SOCIAL SECURITY IN THE UNITED STATES

FOUR LECTURES PRESENTED AT THE UNIVERSITY OF CALIFORNIA · BERKELEY

APRIL AND MAY, 1961

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SOCIAL SECURITY IN THE UNITED STATES

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FOREWORD

In the Spring of 1960, the Chancellor of the Berkeley campus of the University of California appointed a committee to develop plans for an appropriate observance of the 25th anniversary of the passage of the Social Security Act of 1935.

The result of the committee's deliberations was a series of four public lectures held on the campus in April and May, 1961. The lectures were co-sponsored by the Department of Economics, Department of Political Science, School of Law, School of Social Welfare, and Institute of Industrial Relations, all of which contributed to the expenses associated with the series.

The opening lecture, delivered by Robert J. Myers, Chief Actuary of the Social Security Administration, focussed on the changes in the social security program that are likely to be considered in the next decade or so, while Professor Eveline M. Burns of Columbia University, our second lecturer, discussed issues in social security financing. Because of the sharp differences in public opinion on problems of financing medical care, the committee decided to invite two speakers -- Dr. James P. Dixon, President of Antioch College, and Professor Arthur Kemp of Claremont Men's College -- who would present distinctly different points of view on the issues in the health insurance field.

In response to many requests, the lectures are being published under the auspices of the Institute of Industrial Relations, in cooperation with the Chancellor's Committee.

MARGARET S. GORDON
Acting Director, Institute
of Industrial Relations, and
Chairman, Chancellor's
Committee on the 25th
Anniversary of the Social
Security Act

C O N T E N T S

SOCIAL SECURITY: THE YEARS AHEAD

by

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In the past twenty-five years, the role of the Social Security program in the social and economic life of our country has grown rapidly. The term "Social Security" is generally used in this country to denote the Old-Age, Survivors, and Disability Insurance system, which is this nation's pension program covering long-term risks. Actually, as the term "Social Security," is used internationally, it is much broader -- including programs covering unemployment, industrial injuries and diseases, medical care, and temporary sickness. This paper, however, is confined to the development of OASDI.

Any prudent person before planning or predicting the future, will first study the past and present situations. The younger generation today would have difficulty in visualizing the economic society that existed only a quarter of a century ago, when there was no broad protection against the potential absence of income occurring in the event of death, disability, or retirement of the vast majority of workers in the country. It seems as natural as having automobiles and television that if a worker ceases employment after age 65, he should receive OASDI benefits even though the amount involved may seem to many persons far too small. Yet, a mere quarter century ago no such economic security protection was widely available. We might now wonder what happened then to persons in those situations, but this is beyond the scope of this paper.

Past Development

When the OASDI program began in 1937, it applied only to employees in industry and commerce. Beginning in 1950, as both public opinion crystallized and administrative processes matured, coverage was widely extended. By 1956, virtually all types of employment, including self-employment, were covered by the system or by some other public retirement program.

Over these two and a half decades, the types of protection furnished by the OASDI system were gradually expanded. The "OA" portion of the program was in the initial 1935 Act, which provided only old-age retirement benefits and certain lump-sum refunds upon death. The "S" was added in 1939 when monthly survivor benefits were added for dependents of retirement beneficiaries. The "D" was added by the 1956 Amendments, which introduced limited monthly permanent and total disability benefits. The disability benefits since have been extended so that they are available regardless of the age at disability and are supplemented by dependent's benefits.

The relative benefit level of the OASDI program has risen over the years so as to keep pace with, or exceed, rises in the price level, although it has not risen as rapidly as the general wage level. In part, this trend has resulted from the desirability of maintaining the purchasing power of the benefits, and in part from a change in basic philosophy by relating benefits more to immediate social needs than to individual equity principles based on contributions paid or length of time in covered employment.

Current Basic Principles

Now, having seen briefly where we came from, let us review where we now stand. There is no need for a detailed explanation of the present OASDI program because adequate summaries of the system are available. It may be worthwhile to consider the current basic underlying principles: (1) benefits are based on presumptive need; (2) benefits should provide a floor of protection; (3) benefits should be related to earnings; (4) a balance of social adequacy and individual equity should be present in the benefits and (5) financing should be on a self-supporting, contributory basis.

Certain categories of social risk are established by the law, and benefits are paid when these eventuate. For example, old-age benefits are payable only upon retirement, and not automatically upon attainment of a given age. Likewise, benefits for surviving widows are payable only as long as they are not remarried and not substantially employed. The retirement criterion is frequently misunderstood as a means test that is unfairly applied only to earned income and not to investment income. The test is logical for a program covering the risk of retirement, without penalizing individual and group thrift.

It is generally agreed that OASDI benefits should provide only a minimum floor of protection against the various risks. There is, however, a great diversity of opinion as to how far apart the floor and the ceiling should be. At one extreme are those who believe that the floor should be so low as to be virtually non-existent. At the other extreme, some believe that the floor should be high enough to provide a comfortable standard of living, disregarding any economic security that private or group methods might provide. The middle ground is that the benefits along with other income and assets reasonably to be anticipated, should be sufficient to yield a reasonably satisfactory minimum standard of living for the great majority of individuals. Any small residual group still in need should be taken care of by supplementary public assistance.

Because of the "floor of protection" concept, it seems desirable that benefits should be relatively larger for those with low earnings than for those with high earnings. Accordingly, the OASDI benefit formula has always been heavily "weighted," with a higher benefit rate applying to the lower portion of earnings than to the higher portion. Since contributions (or taxes) are directly proportional to earnings (up to the maximum earnings base) there is some public appeal in the fact that higher earnings (and taxes), will lead to higher benefits.

Whenever a social security system requires contributions from the potential beneficiaries, the question of individual equity versus social adequacy arises. Individual equity means that the contributor receives benefit protection directly related to, or actuarially equivalent to the amount of his contributions. Social adequacy means that the benefits will be sufficient to provide a certain standard of living. The two concepts thus conflict. Social security systems usually adopt a benefit basis falling between complete individual equity and complete social adequacy, but with the tendency more toward social adequacy than individual equity. If individual equity were to prevail completely when a system is started, the benefits paid in the early years of operation would be small, and many years would elapse before the system would begin to meet the purposes for which it was established. Nonetheless, it is possible to maintain a degree of individual equity.

Individual private insurance policies are, of course, necessarily based on the individual equity concept. This does not mean that each individual will necessarily always get back exactly his payments plus interest (as in the case of a savings-bank account or some government bonds). Rather, insurance company contracts have premium rates actuarially determined for the benefits provided, so that policyholders in the same risk class pay the same amount for the same benefit. Due to random chance, the relationship between premiums paid and benefits received under a private insurance company contract will vary considerably for a given selected group of presumably identical risks. But no one can foretell in advance which of the group will die early (and thus receive benefits far in excess of premiums) and which will die after many years of premium participation.

The conflict of individual equity and social adequacy can be well seen by considering the proportion of current OASDI benefits that, from an actuarial standpoint, have been "bought" by the contributions of the covered workers involved. At the present time, for all beneficiaries on the roll, this ratio is probably about 5 per cent — the other 95 per cent, it could be said, coming from the pooled contributions of all covered employers (past, present, and future). In certain extreme cases, the ratio can be well less than 1 per cent.

The concept that covered workers and beneficiaries have "bought and paid for" their benefits is not applicable in a social insurance system, such as OASDI. Consider a covered worker who retired at the beginning of 1940 with the maximum monthly benefit then payable, $41.20 and who had paid $90 in employee contributions. At the present time, he would be receiving a monthly benefit of $89. From an individual-equity standpoint, he had "paid for" none of the subsequent increases in his benefit, which more than doubled. Such a result is, of course, not consistent with individual equity principles but is both reasonable and desirable for a social insurance system in a dynamic economy. Some persons might go so far as to say that his original contributions were made under the principle that they would buy all future increases in benefits that might result from an expanding economy or legislative liberalization, including expansion into new areas, such as medical care.

The principle of self-support means that no general revenue appropriations will be needed; instead, the OASDI benefits and administrative expenses will be paid out of the contributions (taxes) from workers and employers, plus the interest earned on the fund that results from the excess of income over outgo. The assets are invested in United States government securities; interest on these securities does not represent "subsidy" from the General Treasury, since interest on the National Debt has to be paid, whether the securities are held by the trust fund or by private investors.

The basic financing principle for OASDI is that the program should be completely self-supporting from contributions of workers and employers. Self-support can be achieved by any number of different contribution schedules -- ranging, at one extreme, from a schedule sufficiently higher in the early years than in the later years to produce a "fully funded reserve" to, at the other extreme, a schedule slowly graded upward so that "pay-as-you-go" financing would result. The actual basis adopted for OASDI has been between "pay-as-you-go" and "fully funded," but much nearer the former.

In carrying out this principle, the basis adopted is that the employer and employee share the cost equally, each paying a percentage tax rate on earnings up to a specified maximum amount, such rate gradually increasing to an ultimate level which was originally scheduled to be reached in 1949, but under present law is to be reached in 1969. At the same time, self-employed individuals pay a tax rate equal to 75 per cent of the combined employer-employee rate -- a "political" and "practical" compromise between the employee rate and the combined employer-employee rate.

Possible Future Developments

In considering possible future developments, we may state broadly that there are four different viewpoints prevalent among those who think seriously about the role of OASDI in our economy. These groups are by no means equal in number of adherents or in their importance, and it is not always possible to draw exact boundaries separating the groups.

The first view, held by a relatively small but vocal group, is that the OASDI program and anything of the same nature is undesirable. Accordingly, this group believes that the system should forthwith be repealed and, at best, replaced by a strict means test program.

The second view -- also probably held by a relatively small group, but one that is not so vocal -- is that the present OASDI system should be maintained at exactly its present scope as to protection provided and amount of benefits. The basis for this position is that any development in our economy in the form of higher wages and greater productivity should enable individuals to provide any necessary supplementary and additional protection themselves through private means.

The third view -- quite widely held -- is that the level of benefits and the scope of protection should remain about the same relatively as at present. This would mean that benefits should be adjusted upward from time to time to reflect rises in prices and in the general level of earnings.

The fourth view -- again, held by a sizable number of people, including many whose opinions are quite influential -- is that the nature of the OASDI system should be extended and expanded so as to provide a significantly greater degree of economic protection in the areas covered. At the extreme, under this view, the system would be extended to the point where virtually all economic needs for those affected by any long-term social risks would be provided for.

Now, let us look at the specific directions in which development can occur in the future. Probably the most important element is the general benefit level. For present retirants, the benefits now average close to one-third of gross pay -- disregarding earnings in excess of the maximum creditable amount; most married retirants get benefits close to half pay. Based on past Congressional action, it would seem that as wages rise, and especially if prices also rise, the general benefit level will move upward as a result of periodic amendments.

Some countries have introduced automatic procedures for adjusting benefits to changes in prices or wages, but it does not seem likely that, considering the political situation in this country, such procedures will be adopted here. Instead, the ad hoc measures taken from time to time in the past will likely be continued.

In addition to the changes in benefit level to "keep up-to-date" with prices and wages, there may be proposals for drastically raising the benefit level, possibly by as much as 50 per cent or more, in gradual steps. This would mean that single workers would get benefits of about half pay, and married workers about three-quarters of pay, or relatively close to their former take-home pay. If this procedure were followed, it would, of course, largely eliminate the function of private pension plans and individual savings for old-age.

Closely related to the question of the benefit level is the maximum earnings base subject to contributions and creditable for benefits. This is an area of great controversy. One school of thought would keep this base unchanged at the present $4,800 a year, arguing that any increase in the earnings level means that people can afford to buy more private protection.

Another school of thought would argue for maintenance of this maximum base at the same relative level as in 1958 when it was first adopted. At that time it covered the full earnings of about half the regularly employed male workers -- or viewing it from another aspect, about 80 per cent of the total payroll. Thus, as earnings rise in the future, according to this theory the maximum base would be advanced from time to time in a proportionate manner, as has been done since 1950 when the base was set at $3,600. By this criterion, an increase to $5,400 should be made now.

The remaining school of thought would increase the earnings base to a level such that virtually all except the very highest paid workers would have all their earnings covered, as was the case with the original $3,000 base in the late 1930's. The required base would now have to be somewhat over $10,000, which the proponents of this theory would reach gradually over the next few years. Such a proposal, when interrelated with that for a sizable increase in the benefit level, would mean that virtually all workers could derive sufficient economic support from the OASDI system so that little supplementary savings for old age, either on a group or individual basis, would be necessary -- other than perhaps home ownership.

Another important area where changes may occur in the OASDI system is in regard to the retirement test. If public opinion on desired changes were measured by the number of bills introduced in Congress, the popularity leader by an overwhelming margin would be the repeal or liberalization of the retirement test. In the past, the Congressional committees responsible for OASDI legislation have recommended only moderate changes in this provision, apparently recognizing that most of the public criticism has been due to misunderstanding. Furthermore, interested national groups, such as labor organizations and business associations, have always strongly favored a retirement test.

