NATIONAL HEALTH INSURANCE

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PANEL DISCUSSIONS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

JULY 10, 11, 17, 24; SEPTEMBER 12, 1975

Printed for the use of the Committee on Ways and Means

3073175

U.S. GOVERNMENT PRINTING OFFICE
57-677 WASHINGTON : 1975

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[1] Resigned August 11, 1975.

CONTENTS

Topics of discussion: Page

Broad assessment of American health status and the American health care delivery and financing systems, *Thursday, July 10, 1975* ______ 1

The role of Government in American health, *Friday, July 11, 1975* ____ 91

Private sector role in American health, *Thursday, July 17, 1975* ______ 181

Problems and issues in health care organization, delivery, and financing, *Thursday, July 24, 1975* ______ 257

Panelists selected by the minority Members (including discussion of foreign health systems), *Friday, September 12, 1975* ______ 355

Press releases Nos. 7, 8, 9, and 12 of the Subcommittee on Health announcing details of panel discussions on national health insurance ______ 1, 2, 3

ALPHABETICAL LISTING OF PANELISTS

Bellin, Lowell, M.D., New York City Health Department ______ 100

Burkhart, John H., M.D., Knoxville, Tenn ______ 407

Butler, Lewis H., University of California ______ 92

Cathles, Lawrence M., Jr., Aetna Life & Casualty ______ 197

Cohen, Wilbur J., University of Michigan ______ 267

de Vise, Pierre R., University of Illinois ______ 130

Donabedian, Avedis, M.D., University of Michigan ______ 289

England, Robert G., M.D., Carlinville, Ill ______ 190

Fein, Rashi, Harvard University ______ 14

Feldstein, Martin S., Harvard University ______ 257

Freymann, John G., M.D., National Fund for Medical Education ______ 10

Gammon, Max, M.D., London, England ______ 356

Hamilton, John, M.D., Rochester, N.Y ______ 412

Heim, Richard, Health and Social Services Department, State of New Mexico ______ 126

Klarman, Herbert E., New York University ______ 263

Lejeune, Anthony, Middlesex, England ______ 360

Lofstead, Sigmund J., M.D., Chicago, Ill ______ 365

Lymberis, Marvin N., M.D., Charlotte, N.C ______ 414

Masland, David S., M.D., Carlisle, Pa ______ 421

Masters, Brooker L., M.D., Freemont, Mich ______ 423

McGill, Clinton S., M.D., Portland, Oreg ______ 418

Murley, Reginald S., M.D., London, England ______ 368

Quinlan, Donald, M.D., Northfield, Ill ______ 426

Reinhardt, Uwe, Princeton University ______ 18

Siegfried, Charles A., Madison, N.J ______ 284

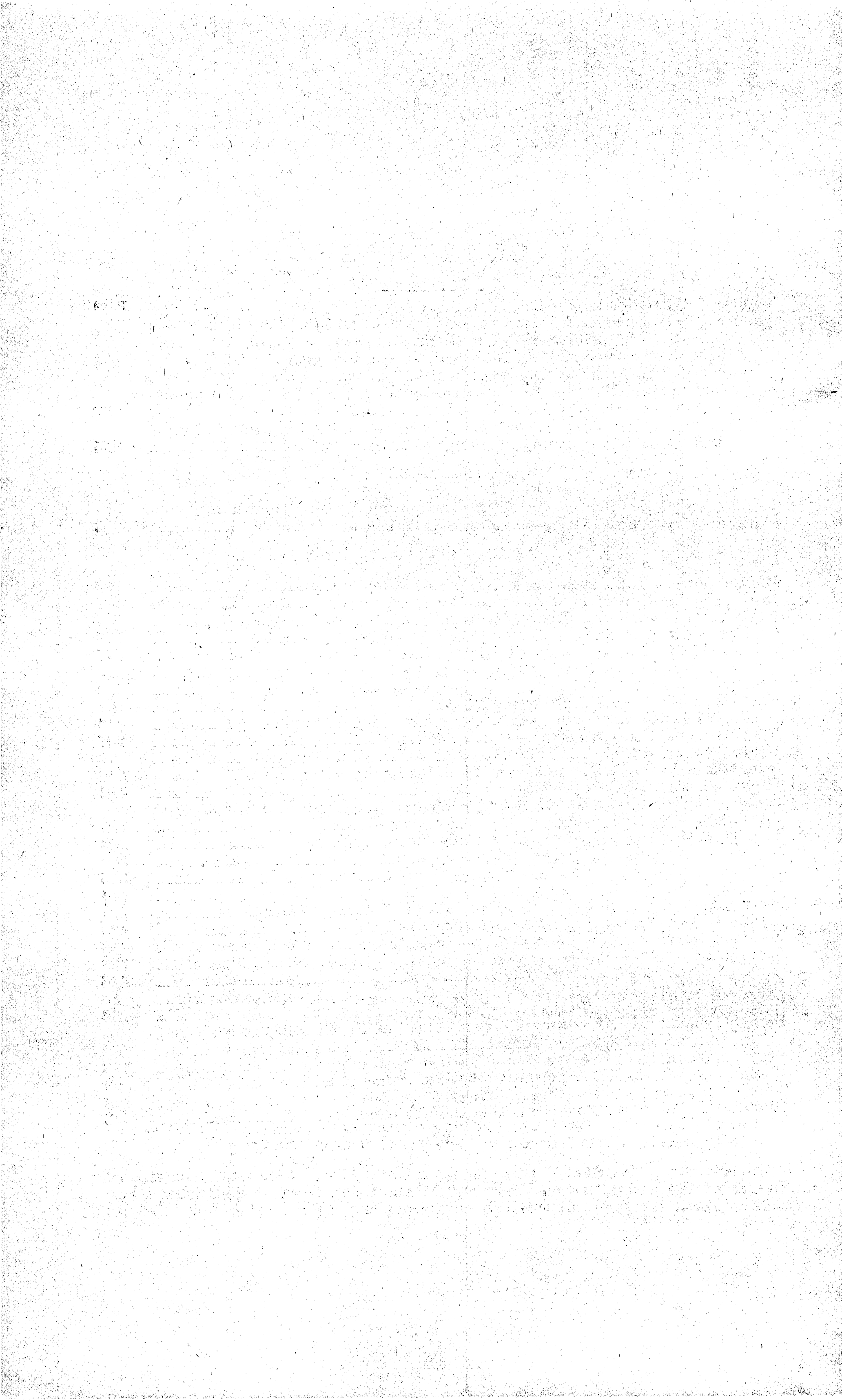
Somers, Herman M., Woodrow Wilson School of Public and International Affairs ______ 182

Stark, Nathan J., University Health Center of Pittsburgh ______ 186

Stephenson, Bette, M.D., Toronto, Ontario, Canada ______ 380

Thompson, John Larkin, Blue Shield of Massachusetts ______ 203

Wynder, E. L., M.D., American Health Foundation ______ 5



NATIONAL HEALTH INSURANCE

(Broad Assessment of American Health Status and the American Health Care Delivery and Financing Systems)

THURSDAY, JULY 10, 1975

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

[The press releases announcing the hearings follow:]

[Press release No. 7 of Tuesday, June 24, 1975]

SUBCOMMITTEE CHAIRMAN DAN ROSTENKOWSKI (D., ILL.) SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, ANNOUNCES PANEL DISCUSSIONS ON NATIONAL HEALTH INSURANCE BEGINNING JULY 10, 1975

Subcommittee Chairman Dan Rostenkowski (D. Ill.) of the Subcommittee on Health of the Committee on Ways and Means announced today the second stage in the Subcommittee's consideration of national health insurance. This stage will involve small panel discussions on the broad issues in national health insurance. The Subcommittee will form these small panels from members of the Advisory Panel on National Health Insurance, which it established earlier this year (see: Press Release Nos. 2, 3, and 5).

The panel discussions will begin on July 19, 1975 at 10:00 a.m. and are also scheduled for July 11, 17, and 24. The sessions will be conducted in the Main Hearing Room of the Ways and Means Committee in the Longworth House Office Building.

It is expected that public hearings and additional panel discussions will be scheduled later in the year on the subject of national health insurance.

In addition, on July 31, the Subcommittee will meet to consider which aspects of medicare it will want to address in public hearings to be held after the August recess. Included in the discussion will be possible action on recent Department of Health, Education, and Welfare medicare regulations which were the subject of a public oversight hearing on June 12, 1975 (see: Press Release No. 6).

[Press release No. 8 of Tuesday, July 1, 1975]

SUBCOMMITTEE CHAIRMAN DAN ROSTENKOWSKI (D., ILL.) SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS RELEASES ADDITIONAL INFORMATION ON NATIONAL HEALTH INSURANCE PANEL DISCUSSIONS FOR JULY

Subcommittee Chairman Dan Rostenkowski (D., Ill.) of the Subcommittee on Health of the Committee on Ways and Means today released additional information about the panel discussions on national health insurance scheduled for

July, first announced on June 24, 1975 (see: Press Release #7). It is expected that the Subcommittee will schedule public hearings on this subject in the late summer or early fall. The membership and structure of each panel discussion is attached.

JULY 10, 1975

SUBJECT: BROAD ASSESSMENT OF AMERICAN HEALTH STATUS AND THE AMERICAN HEALTH CARE DELIVERY AND FINANCING SYSTEMS

Panelists

1. E. L. Wynder, M.D., President, American Health Foundation.
2. John G. Freymann, M.D., President, National Fund for Medical Education.
3. Rashi Fein, Professor of the Economics of Medicine, Harvard University.
4. Uwe Reinhardt, Professor of Economics, Princeton University.
5. Kerr White, M.D., Professor of Health Care Organization, The Johns Hopkins University.

The panel will begin its presentation to the Subcommittee at 10:00 a.m. on July 10, 1975, in the Main Hearing Room of the Committee on Ways and Means in the Longworth Building at New Jersey and Independence Avenue, S.E.

JULY 11, 1975

SUBJECT: THE ROLE OF GOVERNMENT IN AMERICAN HEALTH

Panelists

1. Lewis H. Butler, Professor of Health Policy, University of California.
2. Pierre R. de Vise, Professor of Urban Science, University of Illinois at Chicago Circle.
3. Richard Heim, Executive Director, Health and Social Services Department, New Mexico.
4. Lowell Bellin, M.D., Commissioner of Health, New York City.

The panel will begin its presentation to the Subcommittee at 9:00 a.m. on July 11, 1975, in the Main Hearing Room of the Committee on Ways and Means in the Longworth House Office Building at New Jersey and Independence Avenue, S.E.

JULY 17, 1975

SUBJECT: PRIVATE SECTOR ROLE IN AMERICAN HEALTH

Panelists

1. Herman M. Somers, Professor of Politics and Public Affairs, Woodrow Wilson School of Public and International Affairs.
2. Nathan J. Stark, President, University Health Center of Pittsburgh.
3. Robert G. England, M.D., Carlinville, Illinois.
4. Lawrence M. Cathles, Jr., Retired Senior Vice President, Aetna Life and Casualty.
5. John Larkin Thompson, President, Blue Shield of Massachusetts.

The panel will begin its presentation to the Subcommittee at 10:00 a.m. on July 17, 1975, in the Main Hearing Room of the Committee on Ways and Means in the Longworth House Office Building at New Jersey and Independence Avenue, S.E.

JULY 24, 1975

SUBJECT: PROBLEMS AND ISSUES IN HEALTH CARE ORGANIZATION, DELIVERY AND FINANCING

Panelists

1. Martin S. Feldstein, Professor of Economics, Harvard University.
2. Herbert E. Klarman, Professor of Economics, New York University.
3. Wilbur J. Cohen, Dean, School of Education, University of Michigan.
4. Charles A. Siegfried, Madison, New Jersey.
5. Avedis Donabedian, M.D., M.P.H., Professor of Medical Care Organization, University of Michigan.

The panel will begin its presentation to the Subcommittee at 10:00 a.m. on July 24, 1975, in the Main Hearing Room of the Committee on Ways and Means in the Longworth House Office Building at New Jersey and Independence Avenue, S.E.

[Press release No. 9 of Wednesday, July 23, 1975]

SUBCOMMITTEE CHAIRMAN DAN ROSTENKOWSKI (D., ILL.) ANNOUNCES PANEL DISCUSSION ON NATIONAL HEALTH INSURANCE (WITH PANELISTS SELECTED BY THE MINORITY) SEPTEMBER 12, 1975

Subcommittee Chairman Dan Rostenkowski (D., Ill.) of the Subcommittee on Health of the Committee on Ways and Means, today announced an additional panel on national health insurance, with panelists selected by the minority. The panel discussion will begin at 9:00 a.m. in the Main Hearing Room of the Ways and Means Committee in the Longworth House Office Building.

It is expected that public hearings on national health insurance will begin later in September or early October.

The list of panelists for September 12 will be released in a later announcement.

[Press release No. 12 of Wednesday, Aug. 20, 1975]

SUBCOMMITTEE CHAIRMAN DAN ROSTENKOWSKI (D., ILL.), SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS RELEASES MEMBERSHIP OF PANEL DISCUSSION FOR SEPTEMBER 12, 1975 SELECTED BY THE MINORITY MEMBERS OF THE SUBCOMMITTEE

Subcommittee Chairman Dan Rostenkowski (D., Ill.,) of the Subcommittee on Health of the Committee on Ways and Means today released additional information about the panel discussion on national health insurance scheduled for September 12, 1975, first announced on July 23, 1975. (See: Press Release #9)

A list of the members of the Panel selected to represent the minority follows:

TENTATIVE LIST OF WITNESSES [1]

Panel of Witnesses for 9:00 a.m.:
- Dr. Max Gammon, London, England
- Mr. Anthony Lejeune, Middlesex, England
- Dr. Sigmund J. Lofstead, Chicago, Illinois
- Dr. Reginald Murley, London, England
- Dr. Bette Stephenson, Toronto, Canada

Panel of Witnesses for Afternoon Session:
- Dr. John H. Burkhardt, Knoxville, Tennessee
- Dr. John Hamilton, Rochester, New York
- Dr. Marvin N. Lynberis, Charlotte, North Carolina
- Dr. Clinton S. McGill, Portland, Oregon
- Dr. David S. Masland, Carlisle, Pennsylvania
- Dr. Donald Quinlan, Northfield, Illinois

Mr. ROSTENKOWSKI. The Subcommittee on Health will come to order.

Today the Subcommittee on Health begins active consideration of national health insurance. Instead of first receiving testimony on specific proposals from interested organizations and individuals, we thought it would be useful to begin by exploring, with a series of expert panels, the broad outlines of health care in the Uinted States and some of the major issues we will need to address as we frame a national health insurance bill. Later, probably in early fall, we will likely hold public hearings at which all interested parties can express their views.

At the beginning of this year the subcommittee invited individuals and organizations to submit written statements on the subject of na-

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[1] Additions or changes may be announced at a later date.

tional health insurance. This permitted the updating of testimony presented during the extensive hearings on national health insurance the Committee on Ways and Means completed a year ago, and also offered a fresh opportunity for the expression of views by those who had not previously testified. These statements will soon be available in the form of a printed record thus furnishing the subcommittee the full benefit of the information and views presented before we begin consideration of specific national health insurance proposals.

The panels of experts who will be sharing their knowledge of the American health care system with us during this month were selected, like the larger advisory panel of which they are a part, not to represent the viewpoint of any organized group but rather to let us benefit from the fruits of their own individual studies and experiences in health care and health care financing. There will be ample opportunity later for the expression of official positions by organizations and individuals. Our objective for the moment is simply to learn and try to understand, so that the decisions we make later will be soundly based.

We begin our broad review of this subject with an exploration of American health status, our health care delivery system or systems, and how we finance the $100 billion or so being spent for personal health care. Tomorrow we will take a broad look at the role of Government at all levels in American health. On July 17, we will examine the private sector role. And on July 24, we will take up problems and issues in health care organization, delivery, and financing.

I believe that the subcommittee will agree with me that we should plan for additional sessions like the ones already scheduled with selected members of the subcommittee's advisory panel as we narrow our attention to more specific issues. I say this because one thing that has become clear to me in the months since I assumed chairmanship of this subcommittee is that the American health care system is extraordinarily complex. You cannot change any part of it without affecting other parts—perhaps in ways not able to be anticipated. We need to learn a great deal about the American system of health care, and we must approach the task of framing national health insurance legislation with a great deal of sensitivity and even humility.

I have been looking forward to beginning these panel sessions. We have a fine group of expert witnesses who have agreed to meet with us and I want to have every member participate in these sessions to the fullest.

We hope to proceed somewhat informally today, using a format that will promote understanding and the exchange of views. The panel members have been asked to make a brief opening statement, so as to leave adequate time for questioning and discussion among both panel and subcommittee members.

I would like at this time to open for any comment that any member of the subcommittee would like to make before I introduce the panel.

Mr. DUNCAN. Mr. Chairman, I apologize if you mentioned it in your statement; I didn't have it. I noticed today that we have a panel of people apparently who do not practice medicine and wouldn't have first-hand knowledge of such practice. Are we planning on a panel of actual physicians or people in the medical field who are actually out in the boondocks practicing medicine? I would say that the panel

today is composed of people who have never practiced, I think could have been a little better balanced.

Mr. ROSTENKOWSKI. As I said earlier, Mr. Duncan, it's primarily for an educational process and for the exploration of the experience that these gentlemen have. We expect certainly to have public witnesses and general practitioners at some time in the future.

Mr. DUNCAN. Thank you, Mr. Chairman.

Mr. PIKE. Thank you, Mr. Chairman. I am delighted that we are embarking on these hearings on a subject in which I have been very, very interested for a great many years. I think that I should say at the outset of these hearings, just so you may understand some votes that I cast in the future, that for 25 or 30 years now I have been either a director of a general hospital or a director of a proprietary hospital and an officer thereof. So I do have some frame of reference in regard to this matter.

We are going into this in a very broad sense. When we get to actual voting on an actual bill, which looks a long way down the road, I may feel compelled to vote present sometimes but it will not be for lack of interest on the subject matter.

Mr. ROSTENKOWSKI. I hope, Mr. Pike, that the opportunity for you to cast your vote will not be in the too long distant future.

Mr. Cotter?

Mr. COTTER. Thank you.

A PANEL CONSISTING OF E. L. WYNDER, M.D., PRESIDENT, AMERICAN HEALTH FOUNDATION; JOHN G. FREYMANN, M.D., PRESIDENT, NATIONAL FUND FOR MEDICAL EDUCATION; RASHI FEIN, PROFESSOR OF THE ECONOMICS OF MEDICINE, HARVARD UNIVERSITY; AND UWE REINHARDT, ASSOCIATE PROFESSOR OF ECONOMICS AND PUBLIC AFFAIRS, PRINCETON UNIVERSITY

Mr. ROSTENKOWSKI. Gentlemen, we certainly welcome you. I am hoping this will be a refreshing beginning. I know that we on the panel here and you on the panel there are all certainly hopeful that we can develop some worthwhile legislation. I think we are in total agreement that the country is in need of some health insurance program.

It is at this time that I would like to welcome Dr. Wynder, president of the American Health Foundation; Dr. Freymann, president of the National Fund for Medical Education; Professor Fein, professor of the economics of medicine at Harvard University; and Professor Reinhardt, professor of economics, Princeton University. I am sorry to say that Dr. Kerr White, who was originally scheduled, is ill and will be unable to appear today, but we hope to have him sometime in the future.

Dr. Wynder, if you would like to begin the discussion, please do so.

STATEMENT OF E. L. WYNDER, M.D.

Dr. WYNDER. I would like to comment on the opening statement. I have and I do practice preventive medicine and if we in the medical profession would have succeeded in the practice of preventive medicine, it is unlikely that we would have to hold the hearings today.

It would seem from the history of medicine, as indeed from history in general, that while man has obviously enhanced his knowledge, he has not enlarged his wisdom. Forty-five hundred years have passed since Huang Ti declared in China:

> Hence the sages did not treat those who were already ill; they instructed those who were not yet ill. . . . To administer medicines to diseases which have already developed and to suppress revolts which have already developed is comparable to the behavior of those persons who begin to dig a well after they have become thirsty, and of those who begin to cast weapons after they have already engaged in battle.

Several decades ago, William James Mayo was quoted as saying:

> The aim of medicine is to prevent disease and prolong life. The ideal of medicine is to eliminate the need of a physician.

We would concur that this is still the basic goal of medicine, as indeed is well reflected in an old Greek motto that has become the basic saying of our foundation—that it should be the function of medicine to help people die young as late in life as possible.

THE ISSUE

This being the case, we should ask how our current medical care delivery system is addressing itself to this issue, where the primary problems in achieving these goals lie, and how a program of national health insurance could contribute toward its attainment. With a decreasing birthrate, we are faced over the next few decades with the predictability of fewer wage earners as healthy as possible and reduce the need for unnecessary and increasingly expensive hospitalization among our older individuals.

If we fail in this, our Nation will be required to undertake a major shift of priorities in the national economy; one that would see an ever-increasing percentage of the gross national product tied up in health care delivery services. This would be a task of unprecedented dimensions, and one that might well be impossible within the present productive framework of our Nation, particularly in view of other formidable competing priorities.

The consideration of a national health insurance system is politically natural in the increasingly mutualistic atmosphere of our democracy. A health insurance system immediately brings to mind hospitalization needs and the coverage of disease costs, but if we are not to make of this system an economic monster, I urge you to consider how disease, life, and moneysaving measures can be built into such a system.

That is why I shall stress in my remarks areas involving preventive medicine. I would like to caution, however, that as has been experienced by national health insurance systems in other countries, and indeed from our own experience with medicaid and medicare—a cost-effective health insurance system requires, in order not to be economically overburdened, a disciplined population and a disciplined health care profession in order that its obvious advantages are not destroyed by an overzealous use of its opportunities.

It seems appropriate that, in discussing the health needs of the the United States, one begins by enumerating the major causes of death

and disability in our country, the opportunities for preventing or curing these conditions and the problems we face in combating these major foes of premature death and disability. It so happens that four conditions: Heart disease, cancer, stroke, and accidents, make up 70 percent of all deaths among Americans, while heart disease, arthritis and rheumatism, impairment of back, hips and lower extremities, mental and nervous disorders and hypertension represent 40 percent of the reasons for disability among our population. Therefore, it is in these areas that we need to concentrate if we are to make a significant impact on disease rates in the country.

The major factors contributing to death from heart disease, cancer, and stroke in the United States have been well established by epidemiological and laboratory studies. Factors for which the incidence is most consistent include, for cardiovascular disease—overnutrition (especially with regard to fat and cholesterol intake), hypertension, excessive cigarette smoking and physical inactivity; for cancer—excessive tobacco usage, nutritional deficiencies and excesses, and certain occupational exposures; and for highway accidents, alcoholism and drug abuse, poor highway, and automobile designs.

Thus, in a society where infectious diseases have been largely overcome through sanitary measures, immunization, and antibiotics, the major causes for today's death toll are chronic diseases. This death toll is largely due to unhealthy lifestyles, unhealthy working environments, and disease-inducing products. If we are to prevent these diseases, we need to concentrate on their causes.

PROBLEMS OF DISEASE PREVENTION

It may be asked why, if etiological factors of certain diseases have been established, there hasn't been more progress in the prevention of these diseases. Among the reasons for this failure are man's apparent apathy toward anything preventive—whether with regard to energy conservation, highway safety programs, or health. We tend to live for the present, believing that the future will take care of itself. We also seem to suffer from an illusion of immortality, apparently related to our inability to face death. The problem is further compounded because doctors are trained mainly in therapeutic medicine; and because reimbursement for medical care is nearly totally geared toward therapy. Given these facts, adding that preventive advice given to patients is not as dramatic in public or private terms as combating symptomatic diseases, it is little wonder that many of today's physicians do not stand in the vanguard for the cause of prevention.

The hospital system is another part of the problem. Our hospitals deal primarily with cure, not prevention. Since reimbursement is aimed mainly at inpatient, rather than ambulatory care, and since hospitals are reimbursed for therapeutic rather than preventive care, it is not surprising that the latter is being neglected.

These attitudes are reflected in current practices of the health insurance industry which, again, concentrates largely on reimbursement for therapy for specific disease symptoms and not on prevention. It is unrealistic to expect that the medical and allied professions, in an economic climate such as ours, will behave any differently than any other

segment of society. As long as our society provides economic incentives primarily for therapeutic care, it will be therapeutic care which receives the most attention.

Yet, we know from medical history that the world's major diseases did not succumb to therapy alone; instead the only time they were ever eradicated was when effective preventive measures were applied. This lesson from history also applies to chronic noncommunicable diseases such as cardiovascular disease, cancer, and chronic pulmonary disease—diseases which have a long latent period, which by and large are not likely to be cured in their later stages, but which are often preventable.

RECOMMENDED MEASURES

The following attempts to crystalize the major steps which can lower costs and contribute to a better health care program than the one we presently have.

1. First of all, we, as a nation, must resolve that health care ranks as one of our country's major goals. To accomplish this goal requires the cooperative efforts of various segments of society. It is obvious that the medical profession cannot, by itself, determine which type of a health system would be best for the country. Industry, labor, economists, health insurance experts, Congress, and the public at large need to coordinate their expertise with that of the health professionals in order to arrive at a health care delivery system which is best suited to the needs of the United States.

2. In order to improve the health care delivery system, both medically and economically, several measures should be included in whatever type of national health insurance system is contemplated.

The system must accentuate financial incentives for ambulatory care. Existing hospitals should be reorganized so that they can provide, in addition to therapeutic care, efficient ambulatory care for their communities. Appropriate incentives should also be given to physicians to provide preventive care. Included in this care should also be: Immunizations, maternal and child care, pre- and postnatal care, general health education and motivation, as well as therapeutic care. The ambulatory care unit thus includes both preventive—primary and secondary—and therapeutic programs. The preventive care programs should be of the short- and long-range type and should modify their services in line with the specific needs of various population groups. The ambulatory preventive care program should be extended into the schools where meaningful health programs are currently almost nonexistent. Effective preventive medicine—as is the case with education in general—has its greatest impact on the young.

3. Ambulatory care delivery programs can, to a large extent be carried out by allied health professionals, nurses, medical corps men, health educators, behaviorial psychologists and sociologists who, under the overall supervision of physicians, in many instances can undertake effective therapeutic programs and significantly help in modifying the lifestyles of our people and in detecting early disease.

4. A national health insurance program should not only provide effective ambulatory and preventive care programs but should also provide incentives for the public and the health care delivery system to see to it that such health services are effectively utilized.

5. Recognizing that individuals will always represent the weakest link in preventive procedures, in addition to providing meaningful incentives to utilize cost-effective preventive services, emphasis should be placed on "managerial" preventive measures. These include further development of less harmful smoking products—a measure especially recommended for a society which is likely to continue to condone smoking as socially acceptable—and the modification of American food products toward developing a "prudent" diet, one low in fat and cholesterol and thus more commensurate with today's reduced caloric expenditures, as well as a diet that leads to proper growth of our poor and underprivileged. Managerial preventive medicine also includes reducing workers' exposure to harmful elements through legislation and making certain that no new harmful components are introduced into the environment. It also includes the enforcement of speed limits which, in addition to saving lives, would also help in the conservation of energy. Existing laws with respect to drunken driving and automobile and highway safety should be vigorously enforced.

6. It is suggested that all preventive programs as currently conducted by various branches of HEW and other governmental agencies, be coordinated and supervised by an Office of Disease Prevention to be heated by a Deputy Assistant Secretary reporting directly to the Assistant Secretary.

Finally, I would like to bring the following recommendations to your immediate consideration, that:

7. In any authorization for national health insurance—even in the initial development stage—Specific allocation equal to one-tenth of 1 percent of the dollar authorization be directed toward preventive medicine, research, and evaluation of existing systems.

8. That the chairman with the advice of the committee direct the Secretary of HEW to appoint a task force on preventive medicine for the purposes of examining, on an across-the-board basis, the extent that preventive medicine is presently being practiced for the purpose of determining specific feasibility as to what is accomplishable through preventive medicine.

9. That the chairman with the consent of the committee direct the Secretary of HEW to report within 90 days on the extent of the taxpayer-supported research in the area of evaluating the cost benefit of preventive medicine.

10. That the chairman direct every witness to address themselves to the specific question of how the financial cost of disease care can be reduced through preventive medicine.

In summary, we have emphasized the roles which ambulatory care, preventive care, allied health professionals can, and should play in a national health insurance program. It should be emphasized that all such programs should be continuously scrutinized for their cost effectiveness and cost benefits.

Preventive medicine, if properly advanced, can make a major impact—both medically and economically—on the high rate of disease in this country. It requires a full-time coordinated effort for its goals and aspirations to be fulfilled. We have also set forth the obstacles—scientific, economic, and human—which face the proponents of preventive medicine. To overcome these obstacles requires the understanding and the support of the people and, consequently, the Congress. Congress,

through its legislative powers and particularly through its influence on a national health Insurance program, has the opportunity to make ours a healthier society, one with the lowest infant mortality and highest longevity, and one where our motto of "dying young in life, as late as possible" will be fulfilled. With the scientific evidence available today, with the cooperation of the medical and allied health professionals, and with the determination of the American people, along with legislative stimulus from the Congress, we can make the realization of this motto come true in our lifetime.

STATEMENT OF JOHN G. FREYMANN, M.D.

Dr. FREYMANN. I am John Gordon Freymann, a physician, member of the family practice faculty at the University of Connecticut, and the president of the National Fund for Medical Education. I would like to assure Mr. Duncan I have taken care of patients for 25 years and I am still taking care of them now. I have never been in full-time private practice but I think it is the care of patients, not one's ways of collecting fees that is important. So I understand the problems.

Henry Ford said that history is bunk. I will not argue the point, but history is the only way I know to understand the complex and seemingly irrational organization of the American health care system. My assignment is to take the subcommittee through a brief history to show how our system got to be the way it is. To do this, I will trace three chains of causation which, woven together, have produced what we have today. These three chains are: (1) The organization of health facilities, with particular reference to short-term hospitals; (2) the education of the health professions, with particular reference to physicians; and (3) the financing of health services.

ORGANIZATION OF HEALTH FACILITIES

Pennsylvania Hospital in Philadelphia was the first voluntary—that is, private, nonprofit—hospital in the Nation. Opened in 1750, it was a faithful copy of the hospitals of London. These institutions had evolved a peculiar, tripartite organization over the centuries. I am interested to find that Mr. Pike is a member of this tripartite organization.

The board of trustees, which owned the corporation, was a mechanism for governance that replaced the church after Henry VIII abolished the monasteries in 1536. The hospital administration was employed by the trustees, but the medical staff was an independent cadre of private practitioners. They were not employees because the original hospitals were hospices for the poor. Centuries passed before they became places exclusively for the sick where an attending staff of doctors was needed. Hospitals eventually employed some doctors, but they were apprentice physicians or surgeons.

This medieval model, brought to the Colonies from the mother country, is still followed throughout the United States. All of our voluntary hospitals, secular and religious, have this same basic organization. So do most city and country hospitals, although here the trustees may be elected or appointed officials. The administrative staffs are employed by the trustees, as are the apprentice doctors whom we

now call residents. In the last 25 years, many hospitals have hired full-time, salaried doctors to head major departments such as surgery and internal medicine. But the vast majority of doctors working in these hospitals are practitioners who receive the privilege of using the facilities from the trustees and are paid directly for their services by their patients or by third-party payers.

In spite of their long history, hospitals played a minor role in the American health care system until the 20th century. In 1873, there were only 178 nongovernmental hospitals; by 1909 there were 4,359. Even then, however, hospitals were still primarily places for the poor. Anyone who could afford it was cared for—even operated on—at home. By the 1920's surgery had moved into hospitals, but in 1940, 44 percent of American babies were still delivered at home. Internists were even slower than the obstetricians. Not until the discovery of a panoply of "wonder drugs" and invention of a variety of highly technical diagnostic and treatment techniques did departments of internal medicine become the key components of every hospital they are today.

The magnitude of the change in hospitals—from havens for the poor to social necessity for all—is reflected in the following figures. Between 1936 and 1973, the number of hospital admissions per thousand population rose from 61 to 145. One American in 10 is now admitted to a short-stay hospital at least once every year.

The place of in-patient hospital facilities in the American health care system is important to this committee because half of all national health expenditures occur in this milieu. However, I have another, perhaps more important reason for emphasizing hospitals. They have become the nuclei for medical practice in many, if not most, communities.

Use of hospital ambulatory facilities for diagnosis and treatment has risen far more rapidly than in-patient admissions. Ambulatory visits now exceed admissions by 5 to 1. But since nearly 90 percent of all doctor-patient encounters still occur in doctors' offices, isn't this where the action really is? Yes, if one looks at volume instead of expenditures, the action is in doctors' offices. However, the gravitational pull of hospitals is having a pronounced effect on where these offices are located. Across the Nation, doctors' offices are clustering more and more around hospitals. Thus, although direct fiscal links between hospitals and doctors are infrequent, in a functional sense each hospital has become, or is rapidly becoming, a community health center, or, if you will, a center for community health delivery.

This close association among doctors and hospitals is peculiar to the United States and Canada. In every other major nation, doctors are rigidly divided into an elite cadre of hospital-based specialists, who are usually salaried, and a larger group of less specialized or primary physicians who care for ambulatory patients and are denied access to hospitals. In contrast, the American doctor without hospital privileges is an exception. In fact, the discovery that several thousand doctors in New York City had no hospital association was viewed as scandalous.

I come to the end of this first chain of causation in the evolution of our health care system with this point: The machinery for delivering personal health services to the American people may be divided roughly into 6,000-plus clusters. Each of these consists of a relatively

autonomous hospital and a constellation of doctors, most of whom are in private practice. It is a symbiotic relationship. The doctors are dependent on the hospital's diagnostic, treatment, domiciliary and, to a growing extent, educational facilities. The hospitals depend on the doctors to refer the patients who are the source of 95 percent of hospital revenues.

How did this symbiosis develop? Why don't we have the neat pyramid of health services that other nations such as Britain have: a broad base of primary physicians, a network of secondary hospitals, and a few tertiary hospitals at the apex? For the answer we must look at the other chains of causation.

EDUCATION OF PHYSICIANS

After a promising start in the 18th century at Pennsylvania and Columbia, medical education in the United States went into a long century of decline. Over 400 schools—most of them diploma mills—bloomed and withered during the 19th century. Doctoring fell to such a low estate that it was said medicine was the career for those who were too lazy to farm, too stupid for the law, and too immoral for the pulpit.

Opening of Johns Hopkins Hospital (1889) and Johns Hopkins Medical School (1893) marked the birth of a new era. Hopkins took all that was best in English and French medical education, which was based on clinical experience in hospitals, and combined it with all that was best in German medical education, which was based on research-oriented universities. The result was unique—a medical school in which students were taught by clinician-scientists in a hospital. John Shaw Billings, the unsung genius who conceived Hopkins, never intended it to replace other medical schools, which he saw continuing to produce practitioners. To him, Hopkins was a unique school for future teachers and researchers.

A Kentucky schoolmaster named Abraham Flexner changed all that. His report on the state of medical education in the United States was published in 1910 with the powerful backing of the AMA and the Carnegie Foundation. Hopkins was the only school which completely met Flexner's standards because he wrote the report under the influence of members of the Hopkins faculty who believed medicine was emerging as an exact science on a par with physics and chemistry. Like Moses descending from Sinai, Flexner presented the Hopkins curriculum to the other schools. Those that did not accept it eventually closed their doors, and for the next 60 years American medical students marched in lockstep through a curriculum which had been exemplary in 1910.

The other part of Flexner's credo was that this curriculum should be taught by full-time professors who were not distracted by practice. This took longer to achieve. There was not enough money to pay full-time faculty in most schools until the Congress poured Federal funds into research from 1945 to 1965. This permitted the many schools that had been unable to achieve Flexner's dream of a full-time faculty to finally consumate it.

If I may interject there, Mr. Chairman, this is a beautiful example of how as you said earlier changing one factor in the health care system has completely unexpected results, because this was not Congress intent.

Unfortunately, by the time the last school fell into line the Flexnerian era was over—a victim of its own success. Almost all the infectious diseases that blighted the Nation in 1900 had been conquered by 1954. In that year the death rate suddenly stopped falling and we entered a new era. Now the chief banes of the Nation's health are emotional, environmental, and genetic in origin. Some may be contained but once they are started they cannot be cured but only contained.

But the pattern first cut at Hopkins had been set. Scientific medicine was too complex for a single mind to encompass, so doctors divided into 2 dozen specialists. Scientific medicine, taught on hospital wards full of patients with florid diseases, beguiled students into specialty practice, and general practice whithered and almost died. Scientific medical practice required modern hospital facilities, and two generations of superbly trained specialists brought this message to communities across the land which were eager to provide them with everything they needed.

Thus, we can see how the first two chains of causation intertwined to produce the system we have today. Hospitals flourished and became centers of medical care because scientific practitioners needed them, but post-Flexnerian doctors became what they were largely because they were taught in hospitals where the main thrust was care of and research on acute diseases. The third chain, financing of health services, simply bound the first two more tightly together.

FINANCING HEALTH SERVICES

I will spend the least time on this topic because most of it is well known to the committee.

Health insurance had flitted across the national stage since the early 1900's, but the Great Depression gave it a major role. The earliest plans covered hospital expenses for surgery, and, some years later, surgeons' fees. Over the years, benefits have been extended to cover most hospital expesnes—although many still skimp on psychiatric coverage—and most doctors' fees for services rendered in the hospital. Only recently have benefits been available for ambulatory care—and these are still far from comprehensive. Medicare and medicaid perpetuated this undue emphasis on hospitalization. The reason is simple. Discreet services for acute conditions rendered in 6,000 hospitals are far easier to monitor than comprehensive care rendered in 100,000 offices and clinics. But in their eagerness to control costs the accountants put the finishing touches on the system that had been developing for 200 years. Third-party payers dangled incentives to hospitalization before patients. doctors, and hospital administrators that were impossible to resist. To do otherwise meant the patient paid out of pocket, the doctor had less certain fees, and the administrator staffed empty beds.

CONCLUSION

The vast enterprise which some find so confusing that they call it a health care "nonsystem" evolved through a chance coming together of 18th century organizations, 19th century science and education, and 20th century finance. But evolution has not stopped. It is still going on as the Nation experiments with new methods of delivering care, with new educational techniques, and new financing schemes. We have not come to a dead end. Far from it.

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The problems we face today resulted from the successes of our health care system, not its failures, and if it can continue its evolution I am confident that we can lick the problems of the present and prepare for those this Nation will face in the 21st century. The three chains of causation have not come to an end. Knowing the directions they have taken in the past and the effects these changes have had, we should be able to extrapolate each chain into the future. With a knowledge of history, we can substitute a degree of rationality for mere happenstance as we move ahead.

Flexibility, innovation, evolution—these are the keys to success. But let me close with this caveat. Every other nation that has adopted national health insurance has frozen its health care system at that particular moment in its development. No other nation has been able to use national health insurance has made change slower and more difficult. I respectfully suggest that this committee should resist the temptation to think that one piece of legislation can revolutionize health care.

Americans are always tempted to tear down the old and rebuild from scratch, but the history of previous legislation to effect social changes shows that it is impossible to tear down social systems which have taken centuries to evolve. This is even more true when the hospitals of our health care system represent a $40 billion capital investment, a $50 billion annual budget and employ nearly 3 million people. Like it or not, we must build on what we have, not on airy flights of fancy.

The challenge to this committee, as I see it, is to construct an insurance system that will remove all financial barriers to health care but will not raise barriers to the continuing evolution of our health care system.

Mr. Chairman, thank you for this opportunity to present my views. I wish the committee good fortune in the task ahead.

Mr. Rostenkowski. Thank you, Dr. Freymann.

Professor Fein.

STATEMENT OF RASHI FEIN

Mr. Fein. Mr. Chairman and members of the subcommittee, I wish I, too, could assure Mr. Duncan that I treat patients but the best I can do is say some of my best friends are physicians.

Mr. Chairman and members of the subcommittee, I very much appreciate the invitation to participate in this panel discussion and am pleased to be able to do so.

National health insurance remains one of the most important, unresolved domestic issues that this Congress faces. In part, the postponement of debate on a universal and comprehensive national health insurance program reflects the fact that other high priority matters have commanded the attention of the legislative and executive branches and of the American public. In part, it reflects the complexity of the issues that surround the medical care sector and its financing. It is, therefore, most encouraging that you have decided to move forward with these sessions. All of us who are concerned with the inequities, inadequacies and costs of existing programs and who are con-

vinced that action is required if all the American public is to receive its full money's worth for the over $100 billion spent in the health sector look forward to your deliberations.

In the interests of allowing a maximum opportunity for questions and answers, my prepared remarks are very brief. I have outlined a few major points that may help provide a framework for discussion of the goals and mechanisms of a national health insurance program.

1. The economics of the medical care sector is unlike that of other sectors. We are led astray if we apply the tools of conventional economic analysis: assumptions concerning the goal of profit maximization, assumptions concerning competition consumer sovereignty, and so forth. The medical care system has developed patterns of behavior and of decisionmaking, patterns of resource allocation and funding that set health care services apart from other economic activities. All economic sectors have their own special characteristics, but the health sector is more "special" than others. Perhaps the most critical element of difference is that the key decisionmaker in the medical care drama is the producer (physician); not the consumer (patient). To focus on patient decisions is to misdirect our attention. Patients do not enter or leave a hospital, do not buy drugs, order tests, or elect surgery except as physicians decide for them that they shall consume these goods or services.

While only 21 percent of the $90 billion spent for personal health care is accounted for by physicians' services, the physician "controls" the level of expenditure for other major parts of the health care sector; for example, the $41 billion for hospital care. It is the physician who, in large measure, decides what and how much care shall be consumed. Financing programs that are designed to affect consumer behavior—say, via cost-sharing mechanisms—miss the essential point: it is producer behavior that is at issue. It is the physician, not the patient, who is making the critical and costly consumption decisions.

2. It is a fallacy to imagine that physicians make decisions solely on the basis of "scientific" considerations. Many variables, including economic relationships, affect choices. Medical care services can be produced in different ways, utilizing various combinations of resources. The choices—which services, where offered, for whom—are not determined by medical science alone. They are affected by payment mechanisms, economic incentives and penalties, reimbursement formulas—by the nuts and bolts of insurance contracts, Government regulations, et cetera. If public or insurance dollars are available to pay for certain services—for example hospital care—rather than for other—for example, preventive care—the system will emphasize the former. Physicians and institutions respond to the availability of various resources and to the existing patterns of financial coverage. There is no "neutral" financing program. The issue of the range and scope of benefits, thus, becomes more than an issue of financial protection. It lies at the heart of the resource allocation problem. It affects the direction and costs of the system.

3. Historical developments have emphasized insurance protection for hospital expenses. This is fully understandable since these are the high pricetag items, and both patients and hospitals needed the financial protection. Nevertheless, it is a fundamental error to believe that

all that hospital insurance did was: (1) To offer financial protection, and (2) to permit some persons who required hospitalization to enter the marketplace and obtain these services. We also "force-fed" the hospital sector. We have paid, are paying, and will continue to pay a high price as a result of our emphasis on hospital care. We must avoid the error of believing that the care we finance in the future and the way we finance it will not help shape system response. What you will give priority to in defining a national health insurance program will determine the priorities of the system itself. That, for example, is the reason that many observers, and I include myself here, believe that that which is sometimes termed catastrophic health insurance would be just that—catastrophic.

4. Just as covering some services but not others has not been neutral to the "uncovered" elements of medical care, so the presence of third-party payment for some persons has not been neutral to those without it. Many Americans have no private insurance or coverage through public programs. Those without coverage tend to be the economically vulnerable; for example, persons with marginal or irregular employment, or with low incomes. These individuals face a medical care system whose behavior is influenced by the fact that others have insurance. It is not only that producers prefer to serve those for whom payment is guaranteed. It is also the case that those without protection enter a system whose price levels, standards, and orientation have responded to the presence of insurance. Those without protection become doubly disadvantaged.

5. Insurance coverage meets many needs. For the producer of services it means a guarantee of payment. To patients and potential patients it means the sharing of financial risk and the opportunity to budget. The former point (risk sharing) is self-evident. The latter point, however, has a special, dynamic consequence. Because of the desire for budgeting, consumers will attempt to insure themselves against extremely high deductibles. Thus, the attempt to erect significant cost barriers in order to bring economic "discipline" to decision-making will fail as those who have the economic resources to purchase insurance to cover the deductible will do so. In turn, we would reenter the world of inequity—the world in which some have and others lack protection, the world in which some utilize preventive care services since "they are already paid for" while others postpone care, hoping to avoid the dollar expenditure.

6. The historical development of third-party payment mechanisms has not stressed the achievement of equity or the translation of the concept of access to medical care into operational reality. While, today, there seems to be significant agreement that the uilization of medical care services should not depend on an individual's income, there is still disagreement on specifics and on mechanisms to assure this right: shall a program be universal, shall it cover all services, shall it provide first-dollar coverage? In considering alternative operational answers to these questions, we must remember to assess the administrative costs associated with "refinements." The less comprehensive the range of covered services, the less complete the dollar protection, the less universal the program, the greater the burden of administrative costs. Nor do such mechanisms reduce total costs. We are already spending

over $100 billion in the health field. The issue is how to share these costs—not whether we "can afford" national health insurance. If payment for care comes out of many sources—out of pocket as well as insurance—we do not lower the total costs of health care, but we do increase the total costs of administration. The goal of equity and of low administrative costs is best achieved by departing from the fragmented and categorical approaches of earlier days, approaches which have contributed to our present difficulties.

7. The financing and provision of medical care is "organized" in a highly fragmented manner; that is, out-of-pocket direct payments, private insurance, social insurance (medicare), public payment for costs of services (medicaid), public provision of services (VA). Different patterns apply to various individuals who must be sorted into the "appropriate" program by a host of variables such as age, employment status, income, medical condition. This fragmented approach is superimposed on fragmentation in regard to which services are covered and to what degree. The system's energies and priorities cannot be redirected, given the existing complex patterns of finance. In a sense, the system is both inequitable and out of control, and present economic arrangements underwrite and validate the explosive situation. One key difficulty is that the medical care system does not face an effective budget constraint that would lead to a considered allocation of scarce resources on the basis of potential benefits and cosnumer preferences. The medical care system does not face the discipline imposed by competitive market forces or the discipline of planning. A program that provides for equitable access can be structured to provide for effective control of expenditures. Without such structure, we will continue to watch medical care costs escalate.

Each of these points and others could be elaborated upon. These limited remarks, therefore, do not represent a complete discussion of the issues involved in national health insurance. Nevertheless, in order for my colleagues on this panel to present their views, I must conclude my remarks. Let me briefly summarize the issues that I have mentioned:

1. The key to system performance and system orientation is the physician.

2. The physician is heavily influenced by existing fiancing arrangements and their characteristics.

3. These arrangements have stressed payment for hospital services and have worked to the detriment of other modalities of care.

4. They have also worked to the detriment of those who do not have third-party protection.

5. The fragmented nature of third-party payment systems has reinforced inequity, inhibited system reform, and prevented effective cost control.

The complex nature of the health care economy has made action on national health insurance difficult. It has also made it necessary. None of us underestimates the problems that you face. We are equally certain that you do not underestimate the problems that the public faces.

Let me add one point that arises out of the remarks that have already been made and is not in my prepared text. I will do so very briefly, because I assume it is something we will be discussing.

The word "equity" has not at this point—because we have been describing the system—entered into the discussion in a heavy manner. But it would be fair to note that the perspective I bring to the discussion, and from which I speak, is a perspective that heavily stresses the need for national health insurance, not only because it seems to me that this provides a mechanism for redirecting some of the energies of the medical care system, but because above all, it provides something which I think, is the hall mark of a civilized society, namely, a sharing of the medical care cost so that people are not rationed into the system on the basis of their income on a matter as important as health.

Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Thank you, Professor.

Professor Reinhardt?

