's case deserves the crutall doctor-patient relationship, even though community of care is easily important in strict, not chronic or preventive. care, even though it has been demonstrated that a successful new focus and fresh interest is better for some patients.

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the success of national health insurance will depend very much upon how physicians react. they may have said they favor it, young physicians are not likely to oppose it as strenuously as their older colleagues. nevertheless, a consensus of physicians could throw health care into chaos. whether in the world have physicians had the prestige and respect and influence that they do in the us, and nowhere else. kennedy disagrees with comprehensive prepaid care is attained. senator kennedy disagrees with comprehensive prepaid care. the money would try to alter the career choices of physicians among the specialties. while all this is going on, at the same time, organized medicine's image has been tarnished. the public is not thinking 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 summary 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 medicaid for the entire population. indeed, most americans were receptive to a federal role a decade ago. during the 1969 presidential election the inter-university consortium for political research at the university of michigan found that 69 percent thought that "government ought to help people get doctors and hospital care at a reasonable cost." early public support for a federal role in medical care also helps explain the 1965 passage of medicare and medicaid, despite fierce opposition by the ama. the nixon administration's opposition to national health insurance is based on the argument that it would be uncontrollably inflationary. yeh solves the administration in consisting of a quid pro quo. 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. the basic economic theory and increase in supply slow down inflationary demand. but more md's and support personnel are wanted in a system which quickly loses marginal gains in its general inefficient operation, in population growth, and its increased demand. the most recent confirmation of this was offered in 1958 by the national advisory commission on health manpower, which concluded that we should not continue to expand vast sums, simply to get marginally more services of the same kind. we will need more physicians and other health personnel, it said, 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 the health care system—not from inflation, not from poor financing mechanisms, but from
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 "Medicare," 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. 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 effecting 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." 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-
declared 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 Rubinstein 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 count, 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. 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 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 are highly 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. 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 post-war 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 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 unprotected. 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 staff 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 uninsured, 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 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, 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. 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 exact-
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.

REFERENCES

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NATIONAL HEALTH INSURANCE:
MAJOR PROPOSALS, ISSUES AND GOALS

Anne Senators
Vice-Chairman, New Jersey Medical Assistance
Advisory Council
for the
New Jersey Medicaid Program

Mrs. Senators 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 areas 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. Senators dealt 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


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Task Force on Medicaid and Related Programs to also study the problem of "long-term 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 CNHI 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 children's 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 Griffiths 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.

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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 \( \frac{3}{4} \) 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 \textit{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 CNHI 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 1959 figures, this would have represented a national per capita allocation of approximately $260 (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 prepaid 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—differ 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 Byrdhill of Virginia introduced a new version of Mediterrane—H.R. 19857—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 is 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 separate 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 Javits’ 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 Coisman, 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 subsidies would make up the difference as well as the total cost for "the poor."

Speaking to a special meeting of the United Hospital 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 this 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.

The Welfare Reporter
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. Moreover, the experience of Medicare—where the most careful actuarial projections 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 Medicharet 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 PEP 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.
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 Medieredit. Whereas the latter is too limited, this is too broad and all-embracing. Whereas Medieredit 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 Medigredit faults. Whereas Medigredit is at great pains to try not to interfere with the existing 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 straitjacket everyone into fee-for-service.

With respect to hospitals, CNHI provides only one method of payment—approved budgets. Again, 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 Medigredit “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 appears 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
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 re-insurance 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 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 adminis-
station, in combining a gradualistic approach with a not-too-distant timetable 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 fineses 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 be broad and be used 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 appearance program although there would be appropriate 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 forthcoming, 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 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 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.” In hospitals, this discretion 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 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; 73 per cent were to some extent protected against surgical costs; and 66 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 25 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 guarantees 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 do 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 the 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 health 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 also 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 $7,500 (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, have 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 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 $1,130) 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 AMAs—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.

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..."
Stunning price tag on national health insurance

worry later about funding." A key Congressional staffer con-

fides: "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 healthiniks—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 Con-

gress 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.
Stunning price tag on national health insurance

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 employees 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 economists. 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 employees, 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 Mediplans. 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
Stunning price tag on national health insurance

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.

WASHINGTON INSURANCE NEWSLETTER, INC.

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 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 therefore—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-rate basis according to their aggregate 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 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 creates 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 sacred, 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.
May 7, 1979

CONGRESSIONAL RECORD - Extensions of Remarks

R 4821

UNIVERSAL AND COMPULSORY HEALTH INSURANCE: FULL SPEED AHEAD AND DAMN THE CONSEQUENCES

HON. DURWARD G. HALL

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 7, 1979

Mr. WALL. Mr. Speaker, Colin 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 for the Health Administration, in Chicago, Ill.

