NATIONAL HEALTH INSURANCE SCHEMES

PROCEEDINGS OF A CONFERENCE ON PROPOSED LEGISLATION IN THE UNITED STATES AND ON THE BRITISH NATIONAL HEALTH CARE EXPERIENCE

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A Look at Proposed Legislation in the United States and at the British National Health Care Experience

The Institute of Industrial Relations, University of California Los Angeles, has always attempted to sponsor conferences and seminars that deal with areas of current and developing interest. With at least eight national health insurance bills now before the United States Congress, this topic was chosen for close analysis and discussion at a one-day conference held in Los Angeles on October 7, 1971.

The purpose was to examine all of the proposed legislation and evaluate the various approaches, and at the same time relate our overall health care problem to the British experience in national health care. The Institute was fortunate to have Dr. D. Stark Murray, visiting lecturer from England, as the keynote speaker. Dr. Murray, a Fellow of the Royal Society of Medicine, is a consultant to the British Health Services and one of the world's leading pathologists.

Congressman James Corman, who has introduced one of the bills now being considered, came from Washington to discuss the Health Security Act, and Dr. Russel V. Lee, a pioneer in prepaid health insurance plans, came from Palo Alto to evaluate the various health insurance bills. Members of organized medicine and of the insurance industry presented their respective points of view.

The conference was sponsored jointly by the Institute of Industrial Relations, the Institute's Alumni Association, and the Southern California Association of Benefit Plan Administrators. Proceedings are now available for participants in the conference as well as all those interested in medical and health care plans.

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OPENING REMARKS AND INTRODUCTION

Peter T. Morse

Members and guests, ladies and gentlemen, good morning. I am very pleased to welcome you to this conference on National Health Insurance Schemes, which is being sponsored jointly by the Institute of Industrial Relations of UCLA and the Southern California Association of Benefit Plan Administrators.

We have just begun, and already it is time for our first commercial. Our Administrators Association was born here in Los Angeles some 16 years ago, when funds under joint labor-management trusteeship were in the infancy of their growth and development. It was designed to satisfy the needs of administrators for a meeting place where problems could be brought in for exploration and possibly resolution through discussion and realistic evaluation by other administrators familiar with like or similar problems. The Association flourished as funds proliferated and administration became increasingly complex. We now have some 45 active and associate members and our activities have become much more extensive and sophisticated, although we have never lost touch with the original objectives of the Association: the exchange of experiences and the interchange of ideas. We feel sure that many of you here now would be interested in membership in the Association, and we will contact all of the nonmembers in attendance today in the near future with an invitation for membership. Associate memberships are offered to those who are not actively engaged in fund administration but are active or interested in some peripheral area. That is the end of my commercial. Thank you.

We have on our program an impressive panel of speakers who will take a look at proposed legislation in this field and will examine the extent and probable influence of governmental intervention in our system of medical delivery, and we shall hear from our principal speaker of the experience enjoyed or suffered by the people of England when the practice of medicine became a socialized industry.

Among medical practitioners and medical plan administrators there appears to be currently an atmosphere of uneasiness, of apprehension. Perhaps this is mute recognition, especially since Medicare, of the failure of the profession to be able to deliver medical and hospital care at anything less than catastrophic cost in cases certainly of severe illness or extended hospitalization. Some kind of insurance against such economic catastrophy in one form or another is an absolute necessity today. Our society cannot afford to permit the entire gross income of a family for a year--or for two years and frequently more--to be assigned to pay medical expenses incurred in the treatment and care of a single accident case or major illness.

We have seen our counties and municipalities assume responsibility for treatment of some dread diseases and communicable diseases, perhaps for socially imperative reasons, but nonetheless the cost to the patient is tempered to some extent by ability to pay. The development of other medical programs, with the exception of Medicare, have all been optional, some haphazard, some unsatisfactory. The existence of group practice fee-for-service plans, prepaid HMO's with or without surcharges, Kaiser-type concepts, non-profit Foundations, all are indications that the profession is aware of an acute problem and is groping for answers.

Meanwhile, we are all conscious of the presence of the policeman on the street corner who is watching--the omnipotent, everpresent shadow of Big Government peering over the fences of our various sectors of private medical practice.

Now, there is little question that we who have investments in the private system of the delivery of medical care, whether as practitioners, suppliers, or administrators, tend to be prejudiced against government intervention. But that does not necessarily mean we do not recognize that in our country, as of now, proper health care should be the right of every citizen. Probably if the truth were known, we have all reconciled ourselves to the eventual passage of some form of legislation guaranteeing at least minimal starting benefits under a national health scheme to every American.

How will this fit into our American heritage of freedom of choice, of competitiveness, of personal independence, of an abhorrence of regimentation? Only time will tell, but it may well be that our society has

passed the point when people may be permitted the luxury of fending for themselves in these critical areas. Are we then looking at socialized medicine in some form, and if we are, is it an alternate or a substitute for private medicine? What will be the impact of national health security on existing institutions, on collective bargaining agreements, and on established health and welfare funds?

It is rumored that the Administration in Washington has a plan which recognizes and will correct three areas of inadequate coverage in present voluntary private health plans. These areas are: (1) the medical indigents; (2) the self-employed; and (3) the lack of adequate coverage offered by smaller employers. President Nixon would rely heavily on the existing health insurance industry, with adequate governmental supervision and controls over standards and costs but with significant surcharges accruing to the patient, and he would have the government foot the bill only for the poor.

Representing on the other hand what at this time appears to be the other end of the spectrum of health security plans is the Labor Bill--so-called because Walter Reuther originally outlined its provisions--now referred to as the Kennedy Bill in the Senate or the Griffiths-Corman Bill in the House. Sponsors of this bill consider President Nixon's proposal nothing more than a stop-gap measure totally inadequate to meet the critical condition of health care availability and delivery in our country, and have proposed a health security act with coverage so extensive that its estimated annual cost runs from 60 billion dollars to almost 80 billion.

Our speakers today are going to develop the subject matters I mentioned and undoubtedly a lot more. They are all outstanding men in their particular fields and I am sure you will be stimulated by their presentations.

Our first speaker is Congressman James C. Corman.

THE HEALTH SECURITY ACT

Congressman James C. Corman

Ladies and gentlemen, I am happy to be here today to speak in behalf of the Health Security Act, a new and far-sighted piece of legislation which represents a national commitment to expanding our health resources and improving our system for delivering health care.

As America begins preparing to celebrate its bicentennial in 1976, we, as her people, have every reason to be proud of her rapid technological growth and prosperity. But though we have conquered mass production and computerization and continue to successfully land men on the moon, we have failed to attend to those needs most basic to man's survival--the needs for proper housing, a good education, a clean environment, and the need for adequate medical care.

In spite of our sophistication and affluence, America compares poorly with other industrial nations in the field of health. Statistics sadly reveal that the United States ranks eighteenth in life expectancy for men, and that women in eleven other countries can expect to live longer than the average American woman. Infant mortality is greater in the United States than it is in twelve other countries and we rank seventh in the percentage of mothers who die in childbirth. More startling still is the realization that infant mortality among our nonwhites is twice that of whites, and that five times as many nonwhite mothers die in childbirth as white mothers. The picture is even more distressing as it portrays the conditions of the poor in America. The poor suffer four times as many heart conditions as those in the highest income group, six times as much mental and nervous trouble, six times as much arthritis and rheumatism, six times as many cases of high blood pressure, over three times as many orthopedic impairments, and almost eight times as many visual impairments.

The health crisis in America grows more serious each day. Health costs continue to rise faster than any consumer product, causing more and more Americans to be priced out of the health market. Fewer people, however, are being trained in the health professions, causing our manpower shortage to become more critical each year. And as the manpower shortage increases and it becomes increasingly more profitable to practice in large, urban areas, fewer doctors are attracted to caring for our rural and inner-city health needs.

Realizing that our present health care system is inadequate to provide for the health needs of all Americans and realizing, too, that it fails to operate in behalf of those it serves, it is inevitable that the system must change. We can no longer go along, as in the past, relying on a system that perpetuates waste and inefficiency. We cannot continue to modify an already inadequate system and expect to eliminate the health crisis that now exists. It is time we face up to the real challenge of the crisis and reform the system, making high-quality comprehensive health care available to each and every American.

The health crisis has emerged as one of the most important domestic issues in the country. Among the organizations which have formally recognized the health care crisis are the nation's governors, who at their annual conference more than a year ago called for national health insurance; the United States Conference of Mayors, which resolved for national health insurance in even stronger terms, and a growing list of consumer, labor, civil rights, health, and religious organizations. Leaders of our national government and medical and insurance organizations to whom the words "national health" and "national health insurance" were anathema have now enlisted in the cause of better health, or at least expanded their vocabularies. Most prominent among these groups is the work done by the Committee on One Hundred for National Health Insurance.

The Committee of One Hundred, as it is commonly called, was formed in November 1968 by Walter Reuther, the late president of the United Auto Workers. Joining Mr. Reuther on that Committee were outstanding citizens from the fields of medicine, public health, industry, agriculture, labor, education, the social services, youth, civil rights, religious organizations, and consumer groups. Over the past two years, the Committee has worked diligently to develop a sound program for improving the organization, financing, and delivery of health services to the American people, all the while consulting extensively with representatives of professional associations, consumer organizations, labor unions, business groups, and many other interested organizations. The Health Security Program is the result of these efforts, and it gives careful consideration to the recommendations of all these groups.

The Health Security Act is not a revolutionary proposal for reform--though some have called it that; there is nothing revolutionary about a program which is designed to care for the health needs of an entire population. Nor is there anything revolutionary about wanting to control rising medical

costs by putting health care expenditures within the confines of a budget. And it certainly isn't revolutionary to suggest the introduction of controls which will insure increased efficiency and better quality. Rather than being revolutionary, it is an evolutionary program which will meld all of the presently fragmented segments of the health industry into a system structured to serve the maximum number of people, at a reasonable cost and with the greatest degree of efficiency. To fulfill such a promise is indeed a big order, but I believe that doctors can be persuaded, if financial and other incentives are written into national health insurance legislation, to test, evaluate, and adopt better and more efficient health care delivery systems with built-in quality and cost controls.

The Health Security program starts with the basic proposition that health care is a right, not a luxury, and that the way to attain this right is through a financing mechanism whereby leverage is used to bring about a reordering of priorities, a strengthening of resources, and a restructuring of services. The fact that we are for health care as a matter of right means that all persons legally residents, will be eligible for the benefits of the Health Security program. There will also be buy-in arrangements including agreements for reciprocity for non-residents who are temporarily in the United States.

One of the most useful and valuable innovations of the Health Security program is the Resources Development Fund. Before the benefit program becomes operational, the Resources Development Fund will generate 600 million new federal dollars to improve and strengthen our health care system so as to assure the availability and effectiveness of the covered services when the benefit program begins. The Fund will increase manpower and resources and create new programs of organized health care.

The Resources Development Fund will also provide funds to stimulate the expansion of existing training programs for all categories of health professionals--especially those required as members of primary health care teams such as pediatric nurse practioners, physicians' assistants and dental hygienists. It will emphasize the importance of demonstration programs for the training and placement of allied health professionals and will provide support to meet the special costs to institutions of educating and training minority group students. Funds will also be available to provide stipends to medical and other health profession students.

With certain modest limitations, the benefits of the program are intended to embrace the entire range of services required for personal health, including services for the prevention and early detection of disease, for the care and treatment of illness, and for medical rehabilitation. The four limitations are dictated by inadequacies in existing resources or in management potentials; they deal with

nursing home care which will be limited to 120 days per benefit period except when the home is hospital-owned or managed;

dental care, which will initially be limited to children up to age fifteen;

certain medicines and appliances;

mental health services which have 45-day hospital limits and 20 psychiatric visit limits except when provided through an institution or organization.

Providers of health services will be compensated directly by the Health Security program while hospitals and other institutional providers will be paid on the basis of prospective budgets. Independent practitioners, including physicians, dentists, podiatrists, and optometrists, will be paid through a variety of methods. These include fee-for-service, capitation payments, payment through a medical foundation, by retainers, stipends, or a combination of these methods. Comprehensive health service organizations will be paid by capitation or by a combination of capitation and methods applicable to payments to hospitals and other institutional services, Independent providers, such as pathology laboratories, radiology services, pharmacies, and providers of appliances, will be paid by methods adapted to their special characteristics.

The financial and administrative arrangements proposed are designed to move the medical care system toward organized programs of health services, with special emphasis on teams of professional, technical; and supporting personnel. The Resources Development Fund--containing up to 5 percent of the total amount in the Trust Fund--will be available to support the most rapid practicable development toward this goal of strengthening and improving the nation's health resources. Federal law will supersede state statutes which restrict or impede the development of group practice plans. Thus, the program will do its best to assure increased availability of covered health services. It will not be content with merely contributing further strains on our already overburdened resources.

The Health Security program includes various provisions to safeguard the quality of health care. Under the program,

national standards will be established for participating individual and institutional providers. Independent practitioners will be eligible to participate only if they meet licensure and continuing education requirements, and specialty services will be covered, upon referral, if they are performed by qualified persons. Hospitals and other institutions will also be required to meet national standards and will be required to establish utilization review and affiliation arrangements.

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

The administration of the Health Security program will be concerned primarily with the availability of services, the observance of high quality standards, and the containment of costs within reasonable bounds. Policy and regulations will be established by a five-member full-time Health Security Board, appointed by the President with the advice and consent of the Senate. Members of the Board will serve five-year terms, and will be under the authority of the Secretary of Health, Education and Welfare.

Administration of the program will be carried out through the ten existing HEW regions as well as through approximately one hundred health subareas. Consumer representatives will play a central role in every aspect of the program's administration, and advisory councils with consumer majorities will be created at all levels of administration with every local office functioning as a consumer ombudsman. Technical assistance, planning funds, and development funds will also be available to consumer organizations to develop innovative approaches to the organization and delivery of health care.

The financial operations of the program will be managed through a health security trust fund, similar to the social security trust fund. One-half of the income for the fund will come from federal general revenues with the other half coming from a tax on individual income, employers' payrolls, and nonearned income. Each year, the Board, with the participation of the Advisory Council, will make an advance estimate of the amount available for expenditure--to pay for service,

for program development, and for administration--and will make allocations to the several regions. These allocations will be subdivided among the categories of services and designated for the health service areas, with participation by the advisory councils. Advance estimates, constituting the program budgets, will be subject to adjustments as may become necessary, in accordance with guidelines in the Act. The allocations to regions and to service areas will be guided initially by the latest available data on current levels of expenditures.