STATEMENT OF UWE REINHARDT

Mr. REINHARDT. Mr. Chairman, it is a privilege and a pleasure to join with you, the Members of your committee, and this panel in a discussion of issues surrounding the introduction of national health insurance in the United States. By its very nature, such a system will alter the financial flows accompanying the delivery of health services and thereby the economic incentives and constraints confronting the consumers and the providers of health services. One need not be a card-carrying economist to appreciate the fact that these financial factors tend to influence the performance of the health care system significantly. The designers of the Nation's future health insurance system therefore have the opportunity to do much good—or to do much harm.

You and your committee are to be commended for your decision to precede legislative action on this issue with a series of relatively unstructured roundtable discussion. I trust that my colleagues on the panel join me in the hope that we, as perennial students of the health system, may be able to provide you with useful perspective on the American health care system. I am certain that, as a faculty member in a school of public affairs, I shall benefit personally from participating in your deliberations.

My objective today is not to propose a particular health insurance program, and I do not have a particular point of view I would like to push. Rather, I understood my mandate to be to think about a general framework in terms of which the design of the national health insurance could be developed, and, in the process, to comment on the current health care system which as we have already heard, that system is sometimes referred to as a non-system, as a mess, as a source of perennial crisis, or the worst system in the world. Whether or not these allegations are valid is one conclusion you will have to reach after our deliberations. I shall offer my thoughts on this question in a moment.

In thinking about designing a national health insurance system one could have three distinct objectives in mind.

The first objective would be to design a system simply to be a bona fide health insurance system, the purpose of which would be to protect individuals from catastrophic financial loss associated with illness.

A second objective could be to design the system as a redistributive mechanism that channels purchasing power for health service from middle- and upper-income families to lower-income families and, in

so doing, redistributes available medical services in like manner. This is the point Professor Fein raised in his concluding remarks, namely, that you could stress equity as the main objective of the system.

A third objective for a national health insurance system might be to design the system as a set of financial and administrative levers through which the public sector, or those who run the public sector, can reshape the organization of health care production and delivery in this country. There are quite a few commentators who would like to see health insurance so developed and so used.

To run ahead of my arguments, I would recommend that, in thinking about this issue, Congress' focus on objectives 1 and 2 which do go hand in hand—and leave aside objective 3 for a number of reasons.

A. We don't really know exactly what it is we would like to achieve by moving these policy levers, even if they worked; and

B. We have absolutely no assurance that these levers would in fact work in the desired manner. We do, however, have a fair amount of evidence, when we look abroad to other countries, that these policy levers often work in a perverse manner.

I mentioned that the three objectives may be posed singly or jointly as a package. The point to note is that even if all three objectives are put together into one package, different commentators would give them different relative weights individually. Implicit in each particular weighting scheme would be a particular set of views of what is right ad what is wrong with the current health care delivery system and the current health insurance system in the United States.

I cannot stress sufficiently that such views are very often heavily subjective and depend on particular interpretations of a body of evidence at which all of us look, but, as we all know, on which no two social scientists ever can agree. Because these views are so subjective, the collection of experts that will join you in your deliberations are inevitably going to leave you with a sense of unresolved controversy. I would just like to warn you that such an outcome would not necessarily be an indication of failure of these proceedings.

Now, let me briefly talk about these three objectives, because implicit in them, as I mentioned, are assumptions and perspectives on the American health care system.

Those who would stress Objective 1—including a number of persons who will come before you, some of whom are well-known economists—feel that there is basically nothing seriously wrong with the delivery system, or, if it is, that health insurance is not the vehicle through which to alter the system.

They do, however, feel that there is something wrong with the American health insurance system as distinct from the health delivery system. The mosaic of public and private insurance schemes we have in this country, they feel, has failed at least some segments of society. Why else, may I ask, would the Nation feel a need for introducing a publicly sponsored health insurance system? Implicit in that proposed legislation is the allegation that private health insurance has failed society somehow. There are two reasons for which it could be said to have failed.

First, given the income distribution in this Nation, some families simply cannot afford to buy health insurance even if it were made avail-

able to them at actuarially fair premia. (Actuarially fair premia means that one pays roughly what the average expenditure on a family would be.) Clearly, the fact that the income distribution is such that families cannot afford health insurance does not indicate a failure on the part of the health insurance industry, and the problem could certainly be solved through income redistribution.

There is another problem that can be more properly traced to the health insurance industry in this country. I propose on page 3 of my formal statement that a useful exercise for this committee might be to go through a typical health insurance policy of the sort now being marketed in this country, to imagine a variety of different illness scenarios and then to determine, without expert advice, precisely what the coverage is under the policy. I would suggest that you will find this exercise to be excruciating, as do many American citizens today. The health insurance industry will undobutedly defend itself on the argument that the embroidering of its policies with exclusions and provisos is designed to accommodate a desire for efficiency, and I accept that argument. I do, however, also argue that whatever efficiencies you purchase in this manner are likely to be purchased at a very high price.

First, there is the real possibility that many Americans purchase totally inappropriate health insurance coverage on highly mistaken beliefs about the maximum risks to which they are exposed. You will, without any doubt, be exposed to a famous experiment at the University of Pennsylvania where a good health insurance package had been designed that provided for coinsurance and deductibles, and yet presumably highly educated faculty members bought first dollar coverage. This is often cited as evidence of irrationality. I believe that it was not evidence of that. It was evidence of ignorance, I suspect, and ignorance is quite an excusable trait even among professors. I suggest that these faculty members did not know the maximum risks to which they were actually exposed and were motivated to insure themselves for much higher imagined risks than those to which they were truly exposed.

Therefore, I have, in the fattest letters I could find on the typewriter, recommended in my statement that:

> Whatever Congress does after its deliberations in the area of health insurance, it is to be hoped that it will present to the American people health insurance options or policies that are readily understood by the average person, that explains to the average person the maximum liability to which he or she is exposed, even if such an approach involves some inefficiencies.

Many experts to appear before this committee will argue for coinsurance and deductibles, or what is generically referred to as "cost sharing" on the part of patients. The hypothesis here is that it is the patient who is central to the health care consumption decision and that, if the patient shares in the costs of these decisions, these decisions will be made rationally and efficiently.

I cannot, at this stage, launch into this controversial subject matter. I would not agree with some of my colleagues—and clearly an economist should not agree with the proposition—that the decisions in health care consumption are made only by physicians. I do believe that coinsurance would reduce the consumption of health care in this Nation. However, in deciding whether or not to introduce coinsurance

features in this Nation's health insurance legislation, one must be aware of a number of points that really don't pop out of our microeconomic textbooks.

The first point is this. The objectives being pursued with cost sharing are not likely to be reached in this country, if only a narrow stratum of the population—presumably lower income families—are exposed to cost sharing, while upper income and middle income families and particularly the members of trade unions, manage to avail themselves of first dollar coverage. In this case, perhaps only 10 percent of the American people face coinsurance, and the effort to economize over the whole system is focused on that narrow stratum of the population. Such a system would not only be unfair, but it would not work. Congress might toy with the idea of prohibiting first dollar coverage altogether. I can't imagine how you could do that in the face of the strong objections from the interested parties you are likely to encounter, so I won't dwell on this point.

Second, a system of coinsurance and deductible is likely to be worth its cost only if it can be relatively easily administered. One could certainly design a system of coinsurance and deductibles that would eliminate unemployment in this country altogether simply by creating a large bureaucracy to administer the system. In fact, such system may not be worth its cost.

Third, as already mentioned, a system of coinsurance and deductibles is likely to be self-defeating if it is so complex as to generate enormous psychic costs of uncertainty on the part of the insured. It is generally assumed by economists and everyone else that people suffer from uncertainty, and those psychic costs are very real even if they are not expressed in monetary terms. So, I would like to suggest some caution on a system of coinsurance and deductibles, although as an economist I certainly believe they could be used to reduce health care consumption and hence health care costs.

I would finally like to offer some observations on the assertion that there is nothing amiss in the American health care system.

Later on in my formal remarks, on pages 11 through 13, I list a veritable catalog of complaints that have been lodged against the American health system at one point or another. The list of these complaints is long and varied. On closer examination, many of these complaints are based on value judgments and peculiar interpretation of available data. This being so, some observers of the American health system have sought to reject the current criticism of that system altogether by insisting that ours is the finest health care system in the world.

One point to note here, of course, is that, even if one has the finest health care system in the world, one cannot necessarily argue that one ought not to make such improvements which are feasible. It is also within the domain of public policy to speed those improvements.

But the people who defend the American system may indeed have a point, and I wish to speak to that, because there will again be many people who will come before you who consider ours to be the worst health-care system in the world. We have humbled ourselves considerably before the rest of the world by pointing to infant mortality rates and maternal death rates, on which statistics we rank roughly

11th or 14th. It used to be 18th. It is often thought that the health care system we have in the absence of health insurance is to blame for this. An interesting case in point is the health system of West Germany. I have left with the committee staff a paper describing that system in detail. The residents of West Germany have had universal comprehensive health insurance without coinsurance or cost sharing of any sort for many, many decades; in fact it was introduced in its early phases in 1887. The health care delivery system in West Germany is roughly similar to ours, although physicians in hospitals receive salaries, a method of payment some would like to have in this country. Remarkably, West Germany fares considerably worse on such widely used health status indicators as infant mortality rates and infant death rates.

As a matter of fact, there are some tables before you, I believe, where you will see that the maternal death rates and infant mortality rates in West Germany, which is a fairly homogeneous country, are as shockingly high as those rates now found among nonwhites in this country. I raise this point not to assert that the West German health care system has failed society or to imply that no improvements are available in our system because we are already very much at the top. I wish simply to raise the caveat that health services are not the only input into the production of a nation's health status, and that the introduction of health insurance in this country, a redistribution of access to health services, or even a drastic reorganization of the American health care system may not trigger the improvements we expect from those reforms or may induce changes which we had never anticipated and which we may not like in the end.

In my formal statement I go at length into the second objective, but Professor Fein has already commented on it, and I won't dwell on it. I would just like to offer briefly some remarks on the possibility of using the National Health Insurance System as a lever to alter the health delivery system, that is, on the possible objective.

Two changes are often proposed for the American system. First, one source of evils is said to be the fee for services system. A second source of problems is said to be the fragmentation of the system. For that reason it is often supposed that we ought to move from fee for service to prepayment, and on the delivery side from small solo practices to large group practices.

I would assert that no social scientist with integrity could now come before you and tell you unambiguously——

Mr. ROSTENKOWSKI. Professor Reinhardt, we are going to have to suspend. The committee will recess for 10 minutes. We will return to hear your conclusion, and then the interchange among panel members, and then participation by the members as well.

It is the intention of the Chair to work from the next recess until 12:45 and to recess then from 12:45 until 12 o'clock for lunch and to return at 2 o'clock for further discussions.

[Short recess.]

Mr. ROSTENKOWSKI. The committee will resume its sitting.

Professor Reinhardt, if you will make your conclusion, we will open the panel for comments by other panel members.

Mr. REINHARDT. Thank you, Mr. Chairman. I would just like to summarize briefly the remarks I made.

The first point is, as I mentioned, that the health insurance system in the United States should be designed to be primarily just that, and one of its goals should be to free the American citizen from the psychic costs of uncertainty.

I could not stress that enough because I see that point so rarely made and yet I could not think of anything more important than this feature. In fact, the Canadians have simply and quite boldly eliminated this type of uncertainty. They have introduced a comprehensive health insurance system that leaves the delivery system more or less alone, but gives the Canadian citizen complete freedom from worry about the financial impact of illness. The Canadian innovations certainly deserve consideration by reformers in this country.

In creating such a system in the United States, however, one might—I admit—foster a mushrooming medical sector that eats up ever-increasing proportions of the gross national product.

I would endorse Dr. Fein's comment that there has to be in such a system a bottom line, there has to be an overall budget within which one must make tradeoffs. It is my opinion, and I would advertise it as such, that in this country we will not get away from fee-for-service reimbursement of physicians.

This being so, I would deem extremely necessary in the design of a national health insurance system renewed control by the public sector over the fee schedules that will be used. I think nothing could be more disastrous to the evolution of the American health care system than to perpetuate the system of customary local fees that we now, by necessity, have to adopt in medicare, part B.

I say by necessity because medicare is only a small part of the overall health delivery system. Once the entire system comes under the control of a more unified insurance mechanism, however, the public sector can gain control over the fee schedule negotiations with the American profession as a whole.

A publicly controlled fee schedule could be used to attack one of the major problems the American health system does have, and that is the maldistribution of medical manpower over specialties and over regions of this country. We now pay physicians who prefer—for whatever reasons—Cambridge, Mass., to other parts of this country, two to three times as much to practice in Cambridge, Mass., as we pay them to practice in other parts of the country. It does not surprise me, perhaps because I am an economist, that this generates an unequal distribution of manpower or at least that it ratifies it.

I would suggest that fee schedules could be used to redress these incentives, to make them, at the very least, uniform across the country, as the Canadians have done.

You might be bolder still. You might attempt to establish a system like that in West Germany wherein exchange for gaining a monopoly over the delivery of primary care, the medical profession must assume responsibility for making health care available where and when needed.

We have not done that in this country. I don't believe organized medicine in this country views it as its mandate to make sure that health services are available to all Americans when and where needed. Other countries require their legally monopolistic medical professions to foster an adequate distribution of medical services. In West

Germany fee schedules are used to entice physicians into the so-called cultural hinterlands, into the rural areas. Doctors are paid more for a given service in a rural area than in a city. I think this is an interesting idea. I think we ought to study the effects of that system.

The third point I wanted to make, is that we shy away at this time from attempts to regulate and to reshape through forceful direct regulation the American health care system, for the following reasons:

First, I know of few instances where direct regulation of economic activity really has worked directly and ultimately to the advantage of the American consumer. I need to mention here only transportation which should trigger in your mind an entire catalog of side effects we never intended.

Second, I don't believe that we know precisely where we wish to go in connection with the health care sector. One interesting exercise that you might want to undertake is the following: When somebody asserts that there is a maldistribution of medical services in this country—as we all agree—ask that person to tell you what he or she would deem an optimal distribution to be? In other words, "Can you tell me how many physicians I should have in each specialty in each country in the United States?" Such detailed instructions would be required if the Government were indeed to attempt to regulate directly, as it tried to do in some legislation 2 years ago.

I could go on and analyze changes in the delivery system that are felt to be panaceas; however, when you question social scientists who have evaluated such proposed changes they cannot in all honesty tell you that these proposed changes are unambiguously advantageous.

Finally, I make a plea that in designing National Health Insurance for the United States we look abroad to other nations who have led in that respect: Canada, France, Sweden, England, and West Germany, who have tried many of the changes that are being proposed as panaceas for this country who have sometimes succeeded but who have often failed.

One of the remarkable features which one observes in international comparisons of health systems is that, regardless of what proportion of the GNP is absorbed, the medical profession invariably controls the health care system, and shapes it according to its preferences. We have a faith in this country that if only we tinker a little bit more with the system, if only, for example, we pay salaries to our physicians in this country, we will solve the major problems facing us. I would urge you to look abroad, to invite perhaps foreign experts to come and deliberate with you, and to learn some of the bitter lessons which foreign nations have learned in this respect.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF U. E. REINHARDT, ASSOCIATE PROFESSOR OF ECONOMICS AND PUBLIC AFFAIRS, WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS AND DEPARTMENT OF ECONOMICS, PRINCETON UNIVERSITY, PRINCETON, N.J.

Mr. Chairman, it is a privilege and a pleasure to join with you, the members of your Committee, and this panel in a discussion of issues surrounding the introduction of national health insurance in the United States. By its very nature, such a system will alter the financial flows accompanying the delivery of health services and thereby the economic incentives and constraints confronting the consumers and the providers of health services. One need not be a card-carrying

economist to appreciate the fact that these financial factors tend to influence the performance of the health-care system significantly. The designers of the nation's future health insurance system therefore have the opportunity to do much good—or to do much harm.

You and your Committee are to be commended for your decision to precede legislative action on this issue with a series of relatively unstructured roundtable discussions. I trust that my colleagues on the panel join me in the hope that we, as perennial students of the health system, may be able to provide you with useful perspectives on the American health-care system. I am certain that, as a faculty member in a school of public affairs, I shall benefit personally from participating in your deliberations.

A number of distinct objectives could be posed for a national health insurance system, namely:

Objective 1: The system is to be designed as a bona fide insurance scheme introduced to protect individuals from catastrophic financial losses associated with illness.

Objective 2: The system is to be designed as a redistributive mechanism that channels purchasing power for health services from middle and upper income families to lower income families and, in so doing, redistributes available or projected health services in like manner.

Objective 3: The system is to be designed as a set of financial and administrative levers through which the public sector can reshape the organization of health-care production and delivery.

These objectives may be posed singly or jointly. The point to note is that, even if all three objectives were proposed side by side, different commentators would give them different relative weights individually. Implicit in each particular weighting of the objectives would be a particular set of views of what is right and what is wrong with the current health-care delivery and health insurance systems. Such views are, unforunately, rather subjective. The collection of experts invited to discourse with you on this topic is therefore likely to leave you with a sense of unresolved controversy.

OBJECTIVE 1 AND ITS UNDERLYING ASSUMPTIONS ABOUT THE U.S. HEALTH SYSTEM

Those who stress objective 1, perhaps to the exclusion of the other two, appear to assume either that the current health delivery system is not in need of a

Failure of the existing health insurance system to serve society well can be effected through a health insurance system. By posing the objective, however, one does assert that the current *health insurance system* in this country—the mosaic of private and public insurance schemes—has failed large segments of society. Why else, one may ask, would the nation need to introduce a *publicly* sponsored, bona fide health insurance system in the first place?

Failure of the existing health insurance system to serve society well can be traced to at least two prime causes. First, one would expect that many low-income families would find it impossible to finance the premiums for adequate health insurance coverage, even if these premiums were actuarially fair (that is, were on average as high as the average outlay insurance companies would have to make for such families). This aspect of the problem cannot fairly be laid to the doorstep of the nation's insurance industry. It is a problem that has its root cause in the nation's overall income distribution. The proper remedy clearly lies in altering that income distribution, either through a negative-income tax scheme, or at least through public subsidies toward the health insurance premiums of low-income families.

A second source of inadequate health insurance coverage, however, can be more properly traced to the insurance industry itself. A useful exercise for this Committee might be to go through a typical health insurance policy of the sort now being marketed, to imagine a variety of different illness scenarios, and to infer from the policy, *without expert advice*, precisely what the extent of coverage is for the various hypothesized illness episodes. One suspects that the Committee would find this an excruciating task, as does the typical American citizen. The health-insurance industry will undoubtedly argue that the many riders, exclusions and provisos embroidering its policies are designed to accommodate a desire for efficiency. It can be argued, however, that whatever efficiency is so purchased is likely to be purchased at an inordinate price.

First, there is the real possibility that many Americans ultimately purchase inappropriate insurance coverage on the basis of mistaken impressions. The fact that many Americans purchase first-dollar coverage at premiums quite out of proportion with the maximum loss exposure they *actually* face[1] is consistent with that hypothesis. One suspects that persons making these insurance acquisitions seek to protect themselves against much higher *imagined* risks, an impression that is likely to have been fostered by the complexity of their health-insurance policies.

An added price is paid for this complexity, namely, the uncertainty it creates in the mind of consumers. Standard economic theory and empirical research suggests that uncertainty usually creates disutility (unhappiness) among individuals. Indeed, to eliminate the uncertainty surrounding health-insurance coverage some observers have advocated an insurance system without any copayment whatsoever on the part of the consumer, fully recognizing that so generous a policy may induce some unwarranted increases in health-care consumption.

Whatever Congress, after its deliberations, decides to legislate in the area of health insurance, it is to be hoped that it will present Americans with health insurance options (policies) that are readily understood by the average person, even if such an approach involves some inefficiency at the margin.

Those who view objective 1 as the prime goal of a national health insurance system generally favor a system of deductibles and coinsurance borne by the consumer of health services at the time of consumption. Advocacy of cost sharing rests on the supposition that the demand for many types of health services is "price elastic," that is, sensitive to the out-of-pocket expenses consumers pay at the point of consumption. By forcing consumers to participate directly in the cost of health services, one hopes to reduce what the insurance industry refers to as "moral hazard" and is interpreted to be "unwarranted consumption of insured services," with the accent on *unwarranted.*

This is not an occasion to launch at length into that controversial subject matter. (See, however, a paper entitled "On the Benefit Structure of National Health Insurance," left with the Committee's staff.) Several pertinent observations may nevertheless be offered.

First, the objectives being pursued with cost-sharing are not likely to be reached if only a narrow stratum of the population (presumably lower-income families) are effectively exposed to cost sharing, while upper- and middle-income families, and particularly members of trade unions, have first-dollar coverage. To eliminate this possibility, Congress might toy with the idea of prohibiting first-dollar coverage altogether, although one doubts that such a stricture could be legislated over the objection of interested parties. An alternative would be to alter the tax laws so that all insurance premiums paid by a household (or paid by employers on behalf of the household) must come out of after-tax income. Interested parties (the insurance industry and labor unions) would be likely to object to such a change as well, but the measure might stand a chance of passage.

Second, a system of coinsurance and deductibles is likely to be worth its cost only if it can be relatively easily administered.

Third, as already mentioned, a system of coinsurance and deductibles is likely to generate considerable psychic costs of uncertainty unless that system is easily understood by consumers and the latter can easily infer the maximum risk to which they are exposed.

A few observations may be in order on the putative assertion that there is nothing serious amiss in the American health-care delivery system. As will be seen further on, the catalogue of frequently voiced complaints against the present system is long and varied. On closer examination, many of these complaints involve value judgments or differences in the interpretation of available evidence. This being so, some observers of the American health system have sought to reject the recurrent criticism of that system out of hand by insisting that ours is "the finest health-care system in the world." (One must, of course, observe immediately that even the "finest health-care system in the world" may still be

[1] I am referring here to the much cited instance in which faculty members at the University of Pennsylvania bought first-dollar coverage for very low maximum risk exposure—an instance often cited to demonstrate a strain of irrationality even among the educated. My argument is, pure and simple, that ignorance rather than irrationality explains the incident.

able to accommodate improvements, and that it is certainly within the domain of public policy to speed whatever improvements seem feasible.)

Many of the system's ardent defenders are the parties who have a vested stake in alleging a superior track record. Their statements ought therefore to be taken with the appropriate grains of salt, as everyone in this room surely knows. There may, however, be something to the point that Americans have been far too swift in humbling themselves before the rest of the world—that other nations that have gone down many of the allegedly remedial avenues now being proposed in this country have failed to compile a health-status record even as good as ours. An interesting case in point is the health system of West Germany. (A paper describing that system has been left with the Committee's staff.) Residents of that nation have for many decades enjoyed virtually universal, comprehensive health-insurance coverage without any cost-sharing on the part of the insured. By and large, that nation's health-care delivery system is similar to ours, although hospital-based physicians are salaried and private physicians have no hospitalized patients. Remarkably, West Germany fares considerably worse on such widely used health status indicators as infant mortality rates and maternal death rates. (See the tables appended hereto.) Indeed, on the latter statistic the West German average is roughly equal to the shockingly high ratio reserved for the non-white community in this country.

The point of the preceding paragraph is not to assert that the West German health system has failed society or to imply that no improvements are feasible in our system. The point has simply been to raise the caveat that health services are not the only input into the production of a nation's health status, and that the introduction of health-insurance coverage in this country, a redistribution of access to health services, and even a drastic reorganization of the American health-care delivery system may or may not trigger marked improvements in those indicators of health status on which Americans have so long condemned themselves, or generate many of the benefits expected from these changes.

OBJECTIVE 2 AND ITS UNDERLYING ASSUMPTIONS

An alternative, *single* motive for the introduction of national health insurance might be simply to place into the hands of low-income families the financial wherewithal to purchase adequate health services *and* to redistribute the overall costs of illness in the nation from those afflicted with illness to those blessed by good health. A compulsory, universal and comprehensive health-insurance system with premiums that are unrelated to the risk represented by insured individuals would accomplish that objective. (A sufficiently generous income redistribution system, such as a negative income tax, might be designed to achieve that objective as well. The fear here might be that the poor would not necessarily spend these transfer payments on health services in the manner intended by policymakers.)

Strictly speaking, one could view this objective as the most important mandate for national health insurance and still adhere to the supposition that there is nothing inherently wrong with the organization of the nation's health-care *delivery* system as such. One could even believe that the nation's existing health *insurance* industry has a spotless record. (A private health insurance industry would, of course, naturally tend to categorize individuals by actuarial risk class and set premia accordingly.) With some necessary oversimplification, the Canadian and West German health-insurance systems can be said to have been erected on primarily these notions. These systems are not bona fide insurance systems, nor do they seek to intervene purposefully into the organization of health-care delivery.

Implicit in the proposition of objective 2 is the assumption that lack of ability to pay for health services serves as an important barrier to adequate health care. That assumption in turn implies that one holds the demand for many types of health services to be price-elastic (sensitive to the out-of-pocket expenses consumers pay at point of consumption). Adherents to objective 2 part ways with the pure-insurance school (those favoring objective 1) on the policy implications they derive from the putative high price-elasticity. Adherents to the pure-insurance school see in high price-elasticity the rationale for co-insurance and deductibles. Adherents to objective 2 typically reject cost-sharing on the part of patients, presumably because they deem the consumption of truly unnecessary health services to be a trivial problem and do not wish to see coinsurance deter

consumers from using needed health services. Precisely what health services are "necessary" or "unnecessary" is, unfortunately, a question on which the experts invited to this Committee are unlikely to agree.

In connection with the issue of coinsurance it may be observed that some opponents to cost-sharing appear to rest their case on mutually inconsistent assumptions. Thus, on the one hand they reject cost sharing on the ground that financial barriers (however small) may deter some consumers from seeking needed health care. On the other hand, they suggest that the demand for health services is typically quite insensitive to out-of-pocket expenses in the first place, and that cost-sharing can at best yield only marginal savings in health-care utilization. It is difficult to reconcile these assumptions, unless one is willing to accept the argument that those very few services the demand for which is price-sensitive also tend to be much "needed" services. Since the question of coinsurance is likely to come up time and again before this Committee, members may wish to inquire from opponents of cost-sharing on what set of assumptions they rest their case.

OBJECTIVE 3 AND ITS UNDERLYING ASSUMPTION

Those who would like to see the nation's health-insurance system evolve into an insurance-plus-redistributive scheme rather than a pure insurance scheme typically feel that merely granting the lower-income strata financial access to health services may not be sufficient if health-care provider facilities fail to locate in the areas where such families concentrate (e.g., urban centers or the rural hinterland). Thus one finds demands for a redistribution of purchasing power commonly accompanied by demands for a reorganization of the health-care delivery system. These demand sare based on the popular conception that our existing system is in a perennial state of crisis and certainly incapable of accommodating the additional demands likely to be placed upon it through the introduction of health insurance. While a mere expansion of the existing system along traditional lines might be an expedient solution, the shortcomings of the existing system are held to be sufficiently serious to rule out so simple a policy response. National health insurance is thus seen both as a source of potential problems on the delivery side *and* as a vehicle through which these problems can be solved.

As noted earlier, the catalogue of commonly stated grievances about the existing American health system is long and varied. However, with some simplification the misgivings that have at one time or another been voiced in this respect can be distilled into the following summary:

1. It is held that the existing provider system, composed as it is of several hundred thousand more or less independent decision-makers ("firms"), is really a "nonsystem" that lacks effective planning and coordination. This lack of coordination is said to have resulted in: Widespread duplication of costly facilities, equipment, and patient record systems, and hence unnecessarily high costs of health care; a maldistribution of medical resources, with a relative abundance of facilities in affluent urban areas and a corresponding lack of facilities in the poorer urban or rural areas; and lack of comprehensiveness and continuity of care.

2. It is held that current legal restrictions on medical practice, and in particular current license laws covering both medical and paramedical manpower, tend to: Discourage experimentation with the use of paramedical personnel (physician assistants, nurses, medical technicians) for tasks now requiring scarce and expensive physician time; and discourage entry of labor into the health-care sector since current licensure laws effectively rule out the prospect of upward mobility in the health-manpower hierarchy.

While it is conceded that licensure laws do protect the consumer from unqualified personnel, it is felt that this benefit is not sufficient to offset their stifling effect on cost-reducing innovations in the organization of medical-care delivery.

3. It is suggested that the financial arrangements currently accompanying the delivery of health services, i.e., the emphasis on payment (fee or charge) per-service, combined with the fact that the consumers are typically more fully insured for inpatient than for outpatient care tends to: Deter consumers not covered by third-party payment from seeking relatively inexpensive preventive care in the early stages of a medical condition, thus necessitating more expensive therapeutic care later on; encourage consumers (and their physicians) to substitute costly (but insured) hospital services for less costly (but uninsured) ambulatory care; bar some consumers (the lower-middle class) from access to needed

care altogether; and encourage providers to overprescribe or oversupply health sevices to those consumers who can afford to purchase medical care.

4. With respect to the hospital sector in particular, it is held that the prevalent full-cost reimbursement formula, combined with the fact that a hospital's prestige increases to some extent with the complexity of cases it can handle tends to encourage the acquisition of costly facilities and equipment that are not fully used.

In addition, it is sometimes argued that the pervasive control by the medical profession over almost all facets of the health-care delivery process—e.g. the physician's voice in the management of hospitals—has tended to make the health system more responsive to the intellectual interests of the profession than to the medical needs of consumers. This allegation is sometimes accompanied by the argument that, by virtue of their training, physicians are ill-equipped to manage properly so complex a system as the United States health-care sector and that a restructured delivery system should provide for expanded lay control over the allocation of medical resources.

It will have been noticed that the criticisms enumerated above tend to fall into two major categories: those concerned primarily with the *quality* of the health care received by the American people as a whole, and those concerned with the *Efficiency* (or costs) with which that care is being produced. In other words, almost all proposals for a restructuring of the American health-care delivery system seek to accomplish improvements along either or both of these dimensions. As an economist I feel poorly equipped to address myself to the problem of quality. The following remarks will therefore be confined to questions related to the economic efficiency of the health-care delivery system.

In thinking about ways to reorganize the health-care delivery system it is convenient to divide that system somewhat arbitrarily into two distinct (though much related) components, namely:

A. The *technology* of health-care production and delivery (by which is meant the organization of medical resources within health-care provider facilities, the distribution of available resources among facilities, and the geographic distribution of provider facilities); and

B. The *financial flows* accompanying the delivery of health services from providers to consumers.

Proposals for a reorganization of the *technology* of health-care production generally seek to bring about one or a combination of the following four changes:

1. The consolidation of small, independent provider facilities into larger units, with the aim of reaping potential *economies of scale* in health-care production.

2. The *substitution* of relatively more abundant and/or less costly productive factors for relatively scarcer and/or more costly inputs.

3. *Increased division of labor and specialization of functions* among some types of facilities (especially in the hospital sector) and the integration of specialized units into a coordinated, comprehensive, and efficient delivery system through either full-fledged regional planning or at least the more centralized control inherent in the HMO concept.

4. A significant redistribution of physician manpower among medical specialties (away from specialist services to primary care) and among geographic regions (away from the suburbs of metropolitan areas and toward low-income centers and rural areas).

In some societies, such changes could be attempted simply through regulatory edicts. At one time or another, proposals to resort to direct regulation of health-care providers have come forth in this country as well. Once again, in a statement of this sort there is not room for an extended discussion of the merits and demerits of direct regulation of the health-care sector. (See, however, the Institute of Medicine's *Controls on Health Care*, 1975.) One is, however, not encouraged by the long-run performance of direct regulation in other areas of the nation's economic activities. The impact of public regulation on the nation's transportation industry certainly should give policymakers pause. It seems more in keeping with the American temperament to influence the provider system through manipulation of the financial flows accompanying the delivery of health services.

The financial flows accompanying the delivery of health services furnish an important nexus between a *national health-insurance system* and the nation's *health-care delivery system. Since the insurance mechanism interposes a third party between the providers and the consumers of health services, that financial mechanism can clearly be so designed as to influence both parties—in particular,*

57-677—75——3

to influence the manner in which the production of health services is organized. A rather bold attempt to use the insurance mechanism in this way was incorporated in an early version of the Kennedy-Griffith bill which would have provided for a massive shift away from the traditional fee-for-service reimbursement of physicians (and full-cost reimbursement of hospitals) toward prepayment to providers (HMO's) in return for a promise to deliver comprehensive care when and where needed. The theory was that health-care providers who operate under a prepayment formula have every incentive to prescribe the most efficient bundle of health services capable of treating a given medical condition and to produce whatever services are prescribed in as efficient (least-cost) manner as possible. Whether a nationwide system of health-maintenance organizations would actually service these goals is as yet an open question inviting sustained empirical analysis. *A priori* it can be argued that if an HMO is permitted to package one year's costs into the next year's capitation premium, the incentive to minimize the cost of health maintenance may be considerably blunted. How acceptable the prepayment regime will ultimately be to the typical American physician and patient also remains an open empirical question.

Whatever the merits and demerits of the HMO concept will ultimately turn out to be, as a practical matter the designers of the nation's health insurance system ought probably to be prepared to work primarily with the traditional fee-for-service system. Such a system was incorporated into the Canadian health insurance program and it has also now been widely adopted in West Germany, after decades of experimentation with capitation payments.[2] There is every reason to believe that it will predominate in the United States for decades to come.

The question policymakers must resolve at the outset is whether the determination of the fee schedules to be used under national health insurance are to be left to the good offices of physicians individually and collectively—as is the case where physicians are reimbursed on the basis of "customary local fees"—or whether these fee schedules are to be subject to strong public control. If the former approach is adopted, as might well be the case in the United States, policymakers willingly forego a potentially powerful lever through which the delivery system can be influenced. If the latter approach is used, policymakers ought to explore ways in which that fee schedule can be developed to serve society's interests.

Without dwelling at length on the potential role of fee schedules in a national health insurance system, it may be worth mentioning at least two concrete ways in which these schedules could be used to reshape the health-care delivery system.

First, under a national health insurance system it may be possible to introduce *interregional differences* in the *absolute* level of fees with the objective of encouraging a redistribution of medical manpower toward currently under-doctored areas. Relative to the customary local fees now paid under part B of Medicare, the new fee schedules should enhance hourly physician remuneration in low-income urban centers and rural areas and depress it in areas traditionally preferred by physicians. Lest it be argued that such a policy would not be administratively feasible, it may be noted that medical fees in West Germany, for example, are calibrated toward precisely this objective. The degree of success attained under the West German system merits further investigation.

A second objective that might be pursued with officially administered fee schedules relates to the issue of health-manpower substitution. Current policies are to encourage the substitution of paramedical personnel (physician extenders and allied health manpower) for the time of physicians in the production of health services. Toward that objective, the public sector has subsidized the training of increased numbers of physician substitutes without, however, providing physicians with strong incentives to engage in the desired health-manpower substitution. Bluntly put, upward flexibility of medical fees has enabled even phycicians who make wasteful use of their time to earn attractive incomes. Why such physicians would engage in more extensive task delegation is certainly not obvious.

Under a national health insurance system, attempts could be made to set the *relative* fees for particular medical services so as to provide physicians with strong financial incentives toward more extensive task delegation. More specifically, fees for services whose production could safely be delegated predominantly to lower skilled (and less expensive) manpower should be set in the fee

[2] Actually, the reimbursement scheme adopted in West Germany resembles what would be known in the United States as a "medical foundation" with each foundation covering one entire state. In this connection, see the attached paper on the West German health system.

schedule on the assumption that they are so delegated in every instance. Clearly, under such a schedule a physician who performed a delegatible service himself would effectively price out his own time at the imputed wages of a physician assistant. One suspects that, over time, such a fee schedule would tend to encourage physicians towards greater efficiency in the use of their own time. It would clearly also serve to reduce the overall transfer of income that society at large has to make to the medical-care sector in return for the receipt of medical services. (For a more extended discussion on the potential role of fee schedules in a national health insurance system, see "Alternative Reimbursement Schemes for Non-Institutional Providers of Health Care," a paper left with the Committee's staff.)

CONCLUDING REMARKS

Since this is the first in a series of panel discussions on the issues surrounding national health insurance in this country, the objective of this statement has been to offer one potentially useful framework within which these issues can be discussed in orderly fashion. The objective has decidedly *not* been to furnish the Committee with a blueprint for an "optimal" national health insurance system. A plethora of such proposals already exists. At the very most, the author of this statement would be prepared to recommend a few quite general guidelines for the design of a health insurance system. These recommendations are:

1. Whatever the particular form of national health insurance may be, Congress should offer the American public at least one comprehensive health insurance policy whose provisions are easily understood by the average American and whose language removes any uncertainty concerning the maximum financial risk to which the insured is exposed. Congress may either mandate that each private insurance company offer such a policy, or facilitate the public provision of such policies, perhaps in competition with the private sector. Whatever the case may be, a minimum goal for national health insurance should surely be to free American citizens from unnecessary anxiety.

2. It is important that, at the outset, the public sector (or its intermediaries) gain effective control over the determination of the fee schedules on which noninsitutional providers of health care are reimbursed under national health insurance. Failure to gain control over these fee schedules would mean foregoing one of the more important fiscal levers policymakers can have over the organization of health-care delivery.

3. Congress should shy away from attempts to couple with national health insurance bold attempts to introduce *direct regulatory control over the health-care delivery system.* This recommendation is based not only on the lack of a good performance record of public regulation elsewhere. More important is the fact that the ultimate impact of many of the organizational changes now being proposed is ill understood at this time. No social scientist with integrity could, for example, assert at this time that group medical practice is unambiguously superior to fee-for-service reimbursement, that salaried physicians practice medicine superior to that of fee-for-service practitioners, or that health-manpower substitution will ultimately reduce the cost of health services in this country. Until more is known about these issues, it is probably best to defer drastic changes of this sort and to design this Nation's future health insurance system primarily towards objectives 1 and 2 listed earlier.

4. In designing a national health insurance program, policymakers should search the experiences of other nations for potential lessons. It is surprising, indeed, that in recent debates over national health insurance the highly relevant experiences of Canada. France and West Germany are hardly ever referenced. These countries now operate national health insurance systems not unlike those most compatible with the American setting. Furthermore these countries have implemented a good many of the changes now proposed as panaceas for the shortcomings of the American system. In some instances these changes have yielded expected improvements; in others, there were unexpected and often undesirable side effects. In addition to the health services research now underway on aspects of this country's health system, much can be learned from cross-national comparisons.

Mr. ROSTENKOWSKI. I think the Chair owes the panel an explanation of what is happening here.

When the bells ring, we have to answer a quorum, when the bells ring on three occasions. Something took place on the floor of the

House of Representatives that I have never seen in 18 years. They vacated a quorum. I didn't know that they could do that. I don't know that anybody in Congress knew that they could do that until today, but it has been done. So when the bells ring, members of the panel leave.

If we leave, it is only because we have to answer either a rollcall or a quorum call.

Mr. Pike?

Mr. PIKE. If the gentleman will yield, I would like to say you talk about the monstrosities of the medical system, and I might just mention you are observing one of the monstrosities of the legislative system whereby 435 Members walk over to the House of Representatives, put a card in the slot, push a button marked present, and promptly leave.

I have long since made the determination that I had more important things to do, and, at the moment, this is one of them.

Mr. ROSTENKOWSKI. At this point, for the purposes of writing the record, I would like the panel to understand that any conversation that you have will be in the record, the interchange, plus the fact, that I am sure that we will join in questions in the not-too-distant future.

So if there is any comment that any of the doctors would like to make with respect to the comments that another panelist has made, please feel free to make your observations.

Doctor Wynder?

Dr. WYNDER. I listened to the economist with great pleasure. I would like to ask myself what is the key thing I learned. Perhaps it might be the Sutton law applied to medical care; namely, we have that type of medical care where the money is.

In whatever we do we need to consider that in our kind of society the Sutton law is as likely to apply to medical care as to any other care or any other endeavor.

Second, Dr. Reinhardt mentioned the German system. Sometimes certain languages are perhaps more perceptive to a given issue than our own.

When Bismarck originated the system in Germany, they did not call it health insurance, they called it Krankenkassen. That means it is disease insurance. This is more or less what we have in this country. It was not until 1971 that, by parliamentary law, Germany created for the first time a cancer detection program for which this health insurance would pay.

Thus, historically we have to recall that one reason why the German system, in terms of preventive medicine, had not operated very successfully in the past, is because it dealt with disease insurance.

Let me give you a specific example that may relate to the maternal and to the infant mortality that Dr. Reinhardt referred to.

At one time the German system paid for prenatal care only, the gynecologists and obstetricians and at that time the GP, who did not want to lose a patient, said: "Well, I am not going to send them to an obstetrician-gynecologist, I will do the first examination and I will deliver the baby."

The German system had to change the system to also pay the German practitioner for prenatal care. All of a sudden all mothers were examined during pregnancy.

The final point I would like to make relates to the fact that most of the major diseases that we suffer from in our Nation today are manmade.

Let's take heart attack. Some time ago I had the pleasure to serve on a National Task Force for Arteriosclerosis. After meeting weekend after weekend here in Washington, in the final weekend we said to ourselves: "What's the most important finding we learned during our deliberation?"

The most important thing we learned was that heart attack and arteriosclerosis are not an inevitable consequence of being born or becoming aged. In other words, the leading cause of death in our country is manmade and is therefore man-preventable.

It seems to me that in a system where we are quite willing to pay for all kinds of coronary care units, but are unwilling to pay for preventive programs directed to the prevention of coronary disease, we put the cart in front of the horse.

Preventive services will never be better applied in this country as they are today or in any other country until we give economic incentives for such preventive services to be conducted properly.

Mr. ROSTENKOWSKI. Dr. Freymann?

Dr. FREYMANN. I would like to take issue with Professor Fein. Maybe we can bring some controversy into this discussion. I put this out for his reaction. He stated that producer behavior is the issue in health care costs. I agree superficially that it is. It is the doctor who sends the patients to the hospitals, who writes orders and writes the prescriptions.

There is no question that, at the operation level, producer behavior is a very important component of the cost of health care.

But I submit that there is a deeper level which is beyond the control of the physician. This is really a point of social decision.

Let me use a homely analogy to get across the point I am making.

Let's say the health care system is like a dutiful housewife. The dutiful housewife is being told by her husband, which is society—and the Congress is representing society—"You have spent all you are going to spend on groceries. You had an open-ended grocery budget, and you have been spending more every year. This year we are going to crack down. We are going to have planning and be very rational about how you are spending the grocery money. I am not going to cut it back, but you are not going to get any more."

And the health care system says dutifully, "Yes. We will do that."

But when it is agreed that we are going to be rational and we are not going to spend any more money, the husband says, "By the way, Honey, don't stop serving steak."

Now I submit, as an example of "steak," the provisions in Public Law 92–603, which opened medicare benefits to anyone with end-stage renal disease.

I am not against people with end-stage renal disease, please understand. As a physician I can understand their need. But that was another billion dollars a year on our health care bill.

This was not a medical decision. There were respective physicians in the lobby which got that law through Congress, but this was Congress' decision.

Congress was, I think, reflecting the public, which was saying, "We know there are facilities for keeping people alive with renal disease, and we want them to be available to everybody."

But we can't have everything. We can have steak every night for dinner or we can have economy, but we can't have both.

The ultimate decision, I submit, is not up to the producer or the provider, the physician. The decision is ultimately a social one, and I think it lies in the hands of Congress how it is to be interpreted.

Mr. ROSTENKOWSKI. Professor Fein?

Mr. FEIN. I don't know that we disagree. In the first instance I said producer decisions, and in the second instance I said these are not in fact scientific decisions. They do require allocation of resources and those are heavily influenced by the way legislation is written. It is in that sense that I would differ somewhat, perhaps, with some of the language used by Professor Reinhardt, although I suspect that even here we will end up agreeing rather than disagreeing.

If I heard Uwe correctly, he indicated that there are many things we don't know about the direction that we would like the health care system to go in, and we ought to not only recognize that explicitly, but perhaps recognize it in our legislation.

It would seem to me that in the past, and it is likely to be the case in the future, we will find it virtually impossible to write what we would think, what we would term neutral legislation. The legislation that we write inevitably will direct resources and the more explicit we are about preventive care or early treatment or other areas where we want those resources to go, the better off we will be.

Your reference to the renal dialysis or renal care does prompt me to make one admissional remark on the question of equity. Earlier I said that I started with that perspective, and perhaps I can illustrate it with a story that appeared in the New York Times, December 28, 1970.

It was datelined, Richmond, California, a State that Mr. Corman comes from. It told about a young boy who on December 25th, Christmas Day, was very happy because, in fact, 800,000 coupons had been collected which had been transmitted to one of the cereal manufacturers in the United States as payment for a kidney machine, which would enable him to receive treatment at home instead of going to San Francisco three times a week at $200 per treatment.

It was a very warm story. It was a very marvelous Christmas Day, the child was happy, and the parents were pleased.

I suspect that many of us read that story and said, "It's a great country."

I would like to think that many of us stopped afterward and said, "What the hell kind of system is this that a little boy had to worry Christmas eve whether or not there are going to be enough people across the United States to provide the 800,000 coupons?"

What if they had not? So I think that my objective in National Health Insurance is to take care of that kind of a situation, not at the expense, however, of the situation which arises for many Americans every day, and for all Americans every year of primary care, the kind of things that most of us go to the physician about most of the time, the worry and the concern that arises. I agree with Professor Reinhardt on the importance of that psychic component.

Let me take that one step further. The argument is often made that preventive care is useful and primary care is useful because, among other benefits, it will save us money in the long run.

It is, I think, correct that a number of components of primary care will, in fact, pay for themselves by avoiding long-term treatment which is costly.

Having said that, I would hate to rest my case on that observation, because it seems to me that it is to use a false accounting system.

If there is a child who is sick with a high fever and you do nothing, the child may get better in 10 days, and let me assure you the gross national product will not be affected 16 years later when the child enters the labor force.

But if you do something and it only takes 5 days, you have saved a lot of pain and a lot of concern, and a lot of worry on the part of the child and certainly on the part of the parents, and the normal accounting system that puts everything in terms of GNP does not take account of pain and concern and worry.

I think that it is regrettable that on occasion those programs are favored which can "pay for themselves."

That is a humanitarian component to health care, an awful lot of it is about that, and it seems to me, again to use the phrase of civilized society that in an accounting we ought to pay attention to those components as well so that the thrust for equity is not only for the little boy on the renal side and not only for the people on the preventive side who will, in fact, as a result of the preventive treatment, save the economy's resources, but also for the people, all of us on occasion, who need care and supportive mechanisms and it won't make a bit of difference to GNP, but it will make an awful lot of difference to the quality of life of the Nation.

Mr. ROSTENKOWSKI. Thank you, gentlemen.

Congressman Pike will inquire.

Mr. PIKE. Professor Fein, I am very impressed with your statement about the complexities of deciding who gets what unless we essentially give everybody everything and the cost of doing it, and the choice of making these decisions.

Obviously you feel that any system should provide a kidney machine at home for anyone who needs it. Would you put any limitations whatsoever on the kind of care which should be provided under a national health system?

Mr. FEIN. Let me try and answer that with more than a sentence.

Mr. PIKE. Heart surgery for everyone?

Mr. FEIN. I believe that in fact in this economy with a GNP of over $1 trillion, we can do an awful lot more than we are doing. I believe also that we can do an awful lot more than we are doing within existing budget resources if we had a system which was more rational in its allocation.

I do believe that we would at various levels save money out of the waste that we now have.

Some 2 years ago there was an influenza epidemic in Boston, and the question was asked, as patients were in beds in the halls of the hospitals, "Does this not demonstrate that there is a shortage of beds?"

One of the keen observers, a hospital director faced with that question, found it rather difficult to answer, but when pressed he said, "No. There is no shortage of beds, because 25 percent of the people who are not in the halls, who are in beds, don't need to be there."

We have designed a financing system that encourages their being there, and that is the costly part of medical care, which is to say, I think we could do an awful lot better for the $104 billion we are now doing if we did not have a preference for high cost, technological, institutional care.

A lot of people can be treated in other forms for the same $104 billion.

Two. Other societies, in fact, have demonstrated that you can force and bring a more rational allocation by not having an open-ended budget system, as is the case in the United States.

One of the interesting observations is that in the United States, if you want to know what we spend on medical care, you ask the people at the Social Security Administration, Office of Research and Statistics, approximately 6 months after the end of a fiscal year, "What did we spend in the year beginning a year and a half ago?" but in Britain you know what you are spending, because you have decided what to spend. This does force very hard decisions.