The major reason for the retirement test is that the OASDI program is designed to provide benefit protection against presumed loss of earnings arising from the risks covered by the program. This basis, insofar as retirement benefits are concerned, naturally differs from private insurance which necessarily provides annuities at a prescribed fixed age. The retirement test is a condition of eligibility for benefits and is not a prohibition of benefit payment (or for that matter, a prohibition against working).

Cost considerations are also important in connection with the retirement test. The increased cost would be substantial (about 1 per cent of payroll, which at present would be over $2 billion per year) if benefits were payable solely upon attainment of age 65, rather than only upon retirement.

Paying benefits to fully-employed persons is not socially necessary. On the other hand, to pay partial benefits, or even possibly full benefits in certain cases, to those in part-time or low-paid employment is desirable. The improved retirement test provided by the 1960 Amendments goes a long way toward eliminating inequities and anomalies. It provides some incentive for aged persons to engage in partial employment and to "taper off" as they become older. This new basis will possibly be further improved in the future.

The minimum retirement age, too, is a matter of considerable significance. Just as in the case of the retirement test, there is strong popular pressure for lowering this age. From a logical standpoint, considering the improvements in health conditions and mortality of aged persons that have occurred in the past and that are likely to

occur in the future, it could well be argued that the retirement age should be gradually increased in the future. This has been done in a few countries, even though it is politically difficult. It is not impossible that such action might occur at a far-future date in this country, especially if great breakthroughs occur in the field of medical care for the aged.

Nonetheless, at the present time the trend seems to be in the opposite direction. There is strong pressure currently for lowering the minimum retirement age for men to 62, but with actuarially reduced benefits. The strength of this movement rests on the fact that in certain areas of the country there are relatively high levels of unemployment among workers just below age 65. Further, as the argument goes, making this change will have no cost effect on the program. Underlying this argument is the thought that making available reduced retirement benefits at an earlier age will not generally result in voluntary early retirement or in changed employer retirement policies. If such is not the case, however, there could be very significant effects on our national economy through loss of production by having a reduced labor force, so that the absence of cost considerations may not be the controlling factor.

Currently under consideration is a proposal to increase benefits for aged widows. It is argued, from a social-adequacy viewpoint, that the widow should receive the full basic benefit that a single retired worker gets since it takes such an amount to support one person. Against such a change is the individual-equity viewpoint that a survivor who did not contribute, should not receive the same benefit rate as a covered worker (note particularly the situation of the non-working widow versus her working nonmarried sister). Pending legislation would move part way in this direction by increasing the aged widow's benefit from 75 per cent to 82½ or 85 per cent of the basic benefit.

The final major area of possible benefit development in the OASDI program is into a fourth branch of social security, medical care. Present proposals would extend limited benefits in this area to aged beneficiaries only, although proposals have been made in the recent past for a much wider scope of benefits to all beneficiaries. In the more-distant past, recommendations along these lines would have provided comprehensive protection not only to beneficiaries, but also to all insured workers and their dependents.

The provision of health benefits would, of course, change the "earnings-related principle," since the same services would be provided regardless of the previous level of earnings or contributions. This does not, however, mean that such a change is undesirable, because the existing principles are not necessarily unchangeable for all time to come. I shall not go further into this particular area, since I understand that two subsequent lectures will deal with it in more detail.

In any program as complex as OASDI, there are a great many relatively minor areas where extensions of protection may be urged. Among these are such matters as liberalizing the definition of disability, paying benefits to children beyond age 18 when attending

school, providing benefits for such other dependents as brothers and sisters, etc. Time, however, does not permit considering in detail each of these changes. No doubt, many will be adopted in the future, but from the cost standpoint, and thus from an overall and economic significance, they do not bear the importance of the items previously discussed.

The possible developments in the benefit protection afforded by the OASDI system have been discussed without mention of the necessary financing. Each time legislative activity has occurred, Congress -- particularly, the controlling committees concerned -- has carefully considered the cost aspects of the proposed changes. The enacted provisions have been financed fully, according to the best actuarial cost estimates available. Thus, Congress has attempted to maintain the system on a self-supporting basis by keeping benefit costs very closely in balance, over the long-range, with contribution income.

I would predict that this careful cost consideration by Congress will continue in the future. Accordingly, the only significant development that I can see in connection with the financing is whether the program should remain self-supporting from solely the contributions of workers and employers, or whether, as is common in some countries and as some persons urge here, a specific government contribution should be introduced.

Some persons have argued that a government contribution would result in a more equitable distribution of the cost of the program among the taxpayers. It is stated that the present OASDI contributions are, in certain respects, regressive in that they are a uniform percentage on the first $4,800 of earnings. In rebuttal, however, it can be pointed out that the contributions are not regressive when they are considered in combination with the benefits, which are heavily weighted for persons with the lowest earnings.

As a practical, political matter, it could be argued that a general government contribution might become necessary if the contribution rate should rise to a relatively high ultimate figure, made necessary by liberalizations in the general benefit level. Such liberalizations, combined with extension of the program into other areas, could readily result in an overall cost of between 15 and 20 per cent of payroll. Although such a cost seems high in contrast with that for the present program, advocates of such an expansion can point to the fact that costs of this magnitude are involved in the more liberal private pension plans now in existence in this country and in many foreign social insurance systems. Diverting part of the cost of the OASDI system to a government contribution from general revenues would tend to obscure its cost implications, although in many instances, the covered individuals would still be paying the tax.

All in all, students of social security can expect to have some interesting years ahead -- not only in analysing the developments as they occur, but also in predicting what will come next.

ISSUES IN SOCIAL SECURITY FINANCING

by

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The problem of financing social security systems I take to involve the question of how the necessary revenues are to be secured. It is important to note that this is different from, although in some respects related to, the question of how much social security a country can afford. This latter problem is essentially one of how much of its total income a country wishes to allocate by mechanisms that operate outside the functioning of the economic market. The answer given by each country at any given time is a function of its economic situation, its social values and the nature and extent of competing demands on incomes that are secured through the operation of the economic market. Posed in the form in which it is most commonly expressed, namely whether there is a limit to the proportion of Gross National Product, or National Income, that can be allocated to social security (or even more broadly, to social welfare) the question is one to which no meaningful answer can be given. Indeed, I would seriously question the value of the time devoted by such organizations as the International Labour Office, to laborious (and usually not wholly comparable) calculations of the proportions of national income which social security expenditures form in different countries.

For very little reflection suggests that the exact proportion at any given time is the product of a variety of factors. It depends in part on the level of per capita income. This affects both prevailing attitudes to what is an acceptable minimum level of living for all members of the community and also the willingness of those whose incomes are derived from the economic market to sacrifice some of it to assist the needy. For with high and rising incomes they can both allocate more resources to the non-producers and still enjoy a rising disposable personal income. It depends too on the scope and severity of interruptions to income. If these affect, or are believed to affect, large segments of the population, there will be a greater readiness to assure some minimum flow of income through organized community action, i.e. to adopt more comprehensive social security systems. Thus the depression of the 1930's brought home the fact that unemployment was not confined to a minority of work-shy people but might be experienced by any member of the labor force and with this realization came a willingness to support a comprehensive unemployment insurance system. In Great Britain, the impact of rising medical costs on even the middle-classes explains not a little of the widespread support of

the National Health Service with its attendant costs. The severity of income interruptions explains too the apparent paradox that it is precisely when GNP falls, due to extensive unemployment, that the community is willing to increase the percentage devoted to social security.

The proportion allocated also depends partly on demographic forces, both actual and desired. A large proportion of people in the older, non-productive age groups is likely to increase the proportion of income that is allocated through non-market mechanisms. A concern about a low or falling birthrate may bring support for a system of children's allowances. Social attitudes are also a vital factor. Countries vary in the degree of their sensitivity to their economically less fortunate members. They attach more or less importance to the concept of "the right to an adequate minimum" or to making sure that all their members have access to adequate and high quality health care.

Willingness to devote economically secured income to social security purposes will also be affected by the nature, extent of, and priorities attached to, other demands on incomes. On the one hand, they affect the size of disposable personal income; on the other, some types of governmental expenditure may reduce the need for social security expenditures by reducing the extent or the duration of income loss. (Expenditures on education, or retraining, or development of depressed areas, or on the prevention of family breakdown could all have this effect.) Finally, the methods of financing, in the sense in which I have used the term, also play a role though it is probably minor in relation to these other influences. Undoubtedly, for example, the use of contributory social insurance as a major financial technique increased the willingness of the country to devote a larger proportion of national income to social security measures. A level of income taxation, which otherwise might have been resisted, was accepted because the tax was specifically earmarked for the payment of benefits to the taxpayer in some proportion to the taxes he had paid. Similarly, a method of financing that threw burdens on workers or enterprisers heavy enough to cause them to lessen their productive efforts, might, by reducing levels of national output in subsequent years or by slowing up the rate of growth, cause a community to feel that "it could not afford" so much social security, whereas a different method of distributing the tax burden might have caused the same level of expenditure to be regarded as easily "bearable."

It thus should not surprise us that different countries at any given time, and the same country at different times, find that they can "afford" to devote widely differing proportions of national income to social security measures.

What then are the essentially financial questions that must be faced by any country, regardless of whether its social security expenditures form a small or a large proportion of national income? I suggest they are three in number. Decisions have to be made as to how the cost is to be allocated among various segments of the population, as to the period of accounting, and as to the financial role to be played by the tax systems of different levels of government. All three of these

questions were faced, and answered, in 1935 by the original Social Security Act. The nature of the answers differed for each of the three major social security systems with which the Act was concerned, namely Old Age Insurance, Unemployment Insurance, and Public Assistance. For each of the programs enacted in 1935, the financial issues were so complex, and subsequent developments were so numerous, that time does not permit adequate treatment of all of them. Perhaps our best approach is to ask, for each program, which decisions in the light of 25 years' experience could one have wished had been different.

OASDI Financing

(a) For the all-important Old Age Insurance program (as it was in 1935 before the inclusion of survivors benefits in 1938 and disability insurance from 1956 onwards) one of the three major financial policy decisions was easy. If the program was to apply equally to all Americans in the covered occupations, if people were to be required to pay taxes over their entire working life in return for legislatively promised benefits in old age, then with a highly mobile population and with states dominated by widely differing social philosophies, nothing short of a federally-operated program, financed by federally levied taxes, would ensure fulfillment of the promises made.

The answers to the other two more difficult questions, how the costs were to be distributed among persons and what period of accounting should be adopted, were in large measure determined by two significant policy decisions as to the nature of the program. First, it was to be a benefit system in which legally defined benefits were to be given, in principle, in return for the payment of contributions by potential beneficiaries. Second, it was to be a financially self-contained system, set apart from the general budget, and actuarially sound in the sense that the legislation which promised benefits should also contain taxing provisions designed to guarantee adequate funds for the payment of the benefits as claims fell due.

(b) The decision in favor of a contributory social insurance type of security system in large measure answered the question about the distribution of the costs among persons. But not wholly so, for in strict logic one might have expected the entire funds to have been supplied by the potential beneficiaries, through some earmarked additional tax on income or earnings. This was regarded as impracticable if benefits of some degree of adequacy were to be assured to relatively low income receivers and would have undoubtedly have proved psychologically unacceptable. Furthermore, there was the example of almost every other country with social insurance systems which required employers also to contribute to the cost. But this decision to require employers as well as workers to pay social security taxes made it more difficult to know how, in fact, the costs of the program were divided among persons. For that half of the costs paid by workers, the answer was easy. But the question of the incidence of the employers' share has been in dispute for years. As events turned out, the economic circumstances of the last 25 years, namely an expanding economy, characterized by rising employment, wages and prices, enhanced the probability that

employers were able to pass on much of this burden via higher prices or smaller wage increases than would otherwise have been given.

It thus seems probable that the total effect of the social security wage and payroll taxes has been to throw the major burden on the lower income receivers, and especially on wageearners as a group. It cannot be denied that this is a non-progressive, if not a regressive, method of financing. The tax on wages provides for no exemptions for earnings below any given amount and there are no deductions. Moreover the tax is at a flat rate and, thanks to the taxable limit, applies only to relatively low bracket earnings. As between income levels, this system is in no sense redistributive. Such redistribution as exists occurs within the $4,800 bracket, and exists because of the differential benefit system. Lower paid workers within this bracket get more out of the system, in relation to what they pay in, than the higher paid. Married men with dependents gain relatively more than the single. And thanks to the liberalizations of eligibility that have occurred during the last 25 years, those with short period coverage gain more than those who will claim benefits after paying taxes for an entire working life.