Before I end my remarks and open the discussion for questions, I would like to speak briefly on what advantages the Health Security program offers the American consumer and compare it to the health reform plans of the President and of the American Medical Association.

Under the present fee-for-service system, a patient must pay for his health services as they are administered, leaving the wealthy with easy access to quality health care, the very poor with access to care of questionable quality through Medicaid, but causing wage earners of very modest means to enjoy little or no health care because of their inability to pay. This is a particularly acute problem for the person who makes slightly more than the poverty level. For him the inequities of the system are glaring: while the non-working man on welfare is given some medical care with the good conscience of the government, the man who earns slightly more than the poverty level may be working his tail off and still not be able to afford the health care he and his family need.

So what does the Administration do for those people who work hard, earn very little money, and do not have access to medical care? It makes it compulsory for their employers to buy them insurance policies. Well, this may solve a part of the problem, but think about what is happening in the insurance industry and any of those areas where government has said they will have to buy. It gets expensive. For example, look at auto liability insurance. The insurance industry doesn't really produce money it just spends what it takes in. It can, if you give it policing power, affect what things cost. But that puts the industry on a head-on collision course with the medical profession. And, so, if we try to solve the medical needs of those people who are just above the poverty level, we're going to find either that the insurance companies have to keep them at a very limited amount of coverage or the costs are going to be astronomical.

When I say astronomical, I really mean that because it is found in the Medicaid, say, the Medi-Cal program, that it costs much more to pay the medical bills for the poor than anybody would have believed. I think you'll find this same experience for the next level of people.

With its complicated array of deductibles and co-payments the Administration's bill apparently is attempting to deal with the so-called "overutilization" problem, that is, the problem of how to keep people from going to the doctor when they don't need to. The answer, they say, is to make people pay a portion of the costs. Fix the figure as something that would make them think twice before they run to a doctor. The trouble is, this doesn't work for people in my income bracket or, probably, yours. For $8 or $10 I may well see a doctor when my throat tickles; it doesn't make that much difference to me financially. So they have to make it higher for people in my income category. But if you think of some woman who's trying to support three children in Los Angeles on $200 a month, and her rent is probably $120 and she has to feed them and put shoes on their feet, then you don't have to charge much out of what's left to shy her away from seeing a doctor. This is a very tough problem, because we must then determine who we are keeping away from health care and whom we may want to keep away. Generally, if a person gets there in the early stages of an illness, it will not wind up costing as much as when he waits.

The Administration's bill creates another, related problem. Those of us who have worked with Medicaid or MediCal know that it is hard to get the man out of the category where he is eligible. He can work this week and earn $100, but if he does, he'll be placed in an income bracket where he is no longer eligible for medical care. Then, suddenly,he's scared to death, because if he gets sick, he can't get free care. He, naturally, decides it's better not to work. And that is a problem of public assistance programs.

But the Administration says, well, the answer to that is easy: make everybody spend themselves down to poverty and then let them go. Now, literally, that is the proposal the Administration has. It would solve the notch problem,but the dilemma can be illustrated as follows: assume a woman is trying to work and support her children. She makes a hundred dollars a week and that's $6400 a year, well over the poverty level. One of her children gets sick. The social worker looks over her income and says, "Well, you're going to have to pay the first $1200 of the bill. After that, I'll give you a card that enables you to go to a doctor for free." That's great , except where does she get the $1200? That says enough, I think, about the drawback.

In contrast, the Health Security program would benefit the rich and the poor the black and the white the old and the young the urban dweller as well as the rural and citizens from business and labor alike. It is a system which knows no special-interest group, a system designed to benefit all of America.

To show the contrast of the two systems even more sharply, compare the benefits available to an average worker under each system. A $7,000 a year wage earner would pay $70 a year in payroll taxes for health care under the Health Security Program, despite the costs of his health expenses, but under the Nixon plan the same worker would be required to pay 35 percent or about $100 of the premium for his health policy, plus a $100 deductible for doctors' bills, plus the first two days of any hospital bill, plus 25 percent of every additional cost up to $5,000. A worker with a $5,000 hospital expense under the Administration's plan would be obliged to pay $1,800 of the total bill, a figure representing 25 percent of his salary for the entire year.

In addition to easing the burden of paying for expensive medical care, the Health Security Program will make important reforms in the delivery of health care services. Unlike private insurance coverage which primarily contributes to the increase in the cost of treatment, the Health Security Program will offer incentives for the prevention and early detection of illness, thereby encouraging doctors to keep patients well and easing the overburdening demands now being made on our hospital facilities.

The Health Security Program will also ease the demands made on individual doctors by encouraging the establishment of group practice organizations and emphasizing the importance of expanding our allied health professions. Under a group practice arrangement, the average physician could care for 1200 patients a year in contrast to the 650 he now serves under the fee-for-service program. This more efficient use of medical manpower will increase the average doctor's availability, which will be a blessing to every housewife who has tried to get an appointment for a sick child only to learn that the doctor is booked for the next two weeks.

Turning to the American Medical Association's plan, it is one which would give some tax credit for the insurance in payment of the doctor bill. Tax credits appear irresistible because people don't really have to spend any of their own dollars--they just deduct it from their income tax. This is a fine proposal if you're not interested in making any sense,

because we all know that if you're taking home $125 a week you're not paying enough in taxes to get all the tax advantages that come to the wealthier person. But another problem with the tax credit approach lies with Congress, which is adverse to solving anything through the use of such a device. This is for good reason: if you use tax credits often enough you find out that there is not enough money in the treasury to run the government--and money is in short supply in Washington, both at the federal level and in the Corman household.

My main task here today is an an advocate--an advocate of National Health Security. I am not here as a negativist. I offer for your consideration National Health Security. It is a health program, rather than a sickness insurance program. It is an American program. It builds on top of what we now' have. It is an idea whose time has time. I can think of no better way to celebrate this nation's bicentennial than to make it a dual celebration commemorating both our independence as a nation and our elimination of the health care crisis in Amerika. I am confident it can be done and I urge you to join me in working for the enactment of this vital legislation.

THE OUTLOOK FOR PROPOSED LEGISLATION

DISCUSSION

Floor: Will the hearings be regional or just in Washington?
Congressman Corman:

No. The House doesn't have hearings in the field. Kennedy has the field hearings for his bill. We'll have all our hearings in Washington. I might say that if any of you can testify in Washington, particularly if you have some expertise, we could probably arrange that. Beyond that, if you have testimony that you want to get in the record without appearing yourself, we can arrange that, too. We will have all 25 members of the committee read it; the committee is a tough one, you know.

Floor:

Congressman, earlier in your speech, you said that regardless of who paid the bills the medical costs were somewhere in the area of seventy billion dollars, and you said that who paid it didn't change the amount of it. Later, in a couple of instances, I think you pointed out that who paid it sometimes made a substantial difference in what the cost of the service will be and the volume of services received.

Mr. Corman:

Yes sir, that's true. You get great arguements among people who are in the field as to how to deliver high quality service, and secondly, a quantity at a price that the American people are going to pay. The Kennedy-Griffith bill anticipates that there would be some government regulation as to cost. The point of departure is what it is now, and from that point on you work your way out on how you can get some dollars and man power available for services and so forth. But most people will concede that medical care is in short supply.

The other thing that's tremendously important, of course, is that no matter what the people in the field do to hold the cost down, the cost of medical care is getting much much more expensive because doctors and researchers are finding out how to do some nice things to prolong our lives and they may be terribly expensive. These are things that ol' Doc Brown never had to face, you know. He never had to decide whether or not Mrs. O'Toole could afford a kidney machine. Doctors today have to make those very hard decisions. David Frost wrote a

cute little book. If you have to travel on an airplane, it's the kind of thing you can pick up and throw away. It's a book on the English, and he was pointing out that in England the doctors have replaced the priests because most people have kind of conceded that we really are mortal, not immortal. So the great concern is not how can I meet my maker, but how can I stay here longer? The doctor has the key role in our society. I always say, you know, when making these hard decisions about how much do you really invest in a human life who is probably not going to be around a great deal much longer anyway, I say that when it comes to mine, let expense be no concern.

Floor:

Does it matter who pays? Roughly, we're putting out some seventy billion dollars. Now, this is put out from our own private pocket and in the premium in the health insurance. Now, under the Corman-Kennedy bill, where is the middle man? Would the changers be eliminated? Would there not be some savings?

Mr. Corman:

Well, you could get a real debate. If they'd spend it more efficiently, yes, it's my own feeling that there would be some savings. But I said that our medical bill would probably be higher. There are a certain number of people in this country who need medical care and are not getting it at all. If you set up a system in which you give them access to doctors or access to the hospital, then it's just going to cost us more dollars. They are out there, you know, living in a rural area in Mississippi, or Harlem, and they weren't an expense to anybody, they were going to die without ever having to go do a doctor. But suddently we're going to be concerned about them, too, under this program. If you follow the program, it gives everybody in the country access, and the costs will just have to go up because there are a lot of folks who are going to need it. Now, we want to get some kind of control so that it doesn't go all out of proportion and we are trying to, first of all, develop mechanisms to prevent overutilization, mechanisms which make the doctor reasonable in what he decides his services are worth, and make more hospital beds, more doctors available, more kinds of medical care, and use paramedical people. Now, a $50,000 a year doctor does the things that maybe a $15,000 a year technician could do. I believe the doctors are upset, because they say, "Well, you know, you're really going to it; you're going to have a high school graduate take over." Not at all, but there may be many things that can be done in that field.

The other thing--and this is highly debatable--I come down on the side of group medicine on what I learned about it. That is, if you have a more efficient system of delivery, group practice, particularly in areas such as this where you have a whole lot of people tied to the plan, then you can deliver medical services cheaper. And so that's the way we hope to get a little bit of a handle on it.

I don't mean to understate overutilization. I think there are a lot of people who go to the doctor now who are overutilizing. They can send the doctor a couple of bucks a month, you know. But he doesn't have to do what you say, either; overutilization also results when the doctor is willing to let the patient overutilize his time.

Floor: Do you think that group practice will increase preventive medicine on the part of the doctor?

Mr. Corman:

Yes sir. That's the big thing where group practice, we hope, will get a handle on costs. Now group practice is on a capitation basis. A group of doctors, together with the kinds of facilities that you need for medical care of hospitals, nursing, psychiatric care--they get together, they say to the government, "for $300 a head we'll take care of this block of people." Now, under this bill that block of people couldn't be selected out. They couldn't say, "Well, we'll take care of all the 22-year-old females..." Well, anyway, they couldn't say that in a given area, They have to say that they'll take care of the total population, young, old, sick, well, for so much. You can get some competition at that point,possibly, but then you're going to make some profit based on how little that health care costs. So, the theory is that they do preventive care, they do minimize the expense to the group by tring to keep people well instead of profiting only when they get sick. And so we hope that will make a difference.

Floor:

As a member of the Ways and Means Committee, could you give us an estimate as to whether any bill will come out in this session of the Congress, or must it await a mandate in an election in 1972 where you get any kind of a thorough revamping of the services?

Mr. Corman:

There will be no thorough revamping at all this year. There will be, I believe, in this Congress which, of course, is at the tag end of this year and all next year, there will be some revamping of the relationship between the federal and the state governments in handling the medical care. And

there may be some catastrophic illness legislation. That is as far as the Congress is going to go. Trying to be as realistic about a program that is as comprehensive as this one, you know, we know that this precise plan will not come out. But if you think about some very dramatic change in the total system, I think it's either two years or six years away. It will not come to pass until someone who runs for President makes that a part of his platform and is elected. Now, we talked about Medicare--taking care of the aged. We talked about that for a decade. We adopted it in Congress when a President ran with that as a part of his platform and enough Congressmen ran with him who also had done that. And do that policeman on the street who stands and watches really is the American public. Obviously, you know, you don't vote for a President just on the basis that he's for this or he's for that. The system really does work slowly, but it works. When the American people decide that this is of real concern to them, then they'll do something.

Floor:

One of the problems is that you might have the money, you might have these wonderful plans, but implementation is another matter. What can you do to get doctors to take people on Medi-Cal? I'm sure that you're quite aware that you're quite aware that we have a handful of doctors serving 117,000 people. You can go to some and they'll say, "Oh, you're on MediCal. We won't take you." What are they going to do about this?

Corman:

Well, first of all, the Kennedy-Griffith bill would remove from the doctor's consideration this limitation. We are on short supply of doctors. We need more and I suppose there's no real answer about getting a lot more doctors and we need more hospitals. But at the moment, you know, the doctor who has the consumer out there who wants to do business with him, he has to make a very hard decision. "Do I want to help this patient who can give me a very limited amount of dollars? He was recommended by the other people who had a family doctor because the doctor wouldn't take care of him."

The other thing that doctors will tell you, I'm sure, is that they don't like to handle MediCal patients because the state intervenes as to what kinds of service they can render. And that's terribly unfortunate. I don't know the answer to that one. The state says that they must intervene because doctors are making too much money and that they're offering services that aren't needed.

And the doctors say, "Well, we've got lots of sick people to take care of. We want to use our own judgement as to what they ought to get. And if you're going to take this group of patients and say that we've got to get the authority from Sacramento, we're not going to fiddle with this." Of course, under the very comprehensive program the doctor could decide to take people on whatever criteria he tries to use. He can take the people who he thinks are sick and he can do the most for them, because whether you're indigent or you're making $50 a year, under a compulsory national health insurance law he'll be compensated the same irrespective of which group he treated.

Floor:

Yes, I'm interested on behalf of government employees; does this bill intend to include all citizens? Now, the reason I ask is this: Senator McGee introduced SB 1424, which would provide the same type of care to government employees only to those who are now participating under the health benefit act of 1959. This covers approximately 8 million employees and families. Now, if your bill goes through, what happens to the McGee bill?

Mr. Corman:

There will be no need for it. He thinks he has some opportunity for improvement because we're not going to have a comprehensive compulsory health insurance right away. I think we're going to have one some day, I guess maybe ten years from now. In the intervening time, we have to take care of catastrophic illness. The employer, the government employer has a responsibility to his employee. Unions have to keep on negotiating for more comprehensive plans also to keep the whole thing going. But if we get to the compulsory national health insurance, then there will be no fragmentation to the consumer. There will be no need for Medicare, there will be no need for county hospitals, all of those things. There will be a very dramatic comprehensive change, and it will go through all kinds of drawing stages. I think perhaps it's easier to go to the totally socialized medicine concept. Now, if you're a nice young country like Israel and you start cut with the plan, it works great. And I guess if you're England and you're not too big and there's enough of a social pressure, it works. But here, it will be a very complex thing to do. I think that health insurance can do it.