In Britain it forces the hard decisions because Britain is a poor country. I don't think the decisions would be quite as difficult in the United States.

Three. If we come to a point where, in fact, medical science is able to do things for people that are beyond our budget abilities, even with whatever reallocations we might make from other spending sources, I would like to see a societal decision. Shall there be open heart surgery financed or shall there not? That is a tough one. It is a tough one, because the next question has to be—if society says that in terms of its priorities it can't do primary care and open heart surgery and that it opts for primary care—will you deny open heart surgery to those who can afford to pay for it of their own pocket? That is a tough one.

I know where I stand on it, but I can respect the fact that others would have a different point of view.

Mr. Pike. You know where you stand on it, but I don't know where you stand on it.

Mr. Fein. I don't believe that I feel comfortable in a society in which—remember, when we talk about open heart surgery and the expensive things we are talking about life and death situations—in which life becomes a matter of a marketplace where some can purchase it, life, because they are rich and others can't because they are poor.

Mr. Pike. So as a doctor you will say to the rich man, "You will not get it?" You are not a doctor. You are a professor.

You would say to the rich man, "You would not have it?"

Mr. Fein. I would. Rationing life through a lottery is one thing, but rationing through income and wealth is quite another.

Mr. Pike. It is a tough question and I thank you.

I want to let other people in here, but I would like to ask one question of all of the members of the panel. Taking the totality of

our medical system, nonsystem, monstrosity, whatever you opt to call it, and comparing it with any other nations in the world, tell me which nation you would prefer to swap our system for, if any.

Mr. FEIN. I will take a crack at that.

In many respects I think Canada.

Mr. PIKE. You would swap our system for Canada?

Mr. FEIN. I am including the whole thing of the delivery and the financing system and of culture and attitudes. If I could really have anything, I would prefer the British system. I think, however that we are so far away from that as a society in terms of our social values and our traditions—that to say the British is to say quite a mouthful. I would note, however, that Canada, is much more like our system on the delivery side as well as having traditions and culture of the people much more like ours. Canada has made a very key decision on the financing side, to say, "Thou shalt be insured without deductibles and without coinsurance." That strikes me as a step which this society coud make without great trauma.

Mr. PIKE. Professor Reinhardt?

I would like to go down the panel.

Mr. REINHARDT. I view the Canadian and the American health care delivery systems as being so similar that I cannot make a distinction, between them.

Mr. PIKE. I want to take the totality of it, the delivery and the financing. Whose system would you swap for ours?

Mr. REINHARDT. I think then I would take the Canadian system over ours because of its superior health insurance coverage. I don't think the Canadian system is the finest imaginable system in the world, but I do believe that it is superior to what we now have, and the reason is simply that the average Canadian citizen is free from the enormous uncertainty of the financial impact of illness.

Mr. PIKE. What do you think is the finest in the world? You said you did not think the Canadian is the finest in the world. What do you think is the finest in the world?

Mr. REINHARDT. I might even modify that. I could think of ways in which to improve the Canadian system, but I would say probably the Canadian system is the finest now operating in the world.

As to the delivery system, I really cannot discern any substantial difference between the Canadian and American delivery systems.

In connection with the European systems, I might tell you that in your alma mater, where I ply my trade, we have a project to study the European health systems. I hate to give any conclusions before I embark upon a study. As a social scientist, I can respond to your question only in a few years from now. As a nonsocial scientist ——

Mr. PIKE. Hopefully that won't be too late.

Mr. REINHARDT. Hopefully not. As a private person, I can tell you subjectively that should I travel in Europe I would hop on the first airplane to North America should I become sick in Europe. So I would vote with my feet. I would certainly pick our American system over those in Europe; given my current income.

Dr. FREYMANN. I would say it is difficult to pick a system. Of one thing I am sure: The usual indicators mean very little. Infant mortality, for instance, because how you judge——

Mr. PIKE. Even lifespan?

Dr. FREYMANN. Lifespan is another one, but there are socioeconomic factors affecting life expectancy which are quite independent of the efficacy of the health care system.

So I think I would go along with Professor Fein in saying that if there was a switch to be made, I would also——

Mr. PIKE. The question is should we make the switch, not if there is a switch to be made. Should we make the switch?

Dr. FREYMANN. I will give you the good news and then the bad news. I would say the switch should be made because I quite agree the Canadian citizen has had all the concerns of financing his health care, the direct financing of his health care, removed from his back. That is the good news.

The bad news I say expecting that my economist colleagues may have more up-to-date information. When I last looked at the figures, there was only one nation in the world spending a larger portion of its GNP on health than the United States, and that was Canada. Canada followed Sweden and France in the rate at which its health care costs were escalating and all three nations were way ahead of us. The Canadians are paying for what they are getting.

Mr. FEIN. Could I just comment on the percentage of GNP? This year, though the figures have not been published, it is obvious that as a percentage of the GNP our health care costs will be higher than Canada's but that reflects, gentlemen, the fact that the GNP has not performed very well this year.

Dr. WYNDER. I have not specifically studied the various national health care programs for the different countries excepting as I travel through various parts of the world and hear what the people tell you. I don't think there is a perfect national health care service system anywhere in the world today day, in my view, because the account is always put on the wrong horse, on therapy.

In Germany, for instance, they have gone virtually overboard in providing services for the sick. In Germany today you can go to health spas paid for by the national health service which, I am told, costs Germany 6 billion marks per year.

Now, you could imagine what would happen in this country if every coronary patient could be sent 4 weeks to Palm Springs or to some other nice community. Yet even in Germany they are still debating whether or not the health service system should pay for preventive services as it relates to coronary prevention.

At this moment the system only pays after you already have a heart attack. It does not pay if you have high risk factors. At present the National Heart and Lung Institute has a $12 million per year study going on to determine whether the risk of middle-aged Americans, at high risk for coronary disease could be reduced if we would reduce the risk factors.

Obviously, reducing risk factors for a coronary is a great deal cheaper than open heart surgery.

You may be surprised to learn that in this country, with the kind of health service we have, 50 percent of all Americans never have had their blood pressure taken and of those where it was taken and it was found high, only about a quarter are adequately treated.

So before we talk about health service involving open heart surgery or heart transplant, I would like to see us have a system that treats

the simple things first. They are not very costly and we do know that effective treatment of hypertension will reduce stroke rate by 30 percent at low cost. Certainly such treatment is far more cost effective than to try to treat stroke victims.

I always come back to prevention, because I want you to recognize that many of the diseases from which we suffer today are man-made. We require your wisdom to bring our country into preventive medicine.

One reason that all of the health services in Europe that I have seen are not doing any better is because they are virtually as bad as ours in terms of meaningful preventive services.

Mr. ROSTENKOWSKI. Thank you, Mr. Pike.

I would like to pose this question, and I don't mean by it that members of the subcommittee should run out and buy any airline tickets. But what countries would this panel suggest that our committee visit in order to get a viewpoint on which direction we should move on national health insurance?

I think that it would be most educational, but I was just wondering whether the panel could make a suggestion or suggestions.

Dr. FREYMANN. I would say first and foremost Canada. You can go to other countries, for instance Sweden. Everyone talks a great deal about the wonders of the Swedish system, but I hope that you will ask Dr. Vincente Navarro, who has just written a book on it, to testify before you go to Sweden.

Sweden and Britain are places that everyone thinks of. The reason I pick Canada, is that we have to work with what we have. That was the whole thrust of my presentation. No matter what you see in Sweden and England, it is not applicable to this country, simply because the systems are so different. The Canadian delivery system is so similar to ours that I think it is quite applicable.

Mr. REINHARDT. I would also suggest Canada. In fact, I know that some of your staff—Bill Fullerton, for example—have already begun to study that system. The reason is that Canadian society and the Canadian delivery system are culturally rather close to ours, and we can see what changes can be made in a short time with a system and the impact of those changes in the short run.

The countries in Europe that I would suggest as interesting are France and Germany, where in some instances one can see what has been tried, what has succeeded, and what has failed.

There are some important lessons to be learned. In some respects the West German financing system is akin to what we once called the medical foundation. The German insurance system is literally 1,800 independent small insurance funds that are financed through employer and employee contributions and pension funds. The funds pool their resources at the state level and turn over a lump sum to a physicians' association once a year, and the physicians' association in receipt of this lump sum obligates itself to deliver all contracted services under the insurance policies to the insured.

For example, the physicians' association is responsible for the regional distribution of physicians. The physicians distribute this pot of money among themselves, generally on a fee-for-services basis, and it is they who control health service utilization. Dr. Fein mentioned that it is important to control the behavior of physicians. In West Germany the physicians' associations, play what is known among op-

erations research people as a zero-sum-game. Other things being equal, if one physician bills more, another physician loses. Therefore, the physicians themselves control overbilling. And they use fee schedules to redistribute physicians into areas where there is a shortage of physicians.

I think it would be interesting to see how these utilization controls work, and how the West Germans control drug prices. In West Germany drugs are fully covered by health insurance. There are many reforms we may want to introduce here which the French and Germans have already tried. We can get relevant cost figures there. We can obtain clues on how to administer certain programs or even on how not to. It is for these reasons that I see the French and German systems as interesting case studies from our perspective.

Dr. WYNDER. I would also like to gain more knowledge from the German experience. I read a few months ago that they estimate that unless more controls are exercised over expenditures that by the end of the century the cost for health care will equal that to the entire German budget today. In other words, we can learn from some of these countries to what extent an undisciplined health care system, an undisciplined population, will bring the health care costs to such levels that it cannot be afforded by any society.

I think one thing we can learn from the Germans, and perhaps the Swedish and British experiences, is to what extent costs have spiraled to a level that society can no longer tolerate them.

Mr. ROSTENKOWSKI. Professor Fein.

Mr. FEIN. I would want you to visit Canada in order to at the very minimum listen to individuals who are very much like us who do not have the emotional baggage that we seem to have about the importance of cost sharing and who have had experience in some of their provinces with deductibles and coinsurance and without deductibles and coinsurance and have concluded that which sounds heretical in the United States, that it does not make sense to have coinsurance and deductibles. It think that is a very important lesson.

I would want you to visit Britain, not because I am so pessimistic as to believe that the United States will be in the near future as poor as Britain, but because I think that there one would see the, A, need for central budget decisionmaking, particularly in a poor country but in any country over long periods of time; B, the difficulty that is involved in negotiating with the medical profession; but, C, the opportunities that exist in a society in which there is a rational discourse for negotiation with the medical profession.

I think that I would want you to visit West Germany for reasons in many cases to see how not to do certain things in terms of administrative components, mandating pots of money, and additionally, to see what happens when there is a defined pot of money that society has said represents its priority judgment about the field and how resources can and cannot be allocated.

I think that those three countries would give one a measure of confidence about various critical elements.

I would also urge that you visit, as all of you do, the United States, because there are some lessons to be learned here about what can be done when we try and do things even within the very difficult constraints that are now faced because of the multiple sources of funding and because of the economic situation.

Dr. WYNDER. In case you don't want to travel, I suggest a book written by the Health Minister of Canada. Perhaps your staff could get it for you. It is an impressive kind of account by a health minister as to how he believes medicine should be practiced tomorrow.

It is a booklet that is available from the Canadian Health Services.

Mr. ROSTENKOWSKI. My staff informs me we already have that.

Are there any Communist countries that you feel we should visit?

Mr. VANIK. Socialist.

Dr. WYNDER. One of my colleagues recently returned from China. Of course, in a society like China, if you would really like to wipe out a given disease, you can make the people do that.

He mentioned one particular example which I would like to call to your attention.

There are certain areas in China where the incidence of cancer of the esophagus is very high. The Chinese working cadre will bring populations together and ask them to swallow a tube with an inflatable ballon at its tip. Then as you draw it up, you pull up some cells from the esophagus on which you may make an early diagnosis of cancer of the esophagus.

He tells me that hundreds of people will stand and be asked to swallow this tube, and they will do so. I don't know whether we could get anyone in America to practice that kind of preventive medicine. So in areas where you can make population do things, you certainly can do that.

An interesting question that I asked my friend, was "What is China doing on smoking?"

"Well," he said, "nothing."

In all the time he was in China not one person told him anything about smoking. The probable answers to this may be that Chairman Mao is a heavy smoker and perhaps more importantly that China is a sizable exporter of tobacco.

Dr. FREYMANN. I think China is of particular interest. I am not suggesting that the committee should necessarily go there, but I think it is of particular interest because it is the only nation I know of which has really changed its health care system.

I said before that no nation that has instituted national health insurance has changed its system with health insurance. It has done quite the reverse, it has frozen the system it had.

The National Health Service did not create the British system. That system existed and the National Health Service was superimposed on it, ditto for Sweden and Germany and for all of the Communist nations of Eastern Europe and Russia.

China is an exception. The Chinese really did change their system, and they did it in a very simple way. A highly trained specialist who was a graduate of Peking Union Medical College and did not see the wisdom of becoming a family practitioner in a commune was sent off to a camp to think things over. Amazingly enough, it was not very long before the whole system was changed.

I submit that China is the one nation which has changed its health care system, but no other nation has. There is a lesson in this for us.

Mr. ROSTENKOWSKI. Mr. Duncan will inquire.

Mr. DUNCAN. Thank you, Mr. Chairman.

I want to thank the panel. You have been very helpful. The reason I mentioned at the beginning that we should have some practicing

physician on the panel is when I read the résumé of each of you, that for Dr. Freymann and Dr. Wynder, it shows that you are primarily engaged in research, and in an article that I also read, Dr. Freymann, that you had written, that said there are two factions in the medical profession, one directed toward research and teaching and the other whose occupation is private practice. That is the reason I happened to mention that, that we should have someone whose occupation was private practice. But you have been very helpful.

Someone suggested that perhaps we should go to Canada. It might not be necessary. I was looking at our fact book, and I noticed that in the last few years we have 439 physicians who migrated from Canada into the United States. So perhaps we could talk to some of those without spending the money to go there.

Also we have 364 from England. I understand now that the number is up to over 400, which is more than four medical schools could produce in this country.

It is also my understanding—you might correct me—that the Canadian Government limits the benefits on their national health insurance and also that they only pay 50 percent and the remainder is paid by the Provinces, is that correct?

Mr. REINHARDT. Yes.

Mr. DUNCAN. And it is a complete cost share arrangement that they have with their Provinces.

Is it also true that in Canada they spend less than 1 percent of their gross national product on national defense—they pretty much depend upon the United States for defense—and consequently they are able to put a little greater proportion of their GNP into medical care?

Mr. REINHARDT. I think the latter point is certainly well taken. Even these percentage figures, as Dr. Fein says, do fluctuate considerably; and one has to take them with a grain of salt.

The Canadian expenditure is not really that drastically much more than ours. I don't think it is more than a percentage point more.

Again, one would have to keep this in mind that the Canadians clearly do try to deliver more than we now do for the extra percentage point, and Canada is a somewhat poorer country than the United States.

If you take into account those facts and also the fact that in paying physicians Canada does have to be somewhat competitive with the United States, you should not be surprised that the percentage in Canada going to GNP is somewhat higher than here.

Mr. DUNCAN. In 1973, you said that any national health insurance would place an immediate added burden on the Nation's already strained health care provider system. Is that still your opinion, Dr. Reinhardt?

Mr. REINHARDT. That introduction of health insurance would increase the demand for health services?

Mr. DUNCAN. Yes; you said it would place an added burden on the Nation's already strained health care provider system.

Mr. REINHARDT. Yes; that is still my opinion if the health care delivery system remains organized as it is now.

Mr. DUNCAN. Don't you think we ought to be careful that we don't promise more than we can provide?

Mr. REINHARDT. I think you have to be somewhat gradual in phasing things in. For example, benefit packages can be expanded over time. You might initially be very cautious in covering drugs and increasing drug coverage over time. You might limit physician services. You might indeed initially ask for copayments and deductibles in the expectation you will ultimately phase them out.

I would suspect if full comprehensive health insurance coverage is introduced in the United States now, there would be a strain placed on the delivery system.

Mr. DUNCAN. How long do you think it would take to implement an adequate national health insurance program? Any one of you gentlemen may respond.

Mr. FEIN. Let me begin the answer with the question that you asked Professor Reinhardt about the degree to which you would increase the demand for medical care and strain existing resources. In 1969 Roger Egeberg was appointed as Assistant Secretary for Health. He indicated then he did not think we could have national health insurance in the immediate future because it would strain the resources of the medical delivery system.

In 1969 we waited and it is now 1975. In 1974 instead of $60 billion, we were spending $104 billion. Much of that is explained by inflation, but a good deal of that is explained by an increase in demand which we were able to meet because it is a fact that our medical schools have expanded markedly in the last few years, that is point 1. I don't think it necessarily strained the system.

Point 2: None of us, I think, are here pleading for more and bigger and better dollars for that health care system. I think some of us are saying that the question is "How are we going to distribute the $104 billion that are now being spent and how are we going to share in the goods and services that are already being provided?" That a system will have to ration unless we want to have it cost as much as the public and providers want it to is abundantly clear.

The question is "Do you want to ration on the basis of price and income?" I think that one could implement a national health insurance program quite clearly, that is, with leadtime to work up administrative mechanisms.

I think the system could absorb it. I think the tax system could absorb it. The money, the $104 billion, is already being spent. If one wanted to take time to phase a system in, a full and comprehensive system, I don't think it is necessary, but if one wanted that, I would urge that the kind of phasing in we do have the following characteristics: Each step logically leads to some subsequent step rather than, as we have on occasion done in the past, implement a step which we must then take apart to move to the next level.

Mr. DUNCAN. My time is about up. I want to move on, but let me ask you, how much do you think a full comprehensive health insurance program would cost?

Mr. FEIN. I believe that a full comprehensive health insurance program with a commitment and with a willingness on the part of the Congress to do battle with those who would like to preserve the existing organization would cost slightly less than what we are now spending.

Mr. DUNCAN. Let me ask you this. Do you think we should have a share-cost basis with the States such as Canada has in her Provinces?

Mr. FEIN. Intellectually I like that. I think it has great merits. My difficulty with it is that we are 50 States. They have many fewer Provinces. The disparities between some of our States in terms of resources, in terms of income and in terms of mix of population and their income—in terms of poverty, if you will—are such as to make it difficult for me to see how we could do this while preserving a fundamental principle, namely, that people in Mississippi and people in Massachusetts are all Americans.

Mr. DUNCAN. Where would we get the money? Where would the Federal Government get the money other than borrowing it?

Mr. FEIN. Individuals and business are now spending a lot of money on private health insurance. That is the money that I am talking about.

Obviously it would be silly for me to come before you and say that the Federal budget can pay for all this without increasing the revenues to the Federal budget. I would point out that those revenue increases would necessarily translate into decreases in private consumption for private health insurance.

Mr. DUNCAN. I have several other questions I would like to ask, but I would like to submit them to the panel to answer for the record. I do thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. We are going to work until quarter to 1 and we are going back at 2 o'clock. I don't want to cut off anyone with respect to getting some answers for the record. So if Mr. Duncan could come back at 2 o'clock, fine.

Mr. DUNCAN. Thank you.

Mr. ROSTENKOWSKI. Professor Reinhardt, did you want to say something?

Mr. REINHARDT. Just to clarify the record, it is true the introduction of health insurance would place additional demands on the existing health care delivery system and would burden it. I mentioned the phrase "as it is now organized it would produce some strain," but I don't believe it would break the system.

First of all, we can look to Canada. What happens when a system has additional burdens placed on it? The health care delivery system could utilize more delegation of tasks from physicians to paramedical or physician substitute personnel.

Second, the length of the face-to-face contact with the doctor, the patient visit, could be reduced. Those are the two responses of a health care delivery system to additional demands.

It is in this way that the system accommodates. In a recent paper I wrote—I am not sure which one—I remark upon the unbelievable flexibility a health delivery care system has in accommodating even rapid shifts in demand or composition of demand. I will send you, sir, a table that shows physician-population ratio and physician productivity in three regions in the United States.

New England, which has the highest ratio——

Mr. DUNCAN. The quote I gave you was the health service reports or something. I think it was in that.

Mr. REINHARDT. I see.

Some of the States in the South have the lowest physician-population ratios, and you might think that in those States the number of visits per capita is low accordingly. But in the South physicians delegate more tasks, employ more aides, work harder, and see more patients, so that when you look at the bottom line, the per capita visits delivered are roughly the same as in New England. So the system does accommodate considerably to demand pressures. The question is this: Is the health care given in the South quality health care? I am certainly not qualified to comment on it, but if you allege that it is not quality health care, I invite you to go down there and say so by looking southern physicians in the eyes.

Mr. DUNCAN. I live in the South and I feel fine, thank you.

Mr. ROSTENKOWSKI. Mr. Vanik will inquire.

Mr. VANIK. I just have a couple of questions. Earlier, Dr. Fein suggested that catastrophic coverage would be catastrophic. I was just wondering whether he would tell us why, because there is considerable basis of thought in the Congress that this is one of the things we might do as a minimum.

Mr. FEIN. There is a dynamic quality that all of us have referred to in the health care system. If one insures catastrophic expenditures, this will, in fact, I believe—and I think a number of my colleagues will agree—this will direct resources toward catastrophes and away from prevention of those things, away from preventive care, the primary care which are not costly, but are very, very important to individuals and to the total health care system in preventing those catastrophes.

The insuring of hospital care makes a difference not only in ability to go to the hospital, but also directing resources away from primary care.

Mr. VANIK. Let me tell you some of my own experiences. I am as an individual most deeply concerned about catastrophic coverage in all areas.

I am at a point where I don't insure my automobiles any more against damage that others may incur. I protect others.

I just want to provide public liability. I want to be sure that I have enough because I want to insure protection of the others. I am willing to take the risks that are inherent in that kind of planning and restoring my own property. That reduces the cost to me.

It also takes me out of a lot of discussion and negotiation about small claims and their settlement. I get very angered about the cost of these things in automobiles. For example, I had an automobile totally damaged. The estimate of repairs was $2,845 and I fixed it up for $650—not perfectly, but adequately.

Now the same principle applies it seems to me, in health coverage. I am dreadfully concerned about facing up to a problem where there might be a catastrophic illness in my own family, reducing our standard of living and driving us into hopeless and abject poverty. It can happen to any family.

Now, from the standpoint of cost and manageability doesn't this become something that is achievable in a health plan?

Mr. FEIN. Mr. Vanik——

Mr. VANIK. I am taking care of the normal day-to-day things, you know. We can handle that. But what all of us fear is something might happen that will just be beyond our scope of control.

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Mr. FEIN. Let me be clear. I am not opposed to protection against——

Mr. VANIK. Why is it catastrophic? Why would it be catastrophic for all of us to be putting something into a pool to cover those relatively few people among us who would have to face up to a catastrophic problem?

Mr. FEIN. Because if that is all we did——

Mr. VANIK. That is the best insurance there is.

Mr. FEIN. But if that is all we did, sir, then to use your analogy, there would be somebody to pay the $2,800 bill and, in fact, it would be paid and the resources would be directed in that direction. Additionally, while you and I might very well feel much more secure with catastrophic insurance and, indeed, continue to seek early care, preventive care, primary care, there are Americans for whom that $5 or $15 or $17.50 becomes burdensome.

It would seem to me that if we want to have that taken care of for those Americans, then we need a system which includes both catastrophe and early care.

Mr. VANIK. I don't argue about all of those things. I don't know why catastrophic coverage should detract from the other programs. As a matter of fact, I would like to move to the next question.

That is, in the development of what we are doing here and in our efforts in this committee to develop a program, I wonder whether we shouldn't approach the whole thing with a building-block concept. In other words, getting our keystones in place and then phasing into a total program? Perhaps we would not even build it all at once. I am so fearful that a comprehensive program, as desirable as it would be, would be an awfully difficult thing to establish—it might well become unmanageable. When I talk about the building-block concept, I think about catastrophic coverage being one of those keystones on which we build a total system, and a complete system.

I don't take away from the other possibility, but I want to put that suggestion out to the panel and try to determine how the panel would feel on this kind of gradual approach as against a comprehensive approach.

Yes, Dr. Freymann.

Dr. FREYMANN. Mr. Vanik, I think the problem that arises in comparing the catastrophic approach in health and the catastrophic approach in casualty insurance is that you could drive for 50 years and never have an automobile accident, but everyone is going to die.

Mr. VANIK. We don't all die catastrophically though. Some of us sort of ooze out from date of birth.

[Laughter.]

Dr. FREYMANN. The fact of the matter is that it is very, very difficult to die at home in this day and age.

Mr. VANIK. In my community you are going to die at home because you can't get a doctor. I live out here in Fairfax and the only way to get a doctor is to call an ambulance and get to the hospital. There are no roving doctors any more and the only way you get a doctor is die on a golf course. You might find one there.

[Laughter.]

Mr. ROSTENKOWSKI. On a Wednesday.

Mr. VANIK. That's right, on a Wednesday.

Dr. FREYMANN. This is precisely the reason why people are dying in hospitals.

Mr. VANIK. That is not true now. I am shocked by the great number of deaths that are occurring outside of hospitals and in the home and on the streets and away from where the care is. Do you have figures to back up that, the figures on where deaths occur?

Dr. FREYMANN. No; I don't and it would be very interesting to have——

Mr. VANIK. I would like to have those figures tested because I think the ratio of deaths in hospitals to deaths elsewhere would be shocking. I think we would be shocked to learn how many of our people die alone without anyone around, without any care nearby.

Dr. FREYMANN. You have caught me where I should have figures and I don't, Mr. Vanik, but I certainly agree. There are deaths on the highways, as Dr. Wynder has already pointed out. This is a major cause of deaths and many of these people never get to hospitals. There are also those who drop dead in the street. But what I refer to is the person who lives his full three score and ten years. It is true that a lot of people are still living out their lives and dying at home. But the fact is that it is becoming socially less and less acceptable for this to happen.

One practical reason for admitting dying patients is that it is very difficult to get a doctor to come and attend a person who is dying at home. Furthermore, the law requires that you can't be buried without a signed death certificate.

So what I am leading up to here, sir, is that once a person gets into a hospital, it is very difficult for the staff not to make available to him all the technological facilities that are necessary to sustain life.

Within the last week I watched as a patient in a hospital in Hartford was worked over for 3 hours in a coronary care unit. He had a cardiac arrest. I have no idea of what the actual costs were, but in terms of man-hours I am sure a number of thousands of dollars were spent. The man was 85 years old.

Now the doctors and nurses on that ward are not there to decide whether if a person is of a certain age, he will not receive services that a person 10 years younger would receive. This is where I get back to the point I tried to make earlier.

We are in a box. We have technical facilities where will keep people alive almost indefinitely and those are enormously expensive. Yet we have a limited amount of money. If more and more money is going to be going into perpetuating life, less and less will be available for prevention and primary care.

Mr. ROSTENKOWSKI. Mrs. Keys will inquire.

Mr. VANIK. Mr. Chairman, I would like to say that after we resume, I would like to get a reply from the panel on this question of approaching national health insurance on a piece-by-piece program vis-a-vis the comprehensive bill.

Thank you.

Mrs. KEYS. Thank you, Mr. Chairman, and I would like to thank the panel for excellent testimony. It was very interesting, very informative. So many of my questions have been well covered, but one area that has not been touched upon I would like to propound a theory on and see if there is any disagreement among you on it, and how it could

be influenced either through our medical education or through the adoption of a national health insurance system.

It seems to me if we are going to meet the health care needs of our citizens we need to place a greater emphasis on preventive medicine. This is an important part of the health picture which has not been carried out in terms of the public at large. We are going to have to see the movement out into the community of a great many people other than medical doctors—nurses, medical assistants, para-professionals and the like.

So far, the field of nursing has been strictly confined to a hospital care situation and responding as an assistant to a doctor. How can we influence and change this? Would you agree that this would be helpful? Is it necessary, in terms of stressing the role of preventive medicine, to emphasize things as health education, nutrition education, and moving people out into the community?

Perhaps Dr. Freymann, who has talked about the role of medical education, could comment in this area.

Dr. FREYMANN. Mrs. Keys, I couldn't agree with you more. I think that nursing is probably, with the possible exception of pharmacy, the most underutilized of the health professions.

Patient education is part of the education of every nurse, and I have been on record for many years that the nurse practitioner may very well be the answer to providing primary care.

This is already proving practical in many parts of the country. The problem of getting the nurse practitioner out and delivering care is hung up on the problem of who is going to pay her? This is something else the committee must concern itself with.

So we end up with money again, but I agree with you absolutely that this is a resource that should be tapped.

Mrs. KEYS. Would anyone else care to respond?

Dr. WYNDER. I would like to add to this in the language of building blocks. The building blocks have to include prevention. As I emphasized in my former remarks, it must also include allied health professions. Several studies have shown that if the Public Health nurse does home visits for victims of heart failure, it is done better and cheaper than when these people go to the hospital.

A very important factor, therefore, is to strengthen allied health professionals, not just the nurse and the nurse's aide but also the health motivators, educator, and sociologists. People have to be shown that these allied health professionals can handle several health aspects better than the doctor. For one they are often better motivated and they have more time.

This paramedic forms a very important element in primary care and particularly preventive care.

On a final comment in terms of building blocks, Mr. Vanik, William Osler once said, "Man's best friend is bronchial pneumonia." In other words, you die of old age peacefully at home of bronchial pneumonia.

A typical example of what we should not do is what we did with former President Truman. He was dying of bronchial pneumonia and we should have let him die in peace. Instead, we are trying, as Dr. Freymann said, to keep old people alive artificially, which is not in their interest nor in the interests of society.

I would certainly agree with you, the best way to build up a new health care delivery system is to do it block by block and learn from each country where such blocks have been most effectively used.

One of the things we can learn from China is the example of the barefoot physician. The barefoot physician, as they call it—as we call the allied health professional—has significantly contributed to the preventive care in China.

Mrs. KEYS. Mr. Reinhardt.

Mr. REINHARDT. I believe the point you raise is a very important one, very often overlooked in the entire discusion of health care systems. The ultimate purpose of that particular type of activity is presumably to improve health, however we define that.

So there must be something an economist would call a health production process, as distinct from a health care production process. Inputs into the health production process are medical services, but they are only one part, and in many instances not even the most important part. The patients' socioeconomic environment, hygiene, housing, and nutrition are equally important; and—this is the point to which I would like to come—the patients' own attitude and his own ability to manage this health production process are very important.

Now, some people smoke—my learned colleague next to me, for example—and they are clearly somewhat remiss in so doing. In smoking his pipe, my learned colleague on the left will undoubtedly put a burden on the medical system, perhaps some 10 years hence.

I mention that simply because it is only one manifestation of an opportunity for preventive health care. Not speeding is another example. The number of deaths from motor vehicle accidents is shocking in this country. We could reduce the burden on the health care system imposed by such accidents.

Second, I believe our educational institutions are remiss in teaching health management, as I would call it. Mr. Pike isn't here, so I can slip this in. At Princeton we are enthused about teaching our students about the various toothaches the Pharaohs had. As you know, we can X-ray ancient molars and know that Ramses II had toothaches. We teach that because it is intellectually stimulating.

We do not have a course in human biology at Princeton University, which is one of the greatest—I hope—universities in this country. We do not really teach health management to our students, and yet we clearly should.

Finally, as to the use of paramedical personnel, they could be a source of such education. Once we begin to use paramedical personnel as entry points into the health system, however, we are confronting an extremely complicated issue. And the question I would raise is this: Under whose control will these paramedics practice? The economic and medical control of the physician? Or will you allow these paramedics to practice as independent practitioners?

This is the question Congress would have to address. If you let them practice as independent practitioners, will there be fee-for-service, or how will you pay them? The method of payment has enormous consequences.

I think you would encounter much difficulty in getting away from the first mode, that of putting paramedical personnel under the con-

trol of physicians. If paramedics are employed in such a manner, it isn't clear to me that health care costs won't rise, because each paramedic will be attached to the location of his or her employing physician and maldistribution of services will be perpetuated.

Mr. FEIN. I would only disagree with your last phrase. I think we ought to think about it hard, but not long.

[Laughter.]

Mr. FEIN. By that I mean we have been thinking about some of these problems for a very long time.

I think that it is a problem which illustrates the complexity and interrelationships that the chairman referred to in his opening remarks in the health care system.

We, for example—when I use the word we I mean we the people—financed medical education in the last 20 years in a manner such as to get quite a bit for what we put in. We got research and we got specialization. But we had a side effect. We destroyed in large measure whatever possibilities did exist in our medical schools for emphasis on preventive care and on primary care.

The orientation of the entire medical education care sector to hospital care makes it less likely that physicians would move to those areas or that they would be interested in the training of allied health professionals.

We have instituted payment mechanisms that make it very difficult for allied health professionals. Again, not in order to make it difficult for allied health professionals, but for what were presumed to be good and sufficient reasons without due attention to the side effects that came about.

Above all, we have never in any part of the United States placed a responsibility on any organized body, governmental, private, educational, or any organized body to be responsible in some sense for the medical service delivery system in that community. In early September every year most of us have, all of us have an assurance that the schools will open and that the school board will see to it that there are buildings and classrooms and teachers.

While various communities at various times have had difficulty in meeting that obligation and have had to erect temporary facilities, the schools do open.

I have an exercise that I have for the medical students at Harvard when I teach them, make a series of phone calls saying that you are a new resident and that no pediatrician is prepared to take your children, which is the case in the high-income suburb that I live in, and then ask the dean of medical school: "What shall I do under these circumstances?"

When you receive the answer that: "I sympathize with your problem but it is not the responsibility of the medical school to assure that there are pediatricians in Newton," and you call the county medical association, you will get the same answer. Call the State department of health or the city department of health and you will get the same answer.

I once delivered some remarks on this and a cartoonist encompassed the sum total of my remarks in one cartoon. He had a picture of an envelope that is addressed to "Complaint Department, U.S. Medical Care System," and in the upper left hand corner it said, "John Citizen,

Home Town, U.S.A." There was on the envelope the stamp with the finger pointing to the upper left hand corner saying "Return to Sender, No Such Address." Well, as long as there is no such address and it isn't anybody's responsibility, we can have the situation that we have. We will not change it quickly. But we cannot change it by dabbling at the edges, as if the financing system was unrelated to the distribution of physicians by specialty and by location.

Mrs. KEYS. Thank you.

Mr. ROSTENKOWSKI. Thank you, gentlemen.

It is certainly nice to see the chairman of the full committee, Mr. Ullman, with us.

The CHAIRMAN. Would the gentleman yield?

Let me congratulate you for going ahead with these hearings and for putting on a panel of this caliber.

I wish I could have been here to hear it, but I will be studying the record. The reports I have are most excellent. That is one of the reasons I came over.

These are hearings of great long-range importance and we wouldn't be holding them if we didn't intend to write a piece of legislation. This is a very good beginning. I want to congratulate you.

Mr. ROSTENKOWSKI. Thank you, Mr. Chairman.

The committee will stand in recess until 2 o'clock.

[Whereupon, at 12:55 p.m., the subcommittee was recessed to reconvene at 2 p.m..]

AFTERNOON SESSION

Mr. ROSTENKOWSKI. Well, gentlemen, I think the conversations that have been held back here in the backroom subsequent to your testimony are very encouraging.

I think it has been enlightening in the morning session and I am sure that this afternoon we will be able to shed more light on what we feel we will have to do in creation of a national health insurance legislation.

I would like to pose this question to each of the panel members, preventive medicine, Dr. Wynder, is like the weather. Everyone talks about it, but not many try to do anything about it.

What would be involved in making the concept of prevention a central part of our health care system? How do we get the health professions and the public to accept what structural changes would be needed in the organization of care and what would it cost?

Dr. WYNDER. First of all, there must be incentives for preventive care. It is apparent, as I said in my formal remarks, if we give incentives for only therapeutic care but not for preventive care, we will not have it; because, (a), the health care system is not likely to do it unless it is being paid for and (b) the public at large really does not go for preventive services, because, as I also pointed out, most of us really believe it will never happen to us.

So that even in the German example which we cited before where the German Health Service now pays for cervical smears for women, only 25 percent of eligible German women have availed themselves of this free service.

Part of the incentive is also the way we look at sick days we do not advocate health days. Nearly every worker has so and so many sick

days that he can be off work. But if an individual wants to go to a preventive care facility for an examination, or to a nutrition clinic or hypertension clinic, when he is not symptomatically ill, he must do this on his own time.

In our organization many of our clinics work in the evening because the worker has come on his own time. One of the suggestions I would like to make here, is that we establish health days for our citizens in addition to the sick days that we have now.

The key problem, Mr. Chairman, in preventive medicine, is lack of economic incentives and the human apathy towards anything preventive because we believe that it cannot happen to us. It always hits the guy next to you.

This issue has been with us throughout the ages and I doubt whether we will ever change human beliefs that a particular sickness cannot befall us.

Thus, I feel that we have to provide economic incentives for the health care delivery system to undertake preventive measures, and we must provide more incentives for the individual. Perhaps, we could start this approach in our school system.

Most of our chronic diseases have their beginning at a very early age. Hyperlipedemia really begins early in life from the way we eat. A study was done at Harvard from data available to the health service they could predict who would develop heart attacks later in life.

Studies comparing blood cholesterol level of children in Wisconsin and Mexico showed that the curves hardly overlapped. Thus, one way to begin good preventive procedures would be to indoctrinate our young children in knowing more about their bodies.

We have established at the American Health Foundation a KYB program for schools, a know your body program where at minimal cost we check schoolchildren, determine their cholesterol and hemaglobins, test their eyes and ears and carry out tests for physical fitness, take a history on smoking use and then give them a health passport, which is upgraded every year.

When you get children to know their own bodies they are likely to become more involved in health care than otherwise.

In other words, incentives have to be provided early in life, they have to be provided at a cost-effective level for both the providers and for the consumer.

The final question you asked is, what would it cost?

That is difficult to answer. I personally believe that if you concentrate on primary prevention which is really the way in which I think preventive medicine must go and primary prevention means to identify these factors early in life and reduce them both in the environment and in the individual, then preventive services are cost effective. If you only deal with secondary prevention it is a costly service which is not always cost effective.

Dr. Fein mentioned before that the social security service monitors health care costs in this country. But, when you ask, how much do we pay for preventive services? We really don't know because preventive services have never been appropriately covered by the health economists.

Let me repeat, most of the diseases from which we suffer today in our country are preventable. Prevention needs to start early in life and if we really do our job well we could all die at some old age, free of disease. That is the way our general timeclock has called for us to die. Die we must, but we must not necessarily die sick. If Congress provides the necessary incentives we shall have meaningful preventive services.

Mr. Rostenkowski. Thank you, Dr. Wynder.

Mr. Martin will inquire.

Mr. Martin. Thank you, Mr. Chairman.

Just as I want to commend the panelists for the quality of their presentation, I want to commend the chairman for presenting an equally qualitative panel.

We have had a series of questions, as I am sure you have noticed, that not only give us a chance to give a varying perspective from different points of view, but also give me a chance to catch my breath. But one I wanted to get into was to ask generally of you what each of you sees as the most critical need or the most glaring deficiency in the present American system of health care.

I have to give some background before I breathe deeply here, but we had mentioned in your remarks and in some of the questions, a series of concerns which have been brought to the committee. We have had criticism of relying on or even permitting fee for service.

We have considered the loss of coverage during unemployment periods. This committee has looked into that earlier this year. There is a problem of lack of catastrophic coverage; the need for more personnel; the geographic distribution problem that Professor Fein and others have dealt with.

It has been mentioned about the overgrown orientation toward hospitals that Dr. Freymann has discussed in his introductory remarks. Relative inaccessibility of middle-income people who have neither wealth nor welfare and the problems of preventive medicine.

From this and other subjects we have to deal with, it seems to me, in relation to the Vanik concept of a modular legislative approach there is a need for us to focus on those particular areas that are most lacking at the present time. Therefore, if each of you could sort of conceptualize that for us, it would be very helpful to me.

Start with Dr. Wynder and move across.

Dr. Wynder. I think it might be useful if each panel member would give you an answer in a few sentences listing each priority.

No. 1 greater emphasis on preventive care.

No. 2 greater emphasis on ambulatory care.

No. 3 greater utilization of allied health professionals.

If these three areas would become the basic blocks of the system, whatever system of financing health insurance we will finally settle for, it would be both medically and economically the type of program that our country ought to support.

Mr. Martin. Thank you for that response.

Dr. Freymann?

Dr. Freymann. I will answer this as a physician but it will be interesting to see how my colleagues here answer it and how each of the members of the committee think of it in their own minds.

I think in terms of health needs. If I understand the direction of your question, Mr. Martin, there is no doubt in my mind that what is most needed is those health services included under the rubric of "primary care."

Now, primary care is not very well defined. I define it as lifelong access by a citizen to a health professional who can assist that citizen with whatever problems he or she may face. That is my idea of primary care.

I think that the whole tenor of medical education today, particularly the growing number of family practice programs, are a response to a cry which is heard throughout the country: People cannot get a doctor. They are not talking about getting a doctor to take care of a coronary or to take care of cancer because there are no problems here. There is a financial problem, but the services are there. The question is how to pay for them.

In contrast, primary care services do not exist in many areas of this country.

As Dr. Fein mentioned earlier, you can't even find a pediatrician in an affluent suburb of Boston. This is true across the country in affluent suburbs, ghettoes and rural districts. That, to me, is the problem.

Mr. MARTIN. Thank you, Dr. Freymann.

Professor Reinhardt.

Mr. REINHARDT. I also will enumerate points, rather than saying there is one single important problem.

The first problem I would say is that certain segments of society are denied adequate health services. One reason is simply that these services are not made available to them even if they are financially able to pay for them.

A second reason, of course, is that they are financially unable to pay for them.

A third reason is that they are unable to use the very complex system intelligently. We always assume that everyone in society is properly educated to manage his or her own health and to use the system effectively. That ought not to be assumed.

The second major problem is that an undue number of American families in my view are exposed to high risks, being vulnerable to the large financial losses associated with illness. Even if that number is absolutely rather small, it is nevertheless there. An undue number of families consenquently suffer a type of uncertainty which I think this Nation is right enough to eliminate.

Third—here I am speculating—it is quite possible that we do produce the wrong mix of services. First, there is perhaps too much hospital care being consumed. By hospital care I don't necessarily mean "inpatient care". I think that the attempt in this country to reduce the number of inpatient days is perhaps a misdirected effort.

Inpatient days vary enormously in resource intensity and perhaps what we ought to worry about is how to get people out of highly resource-intensive patient days and into less resource-intensive patient days, that is out of acute hospitals and into extended care facilities. It does not seem to be a wise policy to reduce inpatient care, that is to send people home, when there is no adequate provision for care in these people's homes, perhaps because there are no adults around to care for them.

So, when I talk about the mix of services, the point is that too many acute hospital days are being consumed. Perhaps there should be added consumption of extended care and more ambulatory care.

Although I am not an expert on the economics of preventive care, and I hear many questions raised of how cost-effective preventive care actually is, I would certainly wish to stand lectured on that point by Dr. Wynder. Perhaps we don't do enough preventive care. As to the final point, the use of allied health manpower can backfire on us.

I have written on this extensively and recently have come to the conclusion that the education and employment of an increasing number of allied health professionals may ultimately mean that there are just so many more mouths who nourish themselves on this activity called health care delivery, that there will not take place the delegation of tasks from the physician to the paramedical that we have anticipated, and that the cost of health care will not fall.

The reason why I suspect that the delegation of tasks may not occur is that at the same time that we are increasing the supply of allied health manpower, we are also increasing the supply of physician manpower, and it is not clear to me why these physicians will feel compelled to delegate tasks when some of them in some areas may well be underemployed themselves.

If my hypothesis is correct, and if we do not worry about providing proper incentives for the use of allied health manpower, I think we will find that the use of such manpower will increase the costs of health care substantially.

One way perhaps to use allied health manpower wisely is to remove them from the control of the physicians, as I mentioned before we recessed for lunch.

Mr. MARTIN. Professor Fein?

Mr. FEIN. I think the most important thing would be a recognition that the health system is interrelated in all of its facets and that there is probably nothing that you can do in any single area that would not have a very substantial impact in other areas.

In that sense, or that recognition which the Congress has in many fields, you are aware that housing policy will affect transportation policy and energy usage and so on because patterns exist, and all of that.

Mr. MARTIN. Are you then saying we should not proceed along a modular system?

Mr. FEIN. No. I will come to a modular system a little bit later. But it is important to recognize, I think, that as you proceed you have to worry about side effects. In terms of the priority questions that I believe you are asking for, I would say the first would be achievement of equal access to care and the recognition that one can structure the financing mechanism in a manner that will affect the supply resources. Whether you will have the high intensive hospital care or low intensive hospital care will depend on what you will pay for it.

A friend of mine went out recently, a few years ago, to a city in upstate New York, where the hospital wanted to add additional beds. It was a multistory general hospital, the beds were full and there appeared to be need for yet additional beds.

There was a top story and there the beds were empty. That was an extended care facility and the beds were empty because the physician,

to move the patient from the other floors to this top floor had to fill out a long and complicated form and Blue Shield wouldn't pay the physician for care delivered on that floor. So the patient stayed on the lower floors, at high cost. It was possible to arrange an experiment in which the form was reduced to half a page and Blue Shield on an experimental basis agreed to pay for care on the extended care floor and as a result patients were transferred. Within 3 months the application for yet additional beds was withdrawn, and outmoded facilities were closed down.

The financing mechanism can be used to affect where physicians are, what specialties they will go into, and what kind of care will be delivered. That can be done by duress, it can also be done by incentives.

In that sense I would remind you that at the present time we have created a structure of finance which is providing incentives but they happen not to be the incentives that we would like to see. They happen to be the high cost incentives.

I would also say that a high priority item, therefore, becomes structuring the financing mechanism in the same way that most industries in the United States face finances: All firms face a budget constraint that causes people to ask: "What are my resources and how shall I allocate them to hit the high priority items?"

Given a constraint of resources, given a recognition that financing can affect the supply decisions, one can, I think, within a limited budget, achieve much more equal access to care than we now have.

Now, I have not addressed the modular approach per se, that is, I have not put forward my plan for how to phase something in. I don't know whether this is or is not the appropriate time to start down that path.

Mr. MARTIN. It may be that we have the information or a report on the example you gave of the Blue Cross experiment in New York City, you said?

Dr. FEIN. New York State.

Mr. MARTIN. I would appreciate it if you could direct us to the report on that. That would be very interesting to look into in detail.

Dr. FEIN. I will do so.

[The information follows:]

Cited in "Who Shall Live," by Victor R. Fuchs. On page 99 of his book (Basic Books, 1974), Professor Fuchs refers to a personal communication from Sidney Lee in regard to this matter.

Mr. MARTIN. Both you and Professor Reinhardt commented on the segments of society that have less access to medical health care and I wonder if you could be a little more specific as to which segments we are talking about. Are these the low income, middle income—certainly not the high income.

But are you saying that people who are not covered by medicare and medicaid are still in the group with the least access to medical care or are you saying people who do not qualify for those, but are in middle-income category are the ones or is there some other concept that you have in mind?

Mr. FEIN. I would think that for certain kinds of care, the kind that has been referred to in terms of primary care, most persons cannot easily find that kind of care.

The system isn't organized to do it.

Mr. MARTIN. You are talking about segments of society, not geographic sections.

Mr. FEIN. In terms of population groups I would remind us that the medicare population, people over age 65, some of them of low income, are in fact in today's market prices paying approximately 60 percent of their medical care costs themselves; that is, medicare covers about 40 percent of the medicare costs of the elderly on average. Here we see a social program which over a decade has actually decreased in its positive impacts.

Therefore, it would follow that some portion of the elderly population, those who are not affluent and those for whom medicaid may not pick up things, may be in trouble. They are likely to be in trouble, all of them may potentially be in trouble, given that the medicare program does not have an upper limit as to expenditures.

Indeed the sicker you are and the longer you are sick, the more the benefits phase out. Twenty percent coinsurance for physicians' fees continues ad infinitum, but the number of hospital days phase out. If you are not wealthy enough to have private insurance coverage in addition to medicare, don't stay in the hospital too long.