One significant by-product of the nationwide introduction of social security taxes in 1935 should never be forgotten. The innovation of the withholding tax, thus utilizing the employer as a tax-collection agent, and the pressure on the Treasury after 1935 to occupy itself with the problem of full collection of taxes from even the smallest income receiver, opened the door to a general lowering of tax exemptions. For, until this time, the Treasury had held that it would be both administratively difficult and often fiscally unrewarding, because of the costs of collection, to levy taxes on small income receivers.

If in 1935 we had recognized the full social consequences of the policy of throwing the costs of OASDI on wage and payroll taxpayers, would we have made a different decision? Probably not very materially. For while the financial policy had some obvious disadvantages, it also had advantages and some of these are still relevant. Three major considerations pointed to adoption of the policy of throwing at least a major part of OASDI costs on the potential beneficiaries. First, it seemed necessary, in 1935, to make receipt of a payment from government socially acceptable. Inculcation of the idea that one had a "right" to this benefit because one had paid for it seemed an effective way of differentiating OASDI benefits from poor relief or the then much publicized "dole." As we can now see, this objective has been only too successfully attained. So pervasive today is the idea that OASDI benefits are "earned" that individuals who have secured beneficiary status on the basis of little more than the minimum contribution of six quarters still apparently firmly believe that they have "paid for" or "earned" their benefits. In fact, of course, thanks to the fact that the full rate of tax is not applicable until 1969 and because of the extremely liberal eligibility conditions whereby beneficiary status can be secured after very short periods of covered employment, it will be many years before <u>any</u> beneficiary can truly claim that he has "earned or paid for" his benefits through his and his employer's contributions.

The second justification for taxing the potential beneficiary still holds good, namely it made acceptable a national program which none-the-less made differential payments. The need for the latter stemmed from the desire to make meaningful payments to retired workers in a country characterized by wide geographical and occupational differences in wages. A uniform formula applicable to wages, as the benefit determinant, assured equality of treatment, and the payment of a higher benefit to the higher paid worker could be justified on the grounds that this worker had paid higher taxes.

The third objective of taxing the potential beneficiary was to enhance the sense of social and fiscal responsibility, to bring home to the beneficiary that more liberal benefits cost more money. In this, the country has been amazingly successful. So generally accepted is the idea of the close relationship between benefits and taxes that all proponents of liberalization, and notably organized labor, always couple their proposals with an assertion of their willingness to pay higher taxes to finance them if additional funds should be needed. It is organized labor, for example, that is spearheading the drive to raise the taxable wage limit above $4,800.

Nevertheless, in at least one respect, one might have wished for a change in policy. For the loading of financial responsibility on workers and their employers has applied also to the financing of the quite heavy costs of the unearned benefits with which successive liberalizations have burdened the system, and also to the relatively favorable tax treatment of the self-employed who do not pay their proper actuarial share. Had these costs been charged to the general taxpayer instead of to the contributors in perpetuity, several advantages might have followed. Policy makers might have been a little less lighthearted in the extent of the benefit advantages given to the already elderly or, after 1950, the newly covered. For not only were such people admitted to benefit status after extremely short periods of coverage, but, once admitted, they drew benefits at the level appropriate to their average wages, rather than at some uniform minimum sum, applicable as a transition measure to all who qualified on a less than normal period of coverage. Again, to have assessed against the general taxpayer the costs of these unearned benefits, payable because of a desire to use the OASDI system to deal with the present problem of old age insecurity, might have improved the position of the federal government vis a vis the states in the increasingly frequent disputes as to the extent of federal responsibility for sharing in Old Age Assistance costs. The federal case is, of course, that as OASDI takes over more and more of the people who otherwise would have been OAA recipients, the need of the states for federal aid to finance this program is less and the federal share should be correspondingly reduced. The federal case might have been more effective and appealing if the costs of the unearned OASDI benefits had been a visible direct charge on the general federal taxpayer instead of being concealed in the level premium cost of OASDI, chargeable only to wage and payroll-taxpayers.

But there are even more important considerations. There is a

real question whether we can socially justify the policy of charging the costs of all unearned benefits payable to the present generation of the elderly against relatively low wage receivers and their employers in perpetuity. To have assessed them against the general revenues would have made possible a more progressive method of financing what is clearly a social charge, attributable to our lack of foresight in not adopting OASDI a generation or more ago. And in view of the fact that the country is beginning to realize the advantages of using contributory social insurance as a method of paying for other risks such as medical care, we can well ask whether, knowing what we now do, it was a good idea to burden current and future wage and payroll taxpayers with these unearned benefits. For at some time we shall undoubtedly encounter taxpayer resistance to further tax withholdings, even for social security purposes. Had we not had to increase the OASDI level premium for new entrants from 5½ per cent to 9 per cent to cover the unearned benefits of the present covered group, we would have had a margin of 3½ per cent of payroll to play with for coverage of new risks, such as medical care. Hence, I believe we must regard it as unfortunate that the Congress in 1934 did not accept the proposals of the Committee's old age insurance staff which had envisaged a contribution from the general taxpayer.

(c) The answer to our third financing question, how should the costs be spread over time, was not automatically provided by the decision that the system should be self-supporting from the yield of the selected earmarked taxes. For it would have been equally possible to have provided in the law for a schedule of taxes which rose year by year as anticipated costs rose or to have operated on some reserve accumulation basis. What the "self-supporting principle" did was to impose the necessity of estimating what annual benefit expenditures were likely to be in future years, and this was tremendously important. For these estimates showed that annual costs, expressed as a percentage of payroll, were likely to rise over any period for which it was feasible to make meaningful estimates, due to the gradual maturing of the system and the growing numbers and proportion of the aged in relation to the employable ages. Although in the last 25 years successive liberalizations of the program have greatly speeded up the maturing process, it is still the case that benefit costs are estimated to rise from 6.85 per cent of payroll in 1970 to 11.81 per cent in 2050.

The 1935 decision to levy taxes higher than were necessary to cover benefit outgo in the early years of the program and to use the surplus to build a reserve, the interest on which would meet the annual deficit in later years when the earmarked taxes would yield less than anticipated outgo, was a not unreasonable policy in a new venture of this kind. In making possible an ultimate maximum rate of tax below the annual benefit cost of later years, the modified reserve policy had the further advantage of making more realistic the claim that the beneficiaries of the future were expected to make some significant contribution to the costs of their own benefits, a theory that would have been hard to sustain if, in the early years, future beneficiaries were paying only enough to support the then very low benefit expenditures.

You will have gathered that I attach less importance than do some students to the issue of whether we cling to the reserve principle or not. What is important is the pressure to forecast future costs which the self-sustaining principle has brought about and which, it can fairly be claimed, has been reenforced by the necessity to determine how great a role any reserve is to play. Here our financial decisions of 1935 have been astonishingly successful. Except for a few years in the early 1940's, the Congress has been extremely responsible in its financial and benefit policy. Each proposed change has been considered in the light of its corresponding payroll cost and when, on occasion, later and more exact estimates revealed that the system was less actuarily sound than had been previously thought, subsequent amendments have raised taxes to redress the situation.

Unemployment Insurance

In 1935 the problem of the financing of unemployment insurance took up more of the time of the Committee on Economic Security and its staff and its Citizens' Advisory Committee than any other subject. The differences of opinion mainly reflected the previous sharp cleavage between the proponents of this way of handling unemployment. There was dispute as to whether there should be a single general fund financed by uniform taxes on all employers out of which all claims should be paid or whether there should be separate accounts for each employer (the so-called Wisconsin Plan), or at least some form of experience-rating. In more general terms, it was a difference of opinion as to whether the central objective of unemployment insurance was to provide funds to guarantee the payment of benefits or to impose incentive taxes with the object of encouraging employers to stabilize employment. It is not too much to say that the resulting decisions on two of the three central financing questions were highly unfortunate, while the third, though sound, was never fully adhered to.

(a) On the question of the allocation of costs as between persons, it was decided that the taxes were to be paid by employers and although the door was left open for states to impose taxes on workers, only a handful availed themselves of this opportunity. This preference for employer taxes stemmed in part from the Wisconsin ideology: if incentive taxation was to be important then it was the employer who had to be given an incentive to stabilize. But it was also due to the position of organized labor, which, we must never forget, was formally opposed to social insurance until 1932 and even then gave grudging support only on condition that the costs were charged to the employer "because he was responsible." This position caused the labor movement some intellectual embarrassment in later years by which time they had become the major critics of experience-rating. For the justification for charging the employer only was mainly that he was "responsible" for unemployment and if this view is accepted, employers have a good case for claiming that if their workers do not become unemployed then they should be permitted to pay lower taxes through some form of experience-rating.

The second unfortunate consequence of sole employer financing

was that it gave employers, as the group financially supporting the system, a powerful and persuasive position in the eyes of the state legislatures and a direct interest in exercising that power to oppose liberalization. This interest was intensified by the existence of experience-rating.

(b) On the question of the relative fiscal responsibilities of the federal government and the states, the decision was that the states were to be responsible for benefit costs, while the federal government would meet the costs of administration and would also enact a fiscal device, the effect of which was expected to remove the fear of unfair competition from states desiring to tax their employers even though some others did not.

Looking at the federal-state issue twenty-five years later, after two not very serious recessions in which it has been necessary for the federal government to enact a supplementary unemployment insurance program, and recalling the uneven incidence of unemployment among the states, one might be tempted to wonder why a decision in favor of a federal system did not seem obvious in 1935. Two obstacles stood in the way. First, the general sentiment against federal action and in favor of "states rights." But second, adoption of a federal system would have involved a once and for all decision on the issue of employer reserves (or experience-rating) as against a single fund and a uniform tax rate for all employers. This was resisted by the proponents of the Wisconsin Plan, who, it should be recalled were strongly represented on the Committee and by its Executive Director. It is often asserted that the decision was made on constitutional grounds, but this can hardly have been so. For, quite apart from the contrary recollection of persons who were in the battle at the time, if constitutional reasons against a federal system had been decisive, how was it that the Committee recommended a much larger and more far-reaching federal old age insurance program?

Furthermore, although the battle for a federal system was lost, it would still have been possible to adopt a financing system in which the federal government would play a major policy role, by using some form of a grant-in-aid financed by the selected taxes. This was indeed recommended by a majority of both the technical staff and the Citizens' Advisory Committee. But this too was rejected by the main Committee in favor of the tax-offset, precisely because, for constitutional reasons the grant-in-aid would have made possible more stringent federal standards than would the tax-offset.

The tax-offset did achieve one objective. All the states soon enacted unemployment insurance laws, either because they had wanted to do so before but had been deterred by fear of non-action by other states, or because they did not like the idea of the federal government pocketing the 2.7 per cent tax. And in the end all states adopted experience-rating either because they believed in it or because, thanks to the terms of the Act, this was the only way they could achieve a general lowering of their average tax rate. But because of the absence of federal standards dealing with minimum benefit amount, duration and

the like, the objective of the tax-offset, as events have turned out, have been largely negated. For the states can and do compete, taxwise, with each other: employers in a state with a restrictive or illiberal law will pay lower rates and so under-cut their competitors in more liberal states.

A second consequence of these financial arrangements has emerged as it has become more and more evident that, in fact, the American people regard the federal government as the ultimately responsible authority for assuring income to unemployed people if all other measures prove inadequate. For it now becomes evident that the federal government, through the tax-offset provisions, has in effect ceded to the states access to the richly productive 2.7 per cent payroll tax without laying down any condition that the states shall use these funds to carry at least some specified proportion of the total unemployment burden. Due to the absence of any accompanying federal standards regarding minimum duration of unemployment benefit, we now have the unsatisfactory situation that in recession periods there is pressure for federal action and the federal government finds itself obligated to pay the costs of benefits to workers who, because of restrictive duration provisions in some states, have exhausted benefits after as little as 13-14 weeks.

In the third place, the decision that the federal government was to pay all the costs of administration was unfortunate. It invited friction between the federal government and the states not only because the latter had no financial interest in economy but even more because the former was in the position of meeting administrative costs of a program over whose substantive features, including the nature of benefit and experience-rating formulas, it had no control. Furthermore, until 1953, although it was always assumed that the federal administrative payments were to be financed out of the 0.3 per cent of payroll tax retained by the federal government, there were years in which the "costs of proper and efficient administration" amounted to less than the yield of this tax and the states charged the federal government with making a profit at their expense.

Even more fundamentally, one might wonder at an arrangement which removed from the states all financial responsibility for and control over the very parts of the program where one would have thought the case for lodging responsibility in the states was the strongest. For the problems of administration, checking abuse, developing counselling and placement services or assisted relocation of workers would seem to vary from state to state and be peculiarly appropriate for the exercise of local initiative and experimentation.