Dr. Lee:

I have one more thing to say in reference to that. If the Corman-Kennedy bill passes, the demand for medical services will undoubtedly greatly increase. We know that for sure. Rendering these services is already deficient. I would propose that we give serious consideration to improving the capability of rendering services. And the way to do this is with hospital-based group practice with capitation payment; that is, the patient is controlled from overutilization. You can almost double the capacity, the number of people, that the doctor can take care of in this system. Why don't we concentrate on that aspect at this time. Then, if you have that, it'll be ready for your committee to offer administration of it.

Mr. Corman:

Yes sir. I appreciate the comment. We've just made a change in Medicare to permit that. I think it's substantially improving the utilization of what we already have. Yes, 5 percent of the trust fund would be used to expand available in-services. It's a variety. I'm sure you'll have other speakers that will argue this point. Thank you all very much. I'll see you later.

THE HEALTH INSURANCE APPROACH

Eugene M. Lyons

The health insurance approach of which I speak today is one of several legislative proposals being brought forward in Washington. Usually the proposals are talked about as "national health insurance," but in fact, the problems and issues go far beyond the financing implied by the word "insurance." Indeed, they go to the very heart of medical and hospital practice and manpower, and the solutions will change the structure and organization of the entire delivery system for personal health services.

It is anybody's guess whether or not we will see action on some type of broad national program in the current Congressional session, although measures to deal with specific problems, such as manpower, are well along the way. In any case, it appears that the current debate about the future of the nation's health and medical care system is narrowing down on two questions: (1) Will government take over the entire responsibility for the nation's personal health care delivery system, both in administration and funding? Or, (2) will there evolve a program using the best that now exists in both public and private sectors, with federal funds and regulation used only where critical and necessary in the public interest.

Of course, we in the insurance industry favor the latter possibility. But we know fully well we won't have our way just because we want it. We must have a competent program and must convince the country it is preferable. To this end we in the insurance industry have developed and set forth a national health program. This comprehensive and integrated series of major proposals is named Healthcare and has been introduced as legislation.

The Healthcare legislation, of which I shall speak, has the endorsement of not only the Health Insurance Association of America but also the American Life Convention and the Life Insurance Association of America, which collectively represent more than 500 member insurance companies providing some 90 percent of the private health insurance underwritten by insurance companies in the United States.

Healthcare was put together by a special task force of the Health Insurance Association of America which included a broad spectrum of industry and nonindustry persons. The proposals now have the full endorsement of many organizations in and out of our business. In passing, I might point out that the joint ability of the several hundred competing insurance companies to agree to not only the name but the principles was in itself a significant achievement. Healthcare's five "principles" stand as somewhat of a landmark in industry cooperation and concordance. These five principles are:

1. Every American should have access to quality health care regardless of income.

2. The nation needs a new health care system which combines the strengths of our present system with new programs, reforms, and additions, where the present system, for one reason or another, does not meet the nation's needs.

3. Such a new system should make maximum use of the private sector and judicious use of government funds.

4. The nation should make comprehensive health insurance coverage available to all of its people at the earliest date consistent with the availability of health care services.

5. Action should be taken simultaneously to improve the organization and delivery of health care and to improve the financing of health care.

As a fundamental premise, the concept of any proposed legislation must be viewed in the light of the perspective that influences its creation. Permit me to share with you the issues which were identified that formed the perspective and concept of Healthcare. These issues were identified and isolated as major considerations through extensive search and dialogue with highly qualified sources representing numerous segments of our society, including the health care professions. Our Healthcare legislation supports the fact that we have a strong health care base on which to build--a base that, by relative standards throughout the world today, is achieving results of quality medical care that epitomizes leadership--but it is nevertheless a base which, in our judgement, needs change to foster significant improvement in the level of care available to every citizen.

There are five major problems within our present-day health care system that require solution. These are the same problems causing concern to "Mr. Average American," regardless of his political affiliation or economic status in our society.

1. Cost of health services. We all know we have runaway inflation staring us in the face (and it will certainly require more than a 90-day wage price freeze to control). Some of this inflation during the recent eight to ten years has been caused by escalation in the costs of personnel, cost of facilities, and cost of new equipment and methodology for treatment of serious types of disability. The remaining cost problems are associates with waste, inefficiency, overbuilding, emphasis on institutional care (the most costly type of care), and the absence of any plan for public accountability.

2. Manpower. We are aware of significant shortages in all types of health care services manpower, the maldistribution of available manpower, and the lack of incentives for improvement of productivity of that available manpower.

3. A lack of effective planning, for influencing expansion of facilities and encouraging change and innovation in the delivery system to truly satisfy the requirements of local community need.

4. Gaps in health insurance protection. Insurance policies are lacking in provisions to encourage health maintenance, development and utilization of ambulatory facilities, methodology for their availability to the poor, near-poor, and to uninsurables.

5. Lack of health facilities in the inner city and certain rural communities.

These five problem areas have created the overwhelming pressures for federal legislation which has resulted in the number of proposals we see before Congress for its consideration.

The HIAA Healthcare legislation before Congress has been introduced in the House of Representatives by Congressman Burleson under HR-4349, and in the Senate by Senator McIntyre under S-1490 as the National Healthcare Act of 1971. It addresses each of these five problems of our present health care system.

I'll relate briefly the five action programs contemplated by Healthcare.

Program I: increase the supply and improve the productivity and distribution of health manpower. This is to be accomplished through: (1) Appropriate expansion of federal aid programs for health manpower training and development, along with implementing program consolidation, coordination, and increased efficiency; (2) Improving student loan programs with built-in financial incentives to encourage service in the inner city and rural areas; (3) Provide federal grants to schools to spur training of personnel for ambulatory care and administration of ambulatory care centers; (4) Meet immediate needs through a temporary federal grant program to professional personnel agreeing to serve the next 5 years in areas most critically short of services.

Program II: develop ambulatory health care services. Current and future health resources must be distributed more equitably and effectively. This is to be accomplished by reinforcing the key role and authority of state and areawide comprehensive health planning agencies through: (1) A substantial increase in their financial support; (2) Enlarging their responsibilities to include setting priorities on community needs with emphasis on coordinated health care programs and health education of the public; (3) Certifying as to need for all applications for federal grant, loan, loan guarantee or other government aid for construction or major renovation of health facilities.

Program III: more directly contain the escalation of health care costs and upgrade the quality of health care. This is to be accomplished by: (1) Basing all federal loans, grants, or contracts for a health facility or service on certification of need by a comprehensive health planning agency; (2) Base payment for health care under federally supported programs on prevailing fees and on peer review of those professional services that fall outside of professionally established guidelines assuring appropriate treatment, quality of care, and reasonableness of physicians' fees; (3) Payments to hospitals and other health care institutions under federal programs based on a system of prospectively approved charges.

Program IV: establish national goals and priorities to improve health care. This is to be accomplished through: (1) The President reporting annually to Congress on the State of the Nation's health at the federal, state, and local levels with proposals to improve the organization, delivery, and financing of health care; (2) Congress creating a Council of Health Policy Advisers in the Executive Office of the President--such Council to assist the President in preparation of his report, monitoring and recommending change or consolidation of health-related programs, conducting research, providing guidelines for funding allocations, and developing recommendations for national policy to improve the organization, financing, delivery, and quality of health care.

Program V: improve the financing of health care for everyone. This is to be accomplished by: (1) Federal standards for minimum ambulatory, preventive, and institutional care benefits; (2) Phasing in of benefits on a timetable basis; (3) Use of existing private health insurers including insurance companies, Blue Cross-Blue Shield, and prepaid group practice plans to provide benefits; (4) Federal income tax incentives to help assure that comprehensive benefit levels are maintained under private group and individual plans; (5) Establishment of state pools of private health insurers to provide standard benefits for the poor, near-poor, and those who are uninsurable for health reasons, with those benefits for the poor and near-poor being subsidized by federal and state funds.

Comprehensive health insurance would be made available to all, with the scope of benefits expanded periodically as the capacity of the health care system is enlarged to meet the increased demands for health care generated by the new benefits. The problem of two-class medicine would be alleviated, because the poor, with the aid of government subsidies, would be participants in the same system as those who can provide for themselves.

In short, our program deals realistically with the problems of the existing system. It builds on its strengths and introduces changes in those areas where change is needed. As its primary objective, Healthcare seeks to make quality health care accessible to all. And it proposes to do this by changing the organization of the delivery system, and increasing its capacity by introducing solutions to the special problems of the poor and near-poor, and by making comprehensive health insurance available to all.

The Healthcare approach preserves the pluralistic approach to both the delivery of care and the financing of care. It rests upon broad-based involvement of consumers and communities, and it preserves competition and with it the incentive to experiment and innovate. It is an affirmative and constructive response to these calls for involvement. It speaks not from the motivation of narrow self-interest nor of mere survival of an important segment of our business. Rather, it speaks from a wealth of experience, knowledge, and concern with the public interest that is being brought to bear on all aspects of the problem--not only on the financing element, but also on the vital components comprising organization and delivery of health services.

We have important resources that can be mobilized to create a "total system" for furnishing health care where it is needed, when it is needed, and to everyone who needs it. We know a good deal about the underlying reasons which account for the frighteningly rapid rate of increase in health care costs, and from experience we know much about the mechanisms that could be effective in bringing this increase under control. We are ready, given the proper legislative and public backing, to effect strong controls.

We have learned a lot about cooperation between government and private industry through our participation in the Medicare and Medicaid programs, and through involvement in community health planning. We are prepared to be even more creative in expanding that cooperation. We are in a position to extend our services in the health care field beyond the confines of insurance as such--for example, through the development and financing of community health centers--and we are ready to proceed as soon as we can see how best to do so effectively and soundly.

Healthcare is an affirmative and workable approach to a pressing social need. It draws upon America's unique combination of private interests and public enterprise in a creative and evolutionary fashion. It rejects any stultifying, monolithic all-government program, for experience demonstrates that such an approach inevitably will tangle the individual and family in bureaucratic red-tape. Such a bureaucratic structure, impersonal and resisting innovation and responsibility, stands in sharp contrast to the Healthcare proposal which has within it the relationships and principles that have given this nation a high degree of achievement in all its institutions.

But to suggest to the American public that we have been near perfect in our part of the present medical expense-hospital insurance system would be folly indeed. Our achievements are many, and our response to public needs has in fact been the single most important channel of funds into the system, helping to keep it alive and functioning. But have we controlled costs? Not much. Have we kept hospital and doctor bills down? Not enough. Have we been the "policemen" in the system? No, we haven't. Neither has government, nor have hospitals, nor doctors, nor the Blues. Nevertheless, the brunt of criticism from those who would have an all-government health mechanism is leveled largely on insurors.

Healthcare deals realistically with the problems of the existing system, building on its strengths and introducing important changes in a carefully planned manner in the many areas where change is needed so as to achieve the primary objective of making quality health care accessible to all our people. Let us keep in mind these aspects of Healthcare that are easily overlooked or taken for granted, namely, that the great portion of the industry-backed legislative program can be implemented now! That the cost to government would be a fraction of what an all-government mechanism would require. That in Healthcare we endorse and enhance those elements of enterprise that in fact are the bulwarks of the nation itself. That responsibility and innovation are major elements in our commitment for a viable health system.

We of insurance have our work cut out for us. Healthcare is not a job to be left to others or to be put off while we take care of "more immediate" matters. We are ready to move ahead to build the kind of health system that the American people need and deserve.

WHY ORGANIZED MEDICINE FEARS GOVERNMENT INTERVENTION

Marvin J. Shapiro

I would like to start by very sincerely thanking the organizers of this conference for including someone speaking for organized medicine. Those of us who are active in organized medicine are very conscious that for years conferences, committees, and convocations convened to study the problems of health care and health care delivery have conspicuously omitted us. Many of us understand too well how this has come about.

We recognize that there has been far too much justification for the attitude that organized medicine is a collection of self-serving trade associations with little interest in solving socio-economic problems of health care, and therefore with little to contribute to possible solutions. We sincerely hope that the recent trend toward including organized medicine--as today--indicates an awareness on the part of the general community and particularly of those directly concerned with health care delivery and its problems that organized medicine is changing. I can assure you that the California Medical Association, for a good many years, has been primarily a problem-solving, goal-oriented group, which recognizes that there are real problems and is anxious to contribute to solutions which I believe it well qualified to do. This does not mean that we don't still have those who are oriented toward trade-association thinking. But please believe that their noise is much greater than their influence. I also believe that the AMA is steadily--though perhaps slowly--moving in the same direction, and I believe that it has now moved far enough so that representatives of the AMA should be included in any planning for further government intervention into health care. I think that AMA representatives can make significant, positive contributions and that their input is essential to the development of sound programs.

I suspect that your interest in the innerpolitical workings of the AMA is somewhat less than profound. However, if you will bear with me, I think just a moment on the subject may help clarify subsequent remarks. I think we can all agree that no one speaks for the physicians of the United States, but I do think it should be recognized that it is organized medicine--that is,

the AMA and its component societies--which comes closest to speaking for the majority of physicians who are actively engaged in the care of sick people. The great majority of these are not unreasonable men and recognize that problems exist.

Unfortunately the position of the AMA is skewed. The AMA is under constant pressure from groups of doctors whose philosophy is considerably more to the right than that of the AMA, and also from groups of doctors whose philosophy is considerably to the left. And unfortunately, those of the right have stayed in the AMA and are organized around a splinter group, called The Association of American Physicians and Surgeons. As is not unusual with those of extreme views, they are well-financed, superbly organized, and very very noisy. That their influence on the great mass of middle-of-the-road physicians is out of proportion is not surprising, particularly when one recognizes that those who are more to the left--by which I mean at least liberal--have largely dropped out, are no longer members, or never were members and therefore are not available to provide some sort of balance. Many of the more liberally oriented physicians are employed full-time in universities, public health departments, or closed panel groups. They are eligible for AMA membership and are sorely needed within the organization. As the credibility of the AMA increases in Washington--and I believe it is increasing--their influence within the organization becomes critical.

What, then, is the AMA position on further government intervention into health care? The relatively small group centered around the AAPS aside, organized medicine's fear of government intervention is not fear of the fact but fear of the form. Many practitioners and most leaders of organized medicine have learned to welcome government intervention. I'll not catalog the many forms of government involvement in medical practice which have long been accepted and still are, but I would point out that the overwhelming majority of doctors have learned to accept and welcome Medicare despite the record of the old AMA. We have many reservations about Medicaid-Medi-Cal, but at least in California these are largely on the basis of the way in which the program has been administered and I rather suspect that many of you have the same objections. The California Medical Association was instrumental in the original passage of AB5 and has struggled continuously with the administration--

albeit with limited success--to try to see that the program is run in such a way as to accomplish its original objectives. I think the majority of doctors and the majority of leaders of organized medicine favor national health insurance and look forward to its enactment. We do have some very profound fears as to the form it may take and I ask you to believe that our fears are not based on self interest but in the interest of a successful program.