The medicaid population, we have introduced for this very low-income population, we have introduced coinsurance and copay provisions.

It does not strike me that for that population this is likely to increase access.

There are individuals in many of our States with the States now facing their own fiscal difficulties, who are slightly above that medicaid line but whose income is hardly sufficient to take care of medical care costs at today's market prices. Over $200 a day for a day of hospital care in the city of Boston, for example.

You don't have to be sick very long to run up a whopper of a bill.

So that it is those population groups as well as individuals in the middle-income group when faced with high expenditures because most of our policies phase out after a period of time.

Mr. MARTIN. Thank you very much.

That was very helpful.

Professor Reinhardt, did you have any comment to add to that?

Mr. REINHARDT. I think my colleague has summarized that issue very well.

There are poor and rural areas where, despite the availability of financing there are simply no facilities available.

There are people who encounter considerable difficulty in transporting themselves to health care facilities. Even if one looks at urban centers where out-patient departments of hospitals make health services available, one can easily be misled to believe that enormous amounts of resources are devoted to these people when one studies the level of expenditures on such resources.

For example, in the municipal and voluntary hospital system in New York City, an average ambulatory visit costs between $70 and $100. Can you imagine a routine physician visit to a practitioner costing an average of $70 to $100? That is what it costs in New York City. But you may say these people get a lot of care. On the contrary, $70 to $100 buys a service for which, a short distance down the turnpike I would have to pay only $15.

Where this degree of cost inflation originates is something worth studying. I have not had a chance to sink my teeth into it. But you can certainly be misled by monetary statistics. There are queues in these departments so that the price of availing yourself of certain services acts in as bad a manner as a money price does. You can make the situation uncomfortable enough for patients ration by things other than price. One of the things is to let people wait. So there really is a problem for some segments and they tend to be lower income groups.

Mr. MARTIN. Thank you, and I thank the chairman for generosity in time.

Mr. ROSTENKOWSKI. Mr. Corman.

Mr. CORMAN. Thank you, Mr. Chairman.

I hope my patience will be rewarded with a long 5 minutes.

I was thinking about where would we go for that heart surgery that Professor Fein mentioned. I guess it is fair to look at where we are.

We all know there is a finite limit to the availability of health care. Not everybody that needs heart surgery is going to get heart surgery. But if you consider a 12-year-old boy and an 85-year-old man, the first is poor, the second is wealthy, we will probably patch up the 85-year-old man under the present system. Would you all concede that we probably need to change the present system without knowing where we go from here? Would you concede that where we are probably is not where we ought to be?

Mr. REINHARDT. This gets one into a kind of benefit-cost calculus that some of us are simply reluctant to perform because it is so uncomfortable.

We always talk about the infinite value of human life. It is, of course, true that economists can infer from human behavior that the individual in society actually places a very limited price on his life; otherwise, why would anyone ever speed? Clearly, while driving we are quite willing to put a limited value on our life.

The question of the value of a human life really does arise, and I think it was mentioned earlier that one can make a simple assumption that enormous resources should, if necessary, be devoted to saving virtually any life, irrespective of the age of the person whose life is endangered.

I guess one could use criteria to determine how much effort should be devoted to saving a given human life, but the establishment of such criteria is too uncomfortably hard-hearted to be seriously undertaken.

Fortunately, you have to do that and not I.

Dr. FREYMANN. I should point out to Dr. Reinhardt that it is very easy for him to say and for me to agree, but by 1990 we are going to have 30 million voters over the age of 65, and they may object to setting arbitrary limits by age. On the other hand, those whom we all agree need health services most, those under 18, don't have a vote at all.

So that there are implications here that go beyond matters of pure health care need. But I agree with you, Mr. Corman. I think we should be dissatisfied with where we are. The concern which I expressed and which I think my fellow panelists also feel is that where we go from here to improve the system must be done very carefully.

Otherwise we could throw an incredibly intricate system out of balance and make things worse.

Mr. CORMAN. I must say that I share that view, but the trouble is I frequently get the feeling that some people in the health care system say you know we should go carefully, if at all. I do think we need to go someplace from where we are.

Dr. FREYMANN. May I come back to what I was saying to Mr. Martin? I think the main need to improve the system is providing primary care to the entire population.

This is something that the whole population needs, but that there is at present a grossly inadequate system for paying for any kind of primary care. The only exceptions are the very few people who have major medical insurance coverage.

Mr. CORMAN. Really it is because of economic decisions the Government and insurance industry have made, isn't it?

Dr. FREYMANN. Right.

Mr. CORMAN. But we must write that into the new formats that we need to make.

Dr. FREYMANN. I am working with people who are going into careers as family physicans. What concerns them, and they are frank about it, is whether they can make a go of it financially.

Mr. REINHARDT. On the subject of access to primary care, Dr. Fein has already mentioned that this really touches all Americans. Perhaps no region is more generously endowed with physicians than the State of Massachusetts, particularly the Boston-Cambridge region. Yet I have had an unfortunate experience there involving my own child, in a case that seemed to me to be an emergency. In that instance it was impossible to gain access to our own pediatrician within 2 hours. That was the lack of access of a sort.

We have given one particular profession in this country, a monopoly to serve as entry points into the medical care system. As I mentioned this morning, we have not burdened that profession with the mandate to be responsible for providing those access points when and where needed. Ultimately, we may have to look to other health manpower to provide these entry points. We may have to use paramedical personnel to—say, pediatric nurse practitioners—to remove them from the control of the physicians, to let them practice as independent practitioners and so introduce a degree of competition into the health care market—a degree of competition that has never been there.

I cannot see why a society would want to give to one profession so powerful a monopoly and ask literally nothing in return.

Mr. FEIN. Let me follow up on the comment about the primary care residents. I am in a medical school and I meet a number of young men and women even as they enter school, highly motivated, talking about primary care and so on. Over the 4 years there is a significant attrition in the number who speak that language and have that motivation in part, I believe, due to the pattern of medical education, reinforced, if you will, by a society in which medicine is high drama.

Say to the average American what is medical care, and I suspect that the response will not be, "It is going to the doctor when I am not feeling well." The response will be in terms of surgery and life and death situations. Most medical care isn't about surgery and life and

death in spite of the fact that our TV programs have heroic medicine in our living room twice a week every week.

That is what we are bombarded by and it does affect decision-making. If the student is trained with high drama in the hospital, he is likely to feel that primary care is less prestigious, less interesting and also less economically rewarding. He then, even if he is interested in going into primary care, is aware that if he goes into that field, perhaps his reward will be that 25 years later there will be a profile about him in the Sunday supplement to the Boston Globe. But that is not enough reward.

He is out there lonely because if the medical school isn't interested in him because he isn't in the hospital and he isn't doing the kind of research that has been supported in the past, his professional colleagues are not interested in him. He is out there in the frontlines working very, very hard in a rather difficult situation. Furthermore, there is a situation of which he is aware, that that what he does, sad to say, has less to do with the health of the population than the quality of their houses, the quality of their diet, nature of their jobs, and the opportunity to work.

Yet as a physician, though he knows that rat control is more important than treating the rat bite, he can't do anything about rat control, so he treats the rat bite in a very frustrated and very frustrating situation.

We pay a price for admitting very bright students to medical school. The price is that they are bright enough to see that the American population, Congress, society, have not placed any great emphasis on primary care and given that brightness and given that reading of society they drift voluntarily, but nonetheless into the high specialties, high technologies, highly institutionalized, highly prestigious areas of medicine and then we say, "Gee, there must be something wrong." Indeed there is.

Dr. WYNDER. Could I comment on that? I think Dr. Fein made a point of what is doable is not necessarily what is right and what is not doable is not necessarily wrong.

Many times I am sure you have been in favor of bills that you knew in your heart were right for your citizens in your district and yet you knew that the Congress would not vote for it. Such limitations also apply to medicine. Much of what we have said here we know to be right, but we know it not to be doable.

Some 5½ years ago I gave a long and hard look at this and decided to learn from Einstein, who said, "It is not so much important what people say, it is what they do." So I asked myself what can I do in preventive medicine for this country?

I recognized for reasons stated I could not do it within the medical school. I could not do it within a hospital. So we set up our own organization that we called, and perhaps that is the first smart thing we did—we called it the American Health Foundation.

We just completed a $6 million research institute that specializes in disease prevention. Supported to a large extent by the National Cancer Institute we are looking at risk factors. We recognize that people like Mr. Cotter will continue to smoke because perhaps he is likely to think, as I said before, that he is immortal, so we recognize——

[Laughter.]

Dr. Wynder [continuing]. That for people like him we have to make smoking less harmful. We have a major program on how can we make smoking products less harmful. We recognize that most of us eat in excess in spite of the fact that we are physically not very active. Thus we have a major program on how can we modify the American diet so that we reduce its effects on coronary disease and several types of cancers.

We call this managerial preventive medicine. It may be of interest to you that this new institute stands in Valhalla, New York——

[Laughter.]

Dr. Wynder [continuing]. And perhaps that was kind of a fortuitous choice, because Valhalla implies immortality. Second, we established a health maintainance institute. I would like to extend an invitation to all members of this committee to go through our health maintenance center, to be screened in 90 minutes and to have a nine-page printout on you on the physician's desk that has all your findings reported by the time with all abnormal findings on the first page.

We don't want the doctor necessarily to read all nine pages, so we have the abnormal findings on the first page. Many of these relate to asymptomatic conditions, your blood pressure, your cholesterol. It is a different medicine from the way we learned in medical school. When I was in school, the first question we learned is where does it hurt, what is your chief complaint? Somehow the doctor feels if the patient doesn't have a complaint, he can't be sick. Yet if you have hypertension or hypercholesterolemia, you are in fact potentially in worse health than if you have a cold.

Thus, smoke cessation programs, nutrition and hypertension program were started. We have such programs for adults and children. Clearly this is doable, and if you like to see how it works, I would like to invite all of you to come and see it.

Third, we have established a public health action center because we recognize that it is not just important what we do in our own institution, but how we can affect society. The public health action center has tried to influence the tobacco industry to lower their tar nicotine values with great success. The tar nicotine values are 30 percent less than 20 years ago and we are seeing a reduction in lung cancer among people smoking lower tar cigarettes.

We are trying to affect the diet. Other people have added iodine to salt and reduced goiter in areas where goiter was very common, a typical example of managerial preventive medicine.

We are now newly funded by the NCI to establish sections in health economics. Here we study to what extent can preventive services reduce health care costs, as Mr. Martin asked today.

We are doing work in health motivation, though I believe this to be the weakest area. Only up to certain points can man be motivated toward better health because we always come to the point where man says, "Not me, certainly not now."

And we are involved in school programs. Thus, we have developed an organization that employs today some 200 people that is solely committed to preventive care, an effort that could be duplicated in other States. By so doing I hope that we can make an influence to change the current medical care delivery system.

We need change if we are going to have a better health care system.

Mr. ROSTENKOWSKI. The gentleman from California's time has expired.

I think Mr. Cotter will inquire before he expires. [Laughter.]

Mr. COTTER. Thank you very much.

Frankly, Doctor, I don't want to die of senility. [Laughter.]

Mr. BURLESON. Or any other way.

Mr. COTTER. It has been a most provocative session. I know we have all benefited by the discussion back and forth.

We have had figures made available to us within the past 24 hours that some 80 percent of the population under 65 has basic hospital and medical care insurance and medicaid takes care of the indigent and medicare those over 65.

Now, how far do we go with the National Health Insurance program? Do we go cradle to grave, includes preventive medicine? Or do we take a piecemeal approach and expand the coverages offered by Blue Cross-Blue Shield, or insurance companies in general? Do we expand the care under medicare and medicaid?

This is the question. Would each of you care to comment on it? In other words, how far do we go? Do we do something in between? Do we do it piecemeal? How?

Mr. FEIN. This gets at the question in a different way, the question that Mr. Vanik asked.

Mr. COTTER. On another point, when you start directing doctors as they get out of medical school, we need some in OBG or whatever, I don't think this is right to dictate to doctors what fields they must pursue or where there is a need. But let me return to my basic question. How do each of you suggest we approach national health insurance?

Mr. FEIN. On the latter question, the latter comment, sir, let me just say that while it may be frightening to dictate to doctors where they shall be, under existing financing mechanisms you are, in fact, if not dictating, encouraging doctors to be in certain areas and in certain activities, and in certain kinds of medical care. So it is not as if the Federal Government and third parties have not already directed doctors through economic incentives.

Let me address it——

Mr. COTTER. This should be correctable then?

Mr. FEIN. Yes; it should be and indeed I hope it will be corrected. According to the Social Security Administration, which annually offers us an article on national health expenditures and on private health insurance, I quote:

> Despite the growth of private insurance in the health care field, an estimated 41 million Americans under age 65 have no economic protection through private insurance against hospital costs. 42 million have no insurance for surgical care.

The picture is not quite as bright as one would think when one looks at the number of people who have insurance, because in many cases that number is not 100 percent, of course, but in addition many of those who have insurance have very inadequate insurance. We do not count "Do you have an appropriate policy or adequate policy?".

How far should we go? Well, let me begin with a fundamental principle. It seems to me that there is one Federal program which has in a most adroit fashion intertwined the fate of middle class and upper income Americans with the fate of lower income Americans in such a manner that there is nothing the farmer can do to hurt the poor in that program without hurting themselves.

I refer, of course, to the social security system which encompasses all Americans. From that, and from one additional observation, namely, that it is not likely that we are going to have an adequate program for the poor and the near-poor people if we only address them. I conclude that it would be helpful to have a program like social security, which did encompass all Americans.

If the question is then asked, how would you move today if the Congress were unwilling to go all the way in one fell swoop? That is the question of Congressman Vanik.

Mr. COTTER. Which is a very practical consideration.

Mr. FEIN. It is a consideration. I am not sure it is a practical consideration because, in fact, we are already spending the money. But if that is a consideration, there are, I believe, three options, two of which ought to be rejected. Let me mention them all.

One way would be to phase in a benefits structure starting with certain kinds of benefits and not others. I don't think that is desirable for two reasons: The benefit structure you select will tilt the system in that direction; and, second, it is unlikely that you would select the benefit structure that emphasized primary care given that public would say to you, "Is this what National Health Insurance was about? You are leaving me dangling on hospital expenses and the stuff that frightens me. You haven't done anything." I would remind us all that medicare started talking about hospital care for a very important social, economic, and political reason.

So that if you go for benefits structure, I think you will do harm to the ambulatory care system. The same observation holds for going for catastrophic insurance.

You could phase in by starting with high coinsurance and high deductibles on the theory that that will reduce the impact on the Federal purse and over time you will fill in the gaps. The difficulty with that approach is that those who can afford to fill in the gaps immediately will do so, and you will have a two-class system. You will have the inequities. You will be back where you were.

In addition, you will have incurred in any system which attempts to be refined, high administrative costs associated with sorting pieces of paper.

There is a third mechanism and that would be to start with the benefit package that is comprehensive, that covers the care that one would like to see for all the population, but starts with a segment of the population. I do not suggest a segment defined by income because that is dangerous. We may never get rid of that. But start with a segment defined by age.

You can begin a fully comprehensive program without coinsurance and deductibles for children and pregnant women, perhaps more correctly "pregnant persons."

[Laughter.]

Mr. FEIN. You can start with that kind of a benefit package for a modest sum of money. One of the reasons that it is modest is kids don't use much hospital care. If you began with that package and though no Congress can bind any future Congress, and I am aware of that—if the legislative history——

Mr. COTTER. May I interrupt you?

Mr. FEIN. Yes.

Mr. COTTER. Could we interrupt for a moment?

Mr. ROSTENKOWSKI. We will recess for 5 minutes for the vote.

[Recess.]

Mr. CORMAN. Mr. Pike will inquire.

Mr. PIKE. Dr. Wynder, I have been thinking a great deal about your emphasis on preventive medicine and it leaves me with a small philosophical problem which I am sure you can resolve for me very easily. If we go your route in Valhalla, and people stop dying of these man-made diseases, what are they going to die of and what are the declining years of their lives going to be?

Dr. WYNDER. We shouldn't die of senility, but we should "die young" as late in life as possible.

Mr. PIKE. Does that really happen?

Dr. WYNDER. It should happen the way nature has intended it. A key question really is, and I would like to address this to my friends the economists, there was a paper from England suggesting that the ideal way to die in terms of health economics would be at age 65. In other words, when you are about to lose your productivity.

Mr. PIKE. You have suddenly begun to strike a nerve.

[Laughter.]

Dr. WYNDER. I thought I would say something provocative to my friends on the left here. I suppose you can say "on the left."

[Laughter.]

Mr. FEIN. Thank you.

Dr. WYNDER. If we kept people well and really had a whole population that died at age 80, what would happen—not in this case to our health care system, because these people would die "healthy"—but what would happen in terms of social security cost and other costs? This is a key question that needs to be answered.

The ideal for a physician is, of course, to keep patients well throughout life. Our idea is not to prevent you from dying, but to prevent you from dying of disease. It can be accomplished that we die free of disease.

Now it is up to the health economists to tell us what would happen indeed to other economic factors in our lives if a much larger segment in our population became very much older.

Mr. PIKE. Well, to me very frankly this is much more than an economic problem. While I recognize the validity of the economic aspects of it, is it perhaps not true that the reason people speed and the reason they smoke and the reason they live the kinds of lives they lead, giving them heart attacks, is because that perhaps subconsciously some of them decide that is not such a bad way to go?

Dr. WYNDER. The question you ask has been very central to our thinking and, indeed, on September 29 our organization is having a symposium in New York on "The Illusion of Immortality." We have asked these particular questions to Erich Fromm, Ashley Montague, and together with DeBakey, Robert Berg, and William Sloan Coffin will discuss these points.

In correspondence I had with Erich Fromm on this very point, he indicated that one reason why we take improper care of ourselves is because many of us are chronically depressed. Like you say, some of us may feel well, to go that way is not all that bad.

Another reason which I indicated before which he stresses is that since we cannot face death realistically, we tend to ignore it. A third point that he makes is that we are egotistically in terms of our own immortality and thus believe it cannot happen to ourselves.

A fourth point he makes and he was rather apologetic on this is that the medical profession is so much known to be a healing art rather than a preventer that most of us don't want to go to a doctor when we are well simply because (a) he will not properly deal with us; and (b) if you play the word association game and you say day-night, table-chair—and, now you say doctor and answer healer—in other words, you don't think of our profession as one that primarily prevents. All of these things together, make us shy away from prevention.

Mr. PIKE. Thank you.

Dr. FREYMANN. Could I carry on, Mr. Pike? You are really getting to the heart of the problem.

Let me give you a figure on what would happen if we eliminated all cardiovascular-renal disease, which is our major cause of deaths. Life expectancy of a white male at age 10 would be increased by 12.2 years. The life expectancy of a white male aged 60 would be extended by 11.3 years. In other words if we made this enormous medical advance, the increase in life expectancy on the sunny side of 60 would be only 1.1 years.

We are extending life on into a time when most people are removed from productive existence. So that the problem goes far beyond medical care. If we achieve this Nirvana, if everyone lives out his full biblical "three score and ten," what do we do with them?

Congress is one of the few areas where you can keep on going. Everybody else has to retire at 65.

Mr. ROSTENKOWSKI. The committee will now refer to the question offered by Mr. Cotter.

Professor Fein, if you will continue to address yourself to that.

Mr. FEIN. Thank you.

I was commenting that one approach would be to start with children and pregnant women, one could go a long way for a modest sum in an area where resources are available, in an area where preventive care might most easily be organized and where capitation payment might most readily be accepted by physicians. While, as I indicated, I recognize that no Congress would bind any future Congress, one would like the legislative history of the debate to show that it is the intention of Congress that 1 year after the program is instituted for all persons up to, say, age 19 that the effective age would become age 24, and then 29 and then 34, and over a decade one covers the entire population.

If one wants to move more rapidly, increase the age in 10-year intervals per annum and one does the whole job over a 5-year span. The appropriate interval is easily selected so that the fiscal impact in any one year is about the same as the fiscal impact the year before.

One can do it. One can play with the numbers. It would cost about $12 or $13 billion gross to cover everyone up to age 19 and pregnant women. The net figure would be significantly lower because of medicaid expenditures that are now already involved in that age group.

If the response that you made to such a suggestion were "But there are many Americans who are concerned about catastrophic expendi- tutres, who don't have children and who would feel uninvolved in this program and it would be insufficient to say to them that in a few years they would be covered," that you need something to address that problem, I would respond in the following fashion:

All Americans who are of an age where they don't have children that would be eligible for the program, but who are insured as a family unit, would find a significant reduction in their premiums for insurance by the simple act of covering children. Most insurance pol- icies today have the same rate for a family of two as for a larger family, and if you removed the children, even the family of two would benefit in its insurance premium. But if that were not enough, I could see putting in place a program which said that we would cover children up to age 10, and which would also offer protection of a maximum liability much like CHIP or other proposals that have been made, a percentage of income, for others.

No one in the United States, for example, would face medical bills that will absorb more than 8 percent of his income. That, however, will phase out as we raise the age for total coverage. So that as the age of total coverage goes up from 10 to 20 to 30 to 40 to 50, the catastrophic impact becomes less and less significant because more of the population is fully covered; and eventually it becomes totally irrelevant.

That, I would submit, is a proposal that would not do violence to the structure of the medical care system in terms of placing high priority on expensive items, that would not put in place mandating that we would never get rid of, or coinsurance and deductibles that would cause inequities. It is a program that could be viewed as a way of going in a logical progression to an ultimate goal over a period of time consistent with one's feeling of administrative capability and capacity and so on.

I would make only one additional comment. You will note that I say it is a program that could be put in place over a period of time and in line with one's feeling about administrative capabilities. I did not say it is a program that one would need to put in place over a period of time to meet fiscal problems. I didn't say that for an important reasons.

The expenditures that are required are moneys that are going to be spent out of pocket anyway. They are in the health care system any- way. There is no reason for the Congress to be afraid of national health insurance on the ground that the United States can't afford it.

We are already affording $104 billion. The question is how will we distribute those $104 billion? There is no new money involved. We are not a little underdeveloped country saying "Shall we have a health care system?" We have got one. We have got an expensive one.

So that it is not a fiscal problem, but it may be an administrative problem for any Congressman—I am sure it is—who though recogniz- ing that the money is in the system already is not enamored of in- creasing taxes because he may feel he cannot explain adequately to his constituency that that increase merely substitutes for expenditures that are already made.

Mr. Rostenkowski. Mr. Crane will inquire.

Mr. Crane. Thank you, Mr. Chairman.

I would like to congratulate the Chairman on these hearings; and add that while I share his appreciation of having academicians and people with research backgrounds present expert testimony. I look forward later on to having the opportunity for an exchange with some people actually on the firing line of American medicine. Based upon what has been presented here, none of you would be in disagreement with the idea that national health insurance is a desirable thing. Is that correct?

You are all in uanimous agreement on that point?

[Affirmative response.]

Mr. CRANE. The issue of spending the $104 billion that we are expending annually in behalf of national health care undoubtedly could be more intelligently spent if I were King. I think every one of us shares that assumption. But on the other hand, if to change your perspective ever so slightly, you were to contemplate trying to figure out how to deal in a positive way with some of the deficiencies that you perceive in the American health care system outside of an imposed solution from Washington, D.C.—and I place vastly less faith than you gentlemen apparently do in government's ability to solve problems—what would you recommend within the private sector? We talk about the creation of incentives, but I think we have already created some incentives for a lot of physicians to get into teaching and research than private practice, which is demonstrable evidence to my satisfaction that we in government don't have omniscience. That has created some of the problems in our health care system.

Are there any of positive incentives within the framework of free institutions rather than imposed solutions: that you might suggest?

Anyone on the panel at all I would appreciate hearing from.

Dr. FREYMANN. I would structure the payment system for physicians' services so that the physician who is capable of taking care of 85 percent of the patient care encounters—that is, the family physician, the general internist or the pediatrician—could receive sufficient payment for these services so that he could make a go of practice.

Solo practice or group practice—there are all kinds of ways. I am not making a pitch for any type of practice or for any type of payment. But if we can put money into the system to pay for primary care there will be an incentive for medical students to go into these fields.

Dr. WYNDER. In line with what Dr. Fein said, the emphasis ought to be on the question which is a little bit for medicine as for what Martin Luther said for religion. He said, "If you give me your child until he is 5, he is mine for life." I would say, "If you give me a child until 16, the child would be a good health risk for the rest of his or her life."

The question is how do we do that? As Dr. Freymann says, "Pay the physician." I don't believe that the behavioral modification principles that are involved will suffice in terms of interest to the physician. The training in medical school today, independent of economic rewards, really has involves academic aspects that normally are not part of preventive medicine. Therefore, I don't think that even an adequate payment schedule can we get most physicians interested in that type of primary medical care. Therefore, in addition to economic incentives, we ought to realize that these types of primary preventive programs are best conducted by allied health professionals.

We clearly have to recognize as physicians what we can do best. We do well in therapy, but in terms of primary prevention unlikely to do as well as paramedical people. Therefore, let me repeat our emphasis ought to be on the early health care in prenatal, postnatal, school programs conducted largely by allied health professionals.

Mr. CRANE. Before we go further, can I elaborate on this point because I am intrigued by it? My recollection is that there was a study done on Mormons in this country that indicates that they were vastly healthier, live longer and so forth. The conclusion was made that it is in part because of their religious views on caffeine, cigarettes, liquor, what-have-you.

Are you saying that the development of the proper health habits from birth would probably be vastly more helpful and beneficial in terms of the total health of our national population than trying to repair deficiencies later on?

Dr. WYNDER. I think that is quite clear. In fact, Victor Fuchs, another economist of note, wrote a book, "Who Shall Live?"; and in one chapter he compares the mortality in the State of Utah with that of the State of Nevada.

I don't want to draw any personal conclusions from this comparison excepting that the mortality is very much lower in Utah for a variety of reasons. Dr. Fuchs concludes if this were the health State of the country as a whole, our health economics would be in a very much better shape.

Whether the lifestyle or whatever it is, these early formative years are not only important in terms of intellectual developments, but are clearly important in terms of health development as well.

Mr. CRANE. Dr. Reinhardt?

Mr. REINHARDT. I agree very much with your point that we should perhaps not regulate the health care system too much from Washington, D.C. Of course, you realize that when you raise the question of what we can do, you are talking about intervention of some sort. I guess the issue is this: Are we going to intervene directly through regulatory edict, as we allow the CAB to do in the airline industry, or are we going to use the more subtle financial flows that are more congenial to the American temperament?

I think you are probably talking about the latter.

Mr. CRANE. If you will permit me to intercede for a moment, I think there are actions that we have taken already and I touch upon at least one where through Government assistance we put a disproportionate emphasis on recruiting medical researchers and faculty.

So maybe it is a case of removing some of our previous handiwork. In another area, I read an article in a British medical journal that expressed apprehension over the fact that the British are moving in the direction of FDA with respect to drug approval. Here is an action that we took that has retarded introduction of modern lifesaving drugs into the United States so much so that British physicians consider us 20 years backward in that regard.

Mr. REINHARDT. Yes, as I said, you will see on page 20 of my prepared statement that I come out very strongly against regulation. Incidentally there was a conference last year—or perhaps 2 years ago—at the Institute of Medicine, and the proceedings have been pub-

lished in a book called "Control of Health," in which these issues are debated at length, and the participating economists come out much against direction regulation.

Now Dr. Freymann's suggestion to reimburse primary care physicians so that they can "make a go of it" requires added comment. Primary case physicians in this country are making an average of about $50,000 a year. By American standards I would call that making a go of it.

So the question really——

Mr. CRANE. Do you know what the workweek is for the primary care physician on the average?

Mr. REINHARDT. Yes; we have rather good statistics on that. The average—depending on the specialty—is about 50 to 55 hours. However, these are self-reported hours and they seem to be substantially overstated. I think a more accurate statistic would be between 40 and 50 hours.

Mr. CRANE. OK.

Mr. REINHARDT. I think the proper policy is not one of raising the income of primary care physicians and holding everyone else's income constant. Relative changes in income may in fact have to go the other way. I refer to this point on page 17 of my statement: if we establish a national health insurance system under which physicians are paid on a fee-for-service basis, it is important that the third party gain at least partial control over the determination of the fee schedules. If so, it will be possible to change relative physician incomes through the fee schedule.

The system of customary local fees is exactly one of the evils that we have permitted which tends to motivate physicians to move into areas where they should not go, where they are not needed. We should take a hard look at the system of customary local fees. This will take courage. Ultimately we ought to use fiscal flows to foster an efficient nationwide distribution of health-care personnel. Such a method is quite different from direct regulation, whereby one would—for example—tell a physician he must have three nurses in his office.

Mr. CRANE. Well, except if we can elaborate on this just a little bit—am I exceeding the time constraints?

Mr. ROSTENKOWSKI. Go ahead.

Mr. CRANE. Well, don't hesitate to interrupt me.

We had a discussion in here earlier in oversight hearings on utilization review and the AMA's suit against it. The basic objective of utilization review is cost control and prevention of alleged abuses by physicians in medicaid-medicare programs.

Do you not inevitably, when you get into reviewing fees, payments, conditions for payment and so forth, get a degree of lay judgment imposed upon the professional? It seems to me that that is an unavoidable consequence at least in the legislation drafted to date, the professional standards review organization. That ultimate authority, of course, rests with the Secretary of HEW.

When I put the question to Mr. Weinberger about specific prohibitions in the law against his attempting to provide guidelines or regulations that led to the suit, he simply cited other portions of the law that gave him burdens and responsibilities that highlighted the contradic-

tions within the law. He opted in favor of following one and did violence simultaneously to the other.

So he made a judgmental decision that has resulted in that suit. This is the concern I have. You have lay people that are, in effect, getting into the position of making decisions not just about expenditures and how much you will pay for an appendectomy but you are getting them providing guidelines with respect to medical care that it seems to me should be reserved unto the medical professionals exclusively.

Mr. REINHARDT. There are actually two parameters to the fee schedule. One is the overall absolute dollar amount for an initial office physician visit—for example—or for an appendectomy. But the other is the relative fees; that is, how much more expensive is an appendectomy relative to the initial visit?

If one sets about setting relative fees, I think one is indeed getting into the practice of medicine, although economists surely are bold enough to attempt such an intervention; as for the overall absolute fee level, I don't think we actually are intruding in the practice of medicine by saying an initial office visit of, say, 15 minutes duration should earn the same revenue—or perhaps less—in Massachusetts than it does in Mississippi. That was the type of leverage I was talking about. Only the absolute fee level need be manipulated.

Mr. CRANE. Thank you.

Mr. ROSTENKOWSKI. The time of the gentleman has expired.

Mr. Corman will inquire.

Mr. CORMAN. Thank you, Mr. Chairman.

I would just like to present another view to this problem of the doctors' always telling us that somehow we are interfering in their professional decisions. Of course, that is not true at all. No one ever tells the doctor what he can do for a patient.

We do say how much he will be paid for it if the Federal Government is paying the bill. No one has ever told a doctor he cannot see his medicaid patient once a day or whatever. We just say under certain circumstances you will be paid x dollars for it.

It seems to me we can divide the problem of national health insurance into two parts. One is what effect we are going to have directly on the delivery system itself and one can at least make a fair case for the fact that the delivery system itself is not all that bad now.

The other half of the problem is how are we going to pay for it? A great number of people will concede that the way we pay for it now can be significantly improved on. How you pay for it and how it is delivered certainly has some relationship, but it seems to me you can make drastic changes in that second part without radical changes in the first part or without destroying all that is good in the first part.

Would the panel pretty much concede that or do you have a different view about it?

Dr. FREYMANN. This was precisely the point that I tried to make earlier, Mr. Corman. The experience of other countries has been that national health insurance has frozen the delivery system rather than changed it. To me, this is one of the threats of national health insurance. I do feel that our delivery system is inadequate, but we could actually stop evolution toward improvement by the way these bills eventually become law.

Mr. CORMAN. What would be your guideposts for us as we move down this road? Are you saying we ought not to try to change the way we pay the bill or are you saying when we make the change, that we ought to try to give flexibility to how this evolution in the care itself is carried out?

Dr. FREYMANN. I think we should concentrate on the payment mechanism without attempting to transform the delivery system simultaneously. Since the two are not inseparable, provisions can be put into the payment system which would better fit the delivery system to the perceived priorities of the American public.

This is why I keep coming back again and again to primary care. This is clearly a deficiency, and I believe we can rectify it through the payment mechanism.

Mr. CORMAN. If we devise a payment system that does not give preferential financial treatment to nonprimary care, make it evenhanded, then that is a system which I assume you would be in favor of? In other words, to raise the primary care opportunity for payments to where the very intensive care is already?

Dr. FREYMANN. Yes; replace the overincentives toward using high-cost care. But here, of course, you could go too far. You could end up with all the hospitals going broke even faster than they are now if it were not carefully modulated.

Mr. CORMAN. If everybody had the financial ability to get to the hospital when they needed to get there, I expect they would be full, don't you?

Dr. FREYMANN. They are, sir.

There is a lot of talk about people not getting to hospitals. Well, I think such people are few and far between. That is not our problem. I think everybody can get to a hospital and does, and somebody pays for it.

Mr. REINHARDT. If you ask specifically what in health care legislation should we do about reimbursement of providers, hospital and noninstitutional provider, or physicians, I think that that is so controversial an area and so difficult an area that merits almost an extra session. But if the options you have—one might be for noninstitutional providers to opt for prepayment. The other option is to continue with the fee-for-service system.

My own sense is that you probably won't have the political option to go with prepayment everywhere. You can certainly encourage it and certainly allow it to exist, but I think ultimately the bulk of medical transactions in the ambulatory side will be reimbursed on a fee-for-service basis.

Here you have nevertheless opportunities to provide incentives that would move the sector toward a more desirable state than we are now in. The question is how quickly can you do that?

It is clear now that you could not cut medical fees payable in New York City in half. I wouldn't propose this. But I would propose a more gradual approach. That is to say, in a national fee schedule you would have to regionalize it because they are so different.

I would freeze the high-fee States and let the others drift up. This way no one can really scream, "I can't meet my mortgage payment," because you can say, "Sir, you met it last year out of those fees. You ought to be able to do it this year."

But in the gradual area I would let the underpaid area fees drift up and you could do roughly the same with intraspecialty differences in fees.

Mr. CORMAN. Would you all concede that what is good in fee-for-service medicine can be preserved if that fee is negotiated between the doctor and the intermediary instead of as it is now between the doctor and the patient?

Mr. REINHARDT. Well, much of what is good can be preserved. An argument in favor of fee-for-service is that it encourages productivity on the part of the physician, or that—being paid on a fee-for-service basis—a person by working harder can actually improve his economic status. Those who are against any other form, particularly salary, point out or hypothesize that salaried people have no incentive to go the extra mile.

These are hypotheses that can be tested.

Mr. CORMAN. I am concerned about the entities that negotiate that fee. The doctors are on one side. On the other side, are all the incentives there for negotiating with the intermediary or with the patient?

Mr. REINHARDT. I personally do not believe there are such negotiations between the doctor and patient now.

Mr. CORMAN. Patients feel that way, too.

Dr. FREYMANN. I think much of total physician income is obtained through intermediaries, sir. Again I must admit I don't have the exact figures, and I am sure it varies from specialty to specialty, but most physicians made a lot of their income through hospitalized patients. Note this includes primary care physicians.

The vast majority of inhospital professional fees are negotiated between the doctor and the third-party payer. So I think your point is well taken. Not negotiating directly with a patient doesn't change the doctor-patient relationship one whit.

Mr. CORMAN. The part that discouraged me is the rapid erosion in medicare where lower and lower portions of the elderly's health bill is being paid because the doctors reject the obligation to negotiate with the intermediary and insist on negotiating with the patient.

That is why patient costs are climbing rapidly. I think whatever we do we are probably going to have to reach a decision that if we have fee-for-service medicine, that the fee has to be negotiated between the doctor and the intermediary.

Dr. FREYMANN. Yes. Could I make one more comment about fee for service? I hold no particular brief for it, but I think that it does provide an incentive factor. A study published in 1970 (**Surgery, vol. 68,** pp. 1–19) demonstrated significantly lower productivity among members of medical school faculties on straight salaries as compared with those who could make money from patient fees in addition to their salaries. The greater productivity of the latter group should be no great surprise to anyone.

Fee for service is today's whipping boy. Many people think that is the cause of all our problems. But I would like you to look at Sweden and Canada. In Sweden, 99 percent of all professional fees are prepaid. In Canada, 99 percent are paid through fee for service. Yet these are two of the most expensive countries in the world insofar as the rates of increase of percentage of GNP going into health are concerned.

Mr. CORMAN. I personally do not reject the fee for service at all. I just think the mechanism has to be a negotiation between the doctor and the intermediary if we are going to have a national health insurance system.

Do any of your see the necessity or advantage in retaining the private insurance company in that intermediary role if we go to a broad-based health insurance system?

Mr. FEIN. There are two roles that private insurance——

Mr. CORMAN. Yes. Maybe I ought to specify. One is the fiscal intermediary, and the other is the underwriter, as I understand it. So we ought to address both of those.

Mr. FEIN. I see no necessity or advantage to preservation of the private insurance sector in the role of underwriter. It complicates things and for no good reason.

As for fiscal intermediary, somebody is going to have to process pieces of papers. It is likely that the kind of national health insurance bill that will emerge will require that somebody process pieces of paper.

If that is the case, the question arises who can do it better, cheaper, more efficiently, and if it is the case that the Federal Government can do it better, is the difference between the cost to Government and the cost through the private sector so large as to necessitate getting involved in a political battle?

I would like to think that if the private insurance sector is going to perform the role of fiscal intermediary, it would do so with more stringent standards set for it than was the case initially in medicare because as a representative of the Government, it just cannot process pieces of paper without being involved in the fee structure, the negotiation process perhaps, et cetera, et cetera.

If it is our representative, then it has got to protect the U.S. taxpayer.

I would prefer to see the Social Security Administration perform that function. Yet, it is not a matter of principle. The role of fiscal intermediary can go to the private sector if the private insurance sector can demonstrate that it can do it efficiently. I would say this is not necessarily a role for Government.

Mr. CORMAN. Do any of you find the role of underwriting as being a necessary part of the national insurance program? This is the difference between a compulsory private program and the public program.

Do any of the others of you have a view as to their relative value?

Mr. REINHARDT. The question of necessity is quite clear. You certainly can do without it, as Canada has demonstrated. The Canadians administer their plans——

Mr. CORMAN. Let's avoid administering. But the underwriting is important, whether we go to a compulsory private system or the public system which may be fiscally managed by contract.

Mr. REINHARDT. And the underwriting is eliminated also in Canada. So certainly the elimination of underwriting is feasible, and one can observe the effects of such an elimination in Canada.

The question could be put in another way: Could one live with the private system in which policies are privately underwritten? In such a case, what would be the price one pays for that as far as the Government is concerned?

Well, if one had insurance policies that were somewhat standard—as for example, our homeowners insurance policies—and then allowed the companies to compete, if some companies can manage to compile a better payout record, that would reflect itself in lower premiums. Perhaps one could experiment with that.

But I remain rather doubtful that such experiments would indicate success.

Mr. FEIN. This is not an unimportant issue so maybe I can take an extra minute to take issue with the implication of your remark as an experimental program.

It is in the nature of the Government program that you can scale the premiums which would not be premiums but taxes, to income and you do it every day not only in the income tax, but in the payroll tax.

It is in the nature of the private insurance market that no private insurance company is going to underwrite with scaled premiums as a function of income.

This means that you are going to have a fixed dollar premium. If you then want to provide, different levels of cost to individuals as a function of income, you're involved in a Government assistance for some citizens to meet their premium payments to the private sector if they have low income.

So now you have involved an extra burden of assessing a person's income, transmitting a check from the public sector to the private sector. I think that is a complexity.

If, in addition, you permit the private insurance companies to cream and select the good risks you are going to have different insurance with different premiums as a function of the population that they have managed to address. It is not clear then that the difference in premuims comes out of efficiency. It may come out of selection of risks.

Then we are back at the old ball game that led to the difficulties that Blue Cross got into. The philosophy of a community premium and community rating was great, but then came the private sector and said to the Harvard faculty, "You're healthy, why do you want to be involved with Blue Cross?" I make up the Harvard faculty, that is only an example. We actually have Blue Cross. But they said to the Harvard faculty, "You are healthy, why do you want to pay for the aged? Why not sign up with us and we can give a lower premium?"

The Harvard faculty, being socially responsible, said "No, that wouldn't be fair." [Laughter.]

So they went to Boston University. [Laughter.]

But then when BU did it, they came back to Harvard and said, "Now the difference between Blue Cross, which now has a higher proportion of aged than they once had, and what we can offer you is even greater," and the Harvard faculty which was socially responsible when the difference was low, now that the difference was magnified also signed up with a commercial carrier.

That is where we got to the medicare situation. The strong proponent of medicare in many States was Blue Cross because they couldn't compete with the private sector and keep the old people in the program.

I think that we would find that history repeated if we went the underwriting route with private insurance. I see no reason to repeat that history. We should be able to learn from it.

Mr. ROSTENKOWSKI. Mr. Pike will inquire.

Mr. PIKE. Mr. Chairman, this is going to come as a shock to you, but I have no additional questions. I would simply like to say that I think this panel has been excellent in presenting the background and perspective and I am very glad that we got them here first so now we can let those hard line professionals who are out in the front lines of medicine come in and attack everything that these people in their ivory towers have stood for. [Laughter.]

Mr. ROSTENKOWSKI. Mr. Martin will inquire.

Mr. MARTIN. Yes, Mr. Chairman.

In response to a general question that I had asked earlier about major deficiencies in the present system, as I recall only Dr. Reinhardt indicated a major defect in the present system was the catastrophic costs of long-term care and acute surgery.

The others generally disregarded this in your perspective of the highest priorities with the exception, of course, of Dr. Fein, who consistently rejected it as a target or focus of legislative attention.

Now, it happens that I have introduced a bill dealing with catastrophic coverage so you can understand how I felt that Dr. Fein's characterization of catastrophic as being truly catastrophic was somewhat obnoxious.

I am kidding, of course.

Of course, I had gotten mileage out of the same play on words by describing the risk of starting with that catastrophic coverage which might evolve into a comprehensive program. In my view a comprehensive program would indeed be catastrophic through the device of paying for all your bills for all your ills with a 250- or 350-page resolution to describe how to go about it and the tens of thousands of administrators necssary to explain what is meant 10 years from now by lines 19 and 20 on page 274, or whatever.

Also because it would then ultimately shift the decisionmaking out of the dichotomy that Dr. Fein set out, not from the doctor to the patient, not from the producer to the consumer, but from the doctor to the clerk or from the physician to the bureaucrat.

In what I felt was typical of the entire panel, in his eloquent analysis, Dr. Reinhardt set out three features for this, one, it should be easily administered, and three, there should be a cost-sharing feature to it, deductible feature and copayments.

Dr. Fein, on the other hand, fears any scheme that addresses these rare and unusual costs that do not happen to many people should be avoided because one, it will direct our resources to the long-term care and the acute surgery and bias the system in favor of those, if I recall your answer to Mr. Pike's question.

Second, you made the point that only the person wealthy enough to carry through to the high deductible threshold would benefit from a catastrophic program.

And three, it would be administratively expensive.

What would happen if instead of a complex legislation comprehensively dealing with all of the problems, if we provided that the Government would insure 85 percent of your medical expenses in excess of 15 percent of your adjusted gross income? Here you would have a sliding scale, not an arbitrary level that would be too high for people without substantial wealth. It would have a sliding scale so that for people with $10,000 with adjusted gross it would be $1,500.

There would thus be a deductible feature relative to what your income was. It would be 15 percent of your adjusted gross income.

Then to provide something of a copayments feature the particular formulation that Senator Brock and I have would say that you would have to copay or coinsure for 15 percent of the remaining cost above 15 percent of your adjusted gross income with the Government paying the other 85 percent. It would be simple and not expensive to write such a clause into the contract.

The bill only runs eight pages, and only six deal with the legislative change. Thus if you average about 10 bureaucrats per page, you only need just a few dozen to employ to administer the interpretations in addition to those who would write the checks from the Internal Revenue System.

It would involve a reimbursible tax credit. You could take the credit for previous years' income so if you need the money now you file an amendment to your previous year's tax return. It would seem from appearances to be very simple and I would of course be grateful for any immediate comments that any of you may have, and I will be very grateful to any of you who would send a more detailed response to this.

That sort of leaves not really a question but an opportunity if anyone has an immediate reaction to that.

Mr. FEIN. It may be worth in addition to submitting something for the record, to comment now on some of this and the characteristics of that proposal.

I will be glad to, but maybe you want to begin.

Mr. REINHARDT. Well, evidently here we would have a bill that institutes for cost sharing. Cost sharing is really the goal of the bill, and the desire for cost sharing is predicated on the theory that consumers play a significant role in determining the overall utilization of health services. Or, if consumers do not really have this much power over these decisions, an alternate theory is that a physician acting as the consumer's agent in putting together the treatment package is conscious of his patient's budget constraints, acts as if he were the patient, tries to minimize the cost of the treatment, I think that this really is the philosophy behind it and indeed is the theory proposed by those economists who are in favor of coinsurance and deductibles.

The Martin bill has this attractive feature—at least attractive to those who believe that coinsurance has a role to play in national insurance.

Having just looked at it briefly, I think that there are some problems, however.

As the bill now reads, the amount of risk exposure suffered by insured persons is not insignificant. It will in theory not be finite, and in practice to can go very, very high indeed; this, it would burden the American citizen with precisely the uncertainty that I think our national health insurance should not impose upon the citizen. You really wouldn't know what would happen to you in a given year. Indeed, if your income were $12,000—your adjusted gross income, that is—you could easily become ill enough to incur expenses of $3,000 to $4,000, of which you would have to pay $1,500 to $1,800.

I think a family trying to make it on $12,000 a year would find it enormously difficult to absorb such a shock if they were to incur such expenses 2 or 3 years in a row.

That could be in excess of what we would call a catastrophe.

In addition, you really are taking a fully hands-off posture from the health delivery system, you would have absolutely no control over on the fee schedule at all. All the health-care provider system would know is that some amount of the transfer from the consumer to the providers would somehow be underwritten by the Government.

I really don't see how you could then use national health insurance to provide financial incentives toward a rationalization of the system.

Most of us agree that, whatever the nature of the national health insurance legislation, there has to be, somewhere, some sense of a financial bottom line. The national health insurance system should be constrained to a budget within which allocative decisions must be made. You have to know roughly how much things will cost you some 12 months ahead of time.

In the case of this bill, you wouldn't have any such fiscal information ahead of time.

Mr. MARTIN. With regard to the first problem that you raised, the risk exposure not being finite, wouldn't it be possible to actuarily share that risk exposure by simply paying the premium on the insurance policy related to this tax credit formula?

Mr. REINHARDT. Yes; you certainly could.

Mr. MARTIN. And it would be no worse than what we have now as far as those folks who have income who do insure themselves.

Mr. REINHARDT. But you would wind up with failures of the insurance system that Dr. Fein cataloged and on which indeed I stand corrected. I do want to mention that. There are indeed the problems of adverse risk selection on behalf of insurance companies. Persons seeking insurance who are high risks would find the premium unbelievably high, and you would not have solved that problem, because the people whom the insurance companies deem to be high risks would be the people that would be most exposed and they couldn't get insurance at prices they could afford. That is one of the fears we have.

Or you have to get into the business of subsidizing their premium.

Mr. MARTIN. On that point it would be helpful to get somebody from the insurance industry to handle that.

Thank you, Mr. Chairman.

Mr. FEIN. May I comment on that question, please?

Mr. ROSTENKOWSKI. Professor Fein.

Mr. FEIN. Let me say that I find more attractive the concept of percentage of income as a deductible than I do the older concept of a flat amount. Clearly the percentage of income is more equitable than saying $3,000 or $5,000 which may mean much to some people and may mean much less to others. So in that sense the use of the percentage is desirable.

I find even more attractive, however, the maximum liability concept as embodied in other legislative proposals, the CHIP proposal, the Mills-Kennedy proposal, because there the upper line is set: you will not spend more than a certain sum of dollars—it would be even better to say a certain percentage of income—in any given year.