(c) The third financial question in unemployment insurance, the period of accounting, was answered reasonably enough in 1935. In view of the fluctuations of unemployment from year to year, it made obvious sense not to try to balance the books on an annual basis. Otherwise it would have been necessary to raise taxes or to cut benefits precisely at the time when such action was least socially and economically desirable, namely in a period of rising unemployment. But here, although the initial decision was a wise one, the states have not, in practice, been

prepared to abide by its consequences. For this policy implies an effort to estimate the severity of unemployment over some period of time and the fixing of a rate of tax that will ensure a balance of income and outgo over this period. In fact, the states have so little trusted their own estimates that they have never been prepared to use their reserves when necessary, including the limiting case of allowing them to fall below zero. Instead, the reserve has become an object of worship which must never be allowed to fall below some specified amount. Indeed, because of the linkage of experience-rating schedules with specified reserve levels, we have even seen the fantastic situation of states with sizable millions in their reserves borrowing money from the federal government rather than allowing their reserves to fall below the sacred minimum!

Furthermore, because current experience-rating formulae fail to distinguish between that degree of stabilization that is due to individual employer efforts, and that which results from general economic conditions, we have built in a mechanism for ensuring that if a recession lasts more than one year tax-rates are likely to rise -- the exact reverse of what would make economic sense.

Public Assistance

In the field of public assistance the financial decisions that had to be made were to some extent more restricted. Obviously, in a program making payments to needy people no question of requiring the beneficiaries to share in the costs could arise. Equally obviously, in a residual program whose scope was in large measure determined by the adequacies or inadequacies of the insurance system and where long-run costs were expected at the time to decline as insurance expanded, both the possibility of, and good reasons for, long-period financing and the accumulation of reserves did not exist. The central question in 1935, as today, concerned the respective financial roles of the federal government and the states. And here, with the advantage of hindsight, we can see that two very unfortunate decisions were made. First, federal financial responsibility was limited to some categories only of public assistance recipients. Second, it was decided that federal aid should take the form of an equal matching grant; for all states the federal government would contribute half of the cost of cash payments up to a stated monthly amount per individual. Both of these decisions were to plague us in subsequent years.

(a) First, the limitation of federal aid to some categories only not merely fastened on the country a categorical approach to public assistance which is increasingly deplored by most students in the field, but it also gravely prejudiced the position of the non-federally aided groups. One may admit that, at least prior to 1935, the only way in which to breach the wall of the deterrent poor law was by selecting for more favorable treatment certain groups for whom there was general sympathy (such as widowed mothers or the blind) or whose economic initiative would not be impaired by the receipt of assistance because they were obviously no longer members of the labor market (such as the aged or mothers of young children). Yet it is an open question whether

a determined effort to use the newly available federal aid on a permanent basis to improve the levels of assistance for all needy people, as was suggested by one of the expert committees, might not have met with success. Admittedly there were serious obstacles: the very recency of federal financial participation in any kind of relief programs, the deliberate selection, under the WPA program, of the "employables" as the proper object of federal concern, President Roosevelt's own attitude as expressed in his famous remark "the federal government must and shall get out of this business of relief," together with the increasingly powerful pressure of organizations of the aged for special treatment -- all these no doubt made a categorical approach to federal aid for public assistance seem the easier course. But, so far as I recall, no other alternative was even seriously considered by the policy makers.

The results have, as I said, been unfortunate. Such improvement in the condition of public assistance recipients as has taken place in the last 25 years has, apart from a relatively few states, been confined to persons who fell within the federally-aided categories. Although the number of these has been increased (by the addition of the disabled in 1950 and, on a temporary basis, dependent children whose fathers are unemployed in 1961) the condition of the truly residual group, the recipients of general assistance, has remained deplorable in most parts of the country. This is especially the case in those states where financial responsibility for this program is wholly carried by the localities without any state aid. Indeed in some states general assistance can scarcely be said to exist, and in all too many areas access is uncertain. Payments are low in comparison even to the none-too-adequate payments on the federally-aided categories and the tests of need are more rigorous. For these people the old deterrent poor law is still with us.

Categorization of federal aid took the form not only of restriction of aid to some types only of needy people; even within the aided categories the terms of federal aid differed. The maximum matchable monthly payment for ADC was, and has remained, vastly lower than that for the other categories. Indeed, until 1950 federal aid was not available for payments to the adult caring for the children (usually the mother). Why this federal policy of discrimination against children was adopted it is difficult to say, for even if it be granted that the costs of supporting a child are lower than for an adult, the differential ($30 as against $65) far exceeds any that could be justified on cost of living grounds, as the Federal Advisory Council pointed out last year. Nor can this consideration account for the fact that the lower ADC limit applies also to the adult caretaker.

Surely what one would have hoped for would have been a federal grant-in-aid where the matchable maximum might have differentiated between adults and children by some realistic approximation to relative costs of living and that the offer would have applied to <u>any</u> needy person in receipt of public assistance. This would have left the states free to categorize or not as they wished and their decision would no longer have been influenced by the knowledge that failure to categorize

would involve the loss of federal aid.

(b) The consequences of the second decision in the financing of public assistance have been equally serious. Admittedly the federal bait induced all states to establish programs for the federally-aided categories, conforming to the federal requirements within a relatively few years after 1935. However, it is interesting to note that even today not all states have taken advantage of the grant for the permanently disabled, instituted in 1950. But it soon became clear that there was something unsatisfactory about a matching grant available on the same terms to all states. If its intent was to make it possible for the poorer states to reach some minimum level of adequacy of payments this result was not achieved because to reach any given level the poor state had to provide from its own limited resources exactly as many dollars per case as the rich state and, being poor, the probabilities were that it would also have a proportionately larger caseload. Furthermore, although the amount of federal money flowing to the richer states was in one respect limited (by the matchable dollar maximum), there was already by the 1940's complaint that the lion's share of the federal money in absolute terms was received by the richer states which could afford payments at or above the federal matching limit.

Despite considerable discussion about the advantages of a variable grant, no change was made until 1946. The policy adopted at that time, which has remained in force until now, divided federal aid into two parts. The amount of the monthly grant was still the decisive element, but henceforth the federal share was much greater for the first so many dollars than it was for the remainder. By successive amendments both the dollar amount qualifying for the more favorable grant and the proportion matched have been liberalized so that today for the three adult categories the federal government pays 80 per cent of the first $30 and between 50 per cent and 65 per cent of the remainder up to $65. But the new formula, while giving relatively more help to the taxpayers in states making relatively low grants, did little to encourage them to raise their payments above the limit of the first part of the formula. Because the formula applied equally to all states, it was still true that to reach any given level, the poor state had to supply the same number of dollars from its limited resources as the rich state. Many of the richer or more liberal states did indeed pass the additional federal money on to their assistance recipients sooner or later. But in others, the gain accrued mainly to state taxpayers. One consequence of the new formula was certain. There was an increase in the proportion of costs carried by the federal government in all states. Indeed, because the federal law contained no definition of need, the new formula offered a positive inducement to a calculating state to put as many people as possible in the assistance rolls, for so long as the average payment was held below $30 this would bring into the state four federal dollars for every one put up by the state.

The weakness of this formula lay of course in its use of the average monthly grant as the single determinant. It is true that, in general, the lowest grants are found in the poorer states (though they also occur in such wealthy states as Delaware) and this evidently

appealed to the Congress which seems to have thought mainly in terms of proportions of total payments carried by the federal government. For under this formula it could truthfully be said that in the (mainly poorer) states making payments of only $30 or less the federal government was carrying four-fifths of the cost whereas in the richer states with payments of $65 or more the federal share of the total was only two-thirds or less. Not until 1958 was the fact accepted that if relatively more help was to be given to the poorer states then the formula must discriminate in their favor. Not all states could get assistance on the same terms.

But while at that time the decision was made to vary the federal share in relation to the state's ranking in terms of per capita income (thus introducing a new variable), the full implementation of this policy has been hindered by the original 1935 decision that the federal share should be 50 per cent in all states. It is politically unrealistic to assume that the richer states, who in any case could not gain by a variable formula, would vote in favor of a change that yielded them absolutely less than they had previously received. Variation, if it were to be adopted at all, had to leave all states with at least 50 per cent, and in view of the undesirability of a federal share approaching 100 per cent, this greatly narrowed the range of variability and thus the extent to which relatively more help could be given to the poorer states. The unwillingness of the states to give up that which they had found to be so good led to the further restriction of the variability principle to the second part of the formula, i.e. to payments in excess of the amount carrying the highly favorable matching proportion. As a result, much of the effectiveness of the variable principle is lost. For since, as we have seen, most of the poorer states pay lower grants, they benefit relatively little from the fact that if they were able to pay higher grants they would receive more than 50 per cent of the excess over $30.

In Retrospect

What then must our judgement be as we gather here to celebrate the twenty-fifth anniversary of the Social Security Act, regarding the wisdom of the crucial financial decisions? Clearly the highest marks must go to the OASDI program. Here, the major weakness was the failure to provide that the costs of unearned benefits should be carried by the general taxpayers rather than the wage and payroll taxpayers. In public assistance serious errors were made, some of which, such as restriction of federal aid to limited categories of needy could even now be remedied, but others, such as the failure to realize that the objectives of more adequate assistance in all states required variable, rather than matching, grants, will be more difficult to remedy because a certain pattern has now been established. Unemployment insurance fared least well. Even the most ardent advocates of a federal system would admit today that the state system created in 1935 is supported by too many powerful interests for it to be replaced, despite the fact that the arguments for a federal program are as strong as ever. The federal government is left holding the bag and has relinquished to the states a rich source of revenue which might have been used for a more adequate program for

all Americans. And because of the failure to enact federal benefit standards while permitting experience-rating, interstate competition is still possible and serves to depress benefit standards.

Obviously one could not have expected the framers of the Act to have foreseen all subsequent events, many of which, as I have shown, have served to aggravate the undesirable consequences of some of the 1935 decisions. But, in an academic atmosphere of this kind, we may perhaps take some wry comfort in the reflexion that, on most of these issues, it was the academic experts who were more right than the politicians and administrators. It was they who wanted a contribution from general revenues for OASDI: it was they who wanted a grant-in-aid for general assistance and it was they who as a majority favored a federal unemployment insurance system (or a grant-in-aid as the next best thing) and who opposed experience-rating or employer reserves. Perhaps after all, there is something to be said for the academic study of social security policies!

EMERGING ISSUES IN THE FINANCING OF MEDICAL CARE

by

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Recently Eleanor Roosevelt has written these charming words about imagination:[1]

> "The power of imagination is a kind of defense in childhood. You get away from the realities. It makes you important to yourself. If used correctly, it makes it more possible for you later on to imagine what other people are like and what they think and feel. It helps to keep you curious, anxious to understand....Of course unless it is checked, imagination can remain only a means of escape; but if it is nourished and directed, it can become a flame that lights the way to new things, new ideas, new experience."

In light of the fact that available data concerning the financing and distribution of medical care are inadequate, any identification of trends or predictions must contain elements of imagination. This is particularly true when events are interpreted by a person who has declared judgments between possible courses for future action. But as we shall see, there are other sources of indeterminacy. For many of the issues are related to the dialogue upon which we depend to reach democratic consensus.

I shall endeavor first to identify some data on general phenomena in human affairs which may bear on the special problems under discussion. Then I shall proceed to review selected data describing the financing and distribution of medical care in this country. Finally, I will identify and discuss four issues which I judge to be important at the present time as we look into the decade ahead.

We are living on a pycnotic planet. Technology, war, and communication have effectively condensed the environment of the human species. International dialogue is difficult. But one of the most effective topics of conversation in short-circuiting ideological conflicts has been health. There are common concerns of all people to improve sanitation of the environment and reduce the devastations of preventable illness.

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1. You Learn by Living (1960). Quoted in University College Quarterly, Michigan State University (Spring, 1961).

One billion of the world's population live in countries committed to democracy. One billion live in countries committed to totalitarianism. The remaining third live in countries not yet committed to either of these positions. An essential dilemma of all nations is to struggle with the relationship between technological production as measured by gross national product and human reproduction as measured by population. Social overhead capital is scarce, particularly in the uncommitted countries.

In the United States the total production of goods and services increased in the period from 1929 to 1957 at an average rate of 2.93 per cent per year.[2] The gross national product reached $505 billion in 1960. It is predicted that the rate of increase will accelerate in the next decade to an average of 3.3 per cent per year. We are, then, in an expanding general economy.

The population of the United States is expected to increase by 30 million by 1970. Five-sixths of this increase is expected to occur in metropolitan areas which by 1970 will contain two-thirds of the population.[3] While it is expected that the population in the center of cities will be less by 1970 than now due to out-migration, it is also expected that center cities will more uniformly than now be populated by racial and ethnic minorities who are relatively disadvantaged in socio-economic terms. The suburban rings will be populated by middle-class white families. There will be then an expanding market for medical care generally and present trends will further differentiate the social characteristics of this market within the geography of the urban complex.