The AMA and the practicing physicians it represents having lost credibility in Washington, legislators and administrators have turned elsewhere for advice--for input. Sociologists, public health doctors, economists, union officials, and doctors full-time in academia seem to have had the confidence of the authorities who develop and administer health plan programs. All of these groups have contributions to make, but they cannot provide the critical input which can come only from those of us who actually care for the sick. Our particular concern is that those who have been heard espouse certain principles and alleged facts which we do not accept, which we believe unproven, and which we believe should certainly be more thoroughly and intelligently investigated. Our fear is that if government health programs are organized with these principles accepted and without the advice and experience of the practitioners, they will be poor programs. We fear that such programs would be far more expensive than they should be, that they would not provide the level of health care we all desire, and that therefore before long the programs themselves would be jeopardized.

For instance, the attitude toward co-payment: I'm a diagnostic radiologist in private, fee-for-service practice, and I would estimate that well over half my practice represents unnecessary work done at the insistence of the patient or because the referring doctor thinks he is protecting himself from a possible malpractice suit. I hasten to add that when I was chief of radiology of a large, closed-panel, prepaid health care plan with salaried physicians the percentage of unnecessary procedures was significantly higher, and that in that context very few patients paid anything at all for x-ray studies.

Co-payment is said to be a potential obstacle to needed care--which we concede; but we believe that any program without co-payment to control patient and

physician overutilization would be destroyed by excessive costs. The theory has been advanced that co-payment does not control overutilization. The only evidence I've seen is a study by Kaiser, in which comparable groups with and without a one-dollar fee for office visits had essentially the same number of office visits. Perhaps this proves that co-payment is not an effective control. I think it proves that when people with the income of employed union members think they need to see the doctor, one dollar is no deterrent.

On the other hand, the experience of the federal employees program should be considered; 1.6 million federal employees are and have been covered by Blue Cross-Blue Shield. Until 1968, outpatient diagnostic laboratory and x-ray services, except those related to accidents and surgery, were covered under the supplemental rather than the basic part of the program. Beginning in 1968, these services were covered under the basic part. The only change was that under the supplementary there was a 20 percent co-insurance factor; under the basic, total coverage. In 1970 there were 720,000 outpatient radiological claims as compared to 141,000 in 1967--please note that the number of individuals covered was essentially the same--which represents an increase of 410.6 percent. The dollar amount rose from 1.9 million to 15.7 million or 726.3 percent. Outpatient diagnostic laboratory claims rose from 64,000 to 1 million, up 1,452 percent; laboratory costs rose from 1.5 million dollars to 18 million dollars, up 1,100 percent.

There may be other factors involved, but the primary cause of the explosive increases in utilization must be considered to be the dropping of the co-insurance unless very careful analysis can prove otherwise. We think a sliding scale of co-insurance tied to family income is essential to the success of any national health insurance plan. Our fear is that we may not be consulted, that the present, established position may prevail, and national health insurance may be enacted without co-payment. If the federal employee figures do indeed indicate what happens without co-payment and if one extrapolates from the dollars involved in outpatient diagnostic laboratory and x-ray services for 1.6 million people, disaster might well be predicted.

We do not accept the oft repeated charge that the United States does not have a health care system, but believe we have several parallel and suitably competitive approaches which need to be improved and which need to be better interrelated to provide health care for all the people; which, I guess, could then be called a single system.

We do not believe that closed-panel groups can deliver an acceptable level of care for significantly less money. No convincing evidence has been presented that this is so. Comparisons involving the bakery truck drivers in San Francisco and comparisons involving Medicare patients in the Bay Area definitely tend to indicate that it is not so. Much more careful and complete studies including the out-of-pocket costs of closed-panel members, in addition to their premiums to the closed panel, must be carried out before any such figure as 30 percent cheaper can possibly be accepted.

We have great reservations about the value of testing and examining healthy, asymptomatic people. The theory that by so doing disease will be discovered at a stage when it can be cured or when it can be treated with less expense is beautifully logical but it is far from proven except in a few specific instances such as Pap smears for carcinoma of the cervix. Objective evaluations dealing realistically with cost effectiveness are needed and practitioners should be included in the design of such studies.

Attitudes toward and around fee for service are another of our concerns. Fee for service has been attacked as motivating physicians to overutilize health services--which is true. We believe there are those with credibility in Washington who desire to eliminate fee for service totally, leaving all physicians employees of groups or the government. But since the form of organization which they would substitute--that is, closed panel with salaried physicians--has a built-in powerful motivation to deny service, we believe such total elimination of fee for service would have tragic results for the health care system.

The fundamental problem is one of motivation. We grant that fee for service motivates physicians to overutilize, but we believe that the profession can develop satisfactory controls if given the opportunity. The

rate at which physicians' fees for specific services increases is already well-controlled. The rate has almost exactly parallelled the service component of the cost-of-living index for several years, and this aspect we no longer consider a real problem. Overutilization of number of services is more difficult to control, but we feel we are making progress and believe that this too can be dealt with. Blue Shield of California is just now instituting third-generation computer programs which will instantly indicate unusual practice patterns of any California physician. Possible overutilization will be spotted and referred to the review committee in the area where the man practices. Lest you fear that local peer-review committees might tend to whitewash, as they have in the past--I can tell you that CMA has established a statewide peer-review appeal mechanism. If Blue Shield, Blue Cross, a commercial carrier, the Social Security Administration, or the Department of Health Care Services is dissatisfied with the work of the local committee, they can--and at least in the case of Blue Shield I can assure will--appeal to CMA. I think we can count on the CMA committee being fair, objective, and tough.

We recognize that whoever finances health care, whether it be the government, a union, or an individual, needs predictability of cost. We believe this is best achieved through prepaid comprehensive coverage with the individual physician paid on a fee-for-service basis. Organized medicine thinks this method of health care delivery should be maintained.

Very little has been said or written to indicate <u>why</u> organized medicine believes that fee for service should be maintained. I think we should be able to agree that the academic obstacle course being what it is, physicians are a highly selected group. They tend to be individualistic, aggressive, and of considerably more than average intelligence. But, as in any other group, there are great differences in desire to work, capacity to work, enjoyment of work. Economic status varies; some doctors even have rich parents or wives. Under the fee-for-service system, the doctor who wants to work and enjoys working 60 to 80 hours a week is free to do so and is rewarded in terms which are appropriate to our capitalistic society. We see nothing wrong with this. Equally we see nothing wrong with the doctor who chooses to work 10 or 20 or 30 hours a week and is willing to accept the relatively smaller financial return.

On the other hand, there is a good deal of evidence, in addition to my personal experience, which indicates that with salaried government physicians or members of closed-panel group practices, the majority of physicians will tend to make their work as easy as possible for themselves. And how does a doctor make things easy for himself? Certainly the most common way is by referring patients. Some of the closed-panel groups would have you believe that many referrals indicates better medicine. In fact, what it indicates is poor medicine, for it means that a doctor rather than giving of themself, listening to the patient, making a real effort to understand the patient's problem and deal with it, sluffs off by referring. Having spent a number of years as one of those to whom patients are referred and listening to the anguished cries of the others to whom patients are referred for no apparent reason, I have no doubt of the validity of the previous statement.

Organized medicine does not believe there is any single system for the delivery of health care which can possibly be satisfactory to all of the varied groups in our supremely heterogeneous population. The closed-panel group with employed physicians such as Kaiser Permanente may be quite satisfactory for the union member. It is not satisfactory for the upper-middle class business and professional man, nor is it satisfactory for the economically deprived. Organized medicine's fear is that the pressure for a single system will prevail and we will have imposed a health care system composed solely of multiple closed panels. We think this would be tragic, and so do the leaders of the best of the closed panels. Our hope is that the present leaders of closed panels and organized medicine have established enough credibility so that this will not come about. We certainly hope that those of you here today will join us in working for a national health insurance plan that provides multiple systems of delivery which can be competitive and among which the people can have freedom of choice.

Once again, thank you for the opportunity to take part in today's conference.

MEDICAL CARE--RIGHT, DUTY, OR PRIVILEGE

D. Stark Murray

Ladies and Gentlemen! The subject that you've asked me to speak on today, "Medical Care--Right, Duty, or Privilege," is one that is provocative enough. I didn't ask whether it should be controversial, although it is more controversial than you can imagine at this moment, but I asked whether it would be provocative enough. And I've been given freedom to be so up to the stage where you could start throwing things at me; then I shall retreat. I have approached neither right or duty to the American audience to the subject, but I do consider it a privilege, if you'll ask me to do so. And if you just think about what I just said, you'll get some idea of the variation and the impact of these three words because we have long discussed the question of whether medical care is a right or a privilege. As I shall tell you in a moment, the only country which has clearly put "duty" into its statements is Denmark. We might consider that there are many duties within the health care of this one.

Now, right and freedom go together. This morning a number of the speakers presented their ideas and all introduced the word freedom--freedom of the value of their things. All of the countries have signed the United Nations declaration of human rights. One of the rights which you have accepted in that statement is that health is a <u>right</u> of every citizen in the United States. All the NATO countries have said this. One of the things that I have done in the past few years was to tour the NATO countries with a NATO fellowship and to look at the health systems in every one of those countries. The only country which lags behind the others is the United States. Every other major country has either a very complete system of national health insurance or, in another case, a system developed around a national health center.

If I may just quickly distinguish for all of you these two things: a national health insurance system, don't forget, we had in 1911; you are only 60 years behind the times, nearly 100 years behind Germany, for example, but if you want to clear yourself particularly, you are only 15 years behind Italy which was the last

country to set up a health insurance system. Insurance in this sense, as in all other senses, is something into which you pay money in order to get money out of it. And all the European countries have a form of health insurance in which it is expected, or in fact happens to a large extent, that the citizens pay into a fund a certain amount of money and when they are sick draw out a certain amount of benefits. This is called the typical insurance, and the only thing that puzzles me when I come here is that the first and cardinal principle of all insurance systems whether they are public or private, whether they are mutual or for profit, is that a marginal number of citizens are not covered. Therefore, to have the largest number of all the people in a community, of all the citizens, into one system should be the ideal. Most European countries have started to do this by getting their citizens into a citizens' aid group, or a certain income group. They nevertheless have a subsidiary law which says that they may join a national system voluntarily into which they will have to pay more money in order to get more benefits. But nevertheless, the system must be such that people can move from one section to the other with complete freedom, because the rich today are poor tomorrow and the poor today are rich tomorrow. Therefore, you must insure that if people move from the one end of the poverty line to the other, they still get the benefits, their medical care is not interrupted.

Medical standards, in our sense of the word, is completely divorced from this. In your system, you pay into social security, you pay money into pension funds, you pay money into sickness funds, into unemployment funds, into childrens' allowance plans, into old age pensions, into all that kind of service which have a monetary value. You pay into the unemployment fund because when you're unemployed you can collect benefits. But we distinguish these services, which is a human right. If it is a human right, it must be established; and if it is established, it must be divorced from all forms of paying on an individual basis. You are no longer dealing with the standard, you are no longer given the right, you are being given a system, such as you have here, which fails entirely to provide one of the four freedoms that you've talked about today, and which I have mentioned, the freedom from fear.

I had the most remarkable reminder of this experience when I started speaking in this country. On the same day I talked to a young man who had a lowly paid job in this country and who had worked in Britain on an equally low-paying

job, and a professor at one of your University of California schools who is very eminent in national health care work. And both of them made essentially the same point--that the one thing that is essential for a health service is that it removes fear from the citizens in regard to health. The young man told me how, when he went to Britain, he and his wife not only lost their fear of being ill, for they had illnesses, but they lost their fear of the connectual cost of having a baby. They had their first child while they were in Great Britain, but they wouldn't have had it at that time in this country because they wouldn't have been able to pay the expenses that were involved. The professor said that the English system to him was outstanding, because in fact it had removed all fears which he said, and you can check for yourselves, are fears that many, many people have in America--the fear, first of all, that if they're sick, they'll not get the services.

In view of the statistics regarding the distribution of health care throughout your country, great numbers of people, because of poverty or because of poor distribution of services, evidently do not get good health care. You will realize that this is an important factor. The second fear is the fear that you will not get enough health care. In the professor's view, particularly after he had studied the care of the aged in Britain, he felt that people got enough medical care in almost every respect. The third fear, he felt, was mentioned this morning by a number of people--the fear of overutilization,of overprescription of medical care in this country. And above all, the overuse of surgery, which is shown in numerous reports that are available for study here. The fourth fear, of course, was that the service was going to cost too much. That it was going to be catastrophic. We don't have this word, catastrophic illness in Great Britain.

I am a political animal, I talk more in a fit of anger. But I'm also a member of the British Medical Association, and within the British Medical Association I have not heard for many, many years some of the expressions of fear in relation to medical services used this morning and which you have used repeatedly.

Apart from this, there are many other reasons why health and health care must be a right. It should be a right for every citizen. The first big reason is that this is a basic medical principle. This has nothing to do with economics. This has nothing to do with private

practice or private enterprise. It's just good medicine. Every American doctor, like every British doctor, and every other doctor swears the Hippocratic Oath or some sort or form of it which he repeats and repeats, and he appears to have said what Hippocrates said 2600 years ago--that is, that in going into the home of a sick person the doctor shall have no regard for the patient's social or financial position, but will regard them solely as sick people. This is the basic medical principle on which all medical care systems are based. In the countries of Europe they have developed systems where up to 90 to 100 percent of the population are covered by schemes which are largely financed by government. So the basic medical principle is that the services must be a right and must be freely available to the sick and the deprived.

The second basic principle is a political one. And I would like to say that in Great Britain we did not come to a national health system because we had the sort of economic crisis that you have been talking about. We came to it because we discussed the political basis for this for nearly 60 years. We had a medical association from 1911 which called itself the National Medical Association, and which believed, or the doctors believed, that we had to move on into a situation in which we had a national health system. The British Medical Association in 1938 published a plan for a medical system for the nation. In 1945, it set up a medical planning commission of which I was a member, consisting of representatives from the profession. And at that moment, the profession was leaving the political battle in favor of changes for the national health battle. Ultimately, it was the political animals in the labor party, including myself, who reached the point where this became number one priority.