In the proposal you make there is the 15 percent cost sharing after the deductible with the sky being the limit although I agree one could insure against that.

That, however, is complex.

You and I are in very substantial agreement on the concept of a percent of income. Our point of difference is the number that you chose and the number that I would choose.

The number is important. Martin Feldstein, who once made a similar proposal of a percentage of income, said in proposing 8 percent of income, "But the 8 percent is only used as an illustrative figure."

Well, it is very difficult to discuss a bill where a number is chosen for illustration.

If I take the 15 percent as a serious number, I would conclude it is very high for people of average income in the United States.

If I take it as illustrative, then perhaps we could negotiate.

The figure that I would use is zero. The figure that you would use is 15. The question is where do we end up in between?

Mr. MARTIN. And subsequently.

Mr. FEIN. And subsequently.

Dr. WYNDER. If I can comment on that: It seems to me that in any society, whatever the figure budgeted that is at least the amount that the society will spend. In Germany the average person spends about 10 percent of his income for health insurance. The emphasis should be on what incentives we are going to provide the system to reduce costs not only in terms of preventive care, but in terms we do with therapeutic care as well.

We have certain groups that are experience rated and there are certain amounts of incentives which usually are not great enough to reduce the utilization of health care, or perhaps have a better life style. But most of us are part of the great average. Whenever I heard the word "average" I think of Walter Heller who said average is when a man stands with one foot on the hot coals and one on dry ice and on the average is comfortable. At present there is little incentive given fiscally, medically and preventively to reduce health care costs.

I am surprised we have not mentioned this afternoon IMOs. It is an issue raised particularly by the administration. It has fared not as well as the fathers of this HMO concept had hoped. In part I believe it is because the medical profession really doesn't have its heart behind the HMO concept.

In principle it is good. You have a fixed fee for the system and, thereby, the physician is encouraged to not unnecessarily put a patient in the hospital and practice better preventive care.

We have in some areas, of course, clearly experience-rated phenomenon; for instance, in fire insurance. If I were going to build a house with a straw roof, I am sure my insurance company would have me pay a higher premium than if I used a stone roof. How far do we go? I understand one of your staff fell with her bicycle and hurt her knee cap. Should bicyclists pay a higher health insurance premium than nonbicyclists? What about the people who go skiing every weekend? There are many areas into which you can carry this point. We ought to be aware of course that our entire life style and other factors affect our own health care expenditures.

The point I would like to make is that in addition to worrying about how we are going to pay for health care, all of you who have great fiscal responsibility, should be concerned as to how we can get a better health care system at a lower cost. Members of Congress can perhaps

put more teeth into that aspect of national health insurance than people who are part of the health care scene itself.

Mr. MARTIN. I have no quarrel with what you say and that was really not related to my question. I am not trying to solve the necessities, which you have brought up, with this particular bill. I propose it as a component of one of the building blocks in relation to Mr. Vanik's proposal. I think there is a lot of merit to what you say but certainly the question of what your average percentage is—my point is the Government would not get involved until your expenses, including insurance premiums, until expenses are of a proportionately higher level. Not before then would the Government get involved with the financing.

Thank you all for your response to that. If you could share further thoughts, you could file that for the record.

Mr. ROSTENKOWSKI. You summarized the historical roots and approach to medical education in the United States, Dr. Freymann. I take it you believe changes in our present system are now required. What changes in your view are needed and how shall we go about choosing such changes?

Dr. FREYMANN. My answer to the first is, "Yes, I think changes are needed."

I tried to show that you cannot blame the current state of our health care system on hospitals alone, you cannot blame it on financing alone, and you cannot blame it on the schools alone. Together, these three created the system, and the essence of our current problem is that most doctors are interested in taking care of acutely sick people, preferably if they are in hospitals or can be seen in offices close to hospitals.

You cannot untie this knot simply by changing the educational system, but I think it is crucial that student physicians and graduate students (residents) be given an opportunity to learn primary care in authentic environments.

An authentic environment cannot be created by taking a section of a major teaching hospital and saying, "This is our family practice clinic and you are going to go in there and learn how to take care of families," because the students are too smart. They know where the prestige and kudos are in the institution. I know of one medical school in this country that has really developed a system for teaching students primary care in an authentic environment. That is the University of Illinois at Rockford. There may be others. But at Rockford they are using doctors' offices, many built by the Sears Foundation, which communities around the city were never able to fill. These are being staffed by faculty who are family practitioners and by students and residents. These students do not go to these offices for 3 or 4 weeks of interesting exposure to primary care. From the day they enroll until the day they leave these students spend a certain number of days each week in this environment. They get to know the people of their town as they take care of them. It makes sense to me that this is the way to learn the gratifications of that kind of medical care.

As Dr. Wynder has said, what we were taught in medical school makes primary care look dull. But it isn't. When you talk to these students, they are excited by it. It is fun. It is gratifying.

This is the kind of change I think must be brought into medical education.

Mr. ROSTENKOWSKI. Dr. Freymann, the problems are in the inner cities. I know Rockford. That is not a bad place to live. But when you get to Chicago, or Los Angeles, or New York, in the inner cities, this is where the real problem is with respect to the patient and the general practitioner.

I don't see any incentive for the student to become involved in the ghetto except for something like combat pay. It is just that bad. This is going to be a real problem within the larger urban areas.

Professor Fein?

Mr. FEIN. Some of these areas that are unattractive to physicians are unattractive to other people, including schoolteachers. But schoolteachers are found in that inner-city environment because while they would like to come to Newton, there are no jobs. So they go to the inner city, not because they love the inner city but because the job opportunities are there and not in the suburbs. If an individual is a violinist and would like to play with the Boston Symphony Orchestra, but the Boston Symphony Orchestra refuses to employ him because it doesn't need any more violinists, he does not come to the Congress of the United States and say, "My freedom is being interfered with."

There is an employment market and Americans recognize that they as Americans must choose, to live in Pittsfield, Mass., and not be a maritime engineer, or to be a maritime engineer and give up Pittsfield, Mass., because if you want to be in Pittsfield, Mass., because you grew up there and you want to be in maritime engineering because it is attractive and there are no jobs in Pittsfield, Mass., you must choose. That is true of most of the economic system.

I would like to teach at Princeton, but they won't offer me a job. I don't say my freedom has been abridged.

It is in medicine and it is because of the payment mechanisms in medicine and because of the power of the physician to do good that we have a system in which physician individual decisions can be validated. An individual who sets up a candy store does worry about how many other candy stores there are, what is the competition going to be like and will I make a go of it? A physician does not consider that whether he decides to go into a specialty and select a place. He can validate that decision by offering more care, more neurosurgery than the population needs, if you will, more appendectomies than the population needs; he can generate demand for his product.

There are limits, of course, and I am not suggesting that if we had 10 times as many physicians in the United States we would still be having the same maldistribution that we now have. But within present numbers and within the kinds of numbers that we are generating, the demand for services can be increased by any physician in an area where he is. That is from whence comes the term "overdoctoring." You can have too many doctors in Scarsdale and they will all make a good living. That's why, knowing that, they don't go to the inner city.

With the growth of HMO's for example, that situation is likely to change. The Harvard Community Health Plan, a prepaid group practice does not hire neurosurgeons just because they would like to practice in the Harvard Community Health Plan. The beauty of it is that there is a bottom line figure. There is premium income in the plan and they have to ask whether they need another neurosurgeon. Why pay him if we don't need him?

Now an effective budgeting mechanism that puts money into local areas, that requires a local area to consider what it needs, may not induce physicians to go to Roxbury, but may induce the local area to say we need three more primary care practitioners; we don't need any more neurosurgeons.

I think that what we are wrapped up in, of course, is a very complex problem because our pattern of thought is the market. We like the market, we like to use the market. It is a convenient device. But the market in health care is a very peculiar market. We're also in difficulty because physicians have used words like "freedom" in very unusual ways, ways that you and I don't normally use that word. We know that we must make choices. We don't respond to every candy store that goes bankrupt saying, gee whiz, your freedom has been abridged. But the physician has used the word "freedom" to mean he shall be permitted to choose where to practice as well as what to practice and not to be subject to market forces because third parties ought to pay for whatever he does.

You have got to break that chain somewhere and I would suggest that yes it is important that you hear from the fellows in the firing lines, from physicians, but I would also comment that the physician is not trained, equipped, educated to see the system as a system and I would also suggest most respectfully that what we may need in American medicine is civilian control.

Dr. WYNDER. Mr. Chairman, you brought up a key point, namely, what kind of medical care delivery system shall we have in the inner city. The point to be stressed here: preventive medicine is a job of all society. Overcrowding, bad housing, malnutrition are the key medical problems that face our inner cities. They are by and large not medical problems, they are societal problems. It is easily shown there is more TB, more cancer of the cervix and greater infant mortality, et cetera, et certera, primarily because of their social situation. Unless we can upgrade the housing and the nutrition factors in these inner city areas the medical profession has no chance to have its effect and, therefore, in terms of a national health posture, in terms of our health schedule delivery system, we need to recognize, Mr. Chairman, that if we are going to advance the health state of our country, the medical profession cannot do it alone but we must consider all of these other factors that I mentioned.

Mr. ROSTENKOWSKI. Dr. Freymann?

Dr. FREYMANN. Following up Professor Fein's statement, I would like to address two points:

First: As he said at the beginning of his comments, the usual rules of economics don't apply to the health care system. I will not argue the virtue or the evilness of this. It just seems to be a fact.

Second: What he says is perfectly true; we can't get the docs to go to the boondocks, particularly the inner city. But this is not an exclusively American problem. It is just as much of a problem in every other country in the world except China (as I explained earlier) and possibly Britain.

If I may, I will use an anecdote to make my point: Dr. James Watt was for many years the Chairman of the American Delegation to the World Health Organization. In this capacity, he developed friendship with the Chairman of the U.S.S.R. Delegation to WHO, who was a

senior official in the Ministry of Health in Moscow. One day the Russian said, "I wish we could figure some way to get the doctors to go to Siberia."

Watt said, "Now look, you mean you can't send doctors to Siberia?"

The Russian replied, "Of course we can send them. I could send a hundred of our brightest young medical graduates to Siberia. But then there would be a hundred of them out there figuring out how to get back to Moscow, and there is only one of me."

Mr. ROSTENKOWSKI. Well, Dr. Freymann, what do you envision the hospital of the future to look like if the trend continues as you have outlined it in your statement?

Dr. FREYMANN. I have written a whole book on the subject. (The American Health Care System: Its Genesis and Trajectory. Medcom Press, New York, 1974, 406 pp.) It took me 8 years to write, so I won't try to give you a full description, but I will try to boil down my view of the hospital of the future.

When we think of hospitals today, we still think of a big box full of all kinds of advanced technology where all the patients are horizontal, and where we treat acute crises in the course of chronic diseases. When these crises abate, we send the patients out pretty much on their own devices.

Returning to my theme that we should build on what we have now—the hospitals are there. We can't get rid of them. What we can do is change the vision of what a hospital is. I think we can do this through financing and through education. The center of technology where we take care of these crisis will continue to be an important component, but the main function of the hospital of the future will be comprehensive care (including preventive care) of a population which depends on that institution.

I want to make very clear that when I am describing this hospital of the future I am not talking about hospitals employing physicians. There are already some places where that arrangement works quite well. The Hunterdon Medical Center in New Jersey is an example. But I think we can use any variety of payment and organizational mechanisms. The key feature of my vision is a functional grouping of all types of health professionals about an institution which would still be called a hospital but would have a far broader role in total health care than the hospitals of today.

Mr. ROSTENKOWSKI. Mr. Corman?

Mr. CORMAN. Thank you, Mr. Chairman.

I was going to suggest that either now or if you submit comments on the Brock-Martin bill which is the catastrophic approach; if you address this problem of cost control, it would be fine. I am not sure it is in Ribicoff's bill, but it seems to me logical if you put in catastrophic illness insurance in any form without cost control that we will see a ballooning of certain kinds of care. If I were a normal doctor and I had no cost controls on me and the patient is supposed to cover 15 percent of it, I think I would figure out how to live on 85 percent just in case I couldn't get the 15 because I know the Government will pay the bill. I would like comments on that.

Dr. FREYMANN. Mr. Corman, I agree with you. But I think catastrophic illness insurance would skew the system even more than it already is toward acute crisis care. The problem with catastrophic

coverage is not so much what it would do as what it won't do. That is, it will drain more and more of that "bottom-line figure" we keep talking about into that portion of the health care spectrum which has the least payoff in terms of a healthy population—the treatment of acute crises in the course of chronic diseases. Less and less of the bottom line figure will be available for primary care and the preventive measures.

Mr. FEIN. I would agree with you also, Congressman Corman. All of us sitting here are speaking about health care today. Obviously, we have as taxpayers, as citizens, many other interests. It would be irresponsible to legislate a mechanism that will involve an escalation of costs both because of the kinds of things that are covered or the kinds of fees that would be charged and where you would have a price inflation that would use up valuable resources, leaving us less able to meet the other needs of society. To legislate a blank check is a most dangerous procedure. At least if you pick up a blank check that I signed, you have to consider what is a sensible amount to fill in since I don't have unlimited resources. You might put down $50, figuring that the check won't bounce. Maybe you're a risk taker and you put down a hundred. But you won't go very high. But if a blank check is signed by Uncle Sam, you can put down any number and the check will be cashed. For the Congress to legislate a blank check to the American medical profession would be irresponsible to all the other social needs of the country and the approach which does not have cost control in it is, as we have found with other legislation in the past, a blank check.

Mr. CORMAN. Do any of you have any suggestions for a form for delivery of health care that would upgrade what we do for preventive care other than HMO's?

As I understand it, the primary incentive in HMO's is the economic. You keep the people well, and you will get the same income so you have an economic incentive to keep them well.

Is there anything other than that that would work to this end?

Dr. WYNDER. Dr. Freymann thinks perhaps more of how young medical students could be modified in terms of good health education than I do. As it now stands the majority of the American young physicians living in the present environment will end up in therapeutic care. Therefore, I feel that we have no choice but to better utilize allied health professions. They can do the job better at a lower cost to society than most physicians who perhaps are overtrained for this aspect of medical care.

The allied health professionals are not properly utilized in our society. In our hospitals the nurses are not utilized to their full potential. It has been my experience if you take nurses and challenge them with a position that relates to taking care of patients as for instance hypertensive therapy under a physician's guidance, nutritional advice, or any other behavioral aspects of medical care they do very well.

My key suggestion, cost-wise and indeed in terms of the way we deliver services, would be increased utilization of allied health professionals.

Mr. CORMAN. Are you suggesting that the Federal Government get into the business of deciding according to licensing who can deliver what kind of care?

Dr. WYNDER. This is a possibility. At present laws vary from State to State. There are some States where allied health professionals are utilized very well and there are other States where they are under utilized. In part this utilization seems to depend on the number of physicians in a given State.

To answer you specifically yes, you could very much help in raising the utilization of allied health professionals in our country.

Mr. CORMAN. Did you want to add to that, Dr. Freymann?

Dr. FREYMANN. I would like to throw one of Dr. Wynder's quotes back out, actually the quote of Martin Luther about giving me your child at five. I would like to emphasize, more effective than having physicians or allied health professionals giving health education is to get it into the school system.

Mr. REINHARDT. Yes, right.

Dr. WYNDER. Yes.

Dr. FREYMANN. It is often said we don't have a health education program in this country. On the contrary, we do. It is on television.

In the course of a week, a single station in Detroit carried over nine hours of health-related information. In the judgment of those monitoring it, 70 percent of this was inaccurate or misleading or both.

I don't need to tell you what kind of health education we see on television. It is dedicated primarily to whether you smell good or whether you look good. But it *is* education related to health.

Health education is beyond the purview of a National Insurance Program, but I think it is an important part of National Health Policy. We must develop effective ways to get to our children and teach them good health practices. The drug education programs now offered in our schools are examples of how *not* to teach good health practices. They are all negative. All the children hear is how bad everything is. Good education should be positive. It should be directed toward why they should do things, not why they shouldn't.

Dr. WYNDER. Here is another area where you could help. I go along with Dr. Freymann, health education on TV can play a role but we should not limit it to public service television.

I like to believe—because most kids in most areas don't watch public service television. They watch commercial television. I feel that commercial television particularly on Saturday morning has a duty to have some kind of meaningful health education programs for children who sit glued to the TV set.

These are public air waves. I think they ought to be used at least in part to educate our young and certainly I am in agreement with Dr. Freymann that this is where the action lies.

Mr. CORMAN. There is a legislative proposal before the Congress that Leonard Woodcock refers to as the Health Security Program. It's a broad-based program. If you are familiar with it do you have any comments about it?

Mr. FEIN. I am quite familiar with it. I would comment favorably. It addresses the financing aspects. While I might have reservations about what I would consider details, it does so in an effective manner.

Americans would have access, would not have the economic barriers that many face now in seeking care.

It also addresses the supply considerations. It has a bottom line to it. It puts the money back where people can argue about what it ought

to go for at the local area. In other words, it uses a central financing mechanism while permitting a great diversity in the delivery systems.

It is a big country and it is a different country and we need that diversity in delivery system. If some people want to opt for HMO's, they can do so, but they don't have to do so.

In the present system by contrast, with multiple sources of funds it makes it difficult to organize different kinds of delivery systems. It is tough to start a HMO because it is thought to enroll a medicare population because they are covered by one program, a medicaid population, because we have to go to the Governor to get a contract for that population, and so on. So I have no difficulty with the central budgeting device leading to diversity with the equal access to care and with the supply considerations.

Of the various measures that are before the Congress I would find that the most appealing. In line with my earlier remarks, if one were forced for a variety of political reasons to phase in a program, I would like to have the Corman-Kennedy bill out there as what I am moving toward over a period of time in a manner that will actually get me there.

I would conclude with one additional point. While all of us, and you, have been talking about the complexities of the system and the difficulties and the interrelationships and the central city and the preventive care, I would not want the tone of our remarks to color all of our judgment as we leave this room.

I would remind us that; yes, it is a very complex business but I would also remind us that it is not all that tough to write a good bill on the equity side dealing with financial protection. Other countries have done it.

What is tough is that we are trying to write or talk about a bill that would change the system as well. That's very complex. But the Canadians without any great trauma, and they are not much brighter than we are, have a program and it is not that tough to write a good bill. It may be tough to get the votes for it, but it is not that tough to write a good bill on the financial protection side.

Other countries have done it. We have the benefit of their mistakes and of their good points but that, gentlemen, we can do. It is when we can bring in the system that life does get more complex. It is in that regard that I feel we ought to give this high priority to the access for care, the Kennedy-Corman bill does just that.

Mr. CORMAN. Any other comments from the panelists whether you are familiar with it or not?

Professor Fein very accurately stated what it does, in any event.

Mr. REINHARDT. Yes; I think if one contrasts that kind of bill broadly with the catastrophic risk bill, I also would opt for the former, primarily because it does the catastrophic-risk bills really do not address the one goal that I posited earlier. That goal is to free the American citizen from anxiety which is, I feel, totally unnecessary. At the minimum every American citizen should have a very concise idea of what the maximum potential financial loss due to illness is, if only so that he or she can plan for it.

Second, I would recommend that the maximum risk should be rather low. I think one talks here really of percentages related to income and not just of some absolute amount.

Dr. Fein would have zero as an optimum percentage. I would be willing to go above that but certainly not to 15 percent. This is a matter, as you said, which one can negotiate.

Health insurance legislation ought not be that difficult to write. The difficult part does come as—Rashi Fein has observed—in trying to obtain the goals of health insurance in a cost-effective manner. The problem is to identify the cost effective system and to devise measures likely to goad the health-care sector toward that optimum.

Legislation declaring that a maximum of "*x*" residents can specialize in surgery would have a very blunt impact on a the health care system, as would, for example, a command to a certain doctor to practice in Kansas, quotas, and certificates of needs for physicians.

I think such direct regulations would be appropriate only if one knew what the optimal organization of medical facilities in this country would be. Unfortunately, we do not know precisely what an optimum system would look like. Therefore direct regulations can be counter productive.

On the other hand, one does not necessarily have to give up attempts to modify the existing system. You can use the physical flows that accompany the delivery of health care in this country. Under National Health Insurance the public sector will gain control over these flows, and it could use them as policy levers.

It does seem to me, for example, that in the design of the fee schedules under NHI, there lies an opportunity to change the health care system at the margin in gentle ways that do not strike as bluntly as direct regulation would.

Finally, I believe that there is one measure whose impact might be blunt and yet benign, and that is to remove certain artificial legal restrictions on innovation in the health care sector that have strangled that sector for so many years. I said this morning that licensure in some way has amounted to granting a monopoly to one particular profession. I reiterate that. This method of licensure is not necessarily optimal from society's viewpoint, I would like to see a much more diverse set of entry points into our health care system. I would like to see, for example, legislation establishing independent paramedical practitioners. But clearly that is something you can consider independently from a National Health Insurance bill. Indeed, I would not wish to see you couple it with a National Health Insurance bill. It is merely something you ought to keep in mind.

Mr. CORMAN. We have done precisely in that proposal what you have laid out. We did avoid that latter point for very sound reasons.

Dr. FREYMANN. I am not familiar with all the details of your bill, Mr. Corman, but agree that given the choice between that approach and the catastrophic approach, there is no question in my mind which is preferable, namely, the Kennedy-Corman bill.

I agree with my colleague that National Health Insurance would indeed free the public from financial fear, but I would like to make an appeal: I address it not to you but to the Congress as a whole. Please avoid the implication that there is a connection between National Health Insurance and saving money on health care. I know of no evidence that any health insurance system has saved money.

I would like to point out that we have been here all day discussing purchase of a product, but we have not defined what that product is.

Now, if we were representatives of the Defense Department, I am sure that long since you would have made us tell you how many tanks, how many aircraft carriers, and how many missiles we are talking about.

Even if we were representatives of another service industry such as education, I hope you would have been able to get us to tell you how many students we were going to produce. In other words, you would have insisted that we quantify the product.

Yet, in this entire discussion neither we on the panel nor anyone in the committee has tried to define what we are buying. I think this is why the economics of the health care are so peculiar. We talk about what we are going to spend, not what we are going to buy.

Mr. Corman, but I agree that given the choice between that approach have access to the services of those who the States have licensed to take care of their health needs.

Is that sufficiently definitive?

Dr. FREYMANN. That does not answer the problem. As Dr. Fein pointed out earlier this morning, the provider is not always a physician. There are the other health care providers. But beyond all these is a social demand that certain health resources must be available.

I return to dialysis as an example. There is a social demand to make available to all people who have end-stage renal disease, unlimited resources to keep them alive. This social demand has actually been incorporated into Federal statute.

Mr. CORMAN. Do you know how that came about?

Mr. FREYMANN. Not in detail.

Mr. CORMAN. The detail is that 25 people would die if they didn't have it and they sat right where you are sitting.

If you could bring me 25 of anybody with anything and let us look at them, I can promise you that we will take care of their problem. It is the unseen ones that are difficult to take care of.

Dr. FREYMANN. I am not surprised, and I sympathize with you in facing that dilemma.

The point I am trying to make is that, if we are talking about national health insurance to free people from the fear of being wiped out financially, that is laudable and I am all for it. But we cannot say that and also say we are going to save money and hold down costs. There is no connection between the two.

The costs of keeping people alive are going to increase because our population is getting older and older, and our technology is getting better and more expensive.

We are going to be spending more and more money at the life-preservation end of the health care spectrum unless we define (to use the title of Victor Fuchs' book) "Who Shall I Live." When I say "we," I mean society, not the health professions nor the medical profession.

Who shall live? That, I believe, is the crucial question which will determine how much we spend for health care. Until we answer it we will be unable to control what we spend because we will not have defined what we are going to buy.

Mr. CORMAN. Dr. Wynder, did you have any comment?

Dr. WYNDER. There is nothing that I can add which has not already been said. The bill that includes the basic premise to provide effective health care at a price we can afford should be the right of every citizen in our country.

The point just made in terms of kidney dialysis and the marketing problems we have had in preventive medicine prompt me to say I cannot marshal here even four people who are so delighted they are healthy that they will come here before you, because if we are healthy we take it for granted. Once we become sick, we worry about the sickness that we then have.

Any bill has to make certain that physical restraint is being maintained by whatever health care system operates.

If you give upper limits, you can be certain that that upper level will be spent. Such fiscal restraint must certainly be contained in any bill.

Dr. Freymann stated that perhaps as we get older we will cost our society more in terms of some disease.

I am not that pessimistic. As I pointed out, I do not believe we have to die of ill health. There are, of course, other problems that we can deal with in terms of our aged. I would hate at this point to mention nursing homes but certainly nursing homes, if well run, are a far better and cheaper way of dealing with some of our problems relating to age than hospitals. Hospitals happen to be one of the most expensive ways in which we operate our medical care delivery system.

I do hope that as the weeks come, you will have witnesses from different branches of the health care system. I hope you can ask them how they can reduce the cost of their operations and how they could utilize perhaps some of the bed space now becoming empty for ambulatory and preventive care services.

Mr. CORMAN. Mr. Chairman, on that note I would just indicate for the record that panel 1 has opted for H.R. 21 and I won't ask anybody any more.

Mr. ROSTENKOWSKI. We have to get the votes and talk about the dollars budget.

Gentlemen, it has been most enlightening. The comments, as I said earlier in the back room were just fantastic. You have really begun our discussions and our investigation of the possibility of health insurance on a national scale on a real sweet note.

Professor Fein, did you want to say something?

Mr. FEIN. On behalf of the panel, and I am sure my colleagues would agree with me, I would want to make a comment to you, Mr. Chairman, that if this is the way the Congress always works, then the image that some Americans have of the congressional process is faulty.

If this, on the other hand, is not the way the Congress always works, then, by golly, it should work this way.

Mr. ROSTENKOWSKI. Well, thank you.

Mr. FEIN. Because I am sure we do feel, all of us, that this was a most useful day to us as well as to you in the opportunity to leave feeling that we had an opportunity to share ideas with you and that these ideas then will be accepted or rejected but will be weighed as you debate.

It is a nice feeling to have.

Mr. ROSTENKOWSKI. Professor Fein, this is a new concept. I would like to continue this approach of having the subcommittee really

geared to a dialog, conversational dialog, with our witnesses. I think the advisory panel that we put together, and you are members of it, are certainly going to help us frame legislation that will ultimately mean a great deal to this country.

I would like to say one thing to Dr. Fein. You talk about health education for the young, that it is not all bad.

Well, it is nice to note that you have made the observation that we are not all bad up here, Professor Fein, because we get that all the time, comments on how bad Government is run.

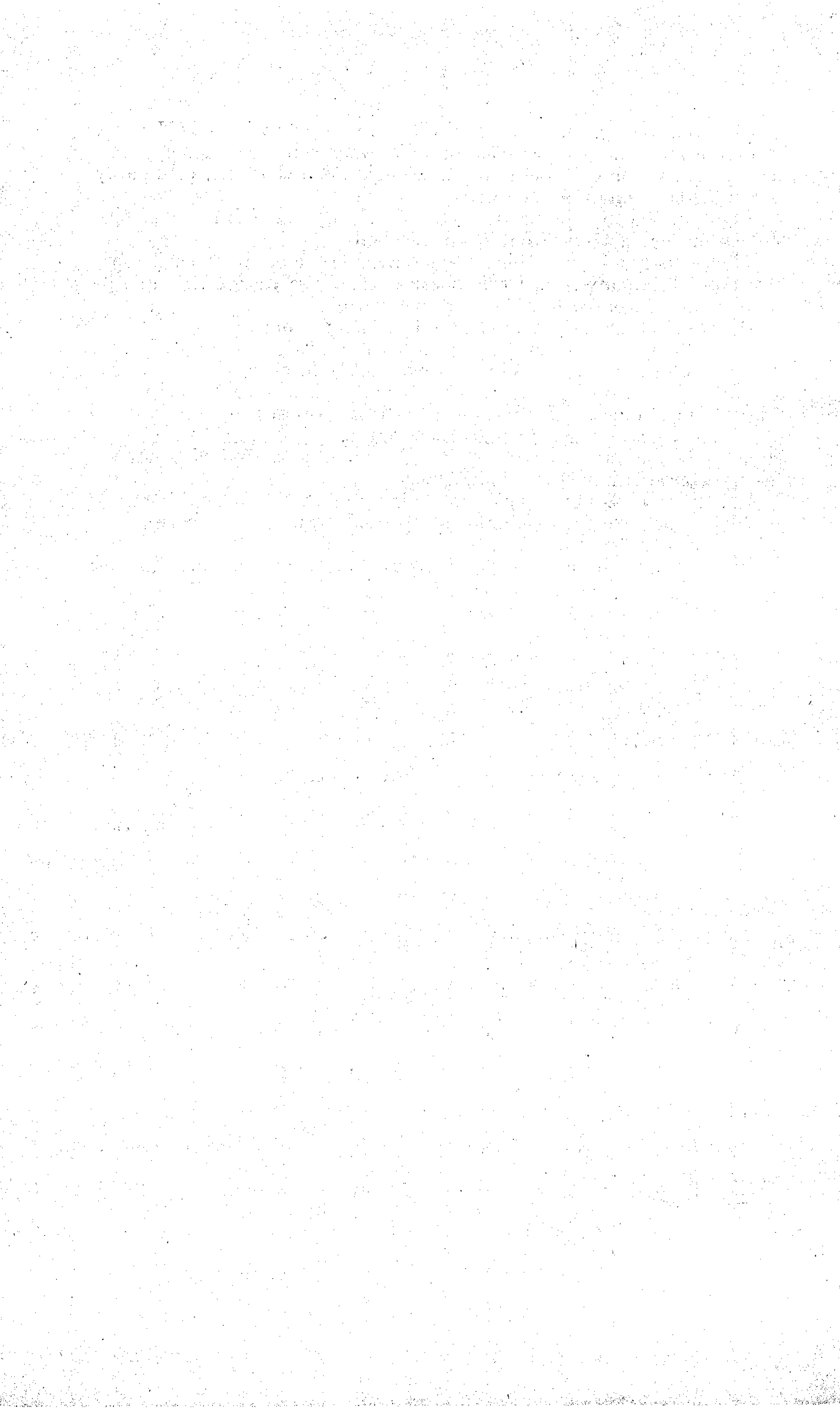
Dr. WYNDER. Mr. Chairman, may I add a final comment.

Some time ago in Japan I was called upon to give a toast. I said, "May a country's greatness in the world not be measured by the height of the gross national product, but rather by a health care service that has in a most effective manner lead to the healthiest people in it."

I hope some day that Congressmen and that Senators would be receiving the most votes from constituents who have successfully labored for a better health care system in America.

Mr. ROSTENKOWSKI. Thank you. This committee will stand in recess until 9 o'clock when we will take up the testimony of the Government's role in national health insurance.

[The subcommittee recessed, to reconvene at 9 a.m. of the following day, Friday, July 11, 1975.]



NATIONAL HEALTH INSURANCE

(The Role of Government in American Health)

FRIDAY, JULY 11, 1975

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. ROSTENKOWSKI. The subcommittee will come to order.

We would like to welcome the professors and doctors this morning. I would like to express our gratitude for taking the time out of your busy schedules to participate with us in these discussions. The format of these meetings are an opening statement by each of you individually and then an opportunity for you to have an exchange and then the panel opens up to questions by the membership from this end.

It is quite informal. We would appreciate your trying to give us answers in as concise a manner as possible because, as you know, we are limited here to 5 minutes on questioning at least the first go-round.

We are looking forward to indepth conversation with respect to the Government's role in the national health insurance. We would like you to know that in yesterday's hearing the Members of Congress that participated in the discussions were quite impressed. I think these are very informative and educational sessions. It really is a two-way street, both for those of us who participate and those who give the knowledge you have to offer.

I would like to present this morning Prof. Lewis H. Butler, professor of health policy, University of California. It is nice to see you back in Washington, Professor.

I would like to present Lowell Bellin, New York City's commissioner of health.

Richard Heim, executive director of Health and Social Services Department, New Mexico; and Prof. Pierre R. de Vise, professor of urban science, University of Illinois, in Chicago. It is nice to see you.

A PANEL CONSISTING OF LEWIS H. BUTLER, PROFESSOR OF HEALTH POLICY, UNIVERSITY OF CALIFORNIA; LOWELL BELLIN, M.D., COMMISSIONER OF HEALTH, NEW YORK, N.Y.; RICHARD HEIM, EXECUTIVE DIRECTOR, HEALTH AND SOCIAL SERVICES DEPARTMENT, STATE OF NEW MEXICO; AND PIERRE R. de VISE, PROFESSOR OF URBAN SCIENCE, UNIVERSITY OF ILLINOIS AT CHICAGO

Mr. ROSTENKOWSKI. If Lew, you will begin with your opening statement, then we will go down in that order, and then we will be open to discussion.

Welcome.

STATEMENT OF LEWIS H. BUTLER

Mr. BUTLER. Thank you very much, Mr. Chairman and members of the subcommittee.

I think all of us here will find this kind of discussion very beneficial. Instead of your having to listen to long speeches from us, this kind of informal exchange is really very productive for us and I hope it will be for the committee.

I have written out a short statement, but rather than just read from that, or even follow it in detail, I thought perhaps it might be more useful for the subcommittee for me to go over some of the mistakes, or at least misunderstandings, that I personally have been involved in in the health policy field when I found myself in HEW doing the health planning as the Secretary for Planning.

That started in 1969, and in going over today's agenda I found it at least useful for me to try to think back and discover how many things we thought were so—at least I thought were so in 1969—maybe it was just my ignorance—and on which we based a lot of our planning and policy, many of which just turned out not to be the case.

So if the committee can get any insight from hearing a story about, in some respects, how not to do some of these things, I would be happy to tell you that story. I apologize for the fact that it comes in somewhat personal terms, but that is the only way I know how to tell it, I guess.

I am sure you have heard a lot about national health expenditures. I must confess it took a long time for it to sink into my head how huge they are and how fast they grow. The numbers are just numbers and they don't mean much until you see them in relation to other things. things.

For example, in 1969, when we started the policy planning in HEW, national health expenditures were about $60 billion. That is only 6 years ago. This year they will be exactly double that, $120 billion. At the time, we were trying to make 5-year projections—I must say that none of our projections indicated that we would reach $120 billion by now. We just didn't believe that the rate of inflation would continue and, of course, it has, and in some respects has gotten worse.

So when you think about a doubling of anything as big as this in a 6-year period, it is a rather significant event.

I suppose the other striking aspect of the expenditures, at least to me, was to see them in relation to other kinds of governmental expenditures.

In 1969, we had the view in HEW that if we could only get the Defense Department's money, we could take care of HEW's needs and, specifically, if the Vietnam war would only end, why, we would be in good shape.

It came as somewhat of a shock to me that the Vietnam war was costing—I can't say only—but it was costing at its peak $25 billion a year. When we did the projections, we suddenly realized that the end of the Vietnam war would have some minor impact, but very little really on HEW's ability to pay its bills, that our expenditures were increasing and a lot of this was due to the health sector. They were increasing at such a rapid rate that the end of the Vietnam war was certainly no salvation for HEW and, of course, that has turned out to be exactly the case.

To give you some sense about that, right today total national expenditures—this is not just Government, but total national expenditures for surgery in medical care, just surgery, now exceeds the cost of the Vietnam war's biggest year. HEW's expenditures for medical care alone—forgetting the welfare and education side of the Department—HEW's expenditures for medical care alone now exceed the Vietnam war in its biggest year.

So gradually some of the enormity of these expenditures began to sink into some heads such as mine that really had not been very much exposed to the problem up until then.

The second characteristic of the medical care area in the role of Government that was sort of slow coming home to us is what was happening with the medicaid program. At that time, of course, most of the attention was devoted to medicare for older persons. Medicaid was a program we knew had a problem, but that was just another problem among many in our view.

Gradually it became apparent to us that medicaid was not just another problem. It was an overwhelming problem. For example, after a couple of years we began to realize that the growth in medicaid expenditures, which, of course, were coming out of general revenues, not out of payroll taxes, but the growth in medicaid expenditures—and keep in mind the Federal Government was only paying half of that—was such that it was going to squeeze HEW's entire budget; that is, biomedical research, education, all were going to be squeezed because of the growth in medicaid and some other so-called uncontrollable programs.

To put it in another framework, I and some others came thinking that the so-called welfare mess—we are talking about cash payments for public assistance—was our biggest problem, and gradually we began to see that the payments under medicaid were going to outstrip cash payments eventually at the rate they were going.

While not all of that has turned out to be the case, because of States cutting back since then in their plan for medicaid expenditures, we are still now at a point where $7 billion is going out for that purpose matched by another $7 billion by the States. That continues to be, at least in my opinion, the No. 1 priority for any approach to health insurance on the way towards national health insurance or as a part of an overall bill.

Perhaps I will make one other comment about the expenditures. At that time medical costs nationwide were inflating at 10 or 12 percent. We, of course, had no idea that inflation generally would become as

57-677—75——7

bad as it has in the United States, but that rate of inflation was double the normal size of inflation for everything else, that is the Consumer Price Index was going up maybe 3 or 4 percent a year, and medical costs were going up double that.

I will refer to this later, but the more we got into it, the more it seemed that there ought to be a way to stop that; that if we could only become more efficient and handle the Government's affairs better and the Nation's and do something about inefficiency in medical care, we would be able to control that inflation.

Now here it is 6 years later and the normal rate of inflation is under control, if you call 6 percent under control, but at least it isn't in double digits this year, and medical care costs are still increasing in the range of 12 to 14 percent this year. So nothing much has changed and we are spending 8 percent of our gross national product.

When I started it was 7 percent, and where it stops it is hard to tell. It leads you to the conclusion that while it is possible to do nothing in this field, that is, to have no further Government initiatives, it is not possible to do that and stop the trend in costs that is going on now. If the problems are to be addressed, at least in my view, it may require spending some money to, in the long run, reverse some of these trends.

Now without going into any detail on the issues I have enumerated in the testimony, I would like to hit five or six basic misconceptions that we had at that time, or at least that I had, that underlay a lot of our thinking about medical care policy. It took a number of years for those to get out of our heads.

The first, and I think you have heard quite a bit about it over the last few months, perhaps even yesterday in the testimony, is the influence of medical care or more medical care on the Nation's health. I remember then we would go up and testify before Senator Kennedy's committee, and we would make statement such as "America is 10th or 12th in health standing in the world and life expectancy and, therefore, we need national health insurance."

Senator Kennedy would say the same thing, and he would also say, "Therefore, we need national health insurance."

Well, we were both wrong. It is very clear now that while there are a great many reasons for having a coherent health insurance system and a national health insurance system, one of them is not to improve these overall health indicators for the country. That is just not going to happen.

Now I could not believe that at first, because I said, "Well, I know people who, if they had had medical care, they would have lived longer or their lives would have been saved or if they had a heart attack, if we would have gotten them to the hospital in 20 minutes, and they would have lived," and "How can you tell me that the cumulative effect is that it won't improve the Nation's overall health?"

Of course, it will improve individual health and there are some groups, particularly the poor, who should have longer life expectancies, but the other factors that influence health, personal habits, stress, employment status, nutrition, the environment, these have such a major impact on these overall indicators that in that picture medical care is not that significant.

So when we talk about the Nation's role in health, which is the Government's role in health, the subject today, we have to remember that

most of what we have been talking about, and I think we will be talking about this morning, is the Government's role in medical care. There are all of these other things the Government is doing that have an enormous impact on health. In that respect your programs for income maintenance, for housing, for nutrition, for jobs, all of those in the long run may turn out to be more important health programs than any program that deals with medical care.

Unfortunately we don't know how to deal with these comparisons, I don't think, at the moment and I don't want to take our time on such a global issue other than just to mention it.

I suppose the next misconception that we have had concerns the amount of science that is in modern medicine. We have made enormous strides in this country in the last 50 years in medicine. As a nonmedical person, an outsider, I have found myself, and still do, with tremendous respect for the quality and dedication of the researchers and the practitioners and so on, particularly now that I am working in a medical center. But the fact is, as my friends will admit in their candid moments, that modern medicine is a very limited thing. We know how to do very well some things and we do not know very much about a great many other things.

What I find myself continuously astonished about now is how little we know about the efficacy of a lot of modern medicine. That is, we do not really know how much good it is doing. There are some indications, and these can be misconstrued and warped, that a lot of our effort is not doing very much good in some measurable sense. It may be doing an enormous amount of good in the psychological sense, and it really is important to care for people and to try to do as much as you can and a lot of medicine is devoted to that. But when you look at the statistics on the rates of recovery or death from cancer or for the major killers, they have not changed very much in 20 years.

So as Government gets more and more into paying the bills for all of this, which of course it is, it is up to 40 percent of the total bill now, it is incumbent on Government to try to find out how efficacious all of this care is and, unfortunately I think, to begin to cut down on some things that do not do very much good, not to mention things that do positive harm. That poses enormous problems. It is hard to measure what does good, since you are experimenting largely with human beings. You can't delay care to someone, on ethical grounds, in order to see whether he is worse off or better off in an experiment, so we have enormous difficulties in doing this. But I think we do have to continually recognize, in thinking about Government's role, that we have not reached perfection by a long shot in medicine, and are way short of that in many respects.

I suppose another misimpression that we had was about what medicine did, that it was largely acute care and that a certain amount of it could be avoided by prevention. But, having marvelously solved the problems of infectious disease over the last 50 years, medical care has turned in increasing portions to care for chronically ill people, people who come back year after year. Most of the great killers that we think of, heart disease and now cancer, we are learning how to manage as a chronic illness. We are faced with dealing with populations that we cannot cure, whose diseases we can only manage.

These are the same populations in many respects that the Committee on Ways and Means deals with in other programs, whether they are called disabled, dependent people, or people receiving supplementary security income. These are all of the same people in many respects, so medical programs are going to have to be coordinated, I hope with our programs relating to these people.

For example, there are about six different programs, all within the jurisdiction of this committee, that may be sending money to the same persons that visit our hospitals at UCLA Medical Center every day. That would be supplemental security income, social security, disability, medicaid, medicare and social services and then there may be vocational rehabilitation and a few other things of that kind.

So the role of government has become increasingly complex and a lot of it focused on the same chronically ill population.

Another point had to do with cost control. I firmly believed at that time that if we could manage the inefficiencies in the program. We could control costs. I used to write big statements about cottage industry and if we could only get it shaped up and make it efficient and do away with profiteering, we could solve the cost control problem.

We went up and testified how our various cost control measures were going to do wonderful things, various kinds of limitations on fees, 75th percentiles and all that. I am not saying all of those things shouldn't have been done and are not worthwhile, but the fact is that medical care costs, given the present system, are inherently uncontrollable. I don't think it is an accident that this rate of inflation has continued the way it has and I think it will continue to go that way for the next decade unless some major change is made in the payment system.

The reason is not all bad at all. Medical care grows every year. Every year a day of hospital care is a different thing than it was the year before. There is more technology, more technique, more good research, more of everything.

In most businesses normal cost constraints cause you not to put in new technologies that will cost more money. You only put them in if you save money. But in the medical care business, this is not so because of insurance which is a necessity to protect people against unforeseen events. Because insurance is there, the money is there and because the money is there, the product grows in size and so no matter how much we do, how well we do with the inefficiencies, we have this inherently ballooning business. To stop that ballooning means that some things that are good to do, at least for some people, can't be done.

So the cost picture is not an easy one to deal with.

The next point is on administration. At that time HEW was having a lot of problems running things and still is. The committee knows a lot about supplementary security income and the kind of difficulties you have in administering those programs, problems with setting up computers and all of that. At least I had assumed that the problems with the health insurance system would not be any worse than that, although we were thinking about national health insurance going to deal with 200 million people, keeping in mind that social security only deals with 25 million now on its computer banks and 200 million is eight times that.

Still that just seemed like a problem of scale to us. Now it seems much more difficult because, as with costs, medical care insurance systems are inherently hard to administer. That is because the things that you have to determine are so subjective.

If you are dealing with social security, all you have to find out is is the person 65? Did the man die? How much did they pay into the system?

With your disability programs, of course, you are getting into trouble there because whether a person is disabled or not is a matter of judgment. But when you get to health insurance, you are then dealing with an enormous number of subjective decisions. Was the care necessary? Was it appropriate? Should the person really have been in the hospital for 5 or 6 days or 2 days or 10 days?

And when you consider that medical care is an art, to some extent, rather than a science, and the number of those decisions you have to make and then you look at that times 200 million people, you have an administrative problem that is absolutely overwhelming.

So that at least leads me to a couple of conclusions. One is that whatever is done should be done on a relatively small scale at the start so we can work out the administrative difficulties. Perhaps, more important, I do not think we can successfully run a national health insurance program on a fee-for-service program. Whatever the merits of the fee-for-service system, I don't think we can get there from here and will have to go to some other kind of lump sum payment system, such as a capitation payment. I don't see how we could run the other system.

Finally, there is the role of the States. I suppose when you get to the Federal Government, as I did, your figure the States have to solve their own problems and you have enough to deal with in the Federal Government. We give far too little attention to the role of the States.

Medicaid, of course, is a State program. Thinking now about the administrative problems of national health insurance, it is clear that the States have to have a major role. In one field alone, long-term care, nursing homes, it is clear that the States are the major actors. We cannot design in my view a national health insurance system without them. We cannot just figure out what the role of the Federal Government is and then fit the States in.

If it isn't designed with the States in mind, and there are others that can speak far more knowledgeably than I, again I don't think we are going to make it.

Mr. Chairman, thank you very much. I will go on later.

Mr. ROSTENKOWSKI. Thank you, Professor Butler.

[The prepared statement follows:]

STATEMENT OF LEWIS H. BUTLER, ADJUNCT PROFESSOR OF HEALTH POLICY; HEALTH POLICY PROGRAM, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Mr. Chairman, Members of the Subcommittee on Health, the discussion today is on the Role of Government in American Health. My prepared remarks will be short so that we will have as much time as possible for informal exchange. My purpose is to describe briefly the current role of government, the future decisions to be made about that role, and some common assumptions that turn out not to be as true as we might expect.

At the risk of going over ground already familiar to the members of the subcommittee, it might be worth while to review a few basic facts about medical care and government expenditures.

For the Fiscal Year just ended, total medical care expenditures for the nation will be in the range of $115 to $120 billion. Last year they were $104 billion. That is about 8% of the gross national product, and makes medical care one of the two or three largest industries in the United States. This year medical costs are inflating at about a 12% rate, twice the general rate of inflation.

The government's share of medical expenditures has, of course, increased enormously since the passage of Medicare and Medicaid in 1965. Total government expenditures, Federal and State, are about 40% of the total. Federal expenditures alone are 27%.

The biggest single item in medical care expenditures, about 40%, is hospital costs. The Federal and state governments pay more than half of these costs.

Not surprisingly, costs of care for older persons over 65 are much higher than for other age groups and are about 10 times as high as for those under 10 years of age.

That is the dollar picture.

Turning to the present role of Government, the Federal Government is involved in almost every aspect of medical care.

Paying medical bills for the elderly, the poor and the disabled is the biggest single item. The 23 million beneficiaries under Medicare now have bills paid by the Federal Government at an annual rate of about $15 billion. Payments to states for 25 million poor people covered by Medicaid programs amount to $7 billion, with the states paying an equal amount.

Financing the training of manpower, principally physicians and nurses ($1 billion).

Promoting regulation and organization of the health industry to improve the distribution and quality of services, and control costs ($600 million); constructing facilities ($1 billion).

Supporting biomedical research, at an annual rate of about $2.5 billion.

Caring for persons to whom the Federal Government has a special responsibility, such as veterans, military personnel and merchant seamen ($8 billion).

State and local governments, in addition to financing and administering the Medicaid program, provide most of the long term care and mental health care, and run most of the institutions serving the poor.

In considering national health insurance and the future role of Government, the question is not whether whole new functions should be taken on but rather how much the current functions are to be expanded and how that is to be done. Specifically, decisions have to be made about:

Medicaid—Should it become a uniform program throughout the country rather than a collection of state programs, should it be expanded to include new groups of people (e.g. laid off workers receiving unemployment compensation), and should the state or Federal government run it?