Medical care in consonance with the technological explosion is increasing in complexity. Evidence for this is found in the growth of medical specialization.[4] In 1923 there were in the United States 146,000 physicians of whom 15,500, or 11 per cent, were specialists. By 1940, among 175,000 physicians, there were 37,000, or 21 per cent, in the specialist category. In 1955, 39 per cent of all physicians, or 84,500 out of a total of 218,000 were specialists. Further indication of the increasing complexity of medical care is found in the increasing use of hospitals. In 1931 the use of specialized and general

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2. H. Stein and E. F. Denison, "High Employment and Growth in the American Economy," in Goals for Americans: Programs for Action in the Sixties, U. S. President's Commission on National Goals (Englewood Cliffs, N. J.: Prentice Hall, 1960), p. 168.

3. Catherine Bauer Wurster, "Framework for an Urban Society," in Goals for Americans..., Op. cit., p. 225.

4. U. S. Public Health Service Pub. No. 263 (Washington: U. S. Government Printing Office, 1952-1960).

hospitals was 900 hospital days per 1000 population. In 1958, with a substantial reduction in length of hospital stay, the use had increased to 1300 days per 1000 population, an increase in this period of 40 per cent. Thus the hospital has become increasingly important in the technology of medicine.

Before completing this sketchy review of general data, there are two points to be made about government, particularly the federal government. The first point is that the citizen's attitude toward government is ambivalent. This has been described by Hutchins as the phenomenon of the two faces of federalism.[5] The general notion in a democracy is that the power of government shall be limited. There is consensus on this point. However, an argument arises about the criteria to define this limitation. Two rather distinct viewpoints can be discerned. The first which flows from the notion that the central purpose is the protection of individual rights would tend to limit government to those functions which ensure for the individual the freedom of speech, the freedom of assembly, the freedom of worship, the freedom of petition and the freedom of the press. Such a government builds checks and balances within itself and permits voluntary associations to act as checks on governmental power. The second view holds that government is a device for achievement, that its role is to undertake to do for the people whatever is needed that they cannot do for themselves, or which, if they did it for themselves, they would not do as effectively as if government did it for them. There are those who believe that the second view is required because of the events of technology and urbanization. Hutchins himself sums up in these words:[6]

> "It is probably fair to say that although the first has dominated our way of talking, the second has described our way of acting."

The second general observation about government flows in part from the first. There is a growing tendency to explore the transfer of the power of government to private groups. Examples of this tendency are to be found in the growth of the device of contract as a means to procure both goods and advice, the establishment of authorities for public works purposes which embrace both public and private characteristics, and the fixing of responsibility on producers for the determination of agricultural subsidies. Such actions do not deal with transfers of constitutional powers from government to private centers. But they do show a tendency to incorporate the administrative powers of government into private groups, which in the view of some has the effect of weakening the effective power of political government.

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5. Two Faces of Federalism, Center for the Study of Democratic Institutions, Santa Barbara, California, 1961.

6. Ibid., p. 8.

We have now established certain facts and conditions. We are in an expanding economy in a condensing world. In the United States the market for medical care is increasing, and this market is subject to geographic definition. Medical care is increasing in complexity. There is not a consensus on the appropriate role of government in the provision of services to people. There is a tendency for the power of government to flow towards private centers.

Let us turn our attention now to a more specific review of medical care expenditures in the United States.[7]

In 1960, 5.4 per cent of the gross national product, or $27 billion a year, was devoted to all health services. This included expenditures for public health, personal health services, construction of medical facilities and medical research. The comparative figure for 1928-1929 was 3.6 per cent. Thus there was a rise in the percentage of gross national product devoted to these services of 1.8 percentage points in this period, or an increase of 50 per cent. Bear in mind that these figures include all health services. For medical care services alone we were spending 14 billions of dollars in 1951.[8] This was approximately the same as was expended for alcoholic beverages, one-fifth the expenditure for food, and one-half the expenditure for clothing. Expressed in terms of proportion of national income, in 1929 expenditures for medical care were 4 per cent and in 1951, 5 per cent, an increase of 25 per cent. Both medical care and total health expenditures appear to be rising relatively and absolutely in the national economy.

Average family incomes are also increasing. The outlook is for a continuation of growth.[9] In terms of 1957 dollars, average family income in 1929 was $3,910, in 1957, $5,480, and is projected for 1975 at $7,300. Medical care costs are at the same time increasing. The increases in hospital costs are greater than in physicians' fees. In 1935, using 1947-49 as a base of 100, the price index for all medical care costs was 70. In that year the index for physicians was 70+ and for hospital room rates 50. By 1959 the medical care price index for all services had risen to 150. The index for physicians' fees was 140, or a 100 per cent increase over 1935. But the increase for hospital room rates was to 210, or a 320 per cent increase. From these data one may conclude that expenditures for health services including medical

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7. Report of the Medical Care Committee to the National Advisory Health Council, U.S.P.H.S., 1961 ms.

8. Michael M. Davis, "Medical Care for Tomorrow," (New York: Harper's, 1955).

9. Report of the Medical Care Committee to the National Advisory Health Council, U.S.P.H.S., 1961 ms.

care are increasing in absolute terms, and that families may if they choose spend more for medical care in the decade ahead.

There are interesting and important trends in the distribution of the private medical care dollar.[10]

In 1948 private medical care expenditures amounted to $52.68 per capita. By 1959 this had doubled and was $104.93 per capita. During this period five cents of the physician's share of the medical care dollar was transferred to the cost of hospitalization. Health insurance accounted for 17 cents more than in 1948. These data reflect both the growing use and the increasing cost of hospitalization. The proportion of the private medical care expenditures for hospital services which was covered by insurance premiums rose from 34 per cent in 1948 to 62 per cent in 1959. Insuring organizations now have a majority control over private income to hospitals. They have not yet attained the same measure of control over the private sector payments to physicians. The trend here is sharply upward. In 1948 insurance premiums accounted for about 10 per cent of the costs of physicians' services. By 1959 this had increased to 36 per cent. Taking insurance premiums for both hospitals and physicians' services together, they accounted for 20 per cent of these costs in 1948 and 50 per cent in 1959. These trends suggest that if insuring agencies chose to do so they could through financial control assume management of the entire hospital sector of private medical care. A similar situation might soon be possible in regard to the sector of physicians' services. Conversely, it indicates clearly that the power of the consumer in managing his expenditures in these sectors is rapidly disappearing.

Health insurance coverage for private medical care has increased substantially in the past decade.[11] In 1948 expenditures for health insurance were 862 million dollars, or 8 per cent of private expenditures for medical care. By 1959 health insurance expenditures had reached $5,139 millions and equalled 25 per cent of private expenditures. At the present time about 127 million persons have some health insurance coverage, but the rate of increase in coverage is slowing down. The recent Interim Report on Health Insurance, derived from data from the U. S. National Health Survey, showed that two-thirds of the non-institutional population of the country had some form of hospital insurance at the time of the study. Nearly as many had surgical insurance and about one-fifth had coverage for physician visits. The concentration of coverage was in the working urban and non-farm populations with middle and upper incomes. There was hospital coverage of

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10. A. W. Brewster, "Voluntary Health Insurance and Medical Care Expenditures, 1948-1949," Soc. Sec. Bull., V. 23 (December, 1960).

11. Report of the Medical Care Committee to the National Advisory Health Council, U.S.P.H.S., 1961 ms.

46 per cent of persons 65 and over, while 37 per cent had surgical insurance and 10 per cent insurance covering visits of physicians. This study begins to define the limits of usefulness of health insurance. Unfortunately the social utility of health insurance cannot be known without knowing the quality of the coverage. It should be clear also that a large segment of private medical care cost, about 40 per cent including costs of dentists' services, medicines, and appliances, is not substantially aided under present health insurance plans. It seems clear that present health insurance tends to be an economic device rather than a device to program improved health services.

Michael Davis, in introducing the issue of public medical care, relates a story worth repeating.[12]

> "The vestrymen of Petsworth Parish in Virginia in 1691 promised Dr. David Alexander 1500 pounds of tobacco if he cured a parish charge of 'distemper.' The patient died, and Dr. Alexander was paid only 1000 pounds."

The essential elements in the public sector of health services are as follows:[13] For health generally in the period from 1950 to 1959 private investment in medical facilities increased more rapidly than public funds, which at the end of the decade amounted to 55 per cent of the total. Thirty years ago public expenditures for all health services were 10 per cent of the total. Now they are 25 per cent for all health services. There are certain general categories of public responsibility, including responsibility for veterans, for the families of members of the armed services, for certain long-term illnesses, and for persons on public assistance.

The public, insurance and other private expenditures for health now stand in proportion to each other as follows. Public expenditures stand at 25 per cent; insurance benefits at 20 per cent; and all other expenditures represent 55 per cent. This reflects the pluralism which now exists in the provision of health services.

We may turn now to four issues of the present and future which are suggested by our discussion to this point. These are: the issue of the further distribution of responsibility between the public and private sector; the effect of the increasing importance of insurance upon the quasi-public operations in the private sector, especially in the relationships between costs and standards; the effects of the organization of medical care on its cost; and the effect of research and education on the cost of medical care.

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12. Michael M. Davis, "Medical Care for Tomorrow," (New York: Harper's, 1955), p. 188.

13. Report of the Medical Care Committee to the National Advisory Health Council, U.S.P.H.S., 1961 ms.

The debate on issues relating to the distribution of responsibility between the public and private sectors for the financing of medical care has in recent years centered on the question of the use of the machinery of social security for the purpose of implementing the principle of social insurance in the field of health. Since the passage of the original legislation in 1935 there has been wide discussion and debate on this issue. Many times legislation has been proposed and introduced to accomplish this end. No legislation has been adopted. Presently the use of the social security mechanism to assist in the financing of medical care to the aged is under sharp debate.

It seems logical that this should be so, particularly in the light of the success of the voluntary insurance mechanism in meeting the demands of the employed group. There are now more than 15 million persons over the age of 65 in the United States. Continuation of our present population trends, and continuation of success in the application of the medical sciences will cause both the number and proportion of older persons in the population to increase. Older persons are not likely to disappear. And as our society has increased resources to deal with its social problems, we tend to view the problems of older persons with increasing compassion for their comfort and happiness. Decreasingly are we angered that they are a burden on the productive economy.

Older persons have special health problmes. They have a high incidence of illness. They are substantially less well protected by health insurance than younger persons. Their incomes, despite social security, diminish rapidly at the point of retirement. Although there is continued improvement of private pensions and social security, private savings are insufficient to meet their medical costs. Substantial numbers must have help from public assistance to meet the costs of medical care.

Granting then that older persons as a group have a special problem which is aggravated because many cannot carry forward the voluntary insurance which they had during their working years, what are the objections to including health insurance for them within the mechanism of social security? There appear to be three which are important to consider. The first two are questions directed towards the social security device in principle. They are the objections that the system destroys individual initiative, and that its management and fiscal policies are unsound.

These objections have been present ever since the original legislation. Folsom,[14] reviewing the progress of the past twenty-five years under the Social Security Act, finds no evidence that these objections are presently valid. Indeed he says, "It would seem that progress has not been hindered by the Social Security System, but in

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14. Marion B. Folsom, "Goals in Governmental and Private Plans for Social Security." Address on Twenty-Fifth Anniversary of the Social Security Act, Washington, D. C., August 15, 1960.

some respects this system has actually helped. It has reduced the fear of unemployment and dependent old age for millions in the population, while for the economy as a whole the payments under the system have served as a stabilizing factor." Folsom also finds that the administration of the fund has been effective in terms of reducing the expense ratio to its present level of about 2 per cent of the benefit payment and that the actuarial phases of management demonstrate an ability to maintain a balance between the costs of benefits projected ahead and contributions to the fund.

A third objection to the use of social insurance for health flows from the idea that it would substantially upset the free market economy which presently characterizes the health field.

This objection no doubt has validity for those who put a higher value on the preservation of the health of the present market economy than they put on the health of the American people. For one thing the use of social insurance would introduce national system and organization into the present situation. There is of course very little which at the present time could be said to be systematic in the way which people get their medical care. We operate here on a laissez faire basis in common with other service industries. However, the introduction of social insurance for older people alone would not drastically disturb the economy. For as we have seen, older persons are not substantially included in the present programs of health insurance, and some of the services which would be provided are already financed by public mechanisms. What is meaningful about the objection is the fear that this kind of protection would work so well for older persons that it would be extended to other groups. This indeed would upset the economics of medical care.

But it seems that this risk may have to be taken. For there appear to be only two ways to meet the public responsibility for medical services to older people at the federal level. One way to do it is through the general method contained in the Kerr-Mills legislation passed by the last session of the Congress. The other is the device of social security. The first method requires a means test for the control of public charity. The second ties the provision of the service to past participation in the productive economy.