The information he has set forth in his remarks are conclusions drawn from a study he recently conducted.

I was particularly intrigued by Professor Anderson's recognition of the need for long-term, or catastrophic type assurance. That, I believe, 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 the Congress in the near future.

I offer this most timely and interesting speech in all those interested in what could easily become this Nation's greatest social problem known for the 1970's.

The speech follows:

UNIVERSAL AND COMPULSORY HEALTH INSURANCE: FULL SPEED AHEAD AND DAMN THE CONSEQUENCES

(By Colin W. Anderson, Ph. D.)

X. The Background

The re-emergence of universal and compulsory health insurance as a viable political issue for the Republican administration after being quiescent since 1932 bears some comment. This issue is for the first time cutting across parties, one of the early signs of conservative 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 lingering on the back burner, like the Continental kitchen stove, from 1836 to 1932. It is also more than passing political interest that not only the function—ideologically—of sponsoring being thezechism of Democracy–Wagner–Marxist–Hill–Williams–Berkman–Clymer is now in evidence.

There were probably two main reasons, not to mention many lesser ones, for this political silence. First, the Social Security Act, the public health sector notwithstanding, was primarily concerned with income maintenance and transfer payments, i.e., the income redistribution, as it were, to mitigate and prevent destitution. The second major reason was that Congress was preoccupied about raising taxes in a country where politicians are so directly and quickly responsive to the mood of the electorate—lient or noisy. As all politicians in democracies know, the tax issue is the exposed nerve of the political process and has generally been a struggle between the private and public sectors or, if you will, between "private affluent and public agencies." Otherwise, in our recently passed bill there would not have been a reduction for everybody, rich and poor alike; to punish excesses, where they were excessive, but none were more unequal than others.

Americans continue to have the reasonable belief that the chief problem of people is an adequate income; secure people

money and they can buy the goods and services they think they need and want—excluding personal health services. Through the years, a reasonable theory would have been that if people have the money, they can express choices within a market and services, and that they will then rise to meet this challenge, given no artificial restrictions on supply. The opposite of this is the view that people have a restricted supply and accept rationing equally, and desire planning to so restrict the 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 have not operated as little as the health services enterprises and because publicly in the current condition of the statutes. When government has been given a mandate—whether Title II and I, better known as Medicare when there has been used to buy services from the private sector, competing for scarce resources and thereby eliminating sliding scale. Congress under the Health and Education Assistance Act in 1949 (Hill-Burton), the Federal Government has been given little control over the value gained to increase the supply to accommodate with recent legislative mandates.

Nevertheless, in the face of imposing universal health insurance legislation, the private sector will be pushed into a financial maelstrom—certainly politically—quite arbitrarily limits to medical costs less than the private sector. Further, it is possible to deal not only that universal health insurance will set limits to funds but also that those who disburse these funds may well be in a large part to determining the restructuring of the delivery system, the Government providing judgment among the proposals. The question is: And as an alternative, universal health insurance is that the present system for enrollees is such families and needs to be restructured. This is quite an undertaking in a society which is fundamentally internationally and in the political system.

In essence, the concept of universal health insurance is that the present system for enrollees is such families and needs to be restructured. This is quite an undertaking in a society which is fundamentally internationally and in the political system.

As one to whom I have written to take an even less severe view, there is no monopoly on confusion as to how to solve the problems in the General current concern about Federalism report—with a proper role of citizen and professional representatives—foster to life, and those who brand new experts on medical care to Puerto Rico and Business Week, to whom the solutions are self-evident. Universal compulsory health insurance is the least untied alternative in this country; and it appears to be believed that such alternatives are easier to solve the problems that are now being tackled. Frequently, it cannot possibly make us understand.

Y believe what is novel about the current interest in universal health insurance in this country is in connection with commitments of such insurance in other countries and previous justifications in this country is that the stimulus seems to event from concern with respect to American health status. That is the usual stimulus of sharing the risk of costly illnesses of disease or of the lower income classes. The per capita limitation of sharing risk is present in view of rather in adequate health insurance benefits here, but there seems to be this, once the government is free to the funding expenditure, will be confined within whatever health services, in the market, the political objectives are limited. By making a primary issue of rising costs, the support of the system is the issue of the so-called vital sector and the ultimate agent of political change. These are legitimate soci}

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tion, i.e., compulsory taxation of one kind or another, may be a financing of health insurance, seems to be the keynote issue overarching all others, and, in fact, governments everywhere are endeavoring to meet the needs of the individual to extend his income as he wished; the patient service is therefore a continuing one, and when the doctor is no longer in practice, the doctor would be compelled to make all payments and provide for practice in order to earn a living. Currently, this issue of computation seems not to be a politically viable one for a comprehensive health plan.