Health insurance for all citizens.—Should it be provided and if so, how? Should it be phased in by groups (e.g. children first?) Should it be limited to coverage for higher cost illness only (catastrophe insurance) or be comprehensive?

Regulation.—How will the flow of money into the system be redirected for the purpose of improving the availability of services, controlling costs and improving quality?

Manpower and facilities.—How will they be geared to increased demand for services resulting from more insurance and technological development?

Research.—How can it be coordinated with insurance coverage? For example, with Medicare currently covering kidney dialysis and transplantation, what priority should be given to research on chronic kidney disease, and how? Should dollars be spent on the development of an artificial heart, considering the costs under national health insurance of inplanting such a device in perhaps 50,000 people per year?

Federal beneficiaries.—Should veterans, military dependents and merchant seamen be brought in under a national health insurance system and if so, what should happen to the Veterans hospitals and Public Health Service hospitals?

The Role of the States.—What will the state function be in all these respects? Perhaps most important, to what extent will the states continue to have a major role in paying medical bills, giving them an incentive to be concerned with effective cost control and regulation?

These are some of the issues that cannot be avoided in any consideration of national health insurance and the role of government in health. They are so numer-

ous and complex that rather than discuss any particular issue in detail it might be more useful to respond to specific questions from the members of the Subcommittee on points of particular interest to them.

There are, however, a number of common assumptions about health and medical care which I would like to review with you because they are directly relevant to these issues. I mention them because they represent what I and at least some others took to be facts about medical care and government's role when we began working on health policy in HEW a few years ago. It turns out that in some cases they are less true than we thought and in other cases just not so at all.

We made these assumptions:

MORE MEDICAL CARE WILL MAKE THE NATION HEALTHIER

Not so.—Other influences on health, such as nutrition, employment, stress, personal life style, and the environment are too strong. The health of particular individuals will be improved, and perhaps the health of some groups, such as the rural poor, but overall national measures of health such as average life expectancy will not be changed.

This has enormous implications for national health policy. It means that the government role in medical care, which is what we have been discussing, is only a small piece of government's role in promoting health. Programs to provide income, employment, housing, education, a better environment, safer roads and cars and so on are all in a sense health programs. This leads into a discussion of how government can set priorities among these programs, which is far too broad a subject for today's agenda. But it does put national health insurance in perspective. National health insurance in any form should be viewed as a way of achieving greater equity in the provision of medical care, or of providing income protection against medical costs, or of controlling medical care for some other public purpose. We should not expect such a program to make us a healthier nation.

MODERN MEDICAL CARE IS HIGHLY SCIENTIFIC AND OF KNOWN EFFECTIVENESS

Not as true as we would hope.—For all the advances in medicine in the past 50 years, particularly in the treatment of infectious disease, the medical art is still a limited one, due largely to our relatively primitive state of scientific knowledge of life processes. We know surprisingly little about the efficacy of many forms of treatment and there are major legal, ethical and technical obstacles to obtaining such information.

This is of growing significance as government pays more and more of the bill for care. A major governmental undertaking will need to be launched to review in whatever ways possible the efficacy of treatment and to tie those findings to governmental payment systems, including national health insurance.

MOST ILLNESS IS ACUTE AND AT LEAST IN PART PREVENTABLE

Less and less the case.—The portion of medical care going to the treatment of chronic illness is rapidly increasing, with the disappearance of infectious disease as the prime concern of medicine. The number of effective preventive procedures as distinguished from measures to manage chronic problems is remarkably small, and as the nation's population becomes older the trend will continue.

The significance for governmental policy is that health insurance programs will have to be integrated more closely with income maintenance and other programs for those in the society we now classify variously as "disabled," "chroncially ill," "unemployable," "handicapped" and "dependent," often referring to the same person with the same problem.

MEDICAL CARE COSTS CAN BE CONTROLLED LARGELY BY ELIMINATING INEFFICIENCY AND PROFITEERING

Not so.—Without question these factors have an impact on inflation in costs, which is currently running at about 12% annually, but the major cost problem is far more fundamental. The combination of a growing technology and an independent source of financing in the form of health insurance makes medical care expenditures inherently uncontrollable, given the present fee-for-service payment system. Each year the product delivered, say a day of hospital care, tends to expand through the addition of new services and new equipment. Since the needs for

care, especially among the chronically ill, are almost unlimited, the possibilities for inflation in cost are similarly unlimited.

For government, this means that if cost control is a major objective, it probably cannot be achieved under the present payment system, at least not without a high degree of governmental interventoni into day-to-day practice procedures. To the extent that a national health insurance plan expands the amount of insurance currently in force, without modifying the payment system, the cost problem should continue to be at least as bad as it is now. Limiting the supply of physicians, hospital beds and other resources then becomes one of the few cost control weapons left to government and it may not be effective.

HEALTH INSURANCE SYSTEMS ARE NO MORE DIFFICULT TO ADMINISTER THAN OTHER GOVERNMENTAL PAYMENT PROGRAMS

Again not so.—The very nature of health insurance makes it difficult to administer if claims against the system are seriously reviewed. A very high number of claims are made annually, particularly if drugs are covered. Since standards about whether care is necessary in a particular situation tend to be highly subjective, given that medicine is at least as much an "art" as a science, controversy is possible over almost any denial of a claim. Further complication occurs because a denial of claims will occur in most instances after the care is given, thereby causing possible financial hardship to the patient.

The question for government then becomes not whether private insurers or a governmental agency should administer national health insurance but whether anyone could run such a system based on the current kind of claims review process. This suggests that at least government should experiment with various administrative forms before committing itself irrevocably to one or the other. It also suggests that alternative simpler methods of payment, such as a lump sum payment per person per year (capitation), may be necessary purely for administrative reasons.

THE ROLE OF THE STATES UNDER NATIONAL HEALTH INSURANCE IS A SECONDARY ISSUE THAT CAN BE DEALT WITH ONCE A BROAD PLAN IS AGREED UPON

Hardly.—If administration of any part of national health insurance is to be decentralized and given to the states, a major overhaul of state mechanisms will be required to avoid the administrative disasters that befell some Medicaid programs. If the Federal government is to take over prime responsibility for long term care, such as nursing homes which now account for a third of Medicaid expenditures, the fiscal implications will be enormous and a Federal program to monitor the quality of care in such institutions will be a necessity. Whatever the decision, integration of existing state and local social service programs with national health insurance will be required.

I know that the Subcommittee has been reviewing these and other questions about the role of government in health and I appreciate having the opportunity to discuss them with you.

Thank you.

Mr. ROSTENKOWSKI. Dr. Bellin?

STATEMENT OF LOWELL BELLIN, M.D.

Dr. BELLIN. Thank you very much.

Before starting my formal statement, I do want to say it was refreshing to hear the comments of Professor Butler. I know that the Subcommittee on Health is aware of the fact that comments so candid are not that common in public testimony and he said a number of things that deserve serious contemplation, although I must disagree slightly with him with respect to the capitation approach.

Mr. BUTLER. I will be mentioning this in my formal testimony.

Dr. BELLIN. I defer to others today who wish to inventory the health benefits that ought to be included in a national health insurance plan. I want to focus only on the field of quality and cost controls.

Publicly funded health programs have gone awry in this country not because this or that health benefit was included or excluded, but because of inadequate quality and cost controls. Make no mistake. Unless we move fast now on the basis of what experience since 1966 should have taught us, we shall be compelled to witness a quality and cost rip-off of national health insurance which will make the previously publicized abuses under medicaid and medicare by comparison appear like chocolate cake.

To be sure, the professional standard review organization (PSRO) is being touted as the mechanism to impose workable quality and cost controls upon publicly funded health care services. I am currently at work with the advocates of the PSRO in New York City, to make Manhattan's prototypical Manhattan PSRO succeed. But I would argue that the PSRO prognosis is guarded at best, and for the following reasons:

One: The PSRO is functionally the ongoing responsibility of the local medical society. The constituency of the local medical society is the membership of the local practicing physicians.

Two: The operative in-house review of the quality of hospital care continues to remain under the control of the hospital staff.

Evidently many of us have yet to derive the appropriate conclusions from the farcical performance of the medicare hospital utilization review (UR) committees since 1966. I shan't rehash in detail what my colleagues in the New York City Department of Health and I have been writing and preaching since our earliest official association in 1967 with New York City medicaid. Rather, I shall share with you certain principles, or truisms, or managerial cliches that we have extracted from 9 years of nonromanticized experiences.

Now to these principles:

One: Most health care professionals, if given a choice, prefer to do good professional work, rather than bad professional work.

Two: Most health care professionals are not saints.

Three: Therefore, some health care professionals—no fewer than 5 to 10 percent—normally succumb to the temptation of the easy moneys available in badly controlled publicly funded health care program. To earn these easy moneys, these health care professionals will do bad professional work.

Four: Bad professional work means one, two, or a mix of three non-exclusive forms of abuse:

a. fraud, that is billing and collecting for phantom services (least important statistically);

b. overutilization, that is, providing reimbursable services justified neither for preventive nor for therapeutic reasons (probably most important statistically).

Five: Professional societies conventionally insist that the percentage of aberrant professionals and the magnitude of abuse are terribly exaggerated by governmental agencies and by the mass media.

Six: Professional societies conventionally insist that their own traditional mechanisms of professional peer review are adequate to control most aberrant professionals.

Seven: It is irrelevant whether such claims by professional societies are advanced in good faith or not.

Eight: What is irrefutable is that the only objective peer review is arm's-length peer review. Peer review by a professional society of its own dues-paying membership constituency is not arm's-length peer review.

Nine: Peer review by a professional society need not be a conscious whitewash to be ineffective. Professional societies almost never pursue a policy of active case finding of malefactors. At best professional societies scrutinize only those cases brought to their attention by complaints. This absence of case finding means ineffective peer review.

Ten: Professional societies lack the means to impose effective disciplinary sanction upon many aberrantly behaving professionals. Many abusers do not belong to the professional society. Threat of expulsion from membership in the society is meaningless to nonmembers.

Eleven: Peer review by professional societies and peer review by hospital staff of work performed by colleagues can be classified as "internal audit." No system can long maintain its integrity and effectiveness on the basis of internal audit alone.

Twelve: To maintain the integrity and effectiveness of such internal audit, it is obligatory to support a program of periodic external audit. This is analogous to governmental bank examiners' checking periodically on the bank's own internal auditors.

Thirteen: The professional Standards Review Organization (PSRO) is but the medical society by another set of initials. The potential deficiencies of the PSRO reflect the deficiencies of all the internal audit mechanisms tried so far in hospital chart review, tissue committees, clinicopathological conferences and medicare utilization review (UR) committees. The fact that at present it has proven politically necessary to promulgate the PSRO is prima facie evidence of the operative inadequacies of each and all these inhospital techniques of quality control.

Fourteen: Although this time organized medicine may get the message and will make the PSRO work successfully, the most ardent enthusiasts for PSRO acknowledge that the prognosis for real success of the PSRO is guarded at best.

Where do we go from here?

There is no alternative but to call upon the public agency to keep the PSRO honest. The public agency to whom to assign this responsibility is the health department. With due respect to my colleagues in welfare, I must insist that to assign responsibility of health care quality control to welfare departments is to trivialize the program. For decades the constitutional deficiencies of welfare departments have assured little better than mediocre health care services under welfare department auspices. To put a health program into a welfare department is to condemn it to guilt by administrative association.

No one advocates assigning the task of health care quality control to the police department, fire department, or sanitation department. We are left logically with the health department.

Only a public agency such as the health department has built-in, legally enforceable, public accountability. Moreover, many local health departments in the country have had regulatory experience in enforcing standards in maternal and child health services. The New York City Department of Health has pioneered in promulgating, monitoring

and enforcing standards of health care services, not only in the maternal and child health category, but also in medicaid, in ambulatory care, in the outpatient clinics of 20 ghetto-medicine-funded voluntary hospitals, in prison care, in private methadone maintenance clinics, in long-term care in proprietary nursing homes and in prepaid capitation care in HIP. Nevertheless, even smaller health departments with no experience or limited experience in these areas are capable of learning and continuing to learn.

METHOD OF ENFORCEMENT

Nine years of experience in the New York City trenches of quality control have proven that judicious withholding of funds promotes more religion on the part of practitioners, hospitals, and nursing homes than conferences, workshops, and pietistic, editorials in all our professional house organs. The courts are ineffective. The judge who deals with foul-mouthed drunks, wife beaters, and child molesters during the morning's work is unlikely to become particularly exercised over an allegation of overutilization of laboratory tests which is presented before him the afternoon of the same day.

Better than the courts is the disallowance of payments by the regulatory agency to control abuses. Such disallowance of payments provides a calibrated administrative response that is practical, prompt, unambiguous, and effective.

Recently a well-known voluntary hospital in New York City had insisted that it could not find a full-time director of ambulatory care, despite the fact that the city health department's contract with that hospital called for such a full-time director. The department's repeated requests had been to no avail. Finally a threat to impose a financial sanction equivalent to the salary of a director brought about prompt compliance.

An ambulatory care director was found. Someone once commented to the effect that the threat of hanging clears the mind most wonderfully. We don't advocate hanging professionals and institutions who abuse public programs. We advocate taking their money away.

HMO AS A SUBSTITUTE

Suppose the millenium as conceived by certain health care idealogs really were to occur tomorrow? That is to say, suppose all fee-for-service were to be supplanted during the next 24 hours by prepaid capitation groups geographically accessible to all Americans? Would such a development obviate the need for quality control under ultimate public agency auspices?

Not at all. To be sure, we would no longer have to deal with the overutilization that derives its impetus from fee-for-service. Instead we would now face the underutilization that derives its own impetus from the tranquilizing salaried reimbursement of clinicians. Poor quality would still remain a problem.

Of course, the health care millenium will not occur tomorrow. The fact is that the population percentage of coverage by the Kaiser-HIP model of payment and delivery has not kept pace with the growth of the American population. A recent front-page story in the Wall Street

Journal described the demise of the well-known Brooklyn HMO group. The bulk of ambulatory care will continue to be delivered to the middle class through traditional solo and partnership practice on the basis of fee-for-service, hence my earlier comments about the medicaid abuses still apply.

One can anticipate that National Health Insurance in a fundamental administrative sense will be medicare and medicaid experience "writ large."

TECHNOLOGY VERSUS IMPLEMENTATION, A CURRENT OUTRAGEOUS EXAMPLE

I do not pretend that the state-of-the-art of health care quality control has a refinement that bring jobs to those of us who must work with it. I would insist, however, that the state-of-the-art of health care quality control is good enough already, if applied, to bring about substantial improvements in the type of health services that the public receives. The problem today is politics, not statistical correlation; courage not chi squares. That is to say, the problem today is implementation, not technology.

Let me share a current grievance with you.

In New York City we have become increasingly infuriated by the system of surreptitious kickbacks from clinical laboratories to referring physicians. Incidentally, there is no reason to believe that this system of paying physicians what is in effect a commission for steering a patient to a specific laboratory is unique to medicaid. It is the old abuse of fee-splitting now in modern guise.

Obviously such a financial incentive promotes overutilization of all laboratory tests. As anyone in the enforcement game can tell you, it is almost impossible to control this abuse—even for the New York City Department of Health that is acknowledged to be the toughest medicaid regulatory agency in the country. The bribers and the bribed rarely will testify against one another.

Twelve months ago I decided to try to outwit the medicaid laboratory fee-for-service system. Here was the plan: All medicaid laboratory work in New York City would be put out on bid. The low bidder for each of the five counties—or boroughs—in New York City would henceforth be responsible for all medicaid laboratory work in that county. This would include pickup at spots geographically convenient for the population as well as the technical performance of the tests themselves.

What were the advantages of the plan?

One: A single laboratory per county rather than many laboratories in the county would be easier to keep under quality and cost control surveillance.

Two: By selecting five low bid laboratories rather than a single one for the entire city, we would avoid rendering the city captive to one firm that might take advantage of us in the future.

Three: By incorporating within the contract a roof or maximum reimbursement for all tests we removed incentives for overutilization.

Four: Because one laboratory per county would have the exclusive rights to medicaid business, there would cease to be any further incentives for kickbacks to referring physicians:

Bear in mind that New York City medicaid has been spending $11 million annually for clinical laboratory work. As I had predicted to the New York City Office of the Mayor, the bids came in for $5.6 million, or about 50 percent less than we had been paying. Certainly all this 50 percent did not reflect savings realized through economies of scale alone. Surely some portion of this 50 percent represented the inflated costs of kickbacks and attendant overutilization.

Now, members of the Subcommittee on Health, you might expect that the initiative shown here to save the taxpayer substantial sums of expenditure would be rewarded with commendation on the Federal level—or if not with commendation, at least with harmless indifference. After all, $5.4 million saved each year means about $1.25 million returned to the city, $1.25 million returned to the State, and $2.5 million returned to the Federal Government.

Well, disabuse yourself of the notion that we received official written commendation from the Federal level. Instead HEW has zealously testified as amicus curiae against us in the current litigation. Incredible as it may seem, HEW takes the position that to put medicaid laboratory work out on bid violates the medicaid principle of "freedom of choice."

As a former private practitioner in Massachusetts, a board-certified internist, I never encountered a single patient who exercised preference for one clinical laboratory over another. Patients are incapable of distinguishing between the relative competencies of two laboratories with respect to the technical performance of a serum uric acid, blood urea nitrogen, blood glucose, complete blood count, or urinalysis. To apply the concept of "freedom of choice" to clinical laboratories is to stretch the meaning to absurd lengths, beyond all connotations ever envisioned by the original framers of the medicaid legislation.

This attitude of HEW, if maintained, may cost the taxpayer $5 million and more per year in New York City in clinical laboratory work alone. But this HEW attitude will impede other initiatives as well. For example, we also want to move into nursing home pharmaceuticals. We know that we can effectuate substantial savings by putting the purchase of proprietary nursing home drugs out on bid as well. Is this plan to die because of HEW's interpretation of "freedom of choice"?

In short, if the subcommittee wishes to bring about some overdue economies and simultaneously elevate quality of care, the subcommittee would do well to scrutinize the entire concept of "freedom of choice." Similarly the subcommittee might review the accompanying papers in the appendix, which derive from our 9 years of medicaid experience in New York City.

FINAL COMMENTS

With the passage of National Health Insurance covering the total population, not only the poor, we may assume that the middle class will be much less docile than the lower socioeconomic class in hanging onto legislated benefits. In contrast to the lamentable history of medicaid, it is likely that there will be no giving of services followed thereafter by a taking away of services. The political penalties that ensue from angering the American middle class would be formidable.

Once promulgated then National Health Insurance will not be repealed. Therefore, it is imperative to avoid the medicaid and medicare administrative absurdities that have promoted so much publicly subsidized overutilization, poor quality, and fraud. We are obliged to assign the job of quality and cost control standards to the health department, or we are obliged to invent another publicly accountable agency like it.

But will this happen? It remains to be seen whether we have learned substantive lessons from the accomplishments and follies of the past decade.

Thank you.

[The additional material follows:]

FORESHORTENED FRANK MEMOIRS OF A FORMER MEDICAID ADMINISTRATOR

(By Lowell Eliezer Bellin, M.D., M.P.H., Professor of Public Health, Head of Division of Health Administration, Columbia University School of Public Health)

Elsewhere I have commented on the desirability of preparing case studies on the implementation of quality control programs of health services—with concentration of those sociological, psychological, political, and organizational variables that are relevant and generalizable. (*11*) Case studies on implementation are to be distinguished from the anthological abundance of descriptive reports on technical refinement and day to day administration of such quality control programs.

How to prepare case studies on implementation? Ideally a competent historian participating in none of the administrative decisions but privy to all their evolutionary details would have to record events as they happened in the manner of military company historians who write up skirmishes and battles. But such a convenient confluence of intellectual talent and current events within one agency is unlikely. The best we can realistically hope for are after-the-fact case studies similar to those in the professional literature of business and public administration. In the meanwhile, pending the preparation of such case studies, participant observers in implementation of quality control programs would do well to record their own administrative memoirs are candidly as they dare.

Of course, autobiographical history authored by protagonist tends to suffer from generic defects: (1) partisanship; (2) subtle self-adultation with the author and his cadre as heros; (3) polemical special pleading; and (4) the perceptual blindness of the single observer as to what actually happened. Yet, these defects need not necessarily inhibit the penning of memoirs, for, to be candid, any paper on any subject develops similar defects, as soon as it departs from the objectivity of charts and graphs to the subjectivity of interpretation. And even the charts and graphs themselves may be deemed objectively suspect because of the selectivity inherent in including some details and excluding others. Often the potential author is reticent for fear that the memoirs will reveal as much about himself as about the program he is retrospectively describing.

It is probable that my collaborative associates would differ from me in summarizing and interpreting the events that we shared. Unquestionably opponents would differ even more. The Rashomon phenomenon certainly will be evident in this very personal document of my impressions of almost five years of administrative responsibility for New York City Medicaid.

MEDICAID ADMINISTRATION IN NEW YORK CITY HEALTH DEPARTMENT

Suffice it to say that New York City Medicaid translated the terms of the Title 19 legislation into a pioneering municipal health department program of promulgating, monitoring, and enforcing standards of publicly funded health care. There was unprecedented on-site auditing in the private offices of private health care practitioners. There was review of the quality of Medicaid care provided by specific practitioners. We applied fiscal leverage by withholding reimbursement whenever we found the quality of care provided to be in violation of our standards. Monitoring and enforcement meant educating the health professionals, the State legislature, the Congress, the public. Enforcement meant in

house hearings, imposition of financial penalties, and suspension from the program. And, of course, enforcement meant periodically antagonizing the professional societies and the individual practitioners.

This paper will not rehash all the activities of the New York City Medicaid program. Many of these have already been described in their technical and administrative detail in the public health and medical care literature. (*1–10; 12–21*) Instead, this paper will present representative material that normally is confined between the lines in prudent, invisible ink.

POLITICAL INTERFERENCE AND HOW IT WAS APPLIED

"Did the Mayor or any other higher up ever apply pressure on you or your staff on behalf of anybody?"

To answer the question explicitly: never did the Mayor, his associates, or any superior of mine in the City government ever to my knowledge communicate an order or a hint to me or my staff to "lay off" anybody during my 4½ years of administrative responsibility for New York City Medicaid.

Even when crass political intervention does occur in the United States, it is typically episodic and self-limited. Substantive political interference uses more durable budgetary means to achieve its ends. Pleasure or displeasure with the specific administration of a program is communicated by granting or withholding public funds. In public administration paranoia is an occupational hazard. One must beware of reading signals of hostility when none in fact exist, when the budgetary cuts are designed to impose austerity in its own right, rather than to punish blundering. But each time we failed to receive all or most of the budgetary support we had sought, we could not help but wonder whether forces in opposition to our administration of Medicaid had finally assembled a working coalition to thwart us.

Where were the "hostiles?"

The daily workings of New York City Medicaid policy predictably provoked consternation and counter-measures among professional organizations and individual practitioners. Representative but by no means comprehensive examples follow:

New York City Medicaid carried out a program of on-site auditing of the office practices of physicians, dentists, optometrists, podiatrists, pharmacists, and chiropractors. Initial practitioner hostility to this unprecedented heatlh department behavior was reflected in a formal resolution of censure by the AMA. (*0*)

New York City Medicaid made a certain number of hours of annual continuing education a requisite for participation by practitioners in the program. (50 hours for physician-general practitioners, and 25 hours each for dentists, optometrists, and podiatrists.) The local medical and dental societies registered public opposition. The dental societies brought injunctive action against the program of compulsory continuing education. (*10*)

Of the 3 chiropractic organizations, one challenged us in the courts because of our decisions (1) to limit the chiropractic fee per visit to $3, and (2) to tighten up administrative procedures to constrain chiropractic overutilizaton. (*3, 9, 12, 13*)

Aside from these conflicts with practitioner organizations, each time a staff decision was made to enforce standards of health services on the part of individual practitioners, we made another enemy.

Tension between Albany as state capital and New York City as metropolis has been a political constant for centuries, no matter which personalities or which political parties occupied the State House and City Hall. But superimposed on this historical conflict between state and city was the nationally publicized, peculiarly abrasive relationship between Mayor John V. Lindsay of New York City and Governor Nelson A. Rockefeller of New York State. In Romeo and Juliet, the servants of the warring Montague and Capulet familes fight one another and spill blood, although the servants themselves are not necessarily committed to the ideological viewpoints of their masters. A similar syndrome inevitably manifests itself in government among some public administrators who identify themselves with the boss' proclivities.

Any Medicaid budget required both State and City approval. At best budgetary procedures involving both the State and City are lengthy and cumbersome. An additional complication is the fact that the State and City fiscal years do not coincide.

Did the budgetary cuts we encountered constitute political interference? Was frugality the motivation behind the cuts? or was the covert motivation the desire to clip the wings of a politically embarrassing program? or was there a complicated mix of both? These quesions automatically came to mind once when the State refused to support our request for a budgetary increase despite the fact that we had conclusively demonstrated during the previous year that every dollar spent for New York City Medicaid auditing returned many more dollars to the general fund.

To some extent the true motivation was irrelevant. Ordinarily we would have abided by the customary procedures and courtesies of private negotiation. But these regrettably had failed. We believed we had persuaded the staff of the New York City regional office of the State Health Department, but the main office at Albany was adamant. Some of our own staff speculated that the Albany office of the State Health Department had concluded that we had co-opted their New York City local staff.

Accordingly I decided to go public. In newspaper and radio interviews I ridiculed the State's purported frugality in holding us to the previous year's budget. I likened such spurious economies to a policy of Tiffany & Co., jewelers saving money by getting rid of its expensive door locks. I appealed to certain State legislators not only of the political left but of the political right as well.

After a few months of this campaign, we were notified that the State had reconsidered our budgetary request and we were to be granted precisely what we had originally asked for.

OUTWITTING THE SYSTEM

Yet we needed to expand our monitoring and enforcing capabilities beyond the budgetary limit imposed upon us. It was clear that in the future we would receive negligible monetary increases either from the State or from the City. Quality of care was not the only issue. Cost control was operationally intertwined with quality control. Every time we constrained fraud, poor quality, and particularly overutilization—the troika of abuses in every health care program—we saved money far in excess of the cost of auditing. Nevertheless, during our negotiations we encountered the political reality that budgetary authorities are loathe to approve a larger operational budget, even though that larger operational budget generates a return of moneys that in effect more than offsets the budgetary investment. In the fiscal interchange the additional moneys recovered or saved by auditing do not accrue on paper to the credit of the agency itself but are ultimately pooled elsewhere in the general fund. On the State level we never found anyone with the grasp to appreciate our argument about the potential economies to be realized and the political power to give us the auditing in house capability we always sought. On the City level we were more fortunate, although not consistently throughout the length of the program.

Almost at the onset of Medicaid in 1967 time was already running out. If constraints on provider abuses were not to be applied promptly and vigorously, the New York State Legislature would in its wrath eschew its initial generous definition of medical indigency and benefits for Medicaid enrollees, and cut back on both.

Because we could not get the moneys, we looked for another way to expand our monitoring and enforcement capabilities. There was on incongruity that might be utilized. Medicaid was so structured budgetarily that expenditures for service benefits could expand almost indefinitely—at least until the State Legislature might choose to redefine eligible Medicaid beneficiaries and Medicaid reimbursable benefits. At the same time there was no similar financial *carte blanche* for local health departments to support in house monitoring and enforcing activities of these ever expanding health care services.

Suppose we could reclassify such auditing activities as Medicaid reimbursable services? If so, we could then contract with specific professional schools to audit quality by re-examining patients who had already received health care services elsewhere. We would reimburse the schools on the basis of a Medicaid visit. We made a preliminary check with the State to determine if there would be legal objection. There was none. We promptly contracted with the Optometric Center of New York and the H. J. Levi College of Podiatry in New York City, each to examine patients respectively in optometry and podiatry.

We chose the patients whose previous Medicaid services we wanted audited. The schools in question examined the patients and sent us the reports. Medicaid

paid for this under the budgetary category of services rather than that of office personnel. Throughout my official association with Medicaid, I had the persistent fear that either the State or the City would renege on the deal and would one day decide to condemn these "patient visits" as a palpable fiction, on the grounds that Medicaid should not pay the schools, since such extra visits, strictly speaking, represented overutilization.

There were other benefits of this maneuver as well. When evidence of poor quality and overutilization in optometry and podiatry ultimately emerged from these auditing activities, the practicing optometrists and podiatrists on an individual basis and through their professional organizations dared not protest the validity of these findings. After all, the alma maters of the majority of New York City's practicing optometrists and podiatrists had collected these data on the professional performance of their own alumni. This muteness of the optometrists and podiatrists contrasted with the strident criticism by the dental societies about a year earlier after we had released similar damaging data on the professional performance of New York City Medicaid dentists. In the dental study the Health Department rather than a dental school had originally collated the data. In turn the dentists and their societies had evinced less hesitation about attacking the competence and good faith of a public agency with presumably an ideological axe to grind.

CONFLICT OF INTEREST OUTSIDE THE AGENCY

One group of providers who we alleged had rendered poor quality care and had committed fraud and overutilization hired a prominent member of the New York State Legislature as counsel. This is legal in New York State. It was to the credit of the State legislator in question that he seemed somewhat embarrassed about his role. He assured us, and with evident sincerity, that he supported our quality control activities and wanted to arrive at a disposition that would satisfy the New York City Department of Health.

Nevertheless we wondered how a State legislator who votes on appropriations for Medicaid, on definitions of Medicaid enrollee eligibility, and on expansion or shrinkage of Medicaid benefits can with propriety represent a Medicaid provider. There is nothing new about this problem. Private law firms in which State legislators and Federal congressmen are members of partners have been representing clients whose interests more than occasionally conflict with the official roles of the incumbents in public office.

In this case even the most sensitive among our staff detected no attempt to bring pressure directly or indirectly upon us. But the absence of an overt attempt to influence the enforcement procedures of a regulatory agency does not exclude the workings of operative influence. No one ever forgets that the legislator-attorney represents the power to fund, and, therefore, to destroy the regulatory agency in question.

CONFLICT OF INTEREST WITHIN THE AGENCY

A routine review of professional activities of the Medicaid auditing staff of part time practitioners disclosed that one staff member was currently engaged in a type of private practice that could be interpreted as a conflict of interest in relation to his official duties. Although his professional activities were legal, strictly speaking, I felt uncomfortable (1) because the behavior was wrong, and (2) because any perceived conflict of interest could jeopardize our credibility as an objective regulatory agency.

Discussion with the practitioner revealed that he had been engaged in this activity for about a year. He had done so, he insisted only upon receiving the formal permission of his then organizational superior, X.Y., (not the real initials) who either had acknowledged or had implied that such a policy concession was necessary to attract and retainable practitioners for the Medicaid auditing staff. Working for Medicaid manifestly meant a substantial financial loss to any practitioner who sacrificed the opportunity cost of moneys that otherwise would have been earned in affluent practice.

Now I had the utmost respect for the ability, integrity and judgment of X.Y., who allegedly had granted the initial permission. But the dimensions of Medicaid had changed enormously since then. Policy had to be modified to keep pace. I explained all this to the practitioner and offered him two choices: (1) either he remain on the Medicaid staff but discontinue the professional activities, or (2) continue the professional activities but resign from the Medicaid staff.

57-677—75——8

The practitioner urged that I discuss this decision with X.Y. Perhaps I would reconsider my decision. I answered that X.Y. no longer had direct line responsibilities for Medicaid. No one else but me now bore these responsibilities. I said that my decision stood.

The practitioner then asked if I minded his discussing the matter with X.Y. I responded that I wanted there to be no misunderstanding about how strongly I felt about this issue. I would interpret any attempt on the practitioner's part to bring pressure by X.Y. upon me as an act of insubordination.

The practitioner replied that he understood my position. He agreed not to communicate with X.Y. Furthermore, he would take steps to discontinue the practitioner activity that I found objectionable.

About one week later I received a telephone call from X.Y. inviting me to his office. My initial assumption that this call was coincidental was shortly disabused by the subsequent subject for discussion. X.Y. apologized forgetting involved in this matter, but he felt obliged to respond to the current pleas of the practitioner at least to discuss the matter with me. I then reviewed with X.Y. my analysis of the current situation, pointing out how matters had changed since X.Y. my analysis of the current situation, pointing out how matters had changed since X.Y. had granted the original permission. X.Y. could be agreed completely with my decision and recounted an analogous incident where he had only just made a similar policy decision within his own current balliwick of responsibility.

I returned to my Medicaid office. I called in the practitioner. I ordered and received his resignation.

MAINTAINING INTERNAL PURITY

A chronic anxiety that troubled me was that at any time one or more among the 300 or so of the Medicaid staff, constituting practitioner and paraprofessional auditors and their associates, would surreptitiously enter into collusive relationships with Medicaid providers whom they were auditing. Temptation is a feature in a program of such fiscal magnitude. A sense of tension customarily accompanied the daily act of opening the newspaper and skimming the headlines. It was therefore prudent to take all practical precautions to render less likely the corruptive infiltration of staff and the imminence of scandal.

Let the dental auditing program serve as a representative example, not only of our internal protective devices but of our uneasy state of mind that produced these. Morton Fisher, D.D.S., M.P.H. the first Dental Director of Medicaid, and currently Director, Bureau of Dentistry, New York City Department of Health, devised these administrative fail-safe techniques.

Each of the 40 or so auditing dentists of the Medicaid staff was assigned to review the quality of professional work performed by practicing dentists whose family names began with specific letters of the alphabet. For example, Dr. Jones on our staff was assigned dentists whose family names began with A and B; Dr. Smith, assigned dentists whose family names began with C and D; and so on. Should there be any future suspicion of collusion with respect to a specific dentist, we could easily identify any collaborating suspect on the staff. But, more important, the potential for collusion was statistically diminished 5–6 fold because the imposed quarantine to specific letters in the alphabet constrained the probability of collusion deriving from personal friendship. Normally people's friends are randomly distributed throughout the alphabet rather than being concentrated among a few letters.

Dr. Fisher imposed an additional safeguard. As a second level of audit he assigned to a separate dentist altogether, now reporting directly to the Dental Director of Medicaid, the responsibility of continually auditing samples of the Medicaid dental audits performed by the rest of the staff.

But what about the remote possibility of collusion even on this second level, i.e. between the auditor and one or more of the staff dentists on the primary level of auditing? As a third level of audit, Dr. Fisher requested that the New York State regional dental officer periodically review the quality of the work of the second level dental auditor.

All these internal devices should not suggest that we suffered from a brooding lack of trust in the integrity of our staff. Indeed, we had reason to believe that our staff was less corruptible than most. We had chosen them with care. We subjected them to continuous supervision. We tolerated no departure from scrupulously ethnical behavior. But, at the same time, we had to proceed on the assumption that there were a host of enemies who would gleefully discredit our staff if given the opportunity. A program, so controversial as Medicaid, partic-

ularly with the unprecedented monitoring and enforcement functions that we were administering, was fair game. The program was compelled to be pure and give the appearance of purity. All these devices against internal corruption and external mockery were designed not only to preserve the intergity of the program but also to protect the reputation of our beleaguered staff of conscientious auditors.

CURIOUS RELATIONSHIPS WITH SUPERIORS OUTSIDE THE AGENCY

The following is the rank of desirability with respect to working relationships between superiordinates outside and above the program and the subordinate program director himself. The increments are arbitrary.

1. Most desirable

Superordinate has a comprehensive understanding of the program. Superordinate has participated with program director in determining objectives and means to achieve these. Superordinate has absolute confidence in the quality of management of the program. Superordinate manifests keen interest in the progress of the program by requesting and analyzing periodic status reports. Superordinate takes the initiative to protect and enhance the program. Superordinate does not permit other valid official responsibilties to divert his attention from the program.

2. Less desirable

Superordinate takes no initiative to protect and enhance the program but responds positively to the initiative taken by the program director to enlist superiordinate's support. Other comments in 1. apply.

3. Even less desirable than 2, but still acceptable and workable

Superordinate neither takes initiative to protect and enhance the program nor responds positively to the initiative taken by the program director to enlist superordinate's support. Superordinate does not interfere, but does not help either. Superordinate possesses other qualities mentioned in 1. but to a lesser degree. The general ambience is one of indifference.

4. Less desirable

Superordinate manifests little understanding or interest in the program and has little confidence in the quality of the management. Superordinate may take active measures to shrink the program or try to run portions of it himself.

The tolerance level of the program director determines at which rank order of relationship he is prepared to resign.

What was the rank level of relationship of New York City Medicaid with the office of the Mayor during my tenure in the New York City Department of Health between 1967 and 1972? If the evolutionary relationship between the office of New York City Medicaid within the municipal health department and the office of the Mayor were to be portrayed graphically over time—from 1967 to 1972, it would begin in 1966 between Level 1 and 2, show a perceptible rise during 1968 and 1969 toward Level 1 and plummet abruptly in 1970 toward Level 3. Why this inconstancy?

The onset of Medicaid in New York State and New York City in 1966 was characterized by generosity and optimism. Indeed, as the financial implications and potential of Medicaid became clearer, the relationship with the office of the Mayor improved. For New York City at least, Medicaid represented, if not precisely a bonanza, at least welcome and belated financial assistance from the state and federal government to provide health services to the City's medically indigent citizens. The 1970 decline in relationship seemed less attributable to the municipal administration's disenchantment with the rising Medicaid expenditures (75% of which was reimbursed by State and Federal government for direct services) than to turnover in key personnel in the Mayor's office. We date the decline to a cluster of events shortly after Mayor Lindsay began his second term of office in 1970. New political intimates now gathered about the Mayor. Mr. Werner H. Kramarsky, Special Assistant to the Mayor and our primary liaison to him, resigned.

It is speculative whether the Mayor's 1970 Presidential ambitions contributed to his inattention to local Medicaid matters. The fact was that after Mr. Kramarsky's departure we found no replacement of equivalent intellectual and political stature who enjoyed the confidence of the Mayor and understood Medicaid. There

now seemed to be no adequate substitute within the Mayor's office to worry particularly about what we were doing with a program that was spending over ¾ of a billion dollars annually for about 2.5 million Medicaid enrollees. In our view the program deserved more scrutiny and concern than the conventional budgetary reviews we were receiving.

Albert Moncure, Deputy Commissioner of Social Service, was my Medicaid alter ego in his own department with responsibilty for overseeing Medicaid eligibility and payment. Once I asked him whether anyone outside his department was currently talking with him or with his commissioner in any sophisticated depth about the program.

He seemed puzzled. "Not at all. I've assumed they've been talking with you or with your commissioner."

"They" were talking with neither of us. On one level, we supposed, this non-communication bespoke trust. On another level, this inattention bespoke neglect presumably due to diversionary activities of greater salience for the public good. The ambience was one of indifference.

The hands off attitude gave Commissioner Moncure and me a free hand, but at the same time precluded the City from seizing major opportunities to restructure publicly funded health services for the City's medically indigent.

One day we thought such an opportunity had arrived. An emissary from the Bureau of the Budget asked me to put together an analysis of alternative ways to spend annual Medicaid moneys to achieve reasonable health care goals. The analysis was needed in a few days. This emissary, I was reliably informed, had the ear of the Budget Director.

I cancelled activities. I put staff immediately to work. I updated my white paper on the subject. I made the deadline.

Then nothing happened. Nothing. There was no acknowledgement. A few months later I followed up and learned that the major attentions of the Bureau of the Budget had been directed to other matters.

In public administration this anecdote is not unique.

THE HEALTH SUPERAGENCY OF NEW YORK CITY

The concept of a health superagency in New York City drew its impetus (1) from the Mayor's decision to coordinate all municipal public health agencies more intensively within a single administrative structure; and (2) from the reluctance of the Mayor to deal separately with individual commissioners of health, hospitals, mental health, and the Office of the Medical Examiner. All relevant commissioners henceforth would report to a single superagency administrator, who in turn would report to the Mayor.

The Health Services Administration (HSA) as the superagency was called, was to concentrate its energies on data collection and analysis that would lead to more intelligent decision-making in health services. The individual agencies within HSA were to continue their traditional responsibilities and line operations as before. For the first few years this division of labor was more or less maintained. But by 1970 with new appointments to HSA marking the Mayor's second term of office, it was evident that the original policy was no longer in force. Instead, the new HSA leadership was moving more and more aggressively into direct line administration of programs of lead poisoning, methadone maintenance, inspection of food establishments, prison health services, etc. These functional incursions did not necessarily imprint themselves in the formal table of organization. Nevertheless program directors soon found themselves compelled to report to two bosses, one within the Health Department and one within HSA. With the passage of time it was clear that much of the reporting within the Health Department had become ceremonial.

This is not the place to discuss the pros and cons of this administrative development, although the literature of public health administration would be enriched by analysis on the part of proponents, opponents, and objective observers of the superagency movement. Whatever such analysis might reveal about the consequences to effectiveness and efficiency of public health administration in New York City, there was certainly no ambiguity *in camera* about HSA's impact upon the attitude of prominent Health Department staff and Board of Health membership. A non-coincidental exodus of professionals of stature from both agencies occurred.

In the meanwhile within the Health Department office of Medicaid we became increasingly dismayed about this train of events. To be sure we had

been unhappy with our functional isolation from the office of the Mayor. We initially had welcomed the idea of HSA participation as a means to reopen our old conduit to the Mayor's office and to optimize our relationships with the Department of Hospitals (now the Health and Hospitals Corporation). HSA as coordinator and advocate were roles that appealed to us. But HSA as functional assimilator of Medicaid itself was unacceptable. We were jealous of our organizational identity. It is proper to list the reasons:

REASONS FOR ORGANIZATIONAL IDENTITY

(1) We were undefensively possessive of our traditional Medicaid responsibilities and prerogatives that we had wrested from so much opposition. In our view other Medicaid programs in the country had yet to attack the problems of quality and cost control with imagination and vigor.

(2) We had assembled and trained a cadre to promulgate, monitor, and enforce standards of Medicaid health care services. We were certain that many of these would join the dismal exodus of Health Department professional if HSA were to infiltrate Medicaid functional turf as successfully as it had encroached on other areas of the Health Department.

(3) Since 1970 HSA had demonstrated a propensity for behavior and style that we found offensive and amateurish: expansion of expensive public relations activities in the guise of health education, adoption of programs of high political visibility but of statistically meager pubic health impact; continued replacement of departing health professionals with inexperienced "managers." According to the argument or the cant, quantification *cum* hard nosed administration would now supplant the dysfunctional sentimentalism of rigid traditionalists.

In our view technique was supplanting rather than complementing qualification and experience. The once great New York City Department of Health of Stebbins, Mustard, Baumgartner, and James was deteriorating into mediocracy.

It was now no longer just a question of preserving Medicaid intact within the Department. We deemed it imperative to preserve every possible enclave as a refuge where competent health administrators might survive in order one day in a more propitious future to emerge and rebuild the Health Department. We concluded that it would be calamitous to Medicaid and to the Health Department if HSA were to take over Medicaid.

It is unimportant whether our analysis was objectively correct. A siege mentality existed and was a factor in our strategy. Perceptions govern the behavior of actors.

Certain factors favored the continuing functional integrity, if no longer the total isolation, of Medicaid from HSA.

(1) The program itself was incredibly complex, encompassing a potpourri of eligibility rules, modifications, modifications of modifications, service benefits, technical issues, interpretations, and in-house history yet to be recorded. Why need HSA go after Medicaid with more vulnerable game in the offing within the Health Department? For the present, HSA obviously viewed restaurant inspection, rat control, etc. as conceptually easier to understand and to administer.

(2) Medicaid required a physician as Executive Medical Director. This was the law. HSA had no available physician on its immediate payroll. HSA had no experienced health administrators. The health professionals in the number 1 and 2 positions in Medicaid originally hired by me reported to me directly. It was not easy for an outside agency to invade a loyal network of peer professionals.

(3) Medicaid was located on 34th Street about 3 miles away from the main building of the Health Department. The geographic separation discouraged casual dropping in from HSA program analysts on scouting expeditions.

(4) New York City Medicaid's activities against provider abuse had enjoyed an excellent press in contradistinction to the journalistic criticism that had been the lot of much of the municipal administration. Medicaid had a reputation of recovering or saving mllions of dollars annually. It would be hard for HSA to classify it as stodgy as some other Health Department programs it had so categorized.

TACTICS

In order to protect the program, we did the following:

(1) We took precautions to assure that there would be no let up in the pace of the program, lest we unwittingly provide some justification to HSA to take over the program.

(2) To the extent possible we exploited every factor favoring the program's functional integrity.

Complexity.—We always behaved with formal correctness. Whenever HSA asked for status reports or programmatic analyses of any kind, we were detailed and meticulously so. Rather than pursuing a policy of withholding information (Knowledge is power. Lack of knowledge means less power), we took precisely the opposite tack, and provided comprehensive information. We would give HSA no grounds to accuse us of insubordination, uncooperative attitude, or insufficient grasp of our own programmatic responsibilities. Our immediately goal was to overwhelm HSA with the obvious complexity of the program in order to give the superagency pause about pursuing incursive tactics.

(3) *Physician.*—Here we could rely open HSA's evident distaste for public health physicians. Although the Health Department, Health and Hospitals Corporation and other municipal health agencies used non-MD as well as MD health administrators in important posts, HSA tended to downgrade the participation of public health physicians. HSA's policies reflected a view that possession itself of the medical degree probably meant a trained incapacity to administer, even if the physician (a) held the Master of Public Health degree, (b) had majored in health administration, and (c) had years of successful experience in increasingly responsible administrative posts. Indeed, experience was suspect and tended to be equated with rigidity, i.e. resistance to the new administrative style. M.D.'s would be tapped consultatively by HSA on strictly technical problems in health, but otherwise the influence of Health Department physicians in substantive formulation of health policies diminished perceptibly from month to month. Whatever the formal table of organization seemed to show, there was an irrational shift of MD's from line to staff functions, and programs analysis people from staff to line functions. But the law resolutely required a physician at the head of Medicaid. At the head of Medicaid was David Lieberman, M.D., M.P.H. as Executive Medical Director, formerly director of State Medicaid Program in Pennsylvania; his immediate subordinate, the Director of Operations was Morton Fisher, D.D.S., M.P.H., who had already acquired a national reputation for setting up the New York City Medicaid dental quality control program. The Executive Medical Director reported to Florence Kavaler, M.D., M.P.H., M.S. (in biostatistics), who was Assistant Commissioner for Institutional Review and Evaluation in the Health Department and whose biostatistics degree protected her presumably from the conventional accusation of inadequate analytical ability. She reported directly to me in my position as First Deputy Commissioner.

There was thus a solid phalanx of experienced health professionals each of whom, promoted by me, was personally loyal to me.

(4) *Geography.*—Here we could stand pat. There was inadequate space at the main Health Department building on Worth Street to accommodate a transfer of a Medicaid staff of over 300 from our West 34th Street operations. Moreover, our West 34th Street office was conveniently adjacent to the Medicaid office of the New York City Department of Social Services who would unquestionably have opposed any contemplated move.

(5) *Press relations.*—The Health Department had received orders that all stories henceforth were to be funneled through the public relations office of HSA, the superagency. We were told quite explicitly that the public relations staff within HSA saw as their major responsibility the enhancement of the HSA public image. At the same time there was conspicous atrophy of effort to present the Health Department's story. The public relations staff of HSA was ordinarily too busy to attend Health Department meetings that produced newsworthy policies and programs.

For example, restaurant inspections, a traditional Health Department responsibility, were now being publicized as an HSA program. In the weekly announcement to the press, HSA, rather than the Health Department, would now list those eating establishments that had persisted in their violations of the sanitary code. It had hitherto been customary for any program status reports to emanate from the office of the pertinent Assistant Commissioner of Health or Program Director Mary C. McLaughlin, M.D., M.P.H., the Health Commissioner, regarded this as sound administrative policy to acquaint the public with the people in charge of the Health Department operations impinging directly upon them. She believed, moreover, that it was good for the morale of the programs and their directors to receive such individual recognition. HSA now supplanted the

Health Department in announcing these announcements of violations in eating establishments. This was but one of a number of similar preemptions that continued to occur. We assumed, therefore, that if Medicaid were to obey the HSA directive about public releases, we could expect that eventually HSA would start releasing under the HSA imprimatur weekly lists of names of aberrant Medicaid practitioners and institutions.