During the war, Winston Churchill made a speech in which he promised every line of the British Armed Forces that one of the things that they would find when they came out of the Armed Forces was a national medical establishment of some kind. The labor party, therefore, gave this absolute number-one priority as soon as it was in power after the war. So there are vast political considerations in this, and they mustn't be forgotten. You have to consider these political implications in any country. And at the moment, as I say, the only country in the NATO group that has not made the necessary political decision is the United States.

Thirdly, and this is an important principle, health care is the concern of the people. The people must know what health is about; they must know what health service is about. We must give them an opportunity of saying and doing things about health. I am not satisfied in this respect that the British system is operative entirely in the right, democratic way. There is in modern Britain a question as to whether we move towards a more democratic system in the sense that more human beings, plain citizens, are involved in the managerial system and in the decisions under which a group of people called managers run the service. This is because our present minister of health was a member of a great business organization before he became minister, and he wants to have the managerial form. Some of the things that we've seen of managers, they have to be controlled and guided just as the others have to be, and we want that guidance to come from the people.

This brings me to the question of that which is entitled "duty." Because once you've reached this point where the health of the people is a concern of the people, there has to be a duty of someone to deal with this question. Norway is the only country which in its public declarations on the subject not only says that it is the right of the citizen to get medical care, but it's the duty of the citizen to seek medical care. Now consider this, those of you who have thought of my over-utilization of the services. I myself do not believe that any human being ever overutilizes a medical service that's properly run, because medical services must deal with a human being who believes he has a problem. The Norwegians go into a much deeper ethical situation on this question. They say not only that the citizen does have a right to medical care, but that he has the duty to seek it and to influence it in every way that he can. And in the Artic Circle, in Iceland, you will find in every community that there would be a committee of lay people responsible for the health of their area and that the doctor of that area is usually the chairman of that committee. So the people and the doctor cannot escape each other. This is a principle that must be applied.

Now, we do not say it is the duty of every citizen. But the system, in fact, lays the duty upon everybody. This is because we have freedom of judgement, and if you will excuse me, you have no freedom of choice here in the United States. For some people there appears to be freedom of choice. For some people there appears

to be the ability to go to the x-ray expert, the surgeon, the psychiatrist, but there are few situations in which the citizen can be the diagnostician.

In Great Britain the fundamental principle is that the patient must choose. The patient must choose his doctor, and he must choose him with understanding. I have just had to change my job as practitioner. I have had the same family doctor for 30 years along with my wife and myself, children, and grandchildren. This, we believe, is a correct relationship between the doctor and the patient. But now I have to find another doctor, but until I do so, I can't use the service, nor can the Queen of England, nor can anyone else--until you establish this relationship with a doctor. As a physician I could choose any specialist to attend me, but it is wrong, basically and fundamentally. I put myself in the hands of my family doctor and I've been well treated. So we have a duty, too. And 98 percent of the people of Britain have chosen. Just think what that means in terms of human relationships, that policy decisions have been reached by 98 percent of the people which must include most of the wealthy people of Great Britain, which means that they do, in fact, use the national health service. We'll come to the exceptions, and that there are exceptions is a basic fact.

The second duty is the duty of the National Health Service to make health services available. If it is the right of the citizen, then it must be the duty of someone to see that services are provided. We are witnesses to all the schemes that you have here this morning in the summary of proposed legislation. One of the deepest weaknesses in them is that it is nobody's duty at any point to see that services are available. There are various arrangements proposed, there are various committees that can be set up, there are various circumstances, there are suggestions for people to do things that they would otherwise not do, but there is no clear duty upon anyone to see that the service is available.

And finally, arising out of this, we believe that medicine, above all things, must be taken out of the market place. I know that the British people, irrespective of the political issues, believe by and large that medicine must be taken out of the market place. Human lives, human care, human comfort is not a matter that should be subject to the ordinary rules of the market place.

If you wish to see this discussed in its truest ethical implications, read the book The Gift Relationship by Richard Titmuss. He is a great believer in ethics. He was entranced by the question of who gives blood to whom in our society today, and he took a sabbatical in order to come here and in order to study the British system in comparison with other countries. He argued that medicine is not in the market place and must not be. An example is the gift relationship of giving blood clearly to a stranger, the stranger whom you can never identify, whom you can never thank, and who cannot thank you as there is no machinery to make this possible, except in very, very small ways. If you give 50 bottles of blcod, you are invited out for a glass of sherry. This is all the thanks we get for 50 donations of blood. And we enjoy it, we love it. He then analyzes this on an ethical basis and argues that this is what we are aiming at when we say that health is the right of every individual. The nation, the community must give with the gift of life, the gift of health to the rest of the community and to the individual. And to those of you who think that your institutions need looking at, you should read this economic study.

We have in Britain a million live donors that we can call upon at any given moment. As he demonstrates in his statistics, a pint of blood is expensive in the United States. Blood is available in Britain to anybody, to any country that asks for it. I was chairman of the largest unit for many years, and I was always surprised at the response for a call for blood that is rare even in your country. In the case of a woman not so long ago, there was no donor in the whole of England, and she was dying from a lack of blood. There were only a few people who had the same blood type which was a very rare one, but a very dangerous one. And within two hours of getting the telephone request, there were donations of blood available at our unit. You see, this is a totally different attitude. That wasn't achieved in the market place. You can't do these kinds of things by any form of marketplace economy.

Now, we believe that this is a fundamental thing that has to be discussed and said. And if you think that I'm going too far, just consider the United Nations human relations declaration. Just make up your minds whether in fact the United States does accept it or not. What I am saying, of course, is that changes must be made and are being made. One of the biggest

changes that I see in this country over the past ten years is the change in attitude. Dr. Shapiro is here because I came to the United States, but in my first visit no man in the medical association would be on the same platform with me. Now they actually shake my hand and discuss health care with me. But when I courted the United Nations on a debate on television in Cleveland with a representative of the AMA from Chicago, he admitted that his organization did not believe in this United Nation's idealism. If this is idealism, then don't accept it. You are bound by the NATO treaty to have a common corps of medical services with all the other NATO countries. But somehow this is not done. You are the only country that does not have it. If this is idealism, you've got to face up to it because this is something that you're in fact involved in.

That brings me to the subject of health care as a privilege. I think this is the only country in which the question of privilege is seriously raised. In no other country will you find spokesmen, such as a former president of the AMA, telling the people that health care is a privilege, and only the privileged should have it; that would be the implication. In no other country is it accepted that the privileged should get something that is better than the rest of the community gets. In all communities there are arrangements which the privileged might want to make, and if they can make them entirely by themselves, then that's okay. We are a great society. We do not deny that private practice in medicine may still go on. What we are saying is that those who indulge in private practice, whether they are physicians or citizens, must do so outside a system which is providing for the bulk of the population. As I've said, those services provide care for 98 percent of the population. And the only people who try to get a privilege in Great Britain today are those who want it not because of the quality of medical care, not because we're not going to get the same quality of medical care inside the national health center, but for personal convenience. All the private practices, with one or two exceptions, in London are entirely inside the national service. And certainly, for example, the man who is going to do an operation on a private patient from whom he's going to get extra money is going to do it. The patient does not claim that he is getting better medical care, but only that he is one of a small privileged group for whom the trade unions, when negotiating, secured better conditions or one who could afford additional cost for his own convenience. He claims only two things: (1) that

he can buy extra, private care, or (2) that he may buy what is always described to me as better scheduling. Instead of the assumption that the physician is making the decision, he will be making the decision for the physician in terms of saying "my operation will be next Wednesday or else," because he is the one who has paid the money for it.

This is the only privilege that is bought in Great Britain today. They carry the insurance for these two items--for privacy and for scheduling. They carry it for nothing else. The moment that they are involved in a situation in which either they have had, for example, a motor accident, and they find themselves in the National Health hospital being treated as an emergency, or the moment that they find they are going to have that kind of ailment for which no insurance company ever provides complete coverage and that the illness is going to go on into old age, then they exercise their right, which is absolute in Great Britain. They can use any health service of the National Health Center they wish. The citizen can choose any individual act, he can in fact come into the hospitals, as Dr. Shapiro will be surprised to hear, and he can choose to pay the x-ray expense. It is the citizen's right.

If you believe that once you have a different system in this country that you are going to have a continuation of private practice as you know it, and a continuation of a very large proportion of the people in America turning to private practice, then you and the private physician are utterly mistaken. Because the moment, and this applies to every country in Europe, the moment you adopt a sufficiently good national system they, the people who used to use private medicine will immediately switch over.

And you know, in a country like Denmark, the men who are in the National Health Services believe that a physician or a surgeon who goes into private practice is as low as they come in the profession. You see, they have switched the whole subject. The problem is not the man who is in private practice who is the highest skilled individual in the community, but it is the man who devotes and gives the whole of his time to the National Health Service.

The statements that were made this morning about the quality of the physicians in a National Service are erroneous because those of us who have those kinds of physicians do not yield to anyone on the quality of medical care that is given. Look at Stockholm and the hospitals there, at Denmark, at Copenhagen, and go to the general hospital and see what salaried officers are doing. And you will see, these persons who downgrade the system and think that the people who are in it are not giving the same quality as those in private practice, you will find that it is utterly wrong. If you consider the question of the delivery of care, as distinct from the actual quality of care, then, of course, all these countries are vastly superior. They are superior because while Denmark, for example, may have two systems, for all practical purposes all of the citizens are under one and all have the same services available. In this country you have over 300 categories of citizens who get their medical care by one system or another, all separate, some of them good, some of them bad. You have the oldest form of health insurance in the world, 200 years old, but most of you never thought of joining until forced to for one reason or another. You have so many categories of citizens that this is in fact one of the things that Edward Kennedy said must be changed. He has taken this fact which results in poor care for many as one of the greatest weaknesses of the present system.

This morning we heard about people in the union organizations, which is just one category, who will get the service in a way that the union has arranged. Another group of people get their health services in another way. You have categorization of so many different types that in fact you are dividing the citizens. I would visualize health and health care as being a unifying influence with the citizenship of feeling that we are all equal members, and not that we are in fact operating within a different kind of society.

Health provides a good way of uniting all. But in this field uniting in health means uniting all in seeking health. We have a vast experimentation here. You are experimenting with different ways of providing medical care, and many individual organizations are developing different schemes. A few days ago I went to Delano, and I came away with the utmost admiration for the young men who were setting up the clinics there for the migrant farm workers in Southern California. But this results in categorization of citizens, which

ultimately leads to poor medical care for many and costly medical care for all. Here in America, you have been trying to say that you cannot buy your way to better health care. You have already been trying that too long, and too long you have been disappointed. You are spending more money on health care than any other country in the world. You are spending 7.1 percent of your gross national product, we are spending 5 percent. We have spent 5.5 percent, but none of the other European countries spends any more than 6 percent of the gross national product. Some countries have twice the number of doctors that you have. Every fourth doctor in the world isn't an American. Every fourth doctor in the world is a Russian, because of the vast service that they have provided. And yet you are spending all this, and you are getting less services for every penny. And much of this cost goes into administration, and despite the claims from our friends in the insurance industry, I don't regard the insurance system in the United States as making any great contribution to the problem. Included in the millions are the profits which the insurance companies make, which does not exist in any of the other NATO countries; insofar as the insurance funds are concerned they have mutual sick funds for all practical purposes, that is, no funds at all.

Indeed, you have experimented to the point that practically nobody is in fact paying for his medical care directly. Gone is the day, in fact, when somebody puts a hand in the pocket and takes out the dollar, and actually hands it over to the doctor.

There is indeed some service for all the citizens in the United States. Certainly millions of people have some at this moment. Yet much of the medical care, especially medical care furnished by governmental agencies, is paid from tax monies. Then there are Blue Cross, Blue Shield, and all the other parties providing third-party payment, but these parties only deal with the cost aspects. They neither plan services nor do they make services available and accessible. It is not in the nature of that kind of procedure to do the things that need to be done to guarantee medical care for all.

Listening to all the speakers today, and particularly the man from the insurance company, I am made aware of the vast resources that are supplied today, but which are not used effectively for a progressive health service scheme. We have heard that a plan should

be supplied by governmental agencies through taxation, which the insurance system will then use. This we believe is wrong. Our insurance, the one group that we have insured, are actually using the resources of the National Health Center. In this country private practice is subsidized by public, by voluntary, and other agencies. And if this is the way you want to do it, then okay. But it will neither achieve complete service for all or control costs. It will still result in the same overlaps, and the one field in which overlaps exist and the one which European experience shows that insurance cannot deal with is the question of hospital cost.

Now, you all know the figures about Blue Cross. Blue Cross was started and devised not for the patient at all. It was started as mainly a device for insuring that the hospitals get certain fees, and in the case of Blue Shield that the doctor gets certain fees. It is a device to insure that the member can pay these fees. Blue Cross was a device originally to insure that the hospital that was bankrupt could be maintained within the community. This was the purpose. And insurance in fact is used as the means to provide in the first place the capital expenditures that are required by hospitals, and in the second place, a growing cost of care within expensive hospitals. You have, of course, the most expensive hospitals in the world. You do things in the way that no other country attempts to do, because other countries have a much clearer sight of priorities. This involves government regulation of hospitals and hospital practices and periodic examinations and inspections.

If you believe that your society can afford to run its medicine on the basis of a voluntary system, then all right, do it that way. But don't forget that it will cost you billions of dollars and then another billion dollars so that the costs that we presently estimate will be billions of dollars higher by 1976. European countries believe that the correct way to provide medicine is first of all to have family doctor systems, and then that the hospitals either be paid or subsidized by the state.

If you can use European countries as an example, you will find that there are different ways of doing this. Some of them buy the beds direct from institutions. In Belgium, they have made an interesting decision: almost 40 percent of the beds in hospitals

are actually already a public hospital and 60 percent of the beds are still in the care of religious organizations. And Belgium has had a great problem of trying to organize and plan a hospital service in which you have to deal with a religious body. But now the government has taken over the basic ownership of every hospital. The basic ownership consists of the land and of the building, but for the time being operating control is in the hands of the individual body which was previously running it. But straightaway, the religious bodies say that health care is an avocation, health care and hospital care was the sort of thing which nuns in the medieval times were suited to do and wanted to do. However, in modern times, with the scientific methods, with the need for greater training and so on, you no longer can expect a nun who has been trained in devotion to Christ to come home and adopt a portion of the latest computer machine and to print forms and all the rest of it, and they are going to slide out of the field. The government will then take over the planning of the hospital itself.

Italy's in the same state. Even in France and Portugal we have the same state--of trying to find a way in which government can take over control of the hospitals. No one system has proven better than others in all cases, but government intervention in some form is inevitable. Don't forget that in the States you're already providing hospital service for the veterans and for all sorts of other people. You've already sunk billions of dollars in buildings of government or government-supported hospitals. And above all, don't forget that medical research in this country entirely or almost entirely comes from government funds. Now, I know that much money is supplied from medical foundations; after all I was connected with research projects, and I know that foundations have provided lots of money for different things. We know that. But the bulk of the money comes from government funds, and everybody in America applauds the work that the National Institute for Health is doing.

And so, friends, don't think I happen to be watching the clock, but you know what it is and why we put one in here. It says 2:23, and that's just about the limit of time provided. So let me conclude that in my view you cannot reach decisions in this field simply by listening to any senator. Since I came to the States, I've been talking about the Kennedy-Corman

bill, the AMA bill, and others as well. You can't do it when the system is being discussed in papers this morning as you are discussing it on an ad hoc basis. You are discussing what you will do in a certain given situation. You are talking as if this hadn't moved. You're talking as if 100 percent of doctors in America were still in private practice and dealing with medicine in that way. All employed doctors are already in some kind of institutions, which is not private practice. And the young medical students and doctors are wanting a way out. They come to me at meetings, they come to me in hospitals, because they don't want this system. If you can devise a system under which a physician has essential freedom to diagnose and to treat his patient, the young men will adapt to it. And this can be done in the United States as it has been in the United Kingdom system, and in all the other European systems. They've got this freedom by completely being out of the market place. They're not subject to government and medical bureaucracy which may apply in the United States today. The bureaucracy of Blue Cross and Blue Shield, which can decide what type of treatment can be provided, is one that you cannot find anywhere else in the world.

You do not have to have that kind of machinery, but you have to decide on the basic principles. The three basic principles that we have decided upon were first of all, we established as a universal principle that there should be none of this categorization. And the great beauty of the Kennedy bill is that at least it makes good sense. It says, we will move into a view in which the United States will view all its citizens as one. And this will bring you into line with the rest of the United Nations. But it lacks two things. It lacks the right of every citizen to care and the duty of the state to furnish such care, and this nobody else has done. The Canadian right to health care is not only for the citizens of Canada in Canada, but when he goes abroad he carries this with him. To give this to the 5 million Americans that cross the Atlantic every year, you would have to take a separate insurance in most cases. You haven't used the word universal as we use it. I haven't been talking to you today about health service in the United Kingdom as well as my own, because we make no exceptions of any kind whatsoever. When a person comes, there is one criteria--that they are sick. And because they are sick, the whole of health services is available. There's no billing, there's no argument or no exclusions. We are proud to do this, and we are

hoping that gradually we shall persuade the rest of the world to do this with us on the basis of reciprocity. At the moment, we have reciprocity with 18 countries, we hope it will increase within the next few years till we have covered practically the whole of the civilized world.

Secondly, the service must be comprehensive. All the talk that has gone on today and will go on for weeks, and for months, and for years, about how you provide health care, cannot provide the preventive care that is needed. You cannot do prevention of illness properly in private practice. And you cannot do it in a private practice system unless you make some form of categorization. For example, you may decide there will be disease prevention for children or disease prevention for those who live in such and such an area, that there will be health education in certain problems, and so on. You cannot, and we haven't yet, spend money as has the Soviet Union to build a complete preventive system. We haven't built up yet what we are hoping to build up in the system, but because it is comprehensive we have to prevent; and we have to educate. And you cannot do this, unless you make a basic decision.

And thirdly, we decided against establishing fees at the time of usage. We have no fee for service. There are fees only for the arriving at cost of different systems including hospital specialists.

We believe that the moment that this service is used that there should not be additional fees, and this, of course, is the beauty of the prepaid systems such as Kaiser, or any similar plans. This is the beauty of that kind of systems that in fact there is no question of fee at the time at which the service is required. But that is the mode. When the citizens have suffered at the hands of ill health, why should he or she have the additional hazard of having to find money? And we believe that this is a basic principle for the prevention and treatment of disease.

Ladies and Gentlemen, you've been very patient. The clock says I should sit down. There are a million other points. The questions I've been asked across the United States indicate dissatisfaction with the present system. I know the subject is one that is going to take a great deal of study and thought in your country. I hope I've not given you the impression that I know

all of the answers here in the States. I hope also I'm not giving you an impression that the British system is perfect. All I can hope is to establish the rise in costs will continue until a system for the delivery of health care is adopted for the benefit of all citizens, which will establish his priorities and enable this institution of medical care to serve all the people of the community. For that reason I suggest that my remarks be accepted as a basis for your consideration, but this is a matter for you to decide on the basis of your own experience and your own desires with consideration given to the experiments and results in all the NATO countries.

EVALUATION OF NATIONAL HEALTH INSURANCE SCHEMES

DISCUSSION

Ted Ellsworth:

Dr. Murray, I think that when I used the word controversial instead of provocative, I meant provocative instead of controversial. I'm sorry that I can't stay for this session, but Charles Kramer is going to moderate the last session along with Pete Morse. When we planned this, we wanted four organizations: the insurance industry, the medical profession, government, and the hospital people. The hospital people couldn't bring anybody unless we paid their way from Pittsburg. I didn't see much sense in that. I thought if it were Pittsburgh, California, I might be willing to go that far. But not from Pittsburg, Pennsylvania. However, although we don't have anybody from the hospital profession, the program proposed by the American Hospital Association is so similar to one that Dr. Lee has made over the few years that I think he will be a fair representative for the hospital profession. Charlie is here, where is Pete, and Dr. Shapiro, and Dr. Lee? We will have a general discussion in which Dr. Lee is going to participate. I'm sorry that I can't stay. Thanks for coming.

Charles Kramer:

It is my task to moderate the program. I think a better evaluation of the various proposals will come from Dr. Lee. This will give him an opportunity to give you his experience with all aspects of medical care. We can get his experience with the Palo Alto Foundation. And, as a moderator, we'll start having the questions as soon as Dr. Lee is finished with his opening remarks.

Dr. Lee:

The first health insurance was devised 2600 years ago. His name was Isaiah. He said, "Sure. We know our strong should take care of the illnesses of those who are weak." So I don't know who you should ask, Mr. Lyons or Dr. Shapiro. I think Mr. Lyons, because he categorized three different types of people who will be covered in our capitation basis, I think that's what he meant--the poor, the near poor, and, I guess, the affluent. Now, who is poor, who is near poor, and who is affluent? And is the quality of the care going to be the same for all the people, or just judged by what your financial backing is?

Mr. Lyons:

I think the first comment is that the industry approach is that the first implementation of the program will actually cover the poor or, in other words, those that fall below a certain level of income. But this is on a much faster and much broader basis than the others as the program is implemented. But the overall program that the health insurance industry is approaching, it gives us a comprehensive approach where it's intended that all Americans regardless of income will be covered. Now, financially, certain individuals will be financed by employer contributions and their own contributions. And then those that haven't the financial ability to pay, they would go into the state-type pools, for then they would have the level of coverage which could be established as the basic criterion of the overall program as a minimum-type benefits.

Dr. Shapiro:

As a matter of fact, it has been stated that much of today's medical expense is already covered or financed by government. The figure of 38 percent has been quoted as representing the governmental share of the medical care bill. If, in addition, one recognized that approximately 90 percent of the population has some type of medical care program, it becomes apparent that very few people are without some medical care coverage. Organized medicine's position is that some medical care coverage is best done by government, some best through industry, and some best on an individual basis. We believe that the best of all of these coverages should be incorporated into a national health insurance plan, rather than legislating a single approach which might be satisfactory for some but highly unsatisfactory for others. We believe that this approach can result in the best system of delivery of Medical care services for the American people.

Floor: What would you do with Medicare?

Mr. Lyons:

Well, Medicare as it now stands, would, let's say, be maintained. In other words, it would not be changed in its present form, although I don't know whether or not that's good. I'd make another comment: I don't think Medicare itself is going to maintain itself in its present form over any extended period of time. I think that they are going to make

some substantial changes in the fee-for-service or in the financial arrangements to the doctors. At least, I hope so.

Dr. Murray:

The suggestion, you see, is just that you keep this kind of problem, the aged people, in a separate pocket. and you view them differently, aged people or young ones, Any insurance man can tell you, the only way he can make his funds hold is in fact to get 10,000 young who are healthy. But because this will not work, we will then see what the National Health Services do not see that you must bring in controls for the doctor. The doctor has to be controlled. This is just nonsense! We set the doctor free to treat the young and the old, and you don't need either controls or separate funding.

Floor:

May I ask one more question? I was a trustee on the Motion Picture Health and Welfare Plan for 17 years and a chairman of it one year. Now, we have a very great slowdown in business in the motion picture industry. About 58 percent of the membership in the motion picture industry lost their battle for health and welfare because of unemployment. Now, are they poor, near poor, or what? They no longer have insurance. Where are they going to get their health services, unless we have a national health insurance?

Dr. Shapiro:

I believe what you are saying is that at the present time we have gaps in insurance protection. There are individuals in all industries, not only the motion picture, who have not been employed long enough to be eligible for coverage. There are many other gaps and there need to be means of covering those individuals who are not now covered.

Floor: What is the solution?

Mr. Corman:

Well, the answer is that that someone has to be the government if the individual hasn't the opportunity or the ability to pay, or the state pools don't or, let's say, the continuation of insurance after unemployment for a period of time doesn't exist. Now, the health insurance act itself includes as an example that individuals have a minimum of three months carry-over upon that unemployment. And that's only the first base. But you are right. It's a question that has to be answered. The gaps have to be covered.

Floor:

Another question for Dr. Murray. I assume that you're somewhat favoring the Kennedy-Corman bill? How do you recon-

cile the issues? I'm not really in complete understanding of how the citizens' funds would be allocated for group practice first, and then distributed to doctors on a fee basis. How do you reconcile that with your concern over the categorization of medical treatment?

Dr. Murray:

Well, if I were examining the bill in detail I would take up and ask for proper explanations and further examinations. This is a device, you see, as I said, the government is working on the principle you are dealing with devices all the time. This is a device that is beginning to shape up, you see. It gets more into group practice, it gets more into the sort of things that Dr. Lee talks about, see? That is as far as you can go. And the fact that you can do any of these things is significant.

Dr. Lee:

The most efficient way to distribute care is through a group-practice on a capitation basis because it controls overutilization and you don't have an open-ended thing like we have with Medicaid as broker. The bill should provide for those who are willing to do it--they should take this on a capitation basis. I will speak to Dr. Shapiro: I would like to see the Los Angeles County Medical Society say to Social Security, "We, for X dollars a month apiece will take care of all the medical services for the old people in this county." So that Social Security will know what the bill is going to be. That sort of thing should be encouraged as much as possible. It will improve the quality of care and it will definitely control overutilization. And I think any bill that is written should be written in such a way as to encourage devices like that. And I would hope to see the AMA, or the County Medical Society, get up and say "yes," we will undertake to take care of the indigent at so much a head and for the old people at so much a head and do it that way and let them divide the money as they see fit.

Floor:

Dr. Lee I don't think will be surprised to know that organized medicine has done just exactly that in California. The proposal has been made to the state, legislation has been put in, and some of you may be familiar with it. It was introduced by a senator from Beverly Hills, Anthony Beilenson. The Beilenson bill says exactly that the California Medical Association using Blue Shield as its tool to do the mechanical part, will make a deal with the state to cover everyone on Medi Cal, for X number of dollars a month. The terms have not been negotiated. We ran into a little problem because the governor didn't seem to be very enthusiastic about this approach.

Dr. Lee:

That is the way to do it. And let's say this, the California Medical Association has become by all means one of the most enlightened and progressive state medical societies in the United States. It's leading the way, and it is people like Shapiro and others that have been responsible for that. And this is one of the ways to do it. I think they deserve congratulations.

Floor: Well, San Mateo has a different approach....

Dr. Lee:

Yes. It's a little bit different idea. Since you raised that, I think it illustrated something very well. Something that has been much in the air for the last hour. That is, what works in part of this County with its 67 doctors, or in San Joaquin with its 340 doctors, is not easily transportable to the State of California. In fact, it's not transportable at all. And the reason I say it's been in the air is that with all due respect I do not think that the British system is transportable to the United States. And I think that while the objectives, as stated by Dr. Murray, should be our objectives, we cannot accomplish them by trying to transport the British system to the United States, nor even by going as far as the Kennedy-Corman bill would go at this time. I think that our problem is one of getting our objectives straight and then figuring out how to get there. And our capabilities are very different from what our objectives might want us to do.

Dr. Shapiro:

Dr. Murray, we have heard considerable discussion here about broadening the base for providing medical care and what are the reasons for hesitating to do so. Now, wasn't Great Britain confronted with the same type of problem? And what did Great Britain do about it; that is, to provide the necessary doctors and hospital facilities?

Dr. Murray:

Well, that's a real point; we'll just have to tackle this problem. Voices said, in 1935 to 1945, exactly what Dr. Shapiro has just said, that you daren't go into this because you haven't got resources and so on. But it must be realized you do not provide a complete health service the day congress passes a bill and the President signs it, any more than we did when the Queen signed our legislation; that was the day the plan started.

The law of distribution requires you to set up the machinery to make the system work. And one of the big things that happens is that whenever it came to a problem like the law of distribution, or whenever it came to the question of what the team was to be, it is your responsibility onto the medical profession. You can do this two ways: you can set up a bureaucracy and you can draft all the doctors into government service, and you can send them all to practice somewhere else. But all that you can say to the profession is that you must have a sense of social responsibility.

So, in the distribution of family doctors we have a system controlled by a medical committee which must be made up of representative members of the medical profession, and it's managed to provide the machinery and the props and all that goes into it. You can tell me the United States is bigger; California isn't any bigger. You have to divide up an area no matter what its size. Dr. Lee just mentioned units of 200,000 to 250,000. We manage units of 150,000 to 250,000, and we think that is a good medical unit. But you divide the country as you will, as you will then see, as we have seen, that some areas have an oversupply of doctors and that other areas are undersupplied. By and large, your areas that have an oversupply of doctors will tend to shift some to other areas. Now, I'm not saying you can correct this completely or that any of our experience is translatable. I'm only saying that every other country has to face this problem.

Now we have a much better distribution of general practitioners. The one group that we could very rapidly expand were the specialists, because every specialist is appointed to a specific job. So you simply have to advertise the job, and if he wants it, he will do it. Do you know what I mean? Not a lot of pressure; just that there is simply a vacancy there. Now this is true in all policy-making in London. We previously thought London was a mecca. And I can tell you now if you go to any of our big general hospitals in any city, you will get the same quality of specialist care.

The mecca in London was always limited both in time and quality. The cost for some surgeons such as the brain surgeon, for example, is very high, and so we have hospital services which are sometimes not completely able to provide all services at all times, but patients are easily transferable by helicopter; all services are easily accessible. These are the things that you have to fit into the pattern. I'm not saying that you have to adopt our system, or the standards we have, but they all have lessons by which you can profit.

Floor:

Dr. Murray, you were speaking about having control over the physician. How is the fee that the physician charges determined?

Dr. Murray:

Well, no physician charges any fee. All physicians are paid by the government, they're all paid by regular payments. And in the case of the hospital doctor, he is paid a salary. Now, he has an option. He can either say, as I said before, "I will be a whole-time doctor," in which case all of his income is from the government. And there are in Great Britain, as there are in this country, doctors who take private patients or are available for emergencies such as night calls, for the weekend, holidays, and so on. Your salary then is based on the services rendered. I could have chosen, but the fellows don't usually do it, I could have chosen a 9-11 contract. In that case, I have two choices, one, that I could also either have a private practice or, two, I could sail my boat or go and play golf or do whatever my preference is, you see.

Now, everyone has this option, unless certain situations must deal with a full-time job like the family doctor's office and others who have no private practice or who have no other possibilities. So, the family doctor is paid a capitation fee; he is paid a fee for every citizen who chooses him as his doctor. Now, because this would not guaranteee his bread and butter coming in every month and because he would have to wait and do arithmetic for the services--he would still get his monthly check--and because we want him to take fewer patients, we pay him double for the first 1,500 and less for the next 1,500. Because he may have a mileage problem in his rural area, we pay some doctors more mileage. Because in some rural situations the population is so limited that a doctor couldn't possibly have enough patients for a normal living, say, if I were a man from Scotland where a man could only get a list of 700 or 800, not the 2,500 list needed to make the top figure, then you give him an extra payment, an incentive to go to these areas. So in the end it's made up of many factors, but every month he gets his check and at the end of the year there may be an adjustment for many reasons.

Dr. Lee:

Now, Dr. Murray, this cost is borne by the government. It would be unacceptable otherwise in the British system. I've had a chance to be in England a number of times in the last few years. And you just mentioned capitation has generally put the individual in the position of having a particular doctor. But when the patient goes to the hospital he has to

take a different doctor. The general practitioner can no longer care for him in the hospital. I think that's wrong from the professional point of view, from the quality of medical care, and a terrible injustice to the primary physician. In my opinion that's the worst thing about the British Health Service. The other thing--I know, this is not part of the system--is the lack of facilities which results in extraordinary and sometimes interminable delays in getting into a hospital. And I think the inflexibility of that will have to be remedied. The third thing, I think, their care of old people--and this is very near to my heart--is very poor indeed, extremely poor when compared to what could be done under the system. The abdication of the general practitioner, especially in regard to older people, when his patient goes to the hospital is the worst feature of your system.

Dr. Murray:

As you see, most of these are philosophical differences, but let me answer this because it's fundamental. We believe that the family or community physician is a specialist in community medicine. We've not achieved this yet. We've got old doctors who still work singlehanded. They've never been involved in community medicine. They only know their own group of patients and they look after them very well. You know, the Dutch want to clarify this issue, and they've got house doctors and hospital doctors. These are two different groups of people doing a totally different job, but they're not cut off, they meet every day. Every general practitioner in my area can call me or any other specialist up to see a patient in his home. He knows everyone intimately. He doesn't want to come into the hospital, that's not his job. You see, in my own hospital area we have a maternity unit, a unit from which specialists are excluded--we're not allowed to go into the door--and we've got a unit run by family doctors for family services. But you're saying that we don't give them a chance.

In 23 years, we've had no pressure from the family doctors to expand these services, no pressure at all because they know that their job is in the community--prevention of disease, education in health for children, the use of all the available community health services. And when you come to the aged, which I fear is a problem in every country, I've no hesitation in saying that the care of the aged is better in Britain than in any other nation or country in the world. And that's because we have a great variety of services. We have the whole nursing program; we have the whole health maintenance program; we have the night-disabled attendant; we have got meals on wheels. Last year we delivered 21 million

midday meals to the aged people of Great Britain who had no chance of cooking for themselves. We really have got the turn on that one. But we have a difference in opinion about where the duties begin and end for the physician. And we think, and so does the whole of Europe, that the family doctor, call him what you like, private physician, community doctor, works in the community, but he is closely linked to the specialist. One of the ways we do it is that in our hospital grounds we have a medical center; it is our educational center. We run meetings continuously, all the time, to which the family doctors all come, and I'm always surprised that so many of them come to meetings twice a week. But there are also a dining club and a bar and you can imagine what kind of an inducement that isto come to a meeting. And this is the way we plan to do it. Now, I'm not saying it's the only way, but it is the European way of doing it.

Dr. Shapiro:

I would like to comment on that for a minute because there is an interesting irony to it. We have heard many people talk today who have stated that the level of care should be the same for all. That is the official position of organized medicine and I certainly personally endorse it. We have now heard Dr. Murray talk about two different levels of doctors, and it may surprise Dr. Lee but I think Dr. Murray is right. I think one of our problems in this country lies with our institutions of medical education in that they tend to overeducate most of our doctors. I think that in order to achieve what has been achieved in Britain, and I think it should be achieved, we need to educate doctors in a completely different way from the way they have been educated in the past. Most of us come from medical schools where we were forced to learn by rote reams of material which has never been of any use since we finished the class and took the final examination. Until we get medical schools in this country with a considerably more realistic approach to how a doctor should be trained, we are not going to be able to get anywhere with the sort of approaches that Dr. Murray has talked about. We have a tremendous job to do in this area, almost an impossible job from the point of view of organized medicine, because the medical schools--the powers that be in medical schools--are more difficult for organized medicine to communicate with than you people are. There has been some improvement but very little.

Floor: How are you going to get to them, doctor?

Dr. Shapiro:

We can just keep trying to get across to them what we think. Interestingly enough, we have one group of the

profession that is very good--that is the students. Because the students recognize this very well, they're bitter about being put through the ropes, over the hurdles that we have all been through in the past. To use their terms, their education is largely irrelevant and those who are responsible for it are not "with it."

Charles Kramer:

I would like to thank Dr. Murray and Dr. Shapiro for their complete evaluations of health insurance.

Floor:

Along what these doctors have been saying, I want to direct this question to Congressman Corman. In your bill, what is there to provide for this increase in medical service in a way that we would make more doctors available to our populace?

Mr. Corman:

A couple of things, one the short-term and the other the long-term. The structure of the bill encourages group practice substantially. And while there are differences of views in the profession, it seems to me that the weight of the evidence is on the side of there being greater utility of group practice than in individual practice. And if there is, if a group of doctors together can take care of more people adequately than they can individually, then that's going to increase the quality of care. Beyond that, the bill provides that 5 percent of the trust fund--that trust fund will be a substantial amount of money--will be used to expand medical schools and the training of paramedical people and to provide more hospitals and convalescent homes and the other things that will be needed. The fact of the matter is that the federal government is cutting back instead of expanding; we now are in a position of cutting back the number of federal dollars we put into medical education and the building of hospitals. This is very unfortunate. Beyond that, as Dr. Murray, having lived through it, realizes, you don't by statute create more doctors and more hospitals. On the other hand, just from a humane point of view, let's look at what we are talking about. We say there are not enough doctors and hospitals and so forth to go around. We have to be selective in whom we take care of. So how do we make the selection? It's all on the basis now of their economic ability to pay now. Perhaps we'd do better if we tried to make it on the basis of medical need, rather than financial ability. In the very early stages, some hard decisions will have to be made by doctors. Are we going to spend more of our time on the critically ill or are we going to take care of the old patients that we used to know under the other system. It's going to be hard, but let's look at it for a moment.

You know, I wouldn't pretend for a moment that you can create a doctor by statute; you can by statute provide dollars that over a long period of time will create a doctor or build a hospital or whatever. So far as the group practice is concerned, I'd point out to you that in many states it's illegal and we have to get over that one. And, of course, our bill would provide that the federal statute would override local prohibitions. We tried to get that into the last changes in Medicare, but we were unable to. Congress wouldn't go along with interposing a federal decision to make group practice illegal, but that's something we are going to have to do if we anticipate relying on group practice taking care of more people.

Floor:

You mentioned paramedics, and do you envision, do the people who are working on this bill right now agree with what Dr. Shapiro says, that there should be expanded medical schools with a different philosophy as to how medicine should be taught.

Mr. Corman:

I don't think that that's going to be accomplished by federal statute. I think that's going to be accomplished by the progressive doctors within the profession, making the decision as to what kind of curriculum we're going to have in the academic world. We are, I suspect, going to do something in that field. There are some states now that are making special provisions for the medical corpsmen who are returning from the service. I don't think the federal government is going to do that. We can, however, go into a state and say, "You can no longer put a man in jail for practicing group medicine." I doubt that we're going to go those other steps and say to a state, "What's more, if a Navy medic wants to come in here and hang up his shingle, you'll have to let him do that." The government isn't going to go that far. But we will, I think go a little ways in removing a substantial portion of what in medical care seem to be unreasonable restrictions.

Mr. Kramer:

May I make a comment on that? The HEW is giving out, probably within a month or so, a fairly comprehensive manpower report which deals with many of the things that you raised on inter-governmental problems. It is going into a whole series of steps to break down the barriers and also to incorporate some of the things that Dr. Shapiro has said about the reorientation of the medical schools.

The important thing about reorientating the medical schools is to bring them closer to care. At the present time, they produce physicians, or specialists, but they don't really do anything about integrating them into the system of care. And one of the things that I think the Administration's proposal envisions is how to use the federal pressure and influence to get the medical schools to do something more.

CLOSING REMARKS

Russel V. A. Lee

Well, Ladies and Gentlemen, I burned the midnight oil last night to compare the various legislative plans that are being discussed here, and then discovered that the document in your folder does it very much better than I could possibly have done it. And I want to congratulate whoever put this together: the number of bills that were recorded and compared is valuable to you, and I advise you to keep it. Before I start, I want to pay my tribute to Dr. Murray's extraordinary address, which was a combination of idealism and pragmatism, and I believe that we all benefited by it. It was a remarkable accomplishment. I want to congratulate you for what you've done.

We have before this next session of Congress, beginning this year and going into next year, the most remarkable number of good health bills that have ever been presented to Congress. And I was just telling Congressman Corman I'm more optimistic than he is about something coming out of it. I think the pressures that are building up are going to be so great that something must be done. Wilbur Mills is a pretty wily character. I suspect that he will take some of the best features of the five-principal proposals and maybe put something together that everybody has to accept because the bill will contain something that everybody proposed. (This is what happened to some degree with the Medicare legislation.)

Well, the first thing that I'm going to talk about very briefly is the Administration Bill. This is an amazing document. I heard Nixon a few years ago ranting against Medicare; that he would now come up with a bill under which the government would provide, free of charge, the premiums for families that have incomes of less than $3,000 a year, and part of the insurance for those who have $5,000 a year, that's an amazing thing to happen in this government in the Administration of Richard Nixon. But it goes far to show what has happened. I don't think anybody, myself included, ever thought the right-wing Republicans would go for that. This bill is presented as an Administration measure, and I don't think anybody is going to object to that. This is really a climactic thing. It's not the whole population, but part of the population that needs the care more than the other, and

now we still have a Republican Administration proposing that the government pay health insurance premiums for everybody up to an income of $5,000 a year--an extraordinary thing. And that's one of the great features of it. Actually, this Nixon bill represented a lot of work in the Department of Health, Education, and Welfare with Elliots Richardson, and I think Richardson deserves a great deal of credit for developing something that Nixon and his Administration would accept. And yet, we will go part of the way in meeting this demand.

Of course, the other bill, the Corman-Kennedy bill which I really prefer to call it because it's easier to say, is more just; it goes all the way. It was the product really of the Committee of One Hundred that Walter Reuther started. I am a member of that committee, but I have dissented somewhat from the findings that it made. As a matter of fact, I think I can claim a good deal of credit for getting Walter Reuther into this. We were appointed by Truman, both Walter and I, to the President's Commission of Health Needs of the Nation, and that Commission was in horrible disorder. After a month it looked as though nothing would come out of it, and Lowell Reed (later of Johns Hopkins), Walter Reuther, and I met in my room and stayed up most of the night. We prepared a plan and said we would present it to the whole Commission the next day, and unless they agreed to accept it we three were going to resign. And Senator Magnuson was so dumbfounded that he accepted our plan, and that was the basis of this very good report of the Truman Commission. Walter got really deep into the medical care problem; it was the first time that he got really interested in it. We've maintained a deep friendship ever since. His death was a great loss.

Now, this bill, as you all know, has gone really all the way in providing comprehensive compulsory health insurance for the whole population. I should say before leaving the Nixon bill, it is in some ways a real bonus to the insurance industry. It goes all the way to support private insurance, claiming as justification that we're so deeply in private insurance that to throw it overboard now would be catastrophic confusion. Well, the so-called Kennedy-Corman bill goes really all the way; everybody is eligible; and it is a compulsory thing. The bill calls for a great deal of federal funding as well as funding from industry. You have it before you now, and I'm not going into the details to that.

There are two other plans that need to be considered: first the plan of the American Hospital Association, the so-called Ameriplan. They did, as Mr. Ellsworth said, steal a little bit of the plan that I made a number of years ago for hospital-based group practice, a feature which they incorporated in it. It has features that I believe will be perfectly acceptable to everyone, though it certainly is not very comprehensive and leads up to medical care that is not really covered as completely as it should be. Second, the bill that Mr. Burleson introduced that the insurance company wrote again represents an extraordinary change in the attitude of private insurance; they have come far in the direction of comprehensive care which most people want. I believe that it has features that really can be synthesized into a combination bill from all that's going on.

Now, the others, there are several others, but I don't think it's necessary to mention those. They are not going to be seriously considered at this time. But they all have elements that, put together, can make a fairly revolutionary type of bill that I think may have a good chance of being passed. I agree with Congressman Corman that the Committee of National Health Insurance bill, the Kennedy-Corman bill, is not going to be passed in its entirety at this time. However, I suspect the principles behind it may well be accepted, particularly because of the Nixon Administration's effort to get on the bandwagon and yield to this real great demand now for some change in delivery of medical services.

All of these bills, I think, have serious defects. I mentioned that this morning and again a few moments ago to Congressman Corman. I think that the fundamental trouble is not that we lack health insurance (I myself am opposed to the passage, at this session, of the bill which I helped write--that is, I'm a member of that Committee of One Hundred, I didn't write any of the phrases) but at this time, I think, there would be a great increase in the demand for medical services if that bill were enacted, a demand that would be impossible to meet because the capability of increasing the delivery of medical services does not now exist. I'm strongly in favor of preceding an enactment of any national medical health insurance by a great improvement in the organization of national health services.

Now, here I'm going to be an evangelist. As many of you know here, all my life I've been an evangelist for group practice. I come by evangelism naturally, as

somebody said at lunch: my father went out to Utah in the days of Brigham Young, as a Presbyterian minister; he started to preach Calvinism and we damn near starved to death. After 52 years of practice, hospital-based group practice supported by capitation, prepayment plan is probably the way to do this in the beginning. These prepayments plans, I think, may well and should be subsidized by government. I am sure, in spite of what Dr. Shapiro said--and I've been in group practice and I've been in private practice as well--a properly organized group practice, if it is supported by capitation prepayment plan, can get just about twice the service from doctors than otherwise. One reason is that in group practice we utilize the paramedical personnel in a much more effective way than any private individual can. They sneered at us, they used to say in the clinic: "Oh, how can you see so many patients today, Russ? Production line medicine--you just get them in and out." Three-fourths of the work done on these patients was done by other people who were smarter than I was in utilizing paramedical personnel.

This is one of the chaotic things in the modern day. I think some kind of group practice has to be done as a matter of fact. All doctors, to a certain extent, now are in group practice in their hospital staff work. Dr. Shapiro is part of a group. He does the radiology for probably 50 or 60 doctors who read their radiology together, but the makeup of their group in a very real sense is not a very formal one. I think the first thing we need to do is to reorganize delivery of medical services at the base. I think that should be done by the establishment of what we could call the community health facilities. These would consist of a hospital, intensive care in the middle, with a going-in hospital, diagnostic rehabilitation hospital coming out on the other side, with facilities for mental illness, for alcoholism, and for gerontology which is rapidly becoming very important. And this with a group who lives or is domiciled immediately adjacent to the hospital and supported by a capitation type of prepayment.

Now, each of these facilities in my study should have between 200,000 to 350,000 people who belong to them. They should be integrated with each other with a cooperative arrangement, so a specialist in one can serve many, like Dr. Shumway can do all the heart surgery in Northern California and neurosurgery, and things like. I think if we can establish a number of these

community health facilities, we will enormously increase the efficiency of delivery of medical services, and then we have our insurance. Let the premiums for these, just like the Nixon bill, like the Kennedy bill, be paid by the government agencies for the indigents or for other people who are responsible for them, employers, employees, and so forth. But the secret to getting the delivery of services is to have these things first. This is what I am now advocating as the solution to the plan. In other words, don't promise all these services until you can deliver them.

I think the first reform has to be at the bottom of the delivery of medical services in a very much more efficient way. This is particularly applicable for rural areas. We're trying to put one in right now in Mendocino County, where I have some ranches, with the center to be in Ukiah and the whole area served by medical and paramedical personnel, and helicopters. Then they can bring in patients from a 150 mile radius, a certain diameter of a circle, by helicopter, and have all the specialists located in Ukiah, the county seat. This is in the process of being put together. We hope to do something like this in the residential area in the beginning of next year.

Well, to summarize, I think this is the great year. We have five proposals, four of them have merit. And it is to my mind amazing that we should get these with the insurance companies, the AMA, the Republican Administration, and still many of the features that are also in the Committee of the One Hundred bill. We have the Corman-Kennedy bill. I strongly believe that this next year may mark the complete change in the attitude of this government toward the provision of medical services, and I hope we'll achieve some of the idealistic results that Dr. Murray spoke to us about. I think it's something that you should all be conscious of, have opinions of your own, and to be able to express them to your congressman.

APPENDIX

HIGHLIGHTS OF NATIONAL HEALTH INSURANCE LEGISLATION

I. THE NIXON ADMINISTRATION BILL

A. Benefits

Hospital & physicians in & out of hospital (including ECF's & home care); baby care including immunizations; vision care for children; out-patient laboratory services; certain other expenses; minimum catastrophic benefits of $50,000 per person per year.

B. Eligibility

Public phase would provide free insurance to families of four with incomes of less than $3,000 per year; graduated schedule of charges for those earning up to $5,000.
Private phase (financed by employers and employees) would cover all workers except state & local government employees, self-employed, domestics, part-time & seasonal workers.

C. Financing

For public phase SS earnings base would be raised initially to $9,800 per year; Medicaid would be replaced (except for aged, blind & disabled) with government paying up to $800 per year for premiums of Medicaid recipients. For private phase employer would pay not less than 65% of premium cost for first 2.1/2 years (employee would pay no more than 35%) and 75% thereafter (25% from employee).

D. Estimated Cost

Up to $8 billion per year in federal funds, plus undetermined employer-employee costs.

E. Administration

Health maintenance organizations to stress preventive care; employers would purchase a "standard benefit plan" with deductibles & co-insurance from private insurers; Medicare Parts A & B would be combined with no charge for Part B; Medicaid would be replaced except for aged, blind & disabled.

F. Medical Practice

HMO's would encourage group practice plans; $545 million for medical scholarships & area health education centers; incentives to get doctors where needed.

G. Cost Controls

Act would include cost controls; all but very poor to pay for part of care.

I. THE NIXON ADMINISTRATION BILL (continued)

H. Role of Insurance Carrier

Employers would purchase "standard benefit plan" from private insurers; a new federal agency will replace state insurance departments to regulate private insurance industry on rates & standards.

I. Chance of Enactment

Political infighters between backers of Nixon & Kennedy will threaten passage of either bill; House Ways & Means Committee more likely to adopt a bill closer to the administration than to Kennedy; Senate Finance Committee more likely to approve only a catastrophic illness plan (a la Sen. Long's).

II. KENNEDY - CORMAN BILL

A. Benefits

Comprehensive benefits for nearly all health services, including physicians, optometrists (and eyeglasses), podiatrists, dental for children up to 15 (later for all), unlimited hospital care, 120 ECF care per spell of illness; prescribed appliances, home health care, lab services & X-ray, mental care, prescribed drugs; no co-insurance or deductibles.

B. Eligibility

Total population; compulsory.

C. Financing

Revised bill calls for 50% from federal funds, 36% from employers, 12% from employees and 2% from self-employed.

D. Estimated Cost

Estimates range from $40 billion to $77 billion per year.

E. Administration

By a five-member Health Security Board reporting to HEW Secretary; regional, sub-regional & local Health Security offices to determine priorities, provider payments, facilities; Health Security Advisory Council for consumers.

F. Medical Practice

Funds allocated first to those in group practice; residual to those on fee-for-service; would redistribute doctors where needed; special funds to train manpower.

II. KENNEDY - CORMAN BILL (continued)

G. Cost Controls

Strong fiscal incentive for group practice; utilization review in hospitals & ECF's.

H. Role of Insurance Carrier

Would eliminate all private health insurers; no provision at present even for intermediaries.

I. Chance for Enactment

Is gaining tremendous support with labor's political power; Sen. Kennedy says he has 47% of votes necessary for passage.

III. AMERIPLAN - American Hospital Association

A. Benefits

Health maintenance & catastrophic illness benefits package; standard benefits package for primary, specialty, restorative and health-related custodial care with emphasis on ambulatory services.

B. Eligibility

Poor & near-poor would be provided coverage without charge; everyone else who bought the basic standard benefits would then get a "free" government program of health maintenance and catastrophic coverage, and could buy supplemental benefits if he chose.

C. Financing

Would replace Medicare & Medicaid; those financially able would purchase package; supplemental benefits available from prepayment plans and private insurance.

D. Estimated Cost

"Not less than (the $70 billion) now being spent"

E. Administration

Through an innovation called a Health Care Corporation (maybe 400 nationwide) which all citizens would be encouraged to join; would bring together health care management, personnel & facilities in given geographical area into corporate structure to provide all levels of care; each state to legislate regulations; National Health Commission would replace HEW Dept.

III. AMERIPLAN (continued)

F. Medical Practice

Every physician would have opportunity to participate in managing Health Care Corporations; incentives would favor ambulatory benefits & preventive care.

G. Cost Controls

Health Care Corporations would review use of services & allocate money; State Bureau of Health Financing would set insurers' rates & determine need for federal funds.

H. Role of Insurance Carrier

Would let health insurers operate almost as they do now; they would "sell" standard benefits (to the financially able) and supplemental benefit packages.

I. Chance for Enactment

Has been called "the most sensible suggestion yet for pulling together the nation's badly disorganized medical resources"; must compete with numerous other NHI proposals for legislative support, making it questionable whether it will get into and out of the hopper by 1972.

IV. SENATOR PELL - Minimum Health Benefits & Health Services Distribution and Education Act

A. Benefits

Annual diagnostic exam; all necessary visits to physicians or ambulatory care facility; 12 days in-patient care per illness or injury; 10 days in long-term care unit; maternity care & specialist services; cost of catastrophic illness exceeding one-fourth of annual income.

B. Eligibility

Total population; compulsory minimums.

C. Financing

Forces employers to provide minimum level of care for employees & their families; coporations; individual would pay for first two days of direct care; federal funds for indigent.

D. Estimated Cost

About $40 billion a year in tax expenditures.

IV. SENATOR PELL (continued)

E. Administration

Employer would contract for health plan or provide services himself (a la Kaiser); regional public corporations would provide services to specific geographic areas; corporations would administer Medicare & Medicaid programs; corporations would be self-sufficient economic entities within 25 years.

F. Medical Practice

Regional corporations would control distribution of medical manpower and determine where taining is needed; doctors would become corporate employees.

G. Cost Controls

Minimum benefits would reduce pressure to use more expensive hospital care; employer encouraged to seek best & least expensive hospital care; providers would compete in costs.

H. Role of Insurance Carrier

Private insurers would have major role in regional corporations.

I. Chance for Enactment

Parts of it stand good chance of being included in whatever NHI bill comes out of Congress.

V. A.M.A. "MEDICREDIT"

A. Benefits

Medicare would remain intact for aged; Medicredit would replace Medicaid for all under 65; private plan policies must provide 60 days of in-patient hospital service & full range of out-patient & physician services in hospital home, office; benefits subject to deductibles & co-insurance.

B. Eligibility

Total population; voluntary.

C. Financing

Income tax credits for purchase of private health insurance; tax credit graduated from 100% (income tax liability of $400) to 10% (liability over $1,300); poor receive health insurance certificates redeemable in lieu of cash; certificates financed through general treasury funds.

V. A.M.A. "MEDICREDIT" (continued)

D. Estimated Cost

1970 cost estimated at $8 billion by AMA and at $15 billion by SSA

E. Administration

Medicare would continue with intermediaries; private insurers would handle own participants under 65.

F. Medical Practice

Does not challenge maldistribution of current resources; peer review by county medical societies mandatory.

G. Cost Controls

Does not address the issue of rising costs beyond urging stronger utilization review; state insurance departments would approve premium rates.

H. Role of Insurance Carrier

Would not make any change in current role of private insurers.

I. Chance for Enactment

Not highly favored because it does not provide for strong cost controls or preventive care; overly concerned with ability to pay but not with distribution.

VI. NATIONAL HEALTH INSURANCE ACT HR-15779 (Griffiths)

A. Benefits

Comprehensive benefits including hospitalization, physician services in home, office or hospital; psychiatric care services, eye exams, prescriptions, physicals and multiphasic screening; some benefits limited or on co-pay ($50 per person or $100 per family per year).

B. Eligibility

Total population; compulsory; dental care limited to children under 18.

C. Financing

1971 revision will provide for 8% tax.

VI. NATIONAL HEALTH INSURANCE ACT (continued)

D. Estimated Cost

In 1969 AFL-CIO estimated program would have cost $35.8 billion (including 5% for administration); estimates now range up to $45 billion.

E. Administration

By a Health Insurance Board under HEW; consumer and health professional advisory councils.

F. Medical Practice

People must register with physician of their choice; grants for education.

G. Cost Controls

Reduces duplication of services & facilities by convering only those ordered by a primary physician; limits costs by pre-negotiated budgets, capitation payments, salaries.

H. Role of Insurance Carrier

No provision for use of private carriers.

I. Chance for Enactment

May be withdrawn, but will probably be allowed to languish.

VII. NATIONAL HEALTH INSURANCE & HEALTH SERVICES IMPROVEMENT ACT SB-2711 (Javits)

A. Benefits

Same as Medicare subject to cost-sharing and limitations; also annual check-ups, limited drug & dental care for children under 8.

B. Eligibility

Total population; compulsory, but an employer could provide coverage through private insurers if such coverage exceeded the government standard.

C. Financing

Tax equal to 10% of payroll (based on $15,000 annual earnings).

D. Estimated Cost

$10.5 billion in first year; $68.1 billion in fifth year.

VII. NATIONAL HEALTH INSURANCE ACT SB-2711 (continued)

E. Administration

By HEW or by state government under contract with HEW; claims processed by private carriers.

F. Medical Practice

Physician payments based on reasonable charges.

G. Cost Controls

Utilization review; contain costs to average wages.

H. Role of Insurance Carrier

Private carriers would act as fiscal agents for government plan and as insurers and underwriters for private plans.

I. Chance for Enactment

With support from New York and the National Governors Conference and the opting-out provision for private insurance, many feel this bill is the "best bet".

VIII. NATIONAL HEALTH CARE ACT (Burleson)

A. Benefits

Physician services (office, home, health facility), lab charges, dental services, prescription drugs, contraceptives, prosthetic devices, physical and speech therapy; eye examinations. Most of these subject to deductibles and co-payment.

B. Eligibility

Total population; voluntary.

C. Financing

Partially through SS funds; largely through individuals paying premiums to administering carriers equal to 18% of their incomes in excess of $2,000, $3,000 or $4,000, depending on size of family; premiums for indigent paid with state & federal funds into state pools; employers could deduct up to 100% of their premium payment from taxes.

VIII. NATIONAL HEALTH CARE ACT (continued)

D. Estimated Cost

HIAA estimates $3.2 billion in additional taxes for first year (total cost of $24 billion).

E. Administration

Council for Health Policy Advisors to counsel President and coordinate all federal health programs; private carriers would provide benefits; Medicaid would eventually be replaced; Medicare would be retained.

F. Medical Practice

Increase manpower supply.

G. Cost Controls

Ambulatory health care centers to reduce use of hospitals.

H. Role of Insurance Carrier

Private carriers & prepaid group practice plans would provide benefits; insurer would underwrite each Qualified State Health Care Plan.

I. Chance for Enactment

A good bill because of its comprehensive approach; will have support of HIAA's 308 member firms which sell 80% of U.S. commercial health insurance.

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