First, foreign experience has shown that it is possible to have free choice of doctor, various methods of paying doctors, and some variety of practices, and doctors remain in strong bargaining positions regarding professional and financial prerogatives. Therefore, there has been a rather complete acceptance of the method of compulsory taxation for collective purposes. The societal security provisions, the Medicare Act for the Aged—Title 16, and the withholding system for personal income taxes have resolved these issues in practice. Further, enrollment in voluntary health insurance is so frequent a condition of employment that an employee has in many cases no choice of whether or not to join a voluntary health insurance plan that may be centered on good compensation or low computation, but now even this discussion has disappeared.

B. Sources of funds

I believe, however, that there are more important issues than that of compulsion, and that related mainly to sources and amounts of funds and sources and methods of controls on quantity, quality, and organization. It is true that the purist rather than the power over citizens financial participation which bears on the enormous influence that a source of funding has on the general organization of a health service when the amount of funds is increasingly centralized and becomes subject to political pressures. 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 homeowners are over, but Medicare not because the homeowners did not even start in that program; the bride with her relatively small dowry from general funds found too daunting a task. Out from the start, I see government as an important and for certain purposes a strategic worldwide resource, but I do not see it as an ample source of funds if it becomes the main source.

C. Equitable access

I place equitable access regardless of income and residence under ideology because this is a value which does not lead itself to rational discussion. When society raises a certain value to a sacred 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 disadvantaged people—admissions rates to general hospitals have more than doubled and the proportion of the population who say they went once in a year has also almost doubled—the ratio of hospital beds and physicians to population has remained almost constant in other words those resources relatively more accessible have absorbed a tremendous increase in demand with only a slight increase in resources. Thus, while there is more technology, more money, and more money. Obviously, universal and compulsory health insurance which will result without a compensatory increase—at least according to present plans—in the supply. This might work.

To those who say that we cannot increase the number of physicians and support the population in this way, the patient, perhaps, not 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 cash program to give doctor with the political force, given the political acceptance of the policy. Sweden, for example, is increasing its physician supply by many thousands through a deliberate public policy, and medical students are already in this pipeline.

Supply, obviously, has not been an obstacle to our ability to equalize access, because the mean governs the supply, the easier it is for equalization to be feasible, people in poverty and rural areas. The current thinking seems to be one of sharing the work, this will be to allow people in rural areas to equal universal health insurance. It would seem to me that universal health insurance means would, therefore, would be more feasible for the poverty areas unless there is a policy using the number of physicians and supporting personnel and establishing many health centers as outlets 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 even in the matter of financing. Already, as in the case of health services there are two schools of thought: pay-roll deductions by medical personnel and employers for general taxes. Of the two the pay-roll deduction tax is quite obviously the more economical in raising funds for health insurance, but the federal government has been the one to go ahead. The pay-roll tax is actually more regressive, legislator however, must be balanced with the political reality that these are the most responsive to the constant changing and expanding needs of the health services which are most responsive to the constantly changing and expanding needs of the health services which are most responsive to the constantly changing and expanding needs of the health services.

A. Supply

Even though the demand has increased tremendously in recent years for hospital beds and doctors, and the proportion of the population who say they went once in a year has also almost doubled—the ratio of hospital beds and physicians to population has remained almost constant in other words those resources relatively more accessible have absorbed a tremendous increase in demand with only a slight increase in resources. Thus, while there is more technology, more money, and more money. Obviously, universal and compulsory health insurance which will result without a compensatory increase—at least according to present plans—in the supply. This might work.

To those who say that we cannot increase the number of physicians and support the population in this way, the patient, perhaps, not enough, I can only say that we can do so if we want to. If there is anything this country

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policies of how people are to buy and receive health services, and, in turn, how services are to be organized and delivered. In the risk financing concept, the public is giving the money so that they can pay for services at whatever prices. In the health service concept, however, the public is paying for the whole range of personal health services and the processes of providing services to people in a highly specialized and organized system.

It is highly unlikely that the Universal health insurance program will more immediately improve the chronic problems of methods of paying for health services, and the whole range of personal health services and the process of providing services to people in a highly specialized and organized system.

The high costs of health services and the high costs of health services, and the whole range of personal health services and the process of providing services to people in a highly specialized and organized system will more immediately improve the chronic problems of methods of paying for health services, and the whole range of personal health services and the process of providing services to people in a highly specialized and organized system.