Accordingly we did not zealously discourage the initiative of newspaper reporters who continued to insist on talking with us directly despite the HSA directive. Stories about Medicaid continued to emerge without previous processing by the HSA office of public relations. There was a detailed article of our identification of a major abuse in Medicaid optometry by one of the most important commercial vendors in New York City. There were stories and favorable editorial comment about how we had terminated the "epidemic" of flat feet in New York City by cracking down on the promiscuous prescribing of so called orthopedic shoes by podiatists who would write bogus diagnoses to justify Medicaid reimbursement to shoe stores. There were articles on our discovery of millions of dollars worth of fraud perpetrated by commercial ambulance companies who sought Medicaid payments.

THE CADRE

Every program needs a critical mass of energetic talent. The cadre needs an extraordinary degree of commitment, almost fanaticism about the social non-expendable nature of the program. On a day to day basis the implementers of a controversial program such as Medicaid are very much alone. They need each other's support and trust in a program that they often come to view as the moral equivalent of war.

Other considerations become secondary. This is not to say that the cadre performs its tasks with no hope of reward. Salary increases and promotions are necessary. But mutual professional esteem, particularly recognition rendered by one's real professional superiors, are equally indispensable.

The evidence of the normative high morale of the cadre are many: the excitment, the pervasive fun, the camaraderie, the long hours of work, the profusion of professional papers, the identification of staff with programs, the swagger, even the resentment sometimes manifested by people of competitive agency programs not so endowed.

These were the characteristics of the Health Department Medicaid staff.

But, for there to be reasonable prognosis for survival of even the most dedicated cadre, there needs to be the benign nurture of the health commissioner.

During my 1967–1972 service with the New York City Health Department. Medicaid was blessed with the tenure of 2 supportive health commissioners—initially Edward O'Rourke, M.D., M.P.H., and thereafter Mary C. McLaughlin, M.D., M.P.H., both of whom played the indispensable roles of patron and protector.

FAILURE AND REGRETS

These brief memoirs properly should include representative failure and regrets. Had we been prescient, or more experienced, we would have done certain things differently. Regretably we could not tap the experience of other programs whether in New York City or elsewhere because ours was the first program of its type and magnitude. This is not to claim that the New York City Department of Health in its role as regulatory agency was doing something totally *de novo*. Health departments or their historical antecedents have been in the business of regulating since their Biblical forebears identified and quarantined lepers. The regulatory activities of New York City Medicaid represented a quantum leap beyond the important regulatory beach-heads originally established by the Children's Bureau in the Crippled Children's Program. The programmatic originality of New York City Medicaid derived from the fact that we took quite seriously the quality control implications of the Title 19 legislation.

What were our failures? and consequently our regrets? A partial annotative inventory hints at a rich lode of detailed future case studies.

(1) *Failure to manipulate Medicaid fees to achieve optimal health goals.*—Had the New York City Department of Health possessed complete control over the Medicaid fee schedule of reimbursement to professioinal and institutional providers of services, we could have tapped the forces of the market place to

encourage the provision of certain desirable services and discourage the provision of others.

In physician care, for example, we could have encouraged more cervical Pap smears. The State rejected our request for a specific supplementary fee for Pap smears over and above what was incorporated within the fee per visit. We felt that such a fee would act as an effective fiscal incentive because too few physicians were performing such smears as part of the physical examination. In contradistinction the State feared that paying a separate fee for cervical Pap smears would act as a precedent for further separate fees for the now fragmentized portion of the physical examination.

On the other hand, we did have the authority to apply a separate fee for tonometry performed by optometrists. As a result of the fee that we authorized, there was a renaissance of tonometric examinations in New York City. This success in optometry made particularly bitter our legal incapability to use the same technique elsewhere. We wanted to manipulate fees particularly in dentistry, since the denial fee schedule seemed almost designed to promote the provision of extractions and dentures rather than preventive dentistry.

(2) *Failure to restructure the practice of optometry.*—We saw Medicaid as our opportunity to eliminate a historical conflict of interest that has plagued optometry since its inception. Optometrists simultaneously have prescribed lenses and have sold glasses. This state of affairs is similar to the situation that would exist were physicians to write prescripitons and simultaneously sell pharmaceuticals as well. We tried to promulgate a regulation in New York City Medicaid that every optometrist who wished to be reimbursed for any Medicaid services would first have to decide if he were to be exclusively (1) a Medicaid refracting optometrist or (2) a Medicaid dispensing optometrist. The predictable protests occurred. The State Health Department subsequently declined to support our petition on the grounds that we had no legal right to limit the scope of professional practice permitted by State optometric licensure.

(3) *Failure to make compulsory continuing education a requisite for participation of practitioners in Medicaid.*—(*10*). This is described elsewhere in detail. Here the New York Health Department and the New York State Department of Education failed to support the pertinent administrative regulation of New York City Medicaid. Actually here the failure was not total. The dental, optometric, and podiatric societies ultimately went on record favoring such compulsory continuing professional education as a requisite for continuing licensure.

(4) *Failure to restructure publicly funded health services.*—Here Medicaid represented a chance missed—not only in New York City, but throughout the country. Surely there had to be a more intelligent way to pay for and deliver publicly funded health services to the 2.5 million New York City Medicaid enrollees in a program costing $750,000,000 annually! Although the mix of administrative constraints compelled certain absurdities, we discerned enough theoretical flexibility within the program to permit overdue changes provided there was exercise of opportunistic ingenuity. In part, what prevented the inception of these changes was the total immersion of key Medicaid people on the local, state, and federal level in the overwhelming start up problems of an enormous program that had begun abruptly rather than incrementally. The division of responsibility between departments of social services and health at each of three governmental levels almost guaranteed no intelligent overall social planning. Within health and welfare departments in the nation—with notable and honorable exceptions—there was a paucity of ingenuity and courage with respect to the administration of Medicaid. Although Medicaid fiscal leverage to enforce standards was available everywhere, there seemed to be almost a difference in state after state, and in city after city—again with notable and honorable exceptions—about applying it.

Well meaning Medicaid administrators from outside New York City would visit us and depart now armed with reprints, memoranda, policy papers, procedures from our files. They customarily vowed to replicate at least portions of the New York City program when they returned to their own communities. We rarely heard from them or about their replications again. Once after a presentation of our material at an APHA meeting, one State Medicaid director called me aside and privately recounted an inventory of reasons why it was manifestly impossible for him to institute anything but ceremonial enforcement of Medicaid health care standards because of certain local political peculiarities. He was right.

GENERAL COMMENT

Quality control programs of health care services are always controversial. If seriously applied, they must provoke the hostility and often the countermeasures of the professionals and institutions being monitored.

Certain attributes of administration are called for: absolute staff integrity in deed and image, superb technical proficiency, a secure political base, a cadre of associates equipped with political cunning and zealotry, altertness and readiness to repel encroachments upon the program's legitimate turf.

None of these attributes is uniquely desirable for quality control. They are all desirable for effective management of any program. But for any future programs, that, like New York City Medicaid, tries to enforce standards of health care services, these attributes will be found to be utterly indispensable.

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Reprint File: Bellin, Lowell E.; M.D.

[From American Journal of Public Health, November 1971]

Medicaid Practitioner Abuses and Excuses vs. Counterstrategy of the New York City Health Department

(Lowell Eliezer Bellin, M.D., M.P.H., F.A.P.H.A., and Florence Kavaler, M.D., M.P.H., F.A.P.H.A.)

Based in three years experience in the New York City Health Department, abuses in the provision of Medicaid are analyzed and methods for dealing with those involved are described.

INTRODUCTION

Neither to pander to administrative voyeurism nor to muckrake Medicaid practitioner abusers is the objective of this paper, but rather to pass along "savvy" in frustrating the behavioral excesses of certain participants in monumentally funded health care programs. During three years of formulating, monitoring, and enforcing Medicaid health care standards, the New York City Health Department has gained insight into (1) the methodology of abuses by a small percentage of practitioners (at least 5% by our estimate); (2) the normative defenses of these practitioners against the department's allegations of such abuses; and (3) the requisite governmental counterstrategy of gathering germane evidence to anticipate these defenses.

THE DIRTY LITTLE SECRET

The accessible health care literature is sanitarily devoid of such mundane information. Has the subject been deemed too charged or repugnant to be discussed save as gossip or savory anecdote? Consider where we would ordinarily inquire—the third party payers.

But the private health insurance companies have traditionally viewed themselves as indemnifying conduits of payment, not as monitors of health care standards. Historically the commercial carriers have kept hands off the professionals, relying on professional licensure for surety of their technical competence and professional worthiness. In short, the companies would have little to publish about administrative enforcement of standards even in the unlikely event that they chose to publish. And what about the nonprofit carriers who allege they maintain quality and cost controls? Blue Cross, Blue Shield and the prepaid plans understandably prefer discreet privacy regarding their negotiations with abusers.

Somehow administrators of public and privately supported health service programs are expected to leave about abuses and their controls—presumably through the grapevine, or through individual enterprise.

NEW YORK CITY MEDICAID

Between late 1966 and 1968, New York City Medicaid burgeoned to encompass its zenith enrollment of 2.5 million citizens and pay out annually about 750 million dollars. By 1970, the subsequently more stringent qualifications for enrollment in Medicaid diminished the number of recipients to about 1.9 million.

Each year about 600 million dollars pass to 18 municipal, 101 voluntary and 27 proprietary hospitals. About 150 million dollars are distributed to the private offices of participating practitioners: physicians, dentists, optometrists, podiatrists, pharmacists, and chiropractors. The swift growth of the program coupled with the bicephalic administration of two separate city agencies posed nettlesome problems. (*6*) The political interplay in standard setting (7, *18*) and the department's unprecedented governmental venture into on-site auditing of the offices of practitioners submitting huge bills (*8, 13, 14, 15, 18*) provoked consternation on the part of some professionals. But the statistics on abuses that the New York City Health Department subsequently released to the press and to the literature blunted overt opposition.

There are 134 professionals, 60 para-professionals and 113 clerks engaged collaboratively in identifying potential abuse. The allegedly errant practitioner comes before an informal hearing to account for professional behavior seemingly at variance with appropriate standards. The Health Department then takes action on the basis of these hearings. (*18*) Previous papers have detailed the Medicaid activities of the New York City Health Department. (1–22)

THE VOCABULARY OF ABUSES

There are 3 major abuses: (1) fraud, (2) unsatisfactory quality, (3) overutilization.

Fraud refers to the practitioner's charging for a service that in fact he never performed.

Unsatisfactory quality refers to the practitioner's performing a health service that fails to meet Medicaid standards.

Overutilization refers to the practitioner's performing a superfluous service, lacking therapeutic or preventive justification.

In dollar value, fraud has been the least important of the three abuses. It is the easiest to identify. The Medicaid abuser who engages in fraud is deemed by the cognoscenti to be stupid, for fraud is easiest to detect and easiest to prosecute. Unsatisfactory quality is de-emphasized in this paper, not because it is rare and unimportant, but because this abuse deserves detailed analysis of its own. We shall concentrate on fraud and overultilization. The inventory in this paper is representative, but by no means inclusive, of every variety of abuse that we have encountered. To avoid repetition we select typical examples. A specific abuse by one type of health professional has its counterpart within the practices of other species of health professionals as well.

FRAUD

In all the professions there may be billing for a mythical office visit; in dentistry, billing for phantom dentures, extractions, or filling; in optometry, billing for glasses never provided; in podiatry, billing for surgery never performed. Two excuses are common:

1. The clerk erred. (Employees are routine scapegoats).
2. The event under investigation occurred because the practitioner misunderstood the contents or policies of the program.

To counteract fraud, direct inspection is indispensable. The New York City Health Department samples invoices, and calls back, and actually examines Medicaid services provided for patients. Health Department staff dentists assess the quality of dentistry. The Optometric Center of New York and the M. J. Lewi College of Podiatry assess the quality of service of their respective professions in accordance with the Health Department's contractual protocol of evaluation. The very existence of a program of direct reexamination represents a deterrent.

FRAUD IN PHARMACY

The major fradulent abuses in pharmacy are "kiting" and "shorting" (*11*) *Kiting* refers to forging upward the quantity of medication originally prescribed by the practitioner. In New York State the physician, the dentist, and the podiatrist may each write prescriptions. The pharmacist may "kite" the quantity of the original prescription, for example, by inserting two more X's to increase a total number of prescribed tetracycline capsules from xx to xxxx. The pharmacist then provides the patient with the originally prescribed quantity, but bills Medicaid for the new and larger quantity. The patient receives the proper amount

of medication. The pharmacist may acknowledge that his act was illegal, but will justify it on the basis of his alleged grievances with Medicaid: the inordinate paperwork, the delays in receiving reimbursement, the errors in payment (almost always at his expense) the personal physical danger implicit in running a drugstore in the Medicaid areas of New York City.

We routinely inspect, for signs of tampering, samples of prescriptions filled by each participating Medicaid pharmacist. We insist on receiving the prescription originally penned by the practitioner, rather than any carbon copy. The original prescription containing the original ink is harder for the amateur forger to alter without leaving some telltale sign for the experienced investigator. With practice even novices become remarkably adept at identifying differing tints of ink and non-compatible handwriting.

Shorting refers to measuring out a quantity of medication less than that originally prescribed by the practitioner. The pharmacist then charges Medicaid for the prescribed amount and pockets the difference. Shorting is sometimes considered to be more difficult to detect, since the pharmacist does not tamper with the written prescription itself. However, shorting may be more dangerous to the pharmacist than kiting, because an alert patient can catch it. Furthermore, in shorting, the pharmacist imperils the patient's life because he provides the patient with less medication than the prescribing practitioner had originally judged necessary to treat the illness.

The pharmacist generally offers the same justification here as for kiting, but shorting affords opportunities for additional excuses of ingenious subtlety.

The errant pharmacist may claim any one or combination of the following: (1) His overall inventory was limited and contained less than the quantity of medication originally prescribed. (2) The supply of the medication was limited because the medication itself was unusual and infrequently prescribed. (3) Despite the pharmacist's instruction to come back, the patient failed to return at a later time to obtain the deficient quantity of medication. (4) The pharmacist owner or his pharmacist employee erred accidently.

To detect shorting we inspect the medicine cabinets of a sample of patients who have received medication from the pharmacist under investigation. Patients themselves have become more sensitized to quantity and volumes and have identified pharmacists who short. The patient may suspect shorting when he receives a bottle too large for the quantity of prescription. For example, a 6 oz. bottle should be full and should hold 6 oz. of medication rather than 3 oz. Then why should a pharmacist give a patient a partially empty bottle? Because he is apprehensive that the Health Department may inspect the patient's medicine, cabinet to look for shorted bottles. Any bottle too small for the prescribed dose is *prima facie* evidence that the pharmacist shorted the prescription. Manifestly 6 oz. of liquid medication, for example, cannot fit into a 3 oz. bottle. Such bottles whose sizes are discrepant from total dosage have been superb evidence of shorting. On the other hand, confronted with a partially empty bottle, the pharmacist might claim that he had originally given the prescribed dose, and that the patient had already taken a portion of the prescription. Should the patient deny that the bottle was full in the first place, the pharmacist can insist that the patient was mistaken.

Our investigators routinely:

1. Collect samples of *common* prescriptions. (It is then impossible for the pharmacist to claim rarity of drug to account for allegedly insufficient inventory, when the prescriptions shorted are as common as tetracycline or cough mixtures).

2. Collect five to ten samples from different patients. (It is then difficult for the pharmacist to claim occasional error).

3. Take testimony from a sample of patients by affidavit if necessary, (a) that the pharmacist never informed the patient that the quantity of the prescription was less than that prescribed, and (b) that the patient had been directed neither verbally nor by written memorandum to return later to obtain the deficient quantity of medication.

4. Collect bottles from the medicine chests of patients to compare bottle-size with the volume of the liquid medication prescribed.

OVERUTILIZATION

The Medicaid fee-for-service mechanism is an implicit fiscal incentive for overutilization. The administrator reviews the printouts of computerized Medicaid payments and ponders whether this or that procedure was performed for

medical or for fiscal reasons. Nor would the sophisticated health care administrator be utterly at ease with a prepaid capitation method of contracting out publicly funded health services. The possibility of underutilization would trouble him, for the less than conscientious practitioner under this system receives the same payment per patient no matter how little or how much care he renders.

M.D. Ping-Ponging

Looking astutely ahead, Freddie saw a better, an altogether more profitable basis for cooperation between Andrew and himself. He would go carefully of course, for Manson was a touchy, uncertain devil.

He said: "Why don't you come in with me and meet Ida? She's a useful person to know, though she keeps the worst nursing home in London. Oh! I don't know! She's probably as good as the rest of them. And she certainly charges more."

"Yes?"

"Come in with me and see my patient. She's harmless—old Mrs. Raeburn. Ivory and I are doing a few tests on her. You're strong on lungs, aren't you? Come along and examine her chest. It'll please her enormously. And it'll be five guineas for you."

"What You mean . . . ? But what's the matter with her chest?"

"Nothing much," Freddie smiled. "Don't look so stricken! She's probably got a touch of senile bronchitis! And she'd love to see you! That's how we do it here—"The Citadel, A. J. Cronin, Little, Brown and Company, Boston—1937, p. 270.

Promiscuous mutual referral among primary physicians and their consultants is no new phenomenon. More than three decades ago in *The Citadel* the author-physician, A. J. Cronin, attacked the identical abuse where physicians bounced patients back and forth between one another, pocketing incidental fat fees in the exchange. For example, a fee-for-service group practice comprising Board qualified and certified physicians, a large percentage of whose practice was Medicaid, billed the city for an inordinate number and percentage of referrals to the group otolaryngologist, gynecologist, urologist, pediatrician, allergist, etc. It was standard procedure for the intake group pediatrician to refer to the group otolaryngologist almost every child with uncomplicated acute otitis media. The otolaryngologist received a $20 Medicaid consultation fee which was then presumably pooled in the group's income.

At the informal hearing concerning ping-ponging, the group rejected the allegation of wrongdoing. They indignantly declared that their consultative policies represented a conscientious level of quality care that they were not disposed to compromise. The group saw no reason to attenuate professional excellence, merely because (a) the patients were medically indigent, (b) Medicaid was a publicly funded program, and (c) the City Health Department was interested in saving money.

M.D. OVERUTILIZATION OF DIAGNOSTIC PROCEDURES

In private self-pay ambulatory care an economic constraint is constantly operative. The physician can never forget that the patient must ultimately pay for his diagnostic tests. Not so in any system where the third party pays. Indeed, when an insurance company or the government reimburses the practitioner, there may actually be a fiscal incentive to order superfluous tests. The practitioner may derive additional income from procedures that his own staff performs or that a contract clinical laboratory performs for him. In the latter case, in effect the practitioner acts as the middleman. For many conditions, simpler and less costly tests may be available, at least as a screening device. Every "enlarged" liver need not be routinely scanned by the specialist in nuclear medicine. Every case of periumbilical pain does not automatically call for the "Big Four": cholecystogram, intravenous pyelogram, gastrointestinal series and barium enema, not to speak of the supplementary small bowel series plus assorted blood tests. The physician may respond in a number of ways when confronted with skepticism about detailed, complex and expensive diagnostic procedures for conditions that theoretically might first have been subject to simpler and less expensive techniques:

1. "Aren't you officials in government aware that it was imperative to exclude "X" disease in the differential diagnosis?"
2. "Haven't you officials read "Y" paper in "Blank" Journal pointing out how "X" disease exists, in a higher proportion of cases than has hitherto been suspected because of the inadequacy of conventional screening?"

(The practitioner then recounts a case history from his own experience where X Disease had been "masked" before being identified by the unusual and expensive diagnostic procedure under question).

3. "The New York City Health Department is ill-advised to use its considerate powers to buttress the status quo in medicine. For government to compel a single level of practice means to risk recurrence of the type of muddled and tragic behavior of the physicians who opposed Dr. Semmelweiss in the fight for cleanliness to prevent puerperal sepsis.

4. "Norms appropriate for the middle class are inapplicable to the poor. What is needed is an entirely different set of standards to assess the patterns of service utilization by the medically indigent."

Are these remarks the serious rejoinders of thoughtfull people or the insincere ploys of practitioners wanting to score a debater's point and make an incidental buck? Certainly there is enough validity in the comments to give the administrator occasional pause as he tries to enforce reasonable quality and fiscal standards of care. But Medicaid was not promulgated to support diagnostic or therapeutic procedures alien to the practice of informed health professionals. We have ruled according to this principle, although we may face the future ridicule of retrospectively prescient critics. There is an old adage about the probability of pathological esoterica that is pertinent: "When you hear hoofbeats in the garden, do not expect to see a unicorn when you look out the window. It will probably be a horse."

Review of invoices is the most useful method to detect the abuse of overutilization. The fee-for-service mechanism of payment conveniently thrusts into bold relief many suspicious patterns of care. Number, frequency, and types of treatment per individual patient not justified by the recorded diagnosis clearly calls for further investigation. This may include on-site office visits, review of records of specific patients, and always comprehensive discussion with the practitioners themselves. It is imperative that the staff discussants be the professional peers of the practitioners. By "peer" we mean that the staff man have at least the same professional degree, maintain membership in the same professional society, and be a part-time practitioner of the same specialty in the city. The staff discussant differs only in that he is on the payroll of the Health Department.

Fraud seizes the headlines, but overutilization is the most costly of the three Medicaid abuses. To brand a pattern of care as overutilization, there must be no ambiguity about the competence of the staff person or persons. Moreover, the alleged overutilization must not be marginal. Where there are gray areas, the practitioner should receive the benefit of the doubt.

PHYSICIAN ABUSE IN NURSING HOMES—UNDERUTILIZATION

The quality of care in nursing homes throughout the United States has been scandalous. Rather than overutilization, underutilization of physician services has been more common. The physician with few patients in a particular nursing home may be reluctant to respond to what appears to him to sound like a nonemergent compliant over the telephone. In consequence, nurses have been known not to bother telephoning, rather than risk the doctor's displeasure.

On the other hand, there have been physicians who make "the 5 p.m. nursing home visit." The jargon refers to the ceremonial visit to a dozen patients at the same home, performed on the way home from the physician's office. The doctor sees all these patients hurriedly and superficially and bills separately fees for service for each.

In 1962 the New York City Department of Social Services Medical Section, began a program of affiliating proprietary nursing homes, either with teaching hospitals, or with medical groups associated with the prepaid group practice Health Insurance Program of Greater New York. The affiliation agreements contained a capitation method of payment. In return, the teaching hospitals and HIP have provided the comprehensive health care services to patients within the nursing homes.

There is general agreement that the quality of care in those affiliated nursing homes (now constituting about 60% of all proprietary nursing home beds in the City) has improved enormously. The arrangement is not foolproof, however. Under the capitation method of reimbursement, the problem is not overutilization but rather underutilization of services. No matter how many or how few services the institution or the physician provides, the provider of services paid for by capitation receives the identical income. It is necessary, therefore, to make periodic checks to certify that the quantity, quality and scope of service accord with the terms of the city's contract.

DENTAL OVERUTILIZATION—OFFICE AND NURSING HOME

Numerous alternatives are often available to treat similar dental conditions. The situation in dentistry is not so clearcut as in other fields. Acute appendicitis must be treated one way. An acute coronary occlusion or a bleeding peptic ulcer likewise needs instant and relatively standard attention. In dentistry the correct therapeutic approach is often disparate. Should the decision be to install an expensive prosethesis with an expectant life of two decades? Or a less expensive prosthesis that will be serviceable for a shorter time? Which approach will amortize itself more frugally in the years ahead? The patient's dental condition may change drastically within a few years so as to require a new prosthesis in any ease. There is room for honest professional disagreement between practitioners and members of the Health Department staff. The situation is obviously ripe for the accusation on the part of some practitioners that Medicaid administrators are prepared always to sacrifice quality for economy.

Dentures represent the most costly item. All dentures are subject to prior authorization procedures. The dentist must submit a treatment plan with supportive dental films before proceeding with fitting the patient with dentures. In 1968, during the height of New York City's Medicaid dental program, our staff modified downward submitted dental treatment plans for a worth from $110 million dollars to $83 million dollars.

As previously mentioned, direct inspection is obligatory in order to disclose overutilization. Such assessment of dental work of patients in nursing homes revealed that a substantial portion of the dentures was unnecessary, ill-fitting, or reposed uselessly in the patient's drawer. We were obliged to reorganize the method of delivering dental services to nursing home residents. The Health Department now provides the dentistry in the nursing homes with staff from its own clinical services.

DRUG OVERUTILIZATION IN NURSING HOMES

The nursing home can be a substantial source of supplementary income to the pharmacist provided there is a reliable "feeder" inside the home—generally a cooperative nursing home director, together with one or more friendly physicians. Prescriptions written for the nursing home patients are thrown the way of an individual pharmacy. But passing prescriptions on to a collaborating pharmacist is only part of the story. For additional shared profits these medications should be prescribed in amounts beyond the therapeutic need if not the biological capacity of the patient to assimilate them. Excess quantities of drugs can build up the inventory of the nursing home and ultimately be resold. For such a deal to be consummated a prerequisite is a sense of confidence between feeder and pharmacist.

The health care administrator must view any situation as suspect where prescriptious for a specific nursing home are being filled primarily by a pharmacy not within convenient distance from the nursing home. Indeed, the further the distance between the nursing home and the pharmacy, the more the health care administrator should be troubled by the possibility of irregularity.

In 1962, four years before Medicaid, the city altered its policies of reimbursement to pharmacies in an attempt to deal with this abuse. The New York City Department of Social Services established a policy of paying only for certain prescriptions for nursing home patients on public assistance. Invoices were honored only for those prescriptions filled in that pharmacy geographically the closest to each of the proprietary nursing homes in the city. In essence, abandoned was all freedom of choice of the pharmacy by either the nursing home patient, physician, or administrator. Geographical accident was the sole determining factor. Individual departure from this policy required special approval. The policy immediately eliminated surreptitious bidding by pharmacies for exclusive nursing home rights plus concomitant promises of profitable kickbacks to cooperative nursing home directors and physicians. The system doubtless eliminated many abuses and potential abusers. But the question remained: What guarantee was there that even some geographically assigned pharmacists might not subsequently enter into kickback deals of their own with nursing homes?

To deal with this contingency it has been necessary to make periodic spot checks of the inventory of each of the nursing homes and review the nurse's medication notes on the patients' records. Do sample patients actually receive the prescriptions that have been written for them by their physician? Or are quantities of unused medications piling up somewhere? Certain nursing homes are subject to special scrutiny when inordinate quantities of medication are prescribed.

PODIATRY OVERUTILIZATION

It was predictable that Medicaid podiatry would become notable for reasons other than just podiatric services. Some clients would view it as a potential mechanism to obtain shoes. Certain podiatrists and shoe dealers would view it as a potential mechanism for profitable abuse. There was a special impetus to get shoes via this unorthodox route in New York City when the City Department of Social Services discontinued its policy of granting special clothing allowances to its clients on public assistance. Therapeutic shoes represent a legitimate ingredient of the podiatrist's armamentarium. Many podiatric conditions require special shoes. Medicaid pays for these. A minority of podiatrists have gained notoriety among our staff for overprescribing therapeutic shoes. Unsurprisingly, the popularity of these podiatrists has diffused among some Medicaid enrollees. For the podiatrist to prosper unethically from shoes it is not even necessary to relay on kickbacks from special shoe dealers with whom the podiatrist may have an amicable working relationship. He can eschew kickbacks altogether. The increase in income from straight podiatry can be formidable as the word spreads that one prescribes shoes with unseemly liberality.

For a minority of podiatrists, unnecessary foot x-rays, strapping, molds and toe jackets have become a favorite method to expand bills without giving services to additional patients.

The routine excuse for podiatric overutilization—insistence on professional excellence—differs in no way from that favored by all other health care practitioners. When questioned, the podiatrist insists that he performed the procedure because the poor deserve to receive the high quality of podiatric care historically denied them.

The health care administrator should suspect improper podiatrist-shoe dealer relationships when patients from a particular podiatrist's practice customarily obtain their therapeutic shoe from a specific shoe dealer—particularly a shoe dealer far from their own homes and from the office of the podiatrist. Always worthy of investigation is the podiatrist who prescribes shoes beyond the norm—no matter where his patients ultimately obtain their shoes. Here too the administrator should be apprehensive about what is going on when patients live far from the podiatrist who provides the Medicaid care. Periodic review of sample cases of foot x-rays, strapping, molds, and toe jackets and repetitive procedures such as nail clipping in nursing homes is called for, particularly when analysis of professional behavior discloses departure from the peer norm. In New York City the Health Department found it necessary to assign one podiatrist to each nursing home and reimburse him on a session basis rather than routine Medicaid fee-for-service. The quality of podiatric care went up while costs went down for podiatry in the nursing home.

GENERAL COMMENT

In order to identify abuses and to assemble evidence, the sine qua non is staff—the proper mix of health care professionals, paraprofessionals, attorneys, clerks, investigators, and the like. In view of the enormous sums likely to be saved or recovered from programs of cost and quality control, theoretically it should be easy to justify the budget for such a staff. The political opposition is formidable, but not invincible. To eradicate abuses by professionals in a health care program is impossible, but the objective, after all, is not to eradicate but to constrain—a concept quite familiar to epidemiologists.

Because of timidity, or for the sake of spurious public relations with professionals or institutions, the administrator may try to oversee a health care program with pseudo controls, basically ceremonial and ludicrously inadequate to discourage or ferret out abuses. This is bad administration and worse politics. If he pursues such folly, let the administrator recognize that he is collaborating in efforts to discredit, to attenuate, and eventually to butcher the socially imperative program he believes he is attempting to protect.

This paper does not deal in detail with the question of the best auspices for such controls. As before, we continue ot insist that government cannot abdicate its responsibility to watch the expenditure of the tax dollar and to protect the consumer. Others may disagree. But there can be no disagreement with the irrefutable truism that has emerged from Medicaid that controls to contain abuses and promote high quality care are indispensable.

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This paper was presented before the Medical Care Section of the American Public Health Association, at the Ninety-Eighth Annual Meeting in Houston, Tex., October 29, 1970.

Mr. ROSTENKOWSKI. Thank you, Dr. Bellin.
Mr. Heim?

STATEMENT OF RICHARD HEIM

Mr. HEIM. Mr. Chairman, members of the subcommittee, Dr. Bellin is always a very hard act to follow.

I appreciate the invitation to present this statement and to participate in this panel before the Ways and Means Subcommittee on Health. My remarks will not address the need for, the extent of coverage of, nor the methods of financial national health insurance. Rather, I shall confine my remarks to the implementation and administration of what may well become the most significant social legislation of the final quarter of this century. I am not so pesumptuous as to think that I have any hard suggestions to present at this time, but I do have a number of concerns based on my experience, which I think are appropriate to share with this subcommittee.

To put my comments in perspective, I should like to briefly describe some of my recent experiences in Government-financed health care programs. For 3 years, from 1967 to 1970, I served as administrative assistant to Clinton P. Anderson, the senior Senator from New Mexico. In this capacity I maintained close liaison with the Senate Finance Committee, of which the Senator was a member, and assisted the Senator during the medicare and medicaid oversight hearings of 1969–70. These hearings, I believe, provide the Congress as excellent springboard for the development of national health insurance.

For the past 4½ years I have been the executive director of the New Mexico Health and Social Services Department. This department is an umbrella organization in the human services area, and includes the following operating agencies: Public health, public assistance, social services, environmental improvement, and a scientific laboratory system. The department administers more than 60 Federal-State programs, each governed by different laws, regulations, guidelines, and accounting and reporting procedures. Approximately 65 percent of the revenue for our present operating budget comes from five Federal agencies through grant-in-aid programs. Because of the complicated funding arrangements and because the majority of our programs deal directly with the citizens of the State, the health and social services department probably is the most complex and sensitive department in the State of New Mexico.

In 1971 when Gov. Bruce King asked me to head up this organization, the department was in virtual bankruptcy. The major cause of the fiscal crisis was overruns in the medicaid program. It became my unpleasant duty to request from the 1971 legislature the largest deficiency appropriation for a single department in the history of the

State. The legislature granted the request, but not before wresting a commitment from me that I would not return to future legislative sessions for further deficiency appropriations. I am happy to report that I have honored that commitment.

To accomplish this, we decided early on that we had to manage rather than be managed by the big-money programs we administer. Four main techniques were utilized:

One: We developed a better financial reporting system than existed in the past.

Two: When necessary, we cut back on the scope of programs. Fortunately it was not necessary to use this device extensively.

Three: We dared to innovate new methods of management and to experiment with new ideas.

Four: We adopted a more aggressive posture in dealing with the Federal Government.

As could be expected, the results of our efforts are mixed. We have had our successes and our failures. I believe, however, that our successes exceed our failures. One of the success stories relates to our innovative approach to managing medicaid.

As I mentioned earlier, the medicaid program was the principal cause of the department's fiscal problems. In early 1971 we set in motion three major efforts to rescue this critically necessary program for the poor of our State. Two of the efforts are completely interdependent.

One: We cut back on the scope and duration of benefits so that the projected expenditures would not exceed the State's budget. This was done as a temporary expedient until the other two efforts could get off the ground and prove their effectiveness. Happily, these restrictions were in effect only 14 months and, except for a few minor services, were completely lifted by July 1, 1972.

Two: Recognizing that rational controls could be exercised best by the physicians of the State who performed or ordered most of the services provided in our medicaid program, the department contracted with the New Mexico Foundation for Medical Care, a nonprofit organization of physicians, to provide peer review of all medicaid claims to determine if the services were medically necessary and appropriate. In effect, New Mexico become the first operational statewide professional standards review organization, even before PSRO's were called for under law.

Three: As the physicians' decision are dependent upon the accuracy and timeliness of the information they are reviewing, the department also contracted with the Dikewood Corp., a New Mexico-based research and development organization, to develop and operate a sophisticated online computerized medicaid information system which simultaneously would perform two functions:

A. The fiscal agent responsibility of receiving processing and paying medicaid claims and providing management information to the department; and

B. Very importantly, to provide all claims information, including patient and provider profiles instantaneously to reviewing physicians.

The Foundation-Dikewood-State system has been in continual operation since September 1, 1971, almost 4 years. Unfortunately, our efforts have been concentrated on doing rather than evaluating, so that we

do not have a complete, objective and thorough evaluation to submit as yet. We do, however, have some preliminary findings to present:

One: Since 1971 the medicaid program in New Mexico has operated within its budget. While total medicaid expenditures in the country have more than doubled in the past 4 years, New Mexico costs have increased approximately 50 percent. Increases result from many factors. Significant factors in New Mexico are a larger number of eligible recipients, inflationary cost increases and changes in eligibility determination and benefits, which have encouraged greater use of benefits both by the young and the aged client population.

Two: Average hospital length of stay has been reduced 24 percent—6.3 days to 4.8 days. At today's average daily charges this represents about $2.5 million per year in New Mexico.

Three: Use of injections in physician office care has been reduced by two-thirds—14 per 100 office visits versus 42 per 100 office visits previously. At today's prices this represents about $200,000 per year.

Four: The total disallowance rate of claims has increased to about 19 percent as opposed to 12 percent before our system went into effect. Approximately $6 million worth of claims are disallowed annually.

Five: Prescription drug costs were reduced 12 percent the first year and another 5 percent the second. Today we spend less on drugs than we spent the year before the new approach was taken, even though drug prices are higher and more people are eligible.

These examples of some of our preliminary findings, Mr. Chairman, convince us that our system, though imperfect, is working. And because of it we have been able to provide the opportunity for quality medical care to eligible citizens of our State without bankrupting the State. In effect, New Mexico implemented and married two sections of Public Law 92-603—The Social Security Amendments of 1972—before the law passed.

I am referreing specifically to section 249-F, which mandates the Department of Health, Education, and Welfare to contract with local physician groups called PSRO's to monitor the necessity and appropriateness of care provided under the medicare, medicaid and maternal and child health programs; and to section 235, which provides to States 90 percent Federal match for the design, development, and installation of mechanized claims processing systems for medicaid, and 75 percent Federal match for the operation of such systems.

New Mexico, under section 249-F, has been designated one of the conditional PSRO's for institutional care review and is one of the two States awarded a demonstration grant for ambulatory review. Further, after long and torturous negotiations with the Department of Health, Education, and Welfare, New Mexico's medicaid management information system has been approved for the 90 percent Federal funding under section 235 for the design, development, and installation of the system.

New Mexico also is the first State approved for the 75 percent Federal funding retroactive to July 1973 for the system's operation.

Having presented as background my personal involvement in attempting to administer a very difficult and complicated Federal-State program, I should now like to offer a few observations about the implementation and administration of a vastly broader Government-sponsored health care program, National Health Insurance.

1. IMPLEMENTATION

As great as some of the pressures are for passage and early implementation of national health insurance, I completely concur, Mr. Chairman, with your remarks before the Group Health Institute that "Implementation of any national health insurance program would take several years * * * and that the leadtime necessary to establish the administrative capacity for any substantive national health insurance program would itself take more than a year." Adequate leadtime to gear up for such a program is absolutely critical.

I further support the concept advanced by former HEW Secretary Wilbur Cohen, in a statement to the House Ways and Means Committee on June 28, 1974, that a comprehensive national health insurance plan be implemented in an incremental step-by-step development manner with due regard to administrative feasibility.

Let me further suggest that all regulations, program guides, and other implementing documents proposed by the appropriate executive agency or agencies be reviewed prospectively by the appropriate committees of the Congress, to insure that congressional intent is being followed and that the plans for implementation are administratively sound. Too often I and other State administrators feel that regulations are not in accord with the intent of Congress, or limit it.

ADMINISTRATION

One: Simplicity. I strongly and respectfully appeal to the Congress not only to concern itself with the goals and objectives of a comprehensive national health insurance program, but also to be seriously concerned that whatever is enacted is capable of being administered by mere mortals. I prefer at this time not to suggest a position on such things as:

A. Who should administer national health insurance—Federal Government alone, State government alone, combination of Federal and State, use of intermediaries or fiscal agents, Social Security Administration or some new Federal bureau; or

B. Whether there should be cost-sharing in the form of premiums, deductibles, and coinsurance; or

C. How and on what basis providers should be paid for their services; or

D. What type of quality and cost controls should be included.

These are all issues which demand careful deliberation. My appeal is that the end results are not such that either the costs of administration will be disproportionately high or that serious administrative error will be inevitable. Let me cite an example.

The national food stamp program has a most noble objective: To provide low-income persons an opportunity for better nutrition. Yet both by law and regulation this program has evolved into such an administrative nightmare that it is impossible for most States to operate the program anywhere close to acceptable error tolerance limits. The tragedy, of course, is that largely because of administrative difficulties and high error rates, the food stamp program suffers from an extremely low public image.

2. THE ROLE OF STATE GOVERNMENT

Again I am not so presumptuous as to suggest what role, if any, State government should have in the scheme of national health insurance. I assume there will be some at least in such areas as licensing of facilities and health professionals, and in the residual responsibility of providing care to individuals who fall through the eligibility cracks or to provide services presently being received by State citizens and which will not be provided under national health insurance. Regardless of the decisions on these substantive issues, I respectfully suggest:

A. That the role of the States be clearly set forth in the legislation;

B. That States be given sufficient lead time so that their political, legislative, and administrative machinery can be permitted to work; and

C. That the Federal agency charged with implementing national health insurance be mandated to involve in a meaningful way representatives of State government in the drafting of those regulations which will affect the States.

SUMMARY

Mr. Chairman, like most Americans I believe that some form of national health insurance is inevitable. I know that the substantive questions such as extent of coverage, eligibility and financing will be given careful consideration by the Congress. My hope is that ample attention also be given to the administrative aspects of the program and specifically: (1) That adequate lead time be provided; (2) that the program be capable of being administered without excessive cost or errors; and (3) that the role of States be clearly set forth, and that the States be permitted ample lead time and meaningful input into the regulations which affect them.

Mr. ROSTENKOWSKI. Thank you, Mr. Heim.

Professor de Vise.

STATEMENT OF PIERRE R. de VISE

Mr. DE VISE. In response to the invitation of the Health Subcommittee I prepared a 34-page paper entitled "The Government Seen as Santa Claus to Mischievous Doctors, and Other Views of the Role of Government in American Health." In this paper I examine the underlying economic, historical and organizational factors which molded the role of Government in health care with particular reference to national health insurance.

I would like now to excerpt from this longer paper for my formal statement.

Compulsory health insurance was first enacted in Prussia in 1854 and extended by Bismarck to the new German nation in 1883. It soon spread to other European countries after the passage of British national health insurance in 1911. Today, all industrial nations, with the important exception of the United States, have some form of compulsory national health insurance as part of their social insurance programs or as a national health service. A more affluent and larger scale national economy, and philosophical and constitutional antecedents help explain the peculiar resistance of Americans to the idea of compulsory national health insurance.

Before the New Deal of the 1930's, Congress and the Supreme Court held that the Constitution placed responsibility for health and welfare matters with the States. Yet the States were unwilling or unable to finance costly welfare measures unless all States were required to do so. Thus, the Federal Government was the only government that could achieve a broad social insurance program.

The Social Security Act of 1935 represents the first milestone in the new Federal role in social insurance. But health insurance was not included because it was feared that the AMA's "unyielding opposition" might jeopardize the passage of the entire social security package. The health insurance amendments—titles 18 and 19—took 30 years, and national health insurance will probably take 42 years after passage of the original Social Security Act.

In both Europe and the United States, health systems emerged in the context of economic resources, from political and social values, and from the influence of pressure groups. Until relatively recently, the American middle class was large and affluent enough to support the health system with private funds through direct payments from private patients and through philanthrophy for the poor.

Perhaps no other nation in the Western World had a sufficiently large and affluent middle class to support a health system for the poor and for the working class. Hence, most European nations turned to NHI, first to underwrite the care of the poor and eventually to insure most of the population.

But in America, advances in technology led to a shift of care from physicians' office to large and expensively equipped hospitals, and the hospitals grouped together into Blue Cross hospital insurance plans, providing hospital insurance to a majority of Americans in the decade between 1940 and 1950.

Government health services and funds expanded greatly to insure major classes of the uninsured, culminating with the passage of medicare and medicaid in 1965. However, the extension of Government programs to the self-supporting segment of the population was not in tune with political and social values. The long gestation of the NHI idea was due, in part, to three strong political traditions: The Jeffersonian view that "that government is best which governs least," the laissez-faire doctrine which assigns government responsibility for insuring maximum freedom for private enterprise, and the public philosophy of "social Darwinism" which limits government social welfare programs for fear of frustrating the "survival of the fittest" mechanism by which society progresses.

The debate over national health insurance has been prolonged by the determined opposition of the AMA ever since the idea first took root in the 1910's and down to the 1970's, and the AMA's two national health insurance bills, even though cost-benefit studies show that doctors would be major beneficiaries of the vast redistribution of income that would result from national health insurance. Conventional political analysis would suggest that a pressure group like the AMA would lobby for, rather than against, the passage of medicare-medicaid and national health insurance, in anticipation that such programs would add about $10,000 to the average annual income of a physician. This is certainly the characteristic of traditional distributive policies where various interest groups ask the government for public lands, income subsidies, pensions, river and harbor improvements, and other assist-

ance. The amazing and almost un-American resistance of doctors to programs designed to make them richer and their patients healthier is truly baffling.

Ideological differences and fear of government controls and their impact on income and freedom of practice are the main explanations given for the opposition of doctors to Federal health programs. To better understand the struggle of organized medicine against government action in health care, we propose a theoretical framework within which we can place this struggle in the context of national changes in resources and subsequent shifts in demands on government.

Resources of wealth, urbanization, and industrialization are the major variables in demands for new legislation. Four policy types may be identified—distributive, redistributive, self-regulating, and regulatory. Groups making demands on government may be scaled on a continuum ranging from fragmentation to integration measured by the unity of activity among groups.

With urbanization has come a shift from fragmented to integrated groups as large organized interest groups have allied with one another according to shared ideologies. However, industrialization and technological advances lead to specialization of function, interest, and demand. We are thus faced with a paradox of increasing aggregation of demands diluted by specialty-induced proliferation of interest and demand.

The U.S. system has become increasingly integrative, bringing shifts in policies of redistribution and regulation. But fragmentation has grown apace with integration. Thus, there are pressures to turn policies of regulation and redistribution back to policies of self-regulation and distribution.

In the case of medical care, the AMA is a highly integrated group that seeks a policy of self-regulation. Although doctors would reap the main benefits of a redistribution policy in health care, the AMA vigorously opposes it because other groups such as employers and labor unions that might be adversely affected could easily enter the decisional system and push for a policy of regulation. Alongside the integrated AMA there are literally hundreds of fragmented special interest groups that make distributive demands on Government.

On the side of the decisional system we have the White House, which seeks an integrated policy, doing battle with the Federal bureaucracy and Congress, which often promote distributive and self-regulating policies on behalf of the fragmented interest groups. These interest groups are out for all they can get, whereas the White House has the responsibility for allocating a fixed budget in a manner that corresponds to the optimum satisfaction of all demands on Government, and to the optimum application of cost-benefit ratios.

Both Secretary Richardson and Secretary Weinberger sought mightily to rein the categorical interests entrenched in the HEW bureaucracy. The attempts to reorder priorities and budgets included reorganization of the health bureaucracy, shifting all the power from the Surgeon General to the Assistant Secretary for Health, decentralization to regional offices, special revenue-sharing, the application of efficiency criteria, and impoundment of appropriations.

The latest attempts at controlling categorical interests are the professional standards review organizations (PSRO's) and the health

systems agencies (HSA's). Both sets of agencies are designed to respond to demands of integrated groups and both have authority to say "no" to spending by categorical interests.

Both the highly integrated AMA and the fragmented categorical interests represent providers, with minimal input from consumers, even though, in the aggregate, Government intervention—or nonintervention—may greviously affect the interest of consumers.

Health consumer groups have been remarkably ineffective in counteracting the pressure from providers. Even if we grant that the AMA is rational in opposing medical care subsidy programs out of fear that adversely affected groups will press for regulation, there remains the puzzling question: How does the AMA's will prevail against the public interest?

AMA membership counts less than 200,000. Yet the AMA has challenged such large groups as the AFL-CIO, the American Legion and the Democratic Party. It has frustrated the health care programs of such popular Presidents as Franklin Roosevelt, Truman, Eisenhower, and Kennedy.

The answer to this mismatch probably lies in the concept of imbalanced political interests. This concept holds that concentrated groups will be more effective in the political process than diffuse ones. Health care programs vitally affect the livelihood of doctors, but may mean insignificant benefits or costs to individuals, whatever the agreegate level of those benefits and costs. The related concept of imbalanced political market tells us that informed voters and rich voters are more influential than the uninformed and the poor.

Some diffuse interests have escalated into concentrated interests due to the high rate of medical inflation 50 percent higher than the rise of the general price level. This high rate of inflation as been caused in part by expanded Federal subsidies. Examples are medicaid costs to States and the Federal Government, social security payroll taxes to employers, and the proportion of fringe benefits absorbed by health insurance to labor unions.

The prognosis is that National Health Insurance with an unregulated fee-for-service system is likely to further exacerbate medical inflation. However, the payment structure is still much too decentralized to deal effectively with medical inflation. Present Federal and state strategies are to cut down on health services to the poor rather than directly confront the concentrated interests of doctors in a self-regulating policy that leads to medical inflation.

The self-regulating policy of organized medicine has contributed to medical inflation through the monopoly power of doctors and hospitals. This power has been used to artificially limit the supply of doctors, to discourage the use of salaried doctors, to restrict the activities of osteopaths, chiropractors, nurses, and other physician substitutes, and to hamper the effective monitoring of costs and appropriate utilization.

The three major responses of Government to medical inflation are (1) to improve market behavior through coinsurance, deductibles and HMO's, (2) to establish public utility regulation dealing with facility construction and rates; nad (3) to create a monopsony of consumers to deal on equal terms with the monopoly of vendors through a strong national system of the kind proposed in the Kennedy-Corman bill.

It will probably take a combination of all three approaches to take medical inflation.

Organized medicine fought vigorously against medicare in the fear that this legislation was the opening wedge to NHI. And indeed the authors of medicare regarded this legislation as the first step in insuring all social security beneficiaries. The HEW bureaucrats were confident that medicare and medicaid would convince doctors and hospitals that Government funding of private health service could work smoothly. However, these hopes were not realized.

The demand for health services on the part of the elderly and the poor exceeded expectations and far outpaced growth in the supply of services. Price inflation at 150 percent the rate of the general price level resulted, and more medicare and medicaid funds were absorbed by inflated doctors' fees and hospital bills than by increased services.

Cost control became the new strategy—cost control not only in public programs, but in the private sector as well, since medicare and medicaid charges are at the prevailing market. A whole battery of cost control modalities came into being—health maintenance organizations (HMO's), certificate of need for hospital construction, utilization review (UR), and professional standards review organizations (PSRO's), to name a few.

Although the original medicare strategy backfired, an even more compelling need to bring the Frankenstein monster under control is propelling us to NHI legislation. The federal role in health care was irreversibly committed by medicare and medicaid. In the 10 years since 1965 the Government share of all health care payments rose from 25 to 40 percent. Government payments for physicians' services jumped from 7 to 26 percent, and payments to hospitals rose from 36 to 49 percent. Federal health programs mushroomed from 100 to 300 in 10 years.

The expanded Federal role in health care must also be seen in the context of the growth in public spending. Government now takes 30 percent of the GNP and is projected to grow to 40 percent in the next 10 years. The trend is definitely toward Sweden where government takes half of the GNP.

The inexorable progress toward the welfare state is the result of long-term processes of industrialization and urbanization. Unfortunately increased Government controls over economic life have not totally prevented inflation and unemployment, any more than controls over health care have prevented skyrocketing costs, maldistribution of resources and a dual care system. But there is no question of retreating. We are irreversibly committed to increasing Government controls simply because of the increasing complexity of economic life. We must simply learn to do better in achieving our goals of social policy, which may mean more experimentation, perhaps in the direction of more controls.

What are the prospects for National Health Insurance in the years ahead? Until the late 1960's the business community and the Republican Party were allies of the AMA. But the more than doubling of medical costs since 1965 made cost containment the major new political strategy in health care. Thus, the traditional debate between the National Health Insurance proponents among Democrats and the AMA opposition is now joined by the administration and its cost-

containment policy. But we have no assurance that the administration and AMA plans would not bankrupt us, or that the Kennedy plan would guarantee health care for all.

These proposals can work only if effective price and mode of delivery controls of the three types already discussed can be implemented. There is no doubt that under free competition subsidies for the medical care of families above the poverty level would result in further shifts of physicians from poverty to nonpoverty communities, raise private practcie fees, and force up medical insurance rates.

Within 3 years health care could take 10 percent of our gross national product, hospital beds would cost $150 per day, a physician's office visit would cost $25, a diagnostic visit $100, and physicians would earn $80,000 a year on the average. If that day should come about, there is no doubt that the pressure on Government to nationalize hospital and medical services would become overwhelming.

The only thing preventing a workable national health insurance program for the United States is that our doctors would not accept it, and our citizens would not impose it on recalcitrant doctors at the present time. We must resign ourselves to an unworkable national health plan that will so exacerbate the present dilemma of poor access and runaway costs that either the doctors or the citizens will have a change of heart, and decide to join the rest of the Western World in making health care part of the public interest.

[The additional paper follows:]

THE GOVERNMENT SEEN AS SANTA CLAUS TO MISCHIÉVOUS DOCTORS, AND OTHER VIEWS OF THE ROLE OF GOVERNMENT IN AMERICAN HEALTH: AN INTERPRETATION OF THE SIXTY-YEAR DEBATE ON MEDICARE AND NATIONAL HEALTH INSURANCE

(By Pierre de Vise, College of Urban Sciences, University of Illinois at Chicago Circle)

THE SIXTY-YEAR DEBATE OVER NATIONAL HEALTH INSURANCE

Underlying any new social legislation is a concept of how to bring desired change to our social structure. Compulsory health insurance is the idea behind a half dozen national health bills now before Congress. The basic idea of pooling resources in order to spread the economic risks of illness goes back to ancient Greece and does not exactly qualify as a new idea. But compulsory national health insurance is essentially a twentieth century idea.

Compulsory insurance was first enacted in Prussia in 1854 and extended by Bismarck to the new German nation in 1883. It soon spread to other European countries after the passage of British National Health Insurance in 1911. Today all industrial nations, with the important exception of the United States, have some form of compulsory national health insurance as part of their social insurance programs or as a national health sevice. A more affluent and larger scale national economy and philosophical and constitutional antecedents help explain the peculiar resistance of Americans to the idea of compulsory national health insurance, or social insurance in general. The Social Security Act of 1935, the Hill-Burton Hospital Construction Act of 1946, the Kerr-Mills Act of 1960, and the Social Security Amendments of 1965 and 1972 are major milestones in the progress toward health insurance in the United States. A brief review of the long legislative history of these programs is instructive for an outlook of future developments.

A few feeble attempts were made by the Federal Government before the New Deal to intervene in health care but most of these were aborted within a few years. The yellow fever epidemic of 1793 led to the Act of 1796 requiring Federal revenue officers to oversee state enforcement of quarantine laws on the grounds that epidemics ignored state borders and therefore constituted interstate commerce.

The act was found unconstitutional by Chief Justice Marshall who reasserted state authority. The 1813 act providing for the free distribution of cowpox vaccine was similarly construed as an attack on states' rights and was repealed in 1822. Another yellow fever epidemic led to the creation in 1879 of the National Board of Health to study better ways to control epidemics and design a national quarantine system. The Board's charter was not renewed in 1884. The Sheppard-Towner Act of 1922, providing Federal subsidies for state programs of child and maternal health, was denounced by the American Medical Association as unwarranted Federal intervention in private medical matters and the act was repealed in 1929.

Before the New Deal of the 1930's Congress and the Supreme Court held that the constitution places responsibility for health and welfare matters with the states. Yet the states were unwilling or unable to finance costly welfare measures unless all states were required to do so. Thus, the Federal Government was the only government that could achieve a broad social insurance program. The Social Security Act of 1935 represents the first milestone in the New Federal role in social insurance. But health insurance was not included because of fear that the A.M.A.'s "unyielding opposition" might jeopardize the passage of the entire social security package. The health insurance amendments (Titles 18 and 19) took 30 years, and national health insurance will probably take 42 years after passage of the original Social Security Act.

It took a great shift in public philosophy during the Depression and New Deal to permit responsibility in social insurance to pass from the states to the Federal Government. In terms of health insurance, the shift is still far from complete. The population covered is limited to the aged and the indigent, and the government enjoys the privilege of funding the programs without effective quality and cost controls assumed by other national governments in their health insurance programs. In both Europe and the United States, health systems emerged in the context of economic resources, from political and social values, and from the influence of pressure groups.

Until relatively recently, the American middle class was large and affluent enough to support the health system with private funds through direct payments from private patients and through philanthrophy for the poor. Advances in medical technology led to a shift of care from physicians offices to large and expensively equipped hospitals. But hospitals grouped together into Blue Cross hospital insurance plans, and in the decade between 1940 and 1950, provided hospital insurance to a majority of Americans. Government health sevices and funds expanded greatly to insure major classes of the uninsured culminating with the passage of Medicare and Medicaid in 1965. But the extension of government programs to the self-supporting segment of the population was not in tune with political and social values.

Perhaps no other nation in the Western World had a sufficiently large and affluent middle class to support a health system for the poor and the working class.[1] Hence most European nations turned to NHI, first to underwrite the care of the poor and eventually to insure most of the population.

MEDICARE AND ITS AFTERMATH

Organized medicine fought vigorously against Medicare and Medicaid in the fear that this legislation was the "opening wedge" to NHI. And indeed the authors of Medicare regarded this legislation as the first step in insuring all social security beneficiaries. The HEW bureaucrats were confident that Medicare and Medicaid would convince doctors and hospitals that government funding of private health services could work smoothly. However these hopes were not realized. The demand for health services on the part of the elderly and the poor exceeded expectations and a outpaced growth in the supply of services. Price inflation at 150 percent the rate of the general price level resulted, and more Medicare and Medicaid funds were absorbed by inflated doctors' fees and hospital bills than by increased services. Cost control became the new strategy—cost control not only in public programs but in the private sector as well since Medicare and Mediaid charges are at the prevailing market. A whole battery of cost control modalities came into being—Health Maintenance Organizations (HMOs), Certificate of

[1] Odin W. Anderson, *The Uneasy Equilibrium* (New Haven, Conn.: College and University Press, 1968).

Need for hospital construction, Utilization Review (UR), and Professional Standards Review Organizations (PSROs), to name a few.

The Comprehensive Health Planning Act and the Regional Medical Program Services Act were enacted in 1966 in attempts to monitor new health services stimulated by expanded federal programs. These proved ineffective and were superseded by the Health Planning and Resource Development Act of 1975.

Although the original Medicare strategy backfired, an even more compelling need to bring the Frankenstein monster under control is propelling us to NHI legislation. The federal role in health care was irreversibly committed by Medicare and Medicaid. In the ten years since 1965, the government share of all health care payments rose from 25 percent to 40 percent. Government payments for phyiscians services jumped from 7 to 26 percent, and payments to hospitals rose from 36 to 49 percent. Federal health programs mushroomed from 100 to 300 in ten years.

Overall, health care costs rose from $38.9 to $104.2 billion in the ten years between 1965 and 1974. In this period, public expenditures increased more than fourfold—from $9.8 to $41.3 billion. The slice of health care costs out of the GNP grew from 5.9 to 7.7 percent. Higher prices caused half of the ten-year growth as medical care inflation rose 50 percent faster than the consumer price index.

The expanded federal role in health care must also be seen in the context of the growth in public spending. Government now takes 30 percent of the GNP and is projected to grow to 40 percent in the next ten years. The trend is definitely toward Sweden where government takes half of the GNP.

The inexorable progress toward the Welfare State may suggest the renunciation of formerly cherished values of laissez-faire and checks and balances. But it is more likely the result of long-term processes of industrialisation and urbanization than of basic changes in political philosophy. The increasingly complex economic forces here and abroad have forced us to regulate more and more of the economy. The Great War followed by the Great Depression and a second World War were the spectacular breakdowns in the existing international social order that led the United States and other nations to follow the path to the Welfare State.

Unfortunately, increased government controls over economic life have not totally prevented inflation and unemployment, anymore than controls over health care have prevented skyrocketing costs, maldistribution of resources, and a dual care system. But there is no question of retreating. We are irreversibly committed to increasing government controls because of the increasing complexity of economic life. We must simply learn to do better in achieving our goals of social policy, which may mean more experimentation, perhaps in the direction of more controls.

WHY DOCTORS OPPOSE NATIONAL HEALTH INSURANCE

Most economic and cost-benefit analyses reveal that doctors and other health care vendors were the major beneficiaries of Medicare—Medicaid and other federal health programs that doctors and other vendors fought so vigorously against. Similarly, projections of cost-benefits would show vendors to be major beneficiaries of the vast redistribution of income that would result from national health insurance. Conventional political analysis would suggest that a pressure group like the AMA would lobby for rather than against the passage of Medicare—Medicaid and National Health Insurance, in anticipation that such programs would add $10,000 a year to the average income of a physician. This is certainly the characteristic of traditional distributive policies where various interest groups ask the government for public lands, income subsidies, pensions, river and harbor improvements and other assistance. The amazing and almost un-American resistance of doctors to programs designed to make them richer and their patients healthier is truly baffling.

Ideological differences and fear of government controls and their impact on income and freedom of practice are the main explanations given for the opposition of doctors to federal health programs. We propose to review the historical development of the stuggle of organized medicine against government action in health care. But first we propose a theoretical framework within which we can place this struggle in the context of national changes in resources and subsequent shifts in demands on government and decisional systems.

THE THREE R'S OF HEALTH POLICY DEVELOPMENT: RESOURCES, REDISTRIBUTION AND REGULATION

We repeat that resources of wealth, urbanization and industrialisation are the major variables in demands for new legislation. There are three criteria for judging the effect of a new policy—group benefits, equity, and consensus. Four policy types may be identified—distributive, redistributive, self-regulating, and regulatory. Groups making demands on government may be scaled on a continuum ranging from fragmentation to integration measured by the scope, diversity and compatibility of demands made as well as by the unity of activity among groups making them.[2]

With urbanization has come a shift from fragmented to integrated groups as large organized interest groups have allied with one another according to shared ideologies. The two major political parties are the ultimate integrated groups. However, industrialization and technological advances lead to specialization of function, interest and demand. We are thus faced with a paradox of increasing aggregation of demands diluted by specialty induced proliferation in interests and demand.

Fragmentation of demand, which characterized traditional American politics, leads to decisional systems based on consensus and to policies of distribution and self-regulation. The U.S. system has become more integrative bringing shifts to policies of redistribution and regulation. But fragmentation has grown apace of integration. Thus, there are pressures to turn policies of regulation and redistribution back to policies of self-regulation and distribution.

In the case of medical care, the AMA is a highly integrated group that seeks a policy of self-regulation. Although doctors would reap the main benefits of a redistribution policy in health care, the AMA vigorously opposes it because other groups such as employers and labor unions that might be adversely affected could easily enter the decisional system and push for a policy of regulation. Alongside the integrated AMA, there are literally hundreds of fragmented specialty interest groups that make distributive demands on government. We now have over 300 categorical health programs resulting from the demands of these groups.

On the side of the decisional system, we have the White House which seeks an integrated policy doing battle with the Federal bureaucracy and Congress which often promote distributive and self-regulating policies on behalf of the fragmented interest groups. These interest groups are out for all they can get, whereas the White House has the responsibility for allocating a fixed budget in a manner that corresponds to the optimum satisfaction of all demands on government, and to the optimum application of cost/benefit ratios.

Both Secretary Richardson and Secretary Weinberger sought mightily to rein the categorical interests entrenched in the HEW bureaucracy. The attempts to reorder priorities and budgets included reorganization of the health bureaucracy, shifting all the power from the Surgeon General to the Assistant Secretary for Health, decentralization to regional offices, special revenue sharing, the application of efficiency criteria, and impoundment of appropriations. The latest attempts at controlling categorical interests are the Professional Standard Review Organizations (PSROs) and the Health Systems Agencies (HSAs). Both sets of agencies are designed to respond to demands of integrated groups and both have authority to say no to spending by categorical interests.

THE A.M.A. AND THE PUBLIC INTEREST

Both the highly integrated A.M.A. and the fragmented categorical interests represent providers' with minimal input from consumers, even though, in the aggregate, government intervention (or non-intervention) may grievously affect the interests of consumers.

Health consumer groups and labor unions have been remarkably ineffective in counteracting the pressure from providers. Even if we grant that the A.M.A. is rational in opposing medical care subsidy programs out of fear that adversely affected groups will press for regulation, there remains the puzzling question: How does the A.M.A.'s will prevail against the public interest? A.M.A. membership counts less than 200,000. Yet the A.M.A. has challenged much larger groups like the AFL–CIO, the American Legion, and the Democratic Party. It has

[2] Robert H. Salisbury, "The Analysis of Public Policy: A Search for Theories and Roles," in Austin Ranney (ed.) *Political Science and Public Policy* (Chicago: Markham Publishing Company, 1968).

frustrated health care programs of such popular Presidents as Franklin Roosevelt, Truman, Eisenhower and Kennedy.

The answer to this mismatch probably lies in the concept of imbalanced political interests. This concept holds that concentrated groups will be more effective in the political process than diffuse ones. Health care programs vitally affect the livelihood of doctors but may mean insignificant benefits or costs to individuals whatever the aggregate level of those benefits and costs. The related concept of imbalanced political markets tells us that informed voters and rich voters are more influential than the uninformed and the poor.[3]

THE A.M.A. AND MEDICAL INFLATION

Medical inflation at a rate 50 percent higher than the rise of the general price level was brought about in part by expanded federal subsidies. It has resulted in escalating some diffuse interests into concentrated interests. Examples are medicaid costs to states and the Federal Government, Social Security payroll taxes to employers, and the proportion of fringe benefits absorbed by health insurance to labor unions. The prognosis is that National Health Insurance with an unregulated fee-for-service system is likely to further exacerbate medical inflation. However, the payment structure is still much to decentralized to deal effectively with medical inflation. Present Federal and state strategies are to cut down on health services to the poor rather than directly confront the concentrated interest of doctors in a self-regulating policy that leads to medical inflation.

The self-regulating policy of organized medicine has contributed to medical inflation through the monopoly power of doctors and hospitals. This power has been used to artificially limit the supply of doctors, to discourage the use of salaried doctors, to restrict the activities of osteopaths, chiropractors, nurses, and other physician substitutes, and to hamper the effective monitoring of costs and appropriate utilization.

The three major responses of government to medical inflation are (1) to improve market behavior through coinsurance, deductibles and HMOs, (2) to establish public utility regulation dealing with facility construction and rates; and (3) to create a monopsony of consumers to deal on equal terms with the monopoly of vendors through a strong national health system of the kind proposed in the Kennedy-Corman bill.[3] It will probably take a combination of all three approaches to tame the monster of medical inflation.

To recapitulate, the long gestation of the National Health Insurance idea is due in part to the fact that the large and affluent middle class was able to subsidize the care of the poor until recently. It is also due in part to three strong political traditions—the Jeffersonian view that "that government is best which governs least," the *laissez-faire* doctrine which assigns government responsibility for ensuring maximum freedom for private enterprise, and the public philosophy of "social Darwinism" which limits government social welfare programs for fear of frustrating the "survival of the fittest" mechanism by which society progresses. The debate over national health insurance has also been prolonged by the determined opposition of the A.M.A. ever since the idea first took root in the 1910's and down to the 1970's and the A.M.A.'s two national health insurance bills.

THE A.M.A. AND NATIONAL HEALTH INSURANCE

The welfare state in Britain and the New Deal in the United States mark the evolution of nineteenth century liberal political philosophies of Stuart Mill and the Manchester School, and of Thomas Jefferson and the Federalists in the two countries. The fewer groups that still voice these political philosophies are now regarded as conservatives, and many of their expressions are derided as reactionary and callous. Three such denigrated slogans of twentieth century conservatism are:

"The business of America is business."

"What is good for General Motors is good for the country."

"Health care is not a right but a privilege."

These political expressions made by the Presidents of the United States, General Motors and the A.M.A. would have been perfectly in tune with nineteenth

[3] Theodore Marmor, "Politics, Public Policy, and Medical Inflation" (in press, 1975).

century libertarian principles of least government, *laissez-faire*, and social Darwinism. But they are no longer considered appropriate in most sectors of society and the economy today, with the flagrant exception of health care.

There is a possible explanation why physicians hold onto these nineteenth century dogmas. Because of their years of demanding training and hard work and their daily exposure to suffering, physicians often become callous to ordinary human feelings. They also become fierce believers in free enterprise, hard work, and self-reliance. In their tendency to value individuals by these standards, doctors develop an image of women and children as the ignorant and the incompetent dependents of men.

Doctors have particularly rigid attitudes about "morals" and people "getting something for nothing." Free health care for children and mothers raises the image and unwed mothers and illegitimate children, guilty on both counts of morals and dependency in the distorted catechism of doctors. These social values explain in part the opposition of the A.M.A. to the Sheppard-Towner Act in the 1920's. It also explains the belief that health care is a privilege, not a right.

An interesting elucidation of the latter concept as recently provided by medical society spokesmen at a national conference on Partnership for Health Planning held in Nashville in February, 1969. These statements were made by B. G. Mitchell, M.D., of Memphis, and reported by the *American Medical News* of March 17, 1969, to represent the feeling of the medical community:

"With the passage of the Medicare law our nation witnessed for the first time a system of taxation of younger working people to provide health care for a segment of our population, whether they needed help or not. The medical profession vigorously opposed this plan and we shall oppose such plans in the future."

"Beware of free medical services or any type of service that creates a feeling of irresponsibility in the public. This is resulting in moral decadence, overutilization, and a something-for-nothing attitude which is difficult to combat. Some element of this moral decay may even spread to the providers of service."

The views reflected in these comments are not often expressed so frankly anymore, but the fact that this was unquestionably the prevailing attitude of the medical profession in the United States for many years has certainly influenced the organization of medical and health services for the last 30 years and is thus a contributing cause, at least, of some of the disjunctions for which the health services are so widely criticized today.

The transformation of the A.M.A. role from a liberal-social guardian to that of a conservative-economic protectionist occurred during the Depression and New Deal of the 1930's. Its nineteenth century values failed to keep pace with the great shift in American political values in the period. Furthermore, debate over national health insurance between 1916 and 1922 converted the A.M.A. from a professional association to a partisan labor union.

Actually, the A.M.A. showed little interest in Federal and state action between the time of its founding in 1846 and the 1870's when it created a section of state medicine and hygiene, which distinguished community health care from private and curative medicine, and which defined public hygiene as the control of contagious disease. The A.M.A. set up its House of Delegate structure in 1901, with members chosen by state societies. The Council on Medical Education was organized in 1904 and produced, in collaboration with the Carnegie Foundation, the Flexner report of 1910, which was to revolutionize medical education. Dr. Flexner's final list approved 66 of 135 schools. Twenty-nine schools were closed between 1910 and 1914.

THE SIX ROUNDS IN THE NATIONAL HEALTH INSURANCE DEBATE

We can identify six rounds in the sixty-year debate over National Health Insurance: 1916–22: In its successful fight against state insurance plans, the A.M.A. transforms itself from a liberal professional association into a conservative protectionist labor union. 1939–49: The A.M.A. defeats Murray-Wagner-Dingell, Taft-Smith-Ball, Truman and Ewing health bills. 1953: A.M.A. defeats Eisenhower's Reinsurance Bill. 1957: A.M.A. defeats Forand bill, a precursor of Medicare. 1960–65: A.M.A. accedes to Wilbur Mills' compromises of Kerr-Mills (1960) and Medicare-Medicaid (1965). 1970s: Administration, Kennedy, and A.M.A. bills are major contenders among a dozen National Health Insurance bills that attempt to repair damage done by Medicare-Medicaid.

Until the late 1960's, the business community and the Republican Party were allies of the A.M.A. But the more than doubling of medical costs since 1965 made

cost-containment the major new political strategy in health care. Thus, the traditional debate between the National Health Insurance proponents among Democrats and the A.M.A. opposition is now joined by the administration and its cost-containment policy. But it is not certain that the administration and A.M.A. plans would not bankrupt us or the Kennedy plan would assure health care to all.

THE FIRST DEBATE ON NATIONAL HEALTH INSURANCE: 1916–1922

The British National Health Insurance Act of 1911 set the stage for the first great debate on insurance. At first the response was favorable to health insurance. It was endorsed in 1912 by the Progressive Party and its candidate, Theodore Roosevelt. The American Association for Labor Legislation (AALL), founded by economists at the University of Wisconsin in 1906, developed a model health insurance bill in 1915. By 1917 twelve state legislatures were considering the bill, eight had appointed study commissions, with the first three to report coming out in favor of the bill. Even the A.M.A. joined the bandwagon. Its Social Insurance Committee, headed by Dr. Alexander Lambert of the AALL, recommended compulsory state-run health insurance in 1916. The next year the House of Delegates approved principles of government health insurance.

The Armistice brought disenchantment and reaction in the United States, not only about the League of Nations but about health insurance as well. The very month after the Armistice, California voters defeated a health insurance plan, and the following April the New York State Assembly defeated a similar bill.

By 1919 the current of reaction which began with the Senate rejection of President Wilson's Peace Treaty became a tidal wave against all social innovation. Health insurance was tagged with both extreme right and left labels—the defeated "Hun" and "Bolshevism." By 1920 the A.M.A. House of Delegates repudiated both its president, Dr. Lambert, and its earlier resolution by coming out in "unequivocal opposition" to health insurance. The insurance and pharmaceutical industries joined the A.M.A. in public campaigns against health insurance. In 1920 and again in 1922 the House of Delegates declared itself against state medicine; "Any form of medical treatment provided, conducted, controlled or subsidized by the federal, or any state government or municipality." Only the Army, Navy, Merchant Marines and U.S. Public Health Service were exempted. The A.M.A. disapproved the Sheppard-Towner Act of 1922 giving grants-in-aid to state programs of maternal and child health. (The program was discontinued in 1929.)

THE COMMITTEE ON THE COST OF MEDICAL CARE

Under the auspices of the Carnegie and five other foundations, the Committee on the Cost of Medical Care (CCMC) was established in 1927. Chaired by Ray Lyman Wilbur, President of Stanford, the CCMC set out five areas for study: (1) incidence of disease and disability; (2) existing facilities; (3) expenditures for services; (4) income of providers; and (5) chronic care facilities. A research staff of 75 under the direction of Harry Moore, University of Chicago economist, produced 27 field studies and a final report in 1932 approved by 39 of the 50 committee members. The sweeping recommendations included the following: "Medical service should be furnished by group practice physicians organized around a hospital to render complete office and hospital care. Costs of care should be placed on a group payment basis, through insurance or taxation or both." The minority members strongly opposed hospital-based group practice. In their report, they argued that medicine was personal service, not mass production; and that the role of government should be limited to the care of indigents, public health, and the armed forces—"everything else belongs to private practice." The minority report urged that the general practitioner be restored to his central place in medical practice—"The GP can treat 85 percent of all illnesses and injuries with very simple equipment." Insurance was secondary: it should be attached to general practice and be under the control of county or state medical societies.

The Journal of the A.M.A. attacked the majority report in an editorial dated December 3, 1932, concluding in these words: "The alignment is clear—on the one side the forces representing the great foundations, public health officialdom, social theory—even socialism and communism—inciting to revolution; on the other side, the organized medical profession urging principles of sound practice of medicine."

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In 1933, the American Hospital Association endorsed hospital insurance as "one of the most effective ways to offset the increasing demand for more radical and dangerous forms of state medicine." Vountary hospital insurance which the CCMC report had passed over lightly, became the "opening wedge."

THE NEW DEAL AND THE SOCIAL SECURITY ACT

In the midst of the Great Depression, Franklin Delano Roosevelt was elected in a landslide in 1932. Early in 1934, FDR appointed a Committee on Economic Security to make recommendations for a program against "misfortunes which cannot be wholly eliminated." Illness was one of the misfortunes. The Committee was composed of the Secretaries of Labor, Treasury, Agriculture, the Attorney General and Harry Hopkins. Many advisory committees were set up, including one on medical care. The original Social Security Bill that was developed by the Committee said that the Social Security Board should study the problem of health insurance. But so many telegrams descended on Congress that the entire Social Security program seemed endangered. In an editorial, J.A.M.A. said some felt the A.M.A. should oppose the entire program. It did not take long for this innocuous reference to be struck out of the bill. But Title V restored the Sheppard Towner Act that had lapsed in 1929. The Social Security Act was passed in August, 1935.

MEETING THE CHALLENGE OF THE PHYSICIAN SURPLUS

The Great Depression further polarized organized medicine and government. While the government met the challenge of economic chaos with the revolutionary New Deal, the A.M.A. responded by greatly increasing its restrictive control over medical schools, particularly their programs, curriculums, and admissions policies. In the first three decades of the twentieth century, restrictions on the supply of physicians were a by-product of the A.M.A.'s successful attack on low-quality medical schools and low admission standards. In the 1930's and 1940's, however, the desire to prevent undue competition and ward off "socialized medicine" became paramount issues. Restrictive policies directed at medical school admissions standards resulted in a steady reduction of medical school admissions during these two decades.

Dr. Walter Bierrin, A.M.A. President in 1934, was the first in a long list of officials to warn of the "social dangers of an oversupply of physicians." In a series of J.A.M.A. articles he called for "real courage and tenacity" on the part of medical societies to "bend" the medical schools to the "urgent social and economic needs of the changing order. He foresaw that the principal function of medical service would be to cut down by half the number of medical schools and physicians. Dr. Bierring confidently predicted that "a fine piece of educational work could well be done if we were to use only half of the 70-odd medical schools in the United States." [4]

Dr. Bierring and his associates might well have succeeded in halving the number of medical graduates had the Depression continued long enough. There was an 18 percent drop in the number of admissions between 1933 and 1938, in spite of an increase in applicants. As it was, the tighter admission requirements did result in halving the number of admissions per 1,000 applicants through the 1930 and 1940 decades. Thus, there were fewer admissions in 1950 than in 1930, though the number of applicants had doubled in the interim.

Attempts by governments, providers, and consumers to ease the physician shortage were consistently opposed by the A.M.A. in this period. In a series of delaying actions and strategic retreats in the 1930's and 1940's, the A.M.A. in turn opposed voluntary health insurance plans, compulsory health insurance legislation, federal aid for medical education, and prepaid group practice programs

THE SECOND DEBATE: 1939–1949, THE A.M.A. VERSUS FDR, TRUMAN, EWING, AND WAGNER

The Social Security Administration was charged with studying and recommending legislation on old age pensions, unemployment compensation, and "related subjects." Many studies on the related subject of health insurance were carried out by the Bureau of Research and Statistics, drawing in part on the massive field studies of the CCMC and of the National Health Survey of 1935–36 based on interviews of 737,000 households.

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[4] W. L. Bierring, "The Family Doctor and the Changing Order," *Journal of American Medical Association*, Vol. 144 (1934), 1997.

FDR appointed the Interdepartmental Committee to coordinate Health and Welfare Activities in 1936. The Technical Committee on Health Care, set up the next year, found existing health care inadequate and called for a national comprehensive heatlh program. This call for action resulted in the First National Conference of Health convened in Washington in July, 1938. It was attended by 176 health care professionals and leaders.

The Second World War set the next stage for the great insurance debate. The A.M.A. successfully opposed the Wagner National Health Bill of 1939 (S. 1620), the Eliot Bill in 1942 (H.R. 7354), the Murray-Wagner-Dingell National Health Bill of 1943 (S. 1161) and 1945) S. 1606), the Taft-Smith-Ball Medical Indigency Bill of 1946, President Truman's National Health Program (1947, 1949), and Federal Security Administrator Ewing's ten-year National Health Insurance plan.

FDR asked for better medical care in Messages to Congress in 1939, 1941, 1942 and 1953. Truman started supporting National Health Insurance in his 1946 Message to Congress. Oscar Ewing called for a second National Conference on Health in May 1948. The National Health Assembly was attended by 800 people. Ewing told them that "we cannot continue to use the purchasing power demand as our exclusive criterion of the adequacy of supply." In 1948, 40 percent of the population was covered for hospital insurance, 23 percent for surgical insurance, and 9 percent for physicians' office services. Ewing predicted that no more than half of the population would ever be insured voluntarily.

President Truman's 1948 election victory panicked the A.M.A. Its House of Delegates met in emergency session and voted an assessment of $25 per member to prevent "the enslavement of the medical profession." The public relations firm of Whitaker and Baxter was hired and a $4.5 million campaign was launched to combat national health insurance and "creeping socialism."

The A.M.A. made a complete turnabout and vigorously espoused the "Voluntary way" of insurance as the "American way" in its campaign to defeat the Truman compulsory health insurance legislation. But as late as 1949, A.M.A. officials were still lobbying to cut down congressional bills designed to stimulate medical school enrollment. In a throwback to 1919 A.M.A. spokesmen linked compulsory health insurance with revolutionary and un-American tags. The A.M.A. claimed credit for the defeat of four senators and for the victory of eight new senators in the 1950 election.

Meanwhile, back at the fort, Truman established the President's Commission on the Health Needs of the Nation in 1951. Paul Magnuson, M.D., of the Northwestern Medical School, was chairman, and Lester Breslow, M.D., of the California Health Department, was staff director. Within a year, the Commission produced its report and recommendations: Government should prod and promote, assist financially but not control or operate health services. Health is a basic human right, and society must assure access to health care and provide health education. Then can personal action reach its full potential, the majority members concluded. They also urged that all methods of private and public financing be given a chance. This time, it was the liberal members who constituted the minority. They protested that states should not have the option not to enter into a federal-state health insurance system.

The A.M.A. claimed victory and concluded its four-year campaign against national health insurance in 1952. Its successful campaign was reflected by the omission of national health insurance in the Democratic Platform of 1952 and candidate Eisenhower's repudiation of it. Years later President Truman was to single out the one-sided debate on national health insurance as his most bitter disappointment.

THE THIRD ROUND: 1953–1957; THE A.M.A. VERSUS EISENHOWER AND THE AMERICAN LEGION

In the 1952 Presidential campaign, Eisenhower said: "American medicine outstripped the world on a voluntary basis and on that basis the needs of Americans will most adequately be met." Eisenhower assured the A.M.A. in 1953 that he continued to oppose socialized medicine and would keep government out of the existing structure of medicine. By that year, 60 percent of the population was covered by hospital insurance. Half of all hospital charges were paid by insurance.

In his State of the Union Message of 1954, Eisenhower proposed the concept of reinsurance. This entailed underwriting and supporting companies that would insure high risk and low income groups. But the A.M.A. would not buy it. Its president, David Allman, M.D., called it the familiar opening wedge and said

government should stay out of health insurance completely. The A.M.A. board claimed reinsurance involved not only subsidization of voluntary health insurance but federal regulation and control as well.

The Reinsurance bill was defeated 238 to 134 in July 1954. Eisenhower reasserted his support of the concept in his State of the Union Message of 1955. That year, Marion Folsom succeeded Oveta Culp Hobby as HEW Secretary. In an interview in the New York Times of August 24, 1955, Folsom called reinsurance the keystone of the Eisenhower health program. But he hinted that the policy would be dropped because "liberals say it can't do the job, won't reach lower income people, and doctors don't want the government to do anything." Reinsurance indeed was dropped after 1956. It was replaced by an emphasis on grants-in-aid for facilities and personnel, and to states for medical assistance to indigents.

After 1954, the A.M.A. became increasingly unhappy over the Veterans Administration policy of giving free care to veterans for nonservice connected disabilities. The VA network of hospitals was the great exception to government reluctance to provide direct health services. By 1954, 60 percent of VA medical care was for nonservice connected illness. Thus it came to pass that the A.M.A. and the American Legion, those two bastions of conservatism, came to blows on the issue of misguided patriotism. The A.M.A. asserted that the Legion was unwittingly planting the seeds of socialization when it continued to foster free medical care for veterans. "It would be unfortunate indeed," a JAMA editorial warned, "that if in our efforts to reward patriotism we were responsible for the creation of a system of government medicine against the will of the majority.

THE FOURTH ROUND: 1957–1960; THE A.M.A. VERSUS THE AFL–CIO AND THE FARMERS UNION

The bell for the fourth round of the debate was sounded by the Forand Bill in 1957, to provide health insurance for the elderly on social security. This time the A.M.A. hired the public relations firm of Braun and Co. and was joined by the insurance and drug industries in opposition to the first Medicare bill. The fight in this round was a little more even, with the AFL–CIO, the National Farmers' Union and the American Nurses Association in support of the bill. Although the bill was defeated in committee by a two-to-one margin in 1960, the simple fact that it was brought to a vote was a signal victory for its supporters. Moreover, the A.M.A. had suffered its first defeat in 1956 by unsuccessfully opposing aid to the totally and permanently disabled elderly beneficiaries under Social Security. The next year the Social Security Amendments of 1957 permitted states to use federal grants-in-aid to pay providers of health services for public assistance recipients.

THE FIFTH ROUND: 1960–1965; THE A.M.A. VERSUS MEDICARE

In the summer of 1960 the stage was set for the fifth round and first real showdown on the floor of the Senate. On one side of the aisle was the Republican subsidy bill endorsed by Presidential candidate Nixon; on the other was a diluted version of the Forand bill endorsed by the Democratic candidate Kennedy. In the middle was a compromise bill endorsed by Representatives Mills, Senator Kerr, and the A.M.A. The Republican and Democratic bills were defeated 67–28 and 51–44. The minimal Kerr-Mills-A.M.A. bill then swept through 91–2.

The Kerr-Mills Act provided between 50 and 80 percent of funds states used in medical aid to the aged. But states had an option to determine eligibility and benefits. Thus by 1953, only 32 of the states had programs in effect. Five states—California, New York, Massachusetts, Michigan and Pennsylvania—with 32 percent of the aged were receiving 90 percent of the Kerr-Mills funds.

In the 1960 election both Nixon and Kennedy promised to strengthen the Kerr-Mills Act if elected. President Kennedy's victory signaled the fifth round in the debate; the A.M.A. launched an all-out effort against "the most deadly challenge ever faced by the medical profession." The grim prospect that the Federal government might ensure the health of the nation's aged, blind, and disabled would be challenged by a 70-man speakers' bureau and a newly-created American Medical Political Action Committee (AMPAC). In the first two months of Kennedy's administration a Presidential task force recommended Medicare; the President endorsed it in a message to Congress; and the King-Anderson bill was introduced. The bill was immediately attacked by the A.M.A.: "Medicare is really Fedicare—a costly concoction of bureaucracy, bad medicine—and an unbalanced budget." After nine days of hearings in August 1961, the bill was allowed to die in com-

mittee. More hearings were held in 1962 and 1963 resulting in 14,000 pages of testimony but no votes.

Some consumer groups were now adding their weight to the debate. The National Council of Senior Citizens was formed in 1961 with AFL–CIO support and counted 600,000 members by 1962. In 1964, the AFL–CIO, over 13 million members strong, spent $1 million in the 1964 elections, and another $1 million for lobbying the following year through its Committee on Political Education (COPE). A.M.A.'s AMPAC also spent a $1 million in 1965.

The November 1964 elections gave the Democrats 32 new seats in the House, for a ratio of better than 2 to 1. The Ways and Means Committee shifted from 15 Democrats and 10 Republicans to 17 Democrats and 8 Republicans and Rep. Mills promised Medicare action in early 1965.

The administration introduced H.R. 1 and S. 1 in January. It did not cover physicians services, an omission pounced upon by the A.M.A. The A.M.A. suddenly proposed its own "Eldercare," administered by the states but including physician care. Eldercare was held to be more comprehensive than Medicare which was projected to cover only a fourth of the health care expenses of the elderly. The A.M.A. trotted out a survey showing that two-thirds of the respondents preferred physician care and selective coverage of the indigent. Rep. Byrnes introduced the Eldercare bill.

At that point, Rep. Mills asked HEW's Wilbur Cohen to merge the two bills. Cohen's resulting "three-layer cake" included Medicare, private insurance for physician care, and an expanded Kerr-Mills for the poor. These became Title 18, Parts A and B, and Title 19.

The new bill passed the House in April 1965. In June, the Senate yielded to the American Hospital Association position that hospital specialists should be covered under Part A (hospital services) rather than Part B (physician services). This threw the A.M.A. House of Delegates into an uproar. The A.H.A. was accused by the A.M.A. President with seizing upon this bill to seek "ever-widening dominion over doctors." An A.M.A. pamphlet predicted that Medicare would result in "a complete takeover of medical practice by A.H.A. and the Federal government." The delegations from nine states voted to refuse to participate in Medicare. Fortunately the Senate-House committee set up to reconcile differences between the two bills put the hospital specialists back in Part B and the signout threat was over. The reconciled bill passed the Senate in July 1965 and the Social Security Amendments of 1965 (Medicare and Medicaid) became the law of the land.

Thus did the United States finally join the rest of the western world in insuring the health of its aged and indigent.

TOWARD NATIONAL HEALTH INSURANCE IN THE 1970'S

The expansion of Medicare/Medicaid insurance to the total working population is the agenda for the current (sixth) round in the insurance debate. The first decisive blows in this round are the Social Security Amendments of 1972 (H.R. 1), which somewhat extend, and somewhat restrict Medicare and Medicaid. In a cut-down version of a catastrophic illness insurance bill, Social Security benefits are extended to 1.7 million people under 65 who are victims of chronic kidney disease. But victims of other crippling diseases are not covered. Private physicians have lost the vendor monopoly, a major cause of the inflationary effect of Medicare and Medicaid, and beneficiaries may now choose to receive their care from an HMO. Perhaps the major impact of the new law is to allow states to greatly reduce Medicaid benefits because of camplaints of waste, fraud, and overutilization in the program. A more effective cost and utilization review mechanism is imposed in the form of PSROs to be made up of peer physicians.

As in the 1960's the two major national health insurance bills are linked with the names of Nixon and Kennedy. But as in 1960, these bills are so divergent ($6.5 versus $8.3 billion the first year according to HEW) that a compromise bill will probably win the day again. Indeed such a compromise bill was attempted by the Ways and Means Committee in August 1974. But the committee could not agree on such issues as financing catastrophic insurance out of payroll taxes or general revenue and on mandatory or optional employee participation.

As in 1965, the A.M.A. has come up with its own alternative plans. The first, "Medicredit," was a voluntary plan financed out of sliding income tax credits. The second plan, introduced in April 1975, called for mandatory employer coverage but voluntary employee participation, and would be financed largely out of general revenues.

WHY THE A.M.A. STILL OPPOSES NATIONAL HEALTH INSURANCE

Organized medicine's fear of the effects of National Health Insurance on freedom, practice, and income of physicians is probably as unfounded today as it was in earlier decades. Physicians were by far the major beneficiaries of Medicaid and Medicare in spite of their opposition. They will likewise be the major beneficiaries of National Health Insurance. By the end of the 1970's organized medicine will likely control even the HMO's and PSRO's that now seem to threaten them.

The opposition of the A.M.A. to social programs that are supposed to enhance the efficiency, quality, and income of physicians may make little sense on the face of it. Various people have accused the A.M.A. of being regressive and reactionary, of being unrepresentative of American doctors, or of shamming protest to disarm potential critics of the huge Federal subsidies of doctors flowing out of Medicare and Medicaid. Some of the A.M.A.'s opposition may indeed be seen as an irrational counterproductive rear guard action for the preservation of the social values of a bygone age. That is due in part to the hard training of doctors and their strong adherence to the work ethic. It is also due to the inability of doctors to accept the advice of nondoctors such as association executives, lawyers, politicians, lobbyists and public relations experts. Evidence of this are the tenuous working relations between the A.M.A. staff and the committees, and the reported low morale of the staff.

But it is hard to question the representativeness of the A.M.A. or impugn its sincerity. It apparently speaks for the great majority of America's physicians, and it speaks honestly for them. Survey after survey confirm the misgivings and anguish of doctors at the prospect of National Health Insurance. In one of the most comprehensive such surveys, reported by *Medical Economics* in August 1971, most doctors (80 percent) believe National Health Insurance is inevitable; 60 percent think patients should pay part of each bill, but 60 percent think poor people should get free care, and a third think old people should not pay; two-thirds prefer the A.M.A.'s "Medicredit" tax credit financing method. Only 12 percent of the doctors think they will gain financially and 40 percent think they will lose income. One-third would refuse to join a group practice required to do so for reimbursement. Two-thirds fear National Health Insurance will worsen medical care; only one-tenth believe care will be improved. Three-fourths would accept physician peer-review boards sponsored by their medical society; one-fourth would accept such boards under hospital sponsorship, and six percent would accept such boards under government auspices. While 60 percent of the surveyed doctors would accept National Health Insurance, 35 percent would retire, 10 percent would shift from practice to research or administration, 10 percent would leave medicine altogether, and 5 percent each would go on strike, leave the country, and take other desperate actions. (These add up to more than 100 because of multiple answers).

A more recent survey of 2,713 senior physicians was reported in the May 1975 issue of *Medical Care*. Despite the fact that 56 percent of the respondents were in favor of some form of National Health Insurance, almost three-fourths said most doctors they knew were opposed. Over three-fourths of the doctors felt that NHI was inevitable. Over half preferred the tax-credit financing method, and 37 percent preferred payroll taxes. With respect to reimbursement, three-fourths favored fee-for-service, only one fourth favored capitation, and merely 14 percent favored salary. Two-thirds felt NHI would adversely affect their work; only 17 percent thought it would improve quality of care, about half predicted NHI would result in unnecessary hospitalization and doctors' services. Over a fourth thought they would earn less money, and 14 percent thought they would earn more. One fifth said the A.M.A. represented their opinion on most matters, half on some matters, and another fifth, on hardly any matters.

In a sense the A.M.A. is looking after the inteersts of its constituency in the well-established American labor union tradition. The A.M.A. is probably wrong in fearing National Health Insurance would destroy private practice, but it is not wrong in thinking that the technological and social forces underlying social insurance would vastly affect doctor-political relationships. Even in the absence of social insurance measures like Medicare, the revolution in medical technology would have made huge demands on the amount and organization of capital and specialized manpower and resulted in greatly expanding the role of what Robert Cunningham calls the third world of medicine—medical schools,

hospitals, private insurance, group practice, and the drug industry.[5] That organized medicine has managed to shape and control these forces, as well as the forces of social insurance, is testimony to both the high social credit of physicians and to the success of their past political and propaganda campaings. According to most opinion surveys, physicians generally occupy the top position among professions and occupations in public esteem, altrusm, and credibility. If television program values are any indication, physicians vie with policemen as the most revered contemporary occupations. What other profession could have maintained this stance after decades of ranting against health programs for the aged, blind, disabled, and indigent mothers and children, and after half a decade of charges of financial exploitation and other abuses in the medical care provided these classes?

How then do we explain organized medicine's continuing paranoia and paroxysm of fear and distrust elicited by the interposition of government and hospitals in the expansion of corporatism and of social insurance? Two reasons are that the business community and the Republican Party are no longer on the side of the A.M.A. in the insurance debate. There are indeed no longer two sides, but rather at least three sides in the current debate on National Health Insurance.

This is the very development that the A.M.A. sought to prevent. In the context of the earlier discussion, the A.M.A. fought against the redistribution policy of Medicare in fear that government and employers would become adversely affected as payers for excessive services at inflated prices and would consequently try to check inflated demand and prices with a policy of regulation.

THREE FACTIONS IN THE CURRENT DEBATE

It is the inflationary effect of Medicare-Medicaid, produced by ineffective cost and utilization controls insisted upon the A.M.A., that broke up the coalition. Up to 1965, the National Association of Manufacturers, the U.S. Chamber of Commerce, and the Republican leadership were generally allies of the A.M.A. But concern over escalating costs of medical care in the United States—which more than doubled since the onset of these programs in 1965—made cost-containment the major new political strategy in health care, and the Federal Administration and the business community its principal proponents.[6] The administration's new cost-containment policy first found expression in the "health cost effectiveness amendments" presented to Congressional committees in October 1969, which culminated in the Social Security Amendments of 1972 already discussed. Big business for its part voiced its disenchantment with the A.M.A. through such manifestoes as the January 1970 issue of *Fortune Magazine* on "our ailing medical system" and such spokesmen as the chairman of I.B.M. As quoted by the Washington editor of *Medical Economics*, Thomas J. Watson, Jr. recanted his former stance "as a dyed-in-the-wool free trader, free enterpriser, and hater of bureaucracy," and declared: 'We do not need National Health Insurance as a political football in 1972; we need a new National Health Insurance law, and we need it now. Indeed, I hope the Administration will put this at the top of its priority list."[7]

The vastly expanded authority of states to reduce Medicaid benefits and PSRO's to cut down on unnecessary medical care and financial abuses are but the first step in the administration's cost-containment strategy. The President in 1973 called for a major shakedown of health programs that are "too fat, too bloated," and assigned the task to Casper ("Cap the Knife") Weinberger, who was moved from Budget to H.E.W. Although the Democrats are identified with the more inflationary Kennedy bill, both Democratic and Repulican platforms in 1972 emphasized cost containment. "Incentives and controls to curb inflation in health care platforms. But the Democrats sought "Universal National Health Insurance" with free choice for both provider and consumer, and at an affordable cost, whereas Republicans opposed "nationalized compulsory health

[5] Robert M. Cunningham, *The Third World of Medicine* (New York: McGraw-Hill, 1958).

[6] Pierre de Vise, "The Social Pressures: Health Care Plans Proposed by the Federal Government, by Corporations, and by Labor Unions May be Regarded as Declarations of Independence from America's Medical Dictatorship," *Hospitals*, Vol. 45 (February 1, 1971), 51–55.

[7] J. A. Reynolds, "Inside Washington: The Net Tightens Around Doctors," *Medical Economics* (April 12, 1971), 230–240.

insurance" because it would triple health care costs and deny free choice. These differences are incorporated in two of the major insurance bills—the Administration's Comprehensive Health Insurance Plