recognizes that "the techniques and disciplines of economics may provide some insight for developing cost-benefit and cost-effectiveness analyses." Accordingly—

> As a necessary prelude to a possible research effort in this area, NIH has supported a recent conference managed by the Brookings Institution. The purpose of this conference, attended by economists and public administrators, was to consider the feasibility of initiating a research program to measure the economic consequences of medical research. Recommendations of the conference will be submitted to NIH by the end of the year [1966] and will include a system of support. On the basis of these recommendations and other considerations, further steps may be undertaken.

Quite different from NIH in the economic relationships of the programs are the health insurance portions of the old-age, survivors, disability, and health insurance system (OASDHI) and the health and medical care portion of the Federal-State program of public assistance. Whereas NIH activities are concerned directly with the specific causes of ill health and means of prevention or cure, the health insurance and assistance programs offer mechanisms for financing the treatment of individuals who need medical care. For the health insurance and assistance programs, economic and financial relationships are central considerations.

The health insurance system (medicare) was not yet in operation when the Social Security Administration prepared its response to the human resources programs questionnaire. Accordingly, the response necessarily deals with prospective consequences of the new program and treats it in the context of the whole broad OASDHI system. It asserts that—

> The health insurance protection for those 65 and over will not only assure better medical care for many older persons but will greatly ease the financial situation of younger families, as well as of the aged persons themselves.

Nearly all persons now 65 or over are eligible for the hospital insurance benefits and the voluntary supplementary medical insurance plan.

Similarly, the major new expansion of health assistance as part of the public assistance system was not yet underway when the Welfare Administration prepared its response. The earlier law included provisions for giving medical assistance to persons on the federally aided public assistance rolls and to aged persons who were unable to pay for medical care although they were not otherwise in need of public assistance. The new authorization, enacted in 1965, establishes a single matching formula for medical assistance for all persons receiving federally aided public assistance payments and for certain other medically needy persons in all age groups. This new program is generally called "medicaid." In the statement in part III, neither the earlier provisions for payments to vendors nor the new program of medicaid is discussed separately from the public assistance program as a whole. The earlier program of medical assistance for the aged is, however, described in an appendix to the Welfare Administration response.

The immediate substantial impact of the "medicare" insurance system is suggested by the magnitude of estimates included in the budget transmitted to Congress in January 1966. Payroll tax collections and related receipts of the hospital insurance trust fund in the fiscal year 1966 were then estimated at $856 million (actual receipts