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planned policy but the results of a loose concept of new areas will continue to have great countervailing leverage, since the spot lights will warn us to be prepared to have 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 interfering in the health services? I am not. I am concerned with the promises that universal insurance will result in containing costs, recognizing services, and assuring equal coverage. The United States, in particular, is concerned that the primary emphasis seems to be on containing costs and reorganizing the services through bureaucratic leverage, whereas in some countries the emphasis has not been attached. My own concept—which I might add, is not easy to specify either—is to expect the user to help pay the necessary costs. A universal health insurance system will not afford this type of dynamism, but perhaps a combination of price controls and public effort will do so. It seems that the current big buyers of services—government, management, government—can bargain for certain delivery methods. If these big buyers can help to keep the government monopoly of funds to contain costs and bring the health services to those who need them, they will be disappointed. Let me tell you briefly what has happened in countries since 1950, especially in the United Kingdom, Great Britain (England and Wales) and Sweden.

Recall that the sources of funds are very different in this country than in Great Britain where the government owns and finances the facilities. From 1950 through 1966 the per capita income increased in all the countries which own and finance the facilities.

It seems to me that universal and compulsory health insurance not only overemphasizes insurance but that it also misinterprets the wrong way to set priorities in the current context. In fact, its inauguration may actually contribute to the same problems which is the poor, which I believe mentioned earlier, a second of which is care for the health-delivery system. The United Kingdom, for instance, has been less effective in containing costs, and Sweden has been more effective. The Swedish system has actually been used for the purpose of certain clinical methods. This is not necessary, but they risk overlooking less tractable problems unless our policies are clear in that respect.

What seems to be emerging as a public policy recommendation from my attempt to think out loud in in the Section, allocate increasing resources of this increasing supply to the poor, the aged, and long-term illness and rehabilitation, induce voluntary health insurance and the cost-sustaining element of the public sector is a private, private sector. If access becomes tight and care becomes more expensive, we will have a private insurance system of medical care and a continuation of "private sufficiency and public squander" in health services.

FOOTNOTES

8. Unpublished data from the Center for Health Administration Studies in preparation for a report by C. W. Anderson comparing the health services in the United Kingdom.
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 S平方
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-sponsored curve-all, are devising a major medical initiative of their own.

In competition with liberal Democrats’ drive for an encompassing national health insurance, the Administration will offer the new Congress a less sweeping, less costly plan. The main aim 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. Thought 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-publicized 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.

“Thirs for the poor. Medicaid offers. It might include the so-called national health-care program for the 10 million recipients of the President’s proposed welfare reform plan—a pledge made last summer—could cost $8 billion to $13 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 outlays could 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 says that it will get heavy stress had 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 Senators 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 firmly bristles with Presidential aspiration; 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 draftsman 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 $27 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 limit 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, nonhospital
Medicine & Politics: Administration Readies a Vast Health-Care Plan

Continued From Page One

The Administration originally assumed that the planned health insurance for poor families would cost no more than the $2.7 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 technicains 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 pursuing a higher beneficiary goal but requiring beneficiaries to pay the first $2,000 of medical expenses. Thus there might be a provision requiring a patient to pay for the first 90 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 future medical 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 guarantee 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. The new program would provide medical care and hospital services worth $300 to $800 a year to a four-member family. This sum is slightly higher than the national average of $500 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 some states, notably New York and California, now are paying much more than the national average under Medicare, a stingy Federal program could require uncomfortable cuts 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 percent age in the Social Security taxes that are paid by both employee and employer; these taxes are already scheduled to rise by 1.36% to 11.8% of the first $7,000 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 outpatient 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 opposition before such a bold move is proposed. One possibility is that the President will simply call for study of the idea.

National Health Insurance: Will It Lower Medical Costs—Or Raise Them?

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 governments' 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 employee 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 1957—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.

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 excellence 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. 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 $56.4 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 for 1972 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-$200,000 "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 enrollments 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 misdistribution of those now practicing.

Americans spend more for medical care—$124.92 per person in fiscal 1970—than any people in the world. In fiscal 1970, which ended last June, the nation's medical bills totaled $77.2 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 1950. 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 $350 billion, or $300 for every man, woman, and child, in 1980.

Despite this alarming 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—still outspend 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 South Side 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 93rd 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 Medicaid plan, which leaves the system essentially unchanged, to the sweeping restructuring of Social 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, 1976). 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 Eilwood, Jr., says that “there doesn’t seem to be any doubts that HEW is proceeding all-out with the HMO idea. Secretary Rich-

ardson has made it quite clear to those connected with it that he intends to push through the idea with or without a Medi-care reform.”

Dr. Eilwood 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. Eilwood adds. “It’s not possible 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 Hospitals 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 equally, accessibility.”

“You cannot have a country of 200 million people where 10 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, if the cost of care will drop only when doctors no longer have a financial stake in their patients’ illness.

“When you lie 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 pay people 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 of payment, 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, all to the Government. If you do 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 93rd Congress.
Human Security

The most sweeping plan of all, this national health-insurance proposal is authored by Sen. Edward Kennedy and Rep. Martha Griffiths, both Democrats. It would emphasize group practice and comprehensive coverage and would cost $36 billion (the authors' estimate) to $77 billion (Hew's estimate) a year. Federal financing 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 protected by an advisory board of local health-care-policy boards. Care would be financed by a 3.5 percent tax on employers' payrolls and 1 percent levied on individual income up to $15,000; Federal funds would pay the rest.

Catastrophic Illness

Sen. Russell Long, Louisiana Democrat, will introduce this bill, approved by the Senate Finance Committee. This bill would create a Social Security-type fund, financed by extra payroll taxes. Consumer protection is provided for the poor and aged; everyone else would be covered by a basic insurance package. Luxury care, such as private hospital rooms, would be available in an added-cost supplementary package.

The hospital group did not estimate Ameriplan's annual costs.

Healthcare

Drawn up by the Health Insurance Association of America, whose 300 member companies write $60 billion in premiums, the plan would promote complete medical care, including dental care for children under 18 and prescription drugs. State and Federal governments would pay premiums for the poor and near-poor. Individuals and employers would pay 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.

Minimum Health Benefits

A blend of HMO, Ameriplan, and socialized medical-care plans is recommended by the Garbage Commission on Medical Education. This bill would be a broader, more comprehensive plan involving Federal financing. The Federal government would finance half of the costs of the plan, which would provide complete medical care for all Americans. The bill would be implemented in stages, the plan would be phased in over a period of years, and the Federal government would pay premiums for all Americans. The bill would provide for the creation of a national health-insurance corporation, which would be financed by a 3 percent tax on employers' payrolls and 1 percent levied on individual income up to $15,000; Federal funds would pay the rest.

Optional Extended Medicare

Prepared by Sen. Jacob Javits, New York Republican, this bill would offer Medicare benefits to all Americans under 65 who choose it. The plan would gradually increase premiums for Federal and employer group-insurance payments. The bill would provide for the creation of a national health-insurance corporation, which would be financed by a 3 percent tax on employers' payrolls and 1 percent levied on individual income up to $15,000; Federal funds would pay the rest.

Estimated costs when fully implemented: $50 billion a year.

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 Griffiths (D-Mich.) and James Coinman (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, Red Cross 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 insufficiencies 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 supporters, 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 full committee 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 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 Sisal 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 (1945-48) 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 NIH agree that rates in medical costs and fees in general have made 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 indexes of medical failure:

- Total medical expenditures in the U.S. have leaped from $26 billion ($145 per person) in fiscal 1960 to $37.2 billion ($224 per person) in 1972, but a substantial portion of the increase has produced little benefit because of a 50 per cent rise in costs.
- About 63 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 101 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 106 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

**Claim 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 HII. 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 wherever between $300 to $300 a year in premiums for private health insurance for needy families, with benefits specified. Needy families would be those with up to four persons at upper level who 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 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 all.

Administration spokesmen claim their proposal is better because (1) the Kennedy bill will actually cost $71 billion a year by 1974, when it goes into effect (a point in dispute); (2) the Nixon version would not run the health insurance industry; and throw away its experiences in administering benefits; (3) it would not, in effect, bend 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 issue 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 died by a 9 to 2 vote last year. This is a Social Security "major medical" proposal, costing an estimated $5.5 billion a year, picking up to 80 percent of hospital costs after the first 60 days and 50 percent of family medical care 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 Sen. Edward S. Muskie (D-Maine), Harris, Birch Bayh (D-Ind.), Hubert H. Humphrey (D-Minn.), George S. McGovern (D-S.D.) and Harold Hughes (D-SD)—to start national health insurance a major campaign issue as the nation moves toward the November 1972 presidential election.

## APPENDIX I

### NATIONAL HEALTH INSURANCE PROPOSALS AND THEIR ALTERNATIVES INTRODUCED INTO THE 91ST CONGRESS

<table>
<thead>
<tr>
<th>Bill Number</th>
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<th>Date Introduced</th>
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### APPENDIX II

**NATIONAL HEALTH INSURANCE PROPOSALS AND THEIR ALTERNATIVES INTRODUCED INTO THE 92ND CONGRESS**

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