The means test is a device, vestigial from an era in which poverty was regarded as a crime against the community. In its modern application it has the effect, so it is said, of protecting the individual from unwittingly becoming dependent upon the state. It also has the effect of maintaining a status quo in the market economy of health by blocking the use of government in the establishment of health insurance programs.

Another view of the means test, to which I subscribe, is that it is a degrading hurdle between the individual and his state which prevents the use of government in meeting effectively health needs. Surely the matter of the health of the citizens is a matter of the general welfare. I would hold that in such a matter wise public policy is to use the machinery of government for achievement rather than protection. The

central issue then in the extension of social security machinery to provide health services to older persons is the issue of the choice of the appropriate role of government in meeting human needs, and whether we can undertake to use government in a fashion which might upset the present market economy.

Out of deference to this last problem, most social security planners have suggested the exclusion of physicians' services from the program of benefits, hoping in this manner to skirt the economic issue. Of course this approach dilutes the quality of program, since medicine is the central profession in the provision of medical care. Apparently then if the social security approach is adopted it will have to commence with considerably less than an ideal program of benefits.

Despite the present formidable opposition I believe that we will legislate to include health insurance for the aged in the social security program within the next decade, probably within the next three years. We will do this because in the end the decision will be a political one which follows the present trend to use government as a means to implement human achievement.

Because I believe this to be so, and because it is in the history of other nations whose culture derives from the same ethos, I believe also that we will increasingly nationalize health services. Those who say that health insurance for the aged is only a step toward the wider use of national health insurance are probably correct. But because of the present apparent vitality of voluntary health insurance and prepayment, and because we have as yet very little sound knowledge as to whether the coverages under such plans are qualitatively up to proper expectations the exact pattern of evolution from this point is by no means clear. In the meantime, some groups such as agricultural workers will not be well provided with health services.

There is of course great resistance to the extension of national health insurance in any form. One would imagine that this derives from the fact that health services are in the private enterprise area. And when the economy is generally strong we can afford to have these services on a profit basis. Government is in general properly loathe to nationalize industries, at least when they are in no grave danger of collapse. So to the extent that the economy remains strong, and the voluntary health insurance programs continue to expand, any movement towards national health insurance for groups other than the aged is likely to be slow.

The possibility that the device of moving public responsibility to private centers of power to avoid the impact of government has been explored. To date it has not offered much promise for general groups in the population, largely for the reason that there are some 1150 insuring organizations. Surely the commercial insurance companies are in competition with each other, and as a group they are also in competition with Blue Cross and Blue Shield. This makes it very difficult to develop a single center or a few centers of power with which government might work. That this is a viable type of alternative however is

demonstrated by the operation of Medicare. The possibility of making it work for both physician and hospital services for any large group would involve the introduction of quality and cost controls on a national basis for both medical and hospital care.

Even under present circumstances the problems of these controls face us. This is the second issue which I wish to discuss, the issue of the effect of the growth of private health insurance in causing operations in the private sector to assume a quasi-public character.

Within the past few years the question of controls has been brought to the attention of the larger community through the public hearings concerning rate increases for voluntary health insurance, which is subject to supervision of state insurance commissioners. In the light of the rather spectacular recent increases in hospital costs, many increases in health insurance premiums have been required. Frequently the effects of inflation have been so extreme that at the time when premiums have been increased it has not been possible also to increase the scope of benefits. This concentration on costs of present services regarded in the light of a situation in which benefits are not yet adequate, has meant that many professional matters have been publicly discussed, including the relationship between the physician and the hospital. There has also been much discussion about the efficiency of the hospital operation.

The point I am making is that voluntary health insurance is under public scrutiny under circumstances which raise issues of cost and quality. And the nature of this scrutiny has political overtones.

The matters which have been opened for public view are largely Blue Cross problems. Blue Cross of course tends to operate on the principle of guaranteeing a quantity of service to the subscriber rather than providing an indemnity to the hospital. It is concerned under these circumstances to return the largest possible amount of the premium dollar in benefits. Other types of health insurance tend to indemnify the hospital and by no means all are mutual in character. We have had very little public review of these programs, but in the end they cannot stand apart from the same scrutiny as has been directed at Blue Cross.

The Somers[15] have reviewed the question of whether cost and quality controls are necessary. Their general conclusion seems to be that such controls, if they could be effective, would go a long way toward the preservation of voluntary health insurance. So far there are only isolated examples of efforts to establish such controls on a voluntary basis. These include control by the carrier which is the essence of the efforts now being carried out by the Blue Cross plan in Philadelphia, control by medical societies, by union management welfare funds, and even by appeal to physicians from industry to keep their fees

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15. Ann R. and Herman M. Somers, "Health Insurance: Are Cost and Quality Controls Necessary?" The Brookings Institution, Washington, D. C., 1960.

down. The Somers conclude that, while there are advantages to diversity in control devices, the present experience projected onto the national scene would be "formidable."

It seems likely that concern for cost and quality controls will continue. It seems unlikely that the present insuring organizations can in the near future agree upon a device which would be nationally operable. What would make it possible to do so would be a change in the character of the hospitals in the country from their present voluntary nonprofit character to profit-making institutions. The nonprofit hospital is a vestige from an era of intense voluntarism. As such it takes a position that as an institution it should not profit from the provision of hospital services. In this respect the voluntary hospitals behave more like government than private enterprise. They are, with government, the major nonprofit portions of the health industry. Physicians, the drug industry and the dental profession all expect a fair return above the cost of doing business. As long as hospitals retain their present character it will be difficult for them to participate in other than public forms of regulation. They will be difficult to persuade that they should participate in private regulation even if such regulation is deemed necessary to the existence of the voluntary health insurance system.

The Somers ask the question whether voluntary health insurance can survive without regulation. The answer is by no means clear, but the evidence points toward the necessity of regulation rather than a continuation of a hands-off policy. Nor does the evidence indicate that even with regulation voluntary health insurance would be as universally effective as social insurance.

One of the special geniuses of our times is the skill of the human animal in organization. The modern corporation is at the center of our free enterprise system. Organization has obvious impact upon the efficient and effective delivery of health services. Indeed, this is one of the attractive aspects of the use of the social security system, for it then becomes possible to bring people and funds together in an orderly fashion. The provision of medical care in this country has been characterized by the rapid development of medical specialization and the increased use of hospitals. A generation ago the family physician could handle a wide range of problems. Now with the expansion of knowledge this is no longer so. Indeed the public now knows this to be so and demands this sort of service. The physician needs not only the help of specialists in medicine but also nurses, social workers, and a wide variety of medical technicians. The increased opportunity which now arises for more comprehensive and continuous medical care introduces problems of organization.

One form of medical organization which is growing is the group practice of physicians. In 1946, 3100 physicians were in full-time group practice. Today 10,100, or 6 per cent, of all practicing physicians in the country are in groups. Groups can have an effect upon the financing of medical care. Through the efficient use of scarce skills they tend to lower the cost of service to the consumer in com-

parison to the traditional referral for fee-for-service practice. It is a safe assumption that if one is concerned about comprehensive and continuous medical care, this care can be performed most economically by groups. Interest at the present time however is not great in comprehensive care, although it may be growing.

Organized medicine has in the past discouraged group practice and is actively concerned that the corporate form of human organization not be applied to medical care generally. Since, however, most hospitals could undertake to be group practices if the barriers to corporate practice were removed, this position of organized medicine does not appear to be wholly in the public interest either in regard to the possibilities of improving the quality of medical care or providing it at lower cost. State legislation defining the role of the hospital could help this situation, but is not likely to be widely undertaken.

There are two other aspects of organization which deserve to be mentioned. These are home care and progressive patient care in hospitals. Home care services when they are substituted for more expensive hospital care have obvious advantages. The development here has been modest to date. Further attention deserves to be given to this need. Progressive patient care is a service within hospitals which grades the intensity of the care to the patient's need, and as such reflects somewhat the same classification of effort as between the hospital and the nursing home. These examples suggest that there are relationships between organization and cost and quality. Much more research and demonstration needs to be undertaken if these relationships are to be fully exploited.

A final issue which requires comment is the relationship between medical education, research in the medical sciences, and the cost of medical care.

Regardless of its form of organization the provision of medical care depends upon the existence of an adequate number of adequately trained physicians. As things presently stand, we are not sustaining the present ratio of physicians to population. The need for new graduates in 1975 is estimated to be 11,000 against 7400 in 1959. Furthermore the number of applicants to medical schools has diminished from 24,000 in 1948 to 15,000 in 1958. One of the economic costs of financing medical care is in the cost of preparation of physicians. Clearly if the present situation is to be improved more money will need to be spent on new medical schools and scholarship assistance for physicians in training.

As the explosion of knowledge continues, we shall need to continue to increase support for research in the sciences related to medicine. And new knowledge will cry for application to help diminish the effects of pain, disability and premature death. The application of this new knowledge may make medical care even more expensive. Progress has its price.

This has been a review of selected data which seemed relevant to an understanding of the trends in the financing of medical care. We have undertaken to examine a few of these trends, here and there making a prediction, but in the main leaving most of the questions unanswered. In the discussion we have taken the view that health is important to the general welfare, and that the availability of health services should not be unduly inhibited by needs to maintain present economic relationships.

All of this discussion has been within the context of the individual of whom Walt Whitman so eloquently wrote:

> "I swear I begin to see the meaning of these things.
> It is not the earth, it is not America, who is great,
> It is I who am great, or to be great -- it is you up there, or anyone;
> It is to walk rapidly through civilizations, governments, theories,
> Through poems, pageants, shows, to form great individuals.
>
> "Underneath all, individuals.
> I swear nothing is good to me now that ignores individuals.
> The American compact is altogether with individuals,
> The only government is that which makes minute of individuals,
> The whole theory of the universe is directed to one single individual -- namely to You."

DISPUTED QUESTIONS IN THE FINANCING OF MEDICAL CARE

by

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To ask an unreconstructed liberal, in the classical sense of the term, to deliver one of a series of lectures commemorating the 25th anniversary of the Social Security Act is something like asking a confirmed pacifist to give a speech at a banquet of professional military men commemorating the great victories of the war. Nonetheless, I consented to do so because, as Mrs. Gordon made clear, the purpose in these lectures is to present several points of view.

Within the limits of time, tolerance and your patience, I shall try to present a brief background of the issues, an ideological position and an examination of some of the issues in voluntary health insurance, of which the role of government in financing medical care is but one.

I shall not attempt, in the interests of brevity, to express a position relative to the entire social security, welfare structure. Instead, I shall try to devote the lecture to a consideration of the issues in the narrower field of health care. Particularly, I shall try to devote time to background issues arising out of the question of providing for health care, medical care and hospital benefits, under the social security payroll tax mechanism and not to the specific controversy currently surrounding consideration of the King bill (H.R. 4222) and the companion bill of Senator Anderson (S. 909) by the Congress of the United States.

The political controversy over health insurance is not new, is not confined to the United States, and is unlikely to cease even if a national health service similar to that in Great Britain were to be established in this country -- a highly unlikely occurrence in the immediate future. As long ago as 1884, the Bismark government in Germany created a form of health insurance to which people within certain income limits were required to join with their employers and the government in purchasing medical care. In England, low income employees having less than $1250 per year were compelled to take part in a prepaid medical service by the 1911 National Health Insurance Act. Since that time almost every large, industrialized country has produced some kind of compulsory or semi-compulsory medical care scheme either through a national, governmental program or by compulsion to join private sickness funds. Also, up to and including the present time, questions of cost, nature of service, and of what proportion of resources shall be devoted to medical and hospital service continue to be "hot" political issues in all these countries as well as our own. In the United States, during the formative years of the Social Security Act

(1934-1936), considerable agitation took place within the Roosevelt Administration for the adoption of a national compulsory insurance program under Title II of the Act. Later, several proposals were made to enact a limited version which would extend hospitalization benefits to all those covered under OASDI -- in 1942 by Representative Eliot; in 1943 and 1945 by Senator Green. In 1948 the Wagner-Murray-Dingell bill touched off a vigorous political controversy by advocating a national compulsory health insurance arrangement among other things, and a limited version, the Forand bill, resulted in a similar controversy in recent years. In the latter part of 1960, Congress passed the Kerr-Mills Act (P.L. 86-778) authorizing federal grants to approved State programs for providing medical care for aged persons of limited means.

The basic economic question, of course, is: How should people pay for their health care? Although I am far from certain as to why this should be so, few other questions seem capable of stirring so much passion in the human breast. In a way this is a shame for there are few subjects other than medical economics -- a term I use despite my distaste for it -- where it is more difficult to make completely true, simple statements and few subjects on which it is of so little value to be rigidly doctrinaire.

At the risk of being accused of belaboring the obvious, it may be helpful to describe the basic ways in which health care can be, and, to some extent, is financed. The first, and most obvious, method of paying for health care is to utilize current income or a savings fund. The latter may be a personal savings fund accumulated by the purchaser of health care or it may be a fund borrowed from others, to be repaid out of future income or revenues. A second mechanism that has developed is the service benefit plan, such as most of the Blue Cross and Blue Shield Plans that sell, on a more or less prepaid basis, hospital and medical benefits expressed in terms of service rather than in money. A decidedly restricted variation of the service benefit approach is the "closed panel" type under which the purchaser buys a right to receive the services of a group of affiliated doctors, usually employed on a salaried basis, together with such hospital or other facilities affiliated with the plan. A third mechanism is what I prefer to call medical care insurance, although popular usage is somewhat broader. These plans sell some form of cash indemnity arrangement rather than service benefits. Still a fourth type of financing mechanism consists of group negotiated contracts, sometimes combining or including forms of service benefit and medical care insurance, negotiated through some group device, such as labor unions and management bargaining. The fifth basic method of financing is through some form of government taxation, whether the tax paid is related to the service or entirely separate.

Purposely, I make no mention of "free" medical care. Although in the narrow sense of voluntary charity, or individual care given by a physician or hospital free of charge, it is possible to speak of "free" medical care, it is not possible to have a system or mechanism for "free" medical care. Most so-called "free" medical care systems are variations of the fifth mechanism -- the payment of medical care by governmental

coercion and the tax mechanism.

How should people pay for health care? How do they do so? How much health care ought they to buy? Under what circumstances and conditions? Merely asking these simple questions reveals the complexity of the subject matter. People have different wants in health care. Just as some people want pink shirts or plaid shirts, and others want white shirts, so people have different wants for health care. To assert that people want the highest quality medical care, as the oratorical phrase goes, or the best shirts, or the best transporation system, or the best government, all beg the fundamental questions involved. The public is a collection of individuals, and the whole is no greater than the sum of its parts. The ultimate wants in health care are the wants of the individuals who form that public; there are no super-individual values or ends. When we ask what does the American public want in health care, we are really asking: What do individual people desire or want in health care?

At present, the United States still has a system of which it is probably true to say that the majority of people, in one way or another, pay for their own medical care. However, it would be both illogical and inaccurate to overlook the several parts of the system that might well be called socialized medicine, if these words were not so highly debased in use. There are, for example, more than 22 million veterans in the United States, who have a legal right to receive health treatment for service-connected disabilities and, under certain circumstances, for non-service-connected disabilities. There are over 300,000 American Indians, and perhaps 50,000 seamen, who receive a medical service paid for by the national government. By the extension of the system of Medicare, wives and children, as well as servicemen, have a legal right to receive medical services free of charge. All levels of government in the United States, as you may know, spend something in the neighborhood of $6 to $7 billion annually on various items of medical care for the aged and non-aged needy, on veterans, on construction of hospitals, on public health facilities, and on medical research. The national government alone operates a considerable number of hospitals, largely for veterans and members of the armed services, and both state and local governments also operate a substantial number of hospitals. Between 2,000,000 and 3,000,000 federal employees have part of their health costs paid by the government as an employer.

On the other hand, the vast majority of the American people pay their medical cost directly or through systems of voluntary insurance or prepayment, at least in part, although I don't think we have ever really determined precisely what part of these do not pay the full cost of the insurance or what part of the premium is paid by employer or trade union.

Typically, how does the average citizen pay for his health care and that of his family? If such a typical person exists at all, he has either a service benefit or medical care insurance plan paying for a substantial part of his large, unexpected medical expenses, such as hospital bills and surgical fees, while he pays for most of the smaller,

or budgetable, medical bills either out of current income or cash reserve.

Protection against large and unexpected health care typically has been handled by voluntary financing mechanisms in the United States. The extent and rate of growth of these mechanisms was largely unforeseen and unpredicted, and has been little short of miraculous. Over 132,000,000 people, well over 70 per cent of the population, have some form of either service benefit, medical care insurance, whether group or individual contracts. This is over twice the number of people who had such coverage ten years ago, and well over six times the number fifteen years ago. Over 50 per cent of the population have the right to some form of health care benefit covering more than one of the categories of hospital, surgical, and regular medical. The most noticeable increase in coverage has been major medical expense insurance -- a type of insurance scarcely available a' all ten years ago, the rate of increase of which is greater than any other type of insurance presently available.

One would expect, from age structure and availability of coverage -- and this is verified by the evidence -- that the largest proportion of those having purchased health care benefits would be families whose chief income earner is a male in the most productive age groups; that is between age 35 and 44. In the early earning years the individual tends to purchase benefits in a variety of ways, and to hold on to it as he grows older. As one might also expect, the proportion of families carrying health care coverage is higher among those with higher incomes than with lower; coverage is greater among urban families than farm families; coverage is greater in the northeast than in the southeast; and in the east than in the west.

Carriers of insurance such as Blue Cross-Blue Shield, offering for the most part service benefit type contracts, cover fewer people than do the commercial insurance and cash indemnity plans. Certain miscellaneous independent plans such as are operated by some of the unions, or by union management health care operations, are numerically of less importance. What the medical profession calls closed panel plans cover about 3½ million people, while other independent plans, including some medical society plans that differ from Blue Cross-Blue Shield more or less in name rather than in content, have 8 or 9 million people enrolled in them. These numbers can be compared with Blue Cross enrollment of over 55 million, Blue Shield of over 45 million and commercial insurance companies over 75 million. Naturally these figures do not add up to the total 125 million persons protected since many people carry more than one type.

Few will deny the great progress made by the voluntary mechanisms during the past twenty-five years. Yet the criticisms are, if anything, sharper and more extensive than before and the differences -- political, economic, ideological -- more violent than before. In fact, some of the increase in coverage was due to the fact that organized labor, somewhat reluctantly, accepted group negotiation of health care contracts as a poor second-choice to its preference for the tax supported and financed

mechanism -- particularly under the social security mechanism.

The very violence of these differences, and the political activities of organized groups, suggest that there may be sufficient recognition of the nature of the ideological spectrum. Differences among people can arise from several sources: one type of difference can be resolved ordinarily by looking at the facts. A second type of difference, less easily resolved than the first, is that arising from illogical or erroneous interpretation of facts. For, as was pointed out so many years ago by the father of modern economics, Alfred Marshall, facts are of no significance until they are examined and interpreted by reason. As Marshall put it, "The most reckless and treacherous of all theorists is he who professes to let facts and figures speak for themselves." This is further complicated by our tendency, and we are all guilty to some extent, of selecting and interpreting the "facts" according to our desires -- according to what we think should be rather than what is -- and to desist too soon even in pursuing "scientific" studies. Particularly is this true in the social sciences where objective measurement is frequently more difficult than in the physical sciences.

But the third type of difference is the most difficult of all; it does not arise out of disagreement over what the facts are, nor out of illogical and erroneous interpretation of those facts, but out of diametrically opposed, antithetical philosophical positions. To the extent that this third type of difference occurs, the matter cannot be settled by an appeal to fact or to logic; it can only be settled, if at all, by persuasion or by fighting it out in the political arena.

Let me state clearly my own position. I want to preserve, to protect and to promote the private -- that is, non-governmental -- practice of medicine in the United States. I am unalterably opposed to any policy that threatens to obscure or to subvert that objective. If it could be proved beyond doubt, and to my complete satisfaction that the best and most efficient medical care could be obtained by some other system, I should still prefer the private practice of medicine for only in this way can the real progress of the future be achieved. To me it is evident that some others have different objectives; and the most extreme among these are those who wish to establish the practice of medicine as a monopoly of a group of salaried physician employees of government. Between these ends of the political spectrum, there are, of course, a great variety of positions and I leave it to your individual judgment as to which end of the spectrum is left -- and which is right.

The question of whether or not to use the payroll tax, social security mechanism is only one part of the struggle evolving a system of health care for the United States. Fundamentally there are only two ways of coordinating the activities of large numbers of people; one is to provide some sort of central direction involving compulsion and coercion. This is the technique of the Army, of the centrally planned state or totalitarian state carried to its logical conclusion. The second method of coordinating the activities of individual people is

through their voluntary cooperation and, indeed, this is the technique of the market place. For a system of health care, the first method requires government intervention to an ever greater degree into the health care mechanism; it requires coercion by the government to bring about a specific end. It is basically paternalistic in outlook, and seeks to achieve a health care system on a basis of what the individual should have -- as judged by some elite group -- rather than what he wants. A health care system based on the voluntary cooperation of individuals, on the other hand, is achieved only through some kind of market mechanism and voluntary exchange bringing about coordination of activities without coercion. A health care system organized through voluntary exchange is a free, private enterprise, competitive exchange system. What we presently have, is not of course, purely one or the other. It is always much easier to state the varying principles in general terms than it is to spell out in detail what actually is, or even what should be. But it cannot be denied, I think, that this fundamental clash of philosophical ideology is noticeable as much, if not more, in the area of health care than in other social problem issues.

Let us consider briefly the normative issues underlying such issues as social security and compulsory health insurance for all or for specific groups such as medical aid to the aged -- whether of the Kerr-Mills Act type involving only aid to needy aged, or the social security mechanism of payroll taxes. The broad, general questions are these: (1) To what extent, if at all, is it desirable for government to subsidize by payment of money large groups of heterogeneous, voting citizens? (2) To what extent, if at all, is it desirable for government to subsidize these large groups by paying for, or providing directly, specific goods and services?

It should be apparent that there are many issues, in addition to those involving medical and hospital care, or old age pensions, to which these basic questions apply. It should also be apparent that a person may logically favor government intervention of the type suggested by the first question while totally disapproving the type of intervention suggested by the second question. For myself, although I should wish to examine carefully each specific application of the principle, I regard both types of intervention as undesirable but the first, given a choice among evils, as decidedly less evil than the second.

The views individuals take in answering these questions determine, to a great extent, the pressures for and against most of the activities that might be termed the "welfare state" if the phrase were not used in a derogatory sense. Similarly, the nature of the spectrum of political attitudes revealed by the various answers made to these questions indicate the possible compromises among the forces struggling in the legislative or political arena.

To alleviate the extremes of indigency, poverty or starvation has long been recognized as a moral obligation on the part of the individual and, to a lesser degree, on the part of the community. The extent of the moral obligation upon family, friends and associates, upon local governments or national governments, or upon voluntary

agencies or religious groups is not objectively determinable and is frequently subject to many interpretations.

Public assistance programs, at the national level, for example, are modern adaptations of the poor laws -- devices looked upon by some as necessary but temporary evils in the development of the economy, necessary to aid the poor, the unfortunate, the handicapped or even the improvident until such a time as rising living standards and educational levels render such assistance unnecessary.

Those who take this view are likely to favor solutions involving direct monetary payments for the relief of individuals on the basis of need, measured by some form of needs test -- whether income, assets, net worth or whatever -- objective if possible, subjective if not.

Quite a different view is held by those who regard the provision of social services, either directly or indirectly, as a permanent function of the national government. Instead of a temporary relief mechanism, this view regards the provision of specific goods and services as a progressively expanding function covering more and more goods and services, and entailing an ever growing proportion of gross national product, national and personal income. It regards as both necessary and desirable the increasing employment of experts to set "standards" and to ensure the "proper" selection and distribution of social goods and services. Those who take this view are less concerned with poverty as such than with programs designed to increase the quantity and quality (frequently measured by the degree of equality involved) of the social distribution. Instead of favoring money distribution, the social view will favor specific service benefits; instead of administration at the local level, the social view will prefer the national level.

Between these two viewpoints lies the entire spectrum of shades of compromise. Some may argue that there will always be a lower level to be treated as relatively poverty stricken. Others may argue that elimination of social expenditure programs, once embarked upon, is too difficult a task to be undertaken politically and, therefore, that the existing level, expressed perhaps as an absolute amount or as a proportion of the national income should be maintained but its expansion opposed or inhibited. The variety of compromise so far as administrative levels and other mechanisms for encouraging frequent reassessment of programs is very great.

Although these basic considerations apply to practically all welfare programs, the nature of the questions can be seen when applied to the question of medical care for the aged. The use of the Social Security payroll tax mechanism is clearly the preferred device to those who regard the social services as a continually expanding function of society. The locally administered medical assistance program exemplified by the Kerr-Mills Act is certainly the preferred mechanism for those who regard the problem of poverty as a limited and temporary one.

The opposition of the American Medical Association, the American

Dental Association and the American Hospital Association to the Social Security, payroll tax mechanism to provide medical and health care benefits to the aged did not take place against the Kerr-Mills Act's attempt to aid the indigent and near-indigent; nor would any such opposition have been aroused by proposals to increase the cash payments to recipients within the existing OASDI structure. If dollar payments, rather than service benefit payments, had been proposed sufficient to permit the individual to buy health care insurance if he chose to do so, the purveyors of health services would have had only a passing interest in the legislation. Underlying the opposition also is the belief on the part of the purveyor groups that the ever expanding social service concept, with standards determined politically by experts rather than by the market forces, would ultimately lead to similar pressures for paying for the medical and health care of the entire population in a similar manner.

Despite my disagreement, I should certainly defend the right of those who believe in it to advocate using the financial mechanism of social security to provide health care benefits, I am much less tolerant of the approach that advocates it for particular groups, such as the elderly. In fact, I am not at all certain that they do not harm their own case. The emphasis placed upon the financial status, indeed the poverty, of the elderly is a weak logical reed on which to rely. The mechanisms for alleviating poverty are many and varied -- whether the poor are the elderly, farmers, negroes, urban slum dwellers or what-have-you. The medical profession, in my opinion, has been quite correct in mistrusting the motivations behind the argument. If the social security mechanism is a logical financial method for purchasing health care for the elderly, it must be so for all the population and for the same reason. Poverty is a false, if not dishonest, issue.

There can be little doubt that the medical profession mistrusts the extension of governmental influence in the various aspects of medical care. With reason, doctors are aware of the evidence strongly suggesting that governmental intervention into these areas tends to develop into a monopoly function of government and, in so doing, reduces the freedom and responsibility of the individual to provide for his current and future health, and other elements of his well-being. Doctors are aware that once such responsibility is lost, once such freedom is surrendered, the decision is well-nigh irreversible. They believe that only with individual freedom of choice can the medical profession assure high quality of medical service. The House of Delegates of the American Medical Association has expressed its position emphatically:

> "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses.
>
> "Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives.

"Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care.

"The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

As might be expected, some individual doctors have expressed it even more forcefully. For example, Norman A. Welch, M.D., Speaker of the American Medical Association's House of Delegates addressing the National Congress on Prepaid Health Insurance, May 13, 1960, said:

"At present all the medical profession wishes is time to expand and improve voluntary mechanisms now available and which we feel sure will perpetuate the freedom of the individual to purchase his medical care in a manner we consider fundamental to the preservation of the way of life for which our forefathers fought and died and which we feel we have a duty to preserve for future generations.

"Let us not substitute for the paternalistic employer a paternalistic government which must of necessity regulate the amount of medical care it will provide. Let us not overnight destroy an effective mechanism in which labor, management, the public and the profession may take an active part and which once destroyed will probably never be rebuilt."

In a speech to the Edison Electric Institute at Atlantic City, F. J. L. Blasingame, M.D., Executive Vice President of the American Medical Association, summarized the medical view as follows:

"As far as the medical profession is concerned, it is dedicated to easing pain, healing the sick, and prolonging human life. Medicine cannot function effectively unless it is practiced in a climate of freedom.

"Physicians, therefore, recognize their stake in preserving our competitive society, with its accent on ability and responsibility of the individual."

Putting aside, for the moment, the basic normative issues, let us consider the weaknesses and strengths of the voluntary mechanisms. Even here it is impossible, of course, to avoid criteria for weaknesses and strengths that are essentially normative in nature. But at least it is possible to consider some of the alleged weaknesses. These, stripped of the emotional words so frequently used, are essentially five: first, it is asserted that voluntary medical care insurance does not or cannot offer complete or comprehensive coverage extending from the first dollar to the last dollar spent on health care of all kinds; second, it is said that the price of medical care has been increasing rapidly and placing some low income persons in a position of being unable

to pay for their health care; third, it is often stated that the very success of the medical and allied professions in prolonging life and eliminating acute illness has so increased the incidence of chronic sickness that a governmental program is necessary to insure continuing "adequate" medical care for all; fourth, seldom stated explicitly in this country, it is asserted that the voluntary system requires people to pay for their own health care and thus prevents using it as an egalitarian instrument for the redistribution of income; fifth, there is criticism of the number and variety of plans and mechanisms available among which the potential purchaser must choose.

Each of these criticisms deserves some comment. Truly voluntary insurance programs cannot meet, and are not intended to meet, the so-called comprehensive test. Insistence on comprehensiveness can lead only to one end, and that is the destruction of the voluntary mechanism and, ultimately, the private practice of medicine. Voluntary health care programs are based upon the application of certain insurance principles. Basically, these are three in number: first, that the expenses be large relative to the individual's income; second, that the individuals are aware of exposure to the risk and are willing to pay the cost, including the administrative cost, of having that risk shifted to the insurer on some kind of insurance or prepayment basis; third, that the risk involved be unpredictable for the individual but predictable for relatively large groups.

Comprehensive coverage in the sense in which it is frequently used, covering medical and health care costs of all kinds, would entail a large number of medical bills that do not measure up to these fundamental principles of health care insurance. Some small bills are unpredictable, such as a doctor's ordinary visit, or simple diagnosis of a minor disease. Obstetrical charges, although relatively large, are, for the most part, predictable; and there are a number of charges in a shadow area that many people, although aware of exposure to the risk, would be unwilling to pay the necessary cost to have transferred to an insurer. Further, some expenses need not be involved in a prepayment mechanism but can be handled less expensively through cash or a post-payment mechanism. In any event, the more comprehensive the coverage, the costlier the insurance or prepayment mechanism.

Those who criticize the voluntary insurance mechanism in payment for health care because of the increased costs of medical care, in my opinion, prejudice the statement of an issue of considerable significance. There is much to be said for the position that the development of the voluntary insurance mechanism was brought about <u>because</u> of the increase in medical costs, rather than that the increase in medical costs was <u>caused</u> by the system developed. But, even leaving this out of consideration, the criticism of the rising costs of medical care begs a more fundamental question; namely, in an extended period of inflation, that is to say, an extended period of rising general price levels, can all prices be expected to rise at precisely the same rate or by the same amount? In all of the periods of this kind for which we have data, some groups of prices have risen more than others. So far as I know, there is nothing to suggest that any of the prices or

groups of prices that have risen more than the general price level in the past twenty or twenty-five years have behaved significantly differently from other particular groups of prices in previous inflationary periods. The evidence would indicate that this is a rather typical behavior, not of any particular price or group of prices, but of some prices advancing more rapidly than others.

The facts of the matter are reasonably well-known, although there are some areas where additional information could be valuable. The principle inflationary push has occurred since 1939, but the result would not be much different if one were able to measure accurately from 1933. The total rise in the past two decades in the Consumer Price Index is slightly greater than the rise in the medical care index. The greatest increase of course has been in hospital rates. But, it is misleading to look solely at prices in a period of substantial increases in the price level without examining changes in money earnings. It is necessary to look at both prices and incomes to determine the questions of changes in terms of real income or real prices. Disregarding changes in the quality of medical care that have taken place in twenty years, the real price of health care to a factory worker is less today than it was in 1939. It required fewer work hours in 1959 to purchase, even at a higher price, the same quantity of medical care that could be bought for a dollar or ten dollars in 1939. In 1939 a factory worker would have worked 15 hours and 54 minutes in order to buy ten dollars worth of medical care. In 1959, for the same quantity of medical care, he would have had to work only 9 hours and 42 minutes -- and this doesn't take into consideration the increased quality of care that he could have purchased. At no time in our history has the average person had as great an ability to pay for medical care as he has at present; and at no time has he been able to buy as excellent medical care as he can now.

The criticism concerning the change from acute to chronic illness is a criticism which I consider unwarranted. There is some additional evidence we need to have concerning the effect upon chronic and acute illness of so-called "break-throughs" in acute illness. It is closely related to the problem of medical care costs and a few observations are perhaps necessary to clarify the reasoning. It seems to me that this is one place in which the economics of health care differ slightly from the usual economics. We are prone to forget that people ultimately must die of something. Every medical success, every medical break-through, creates a new problem that can be, and frequently is, a more costly problem. There can be no doubt that medical advances have been amazing during the past twenty-five years; these advances have changed the nature of sickness to a considerable extent, but it would be foolish to say that they have reduced it in total or that the increase in total expenditures on health care results in any absolute necessity for governmental financing.

This latter point, to the economist, is one of the most intriguing things about so-called medical economics. It is related to the fact that medical science can never achieve what it seeks to achieve. No doctor has ever "saved a life" but many doctors have prolonged many lives and, more important, have enhanced the dignity of living. Unlike innovation

in other things, medical innovation almost always leads to increased total costs or expenditures. There seems to be no one in the world of medical care services having as his primary and direct interest the reduction of medical costs. People are unwilling to accept the same services they were getting in the medical care area ten or even five years ago even at lower prices. To me this is not only desirable but is also, at least in part, one of the great strengths of the voluntary system. Successful prolonging of life for a significant proportion of the population would result either in an increasing percentage of persons who have chronic illness or in a sharp shift in the nature of acute illness. One or both of these developments must occur. If it is the former, persons having chronic illness do not always need general hospital care; frequently not even care in nursing homes or convalescent homes. Steps to insure efficiency and economy in all aspects of medical care are most effective when they work through the patient which means through the voluntary mechanism.

Unlike Europe, the objective of redistributing income by systems of health care is seldom expressed specifically in this country, although it seems to have an influence even here. Perhaps such an aim is not a necessary part of health care systems, or even what one might call the welfare state itself. But the end result in almost all areas where non-voluntary systems have been established, including our own, has been the development of health care systems capable of being employed as tools for the redistribution of income. As one studies the effects of application of the welfare instruments to health care, it is impressive that there is first of all a compulsion requiring everybody to insure against health risks or to contribute to a system which purports to insure him against such risks. Coupled with this, very frequently, has been a requirement that he insure through one unified state organization; and this requirement is usually based upon assertions that this is necessary for efficiency and economy. The requirement is not always stated in so many words but the net effect is virtually to make impossible a continuation of the voluntary mechanism. The instrument, and a monopoly instrument at that, thus produced is certainly capable of doing things and providing things that a voluntary arrangement could also supply. But it also becomes an instrument of social control and can be used for other purposes. Whatever assistance, aid, subsidization and so on, is provided can be made dependent upon the imposition of all sorts of special conditions. In other countries at least, this has become in the course of time the governing consideration. It has the potentiality of being used as an instrument for an unlimited redistribution of both the quantity and quality of income.

The criticism of the multiplicity of plans, coverages, rates, and many other factors is sometimes referred to as a weakness. I disagree. To me this is the greatest strength of the voluntary mechanism. The important thing is to permit the individual to have as much choice in the selection of the type of health care plan which he wants to receive as is possible under the circumstances. The matter should be, as far as possible, one of freedom of individual, personal choice. It may be that some people do not want any health care plan at all. I confess that I would prefer that they be permitted not to have any; or,

at the very most, be required to furnish evidence that they have sufficient assets to assure themselves reasonably satisfactory health care. Even assuming that most people prefer a particular kind of plan, whether it be employee benefits, with or without Blue Cross or Blue Shield or some other device, there is available to them a wide variety of commercial health insurance or medical care insurance if they wish to supplement these plans or to handle their own individual problems in a somewhat different fashion. In fact, I think the outstanding achievement of our health care financial mechanism, is the great variety of plans available for people to buy, using their own judgment in providing for their own well-being in the purchase of health care.

Whether we like it or not, all of us constantly have to make judgments that involve setting economic factors on the one hand against non-economic factors on the other. These evaluations range in importance from the most insignificant item to the most significant evaluation in the world -- our life -- and such evaluations must be made whether one is wealthy or poor. It may be as I say, that we don't like to make them; it may be that we would like to push them off onto somebody else, but the fact of the matter is that we cannot really avoid them. The important question it seems to me is not whether or not the individual is competent to make medical judgments, but whether or not these evaluations which he must make, in one form or another, can be made by somebody else <u>for</u> him.

We live in a society still essentially free, one that gives to the individual person the right not only to choose his physician but to make other choices as well. Indeed, we have even permitted the individual person to choose to use his capital and his services to advocate the abolition of freedom of choice itself. Throughout the history of mankind this sort of society has not been the general rule but the exception. Perhaps this is inevitable. The totalitarian collectivist principle is simple and straightforward; it appeals to those who say, "Do something now." The necessity of restraint, group and individual, the recognition of ignorance and the imperfection of human knowledge, and the denial of a millennium and the aim of establishing conditions that make life not perfect but workable -- all these attributes of a free-choice society constitute a highly sophisticated doctrine.

It is sobering to see the growing number of so-called leaders of political thought or politicians who advocate an ever-growing governmental assumption of responsibility for all sorts of complex economic and social problems -- full-employment, care for the aged, care for the indigent, government health services, subsidized housing, and so on and on. Yet the moral ethic on which our civilization rests emphasizes individual responsibility. Can such a civilization survive? Perhaps, but only if it recognizes the difference between freedom of choice and freedom from choice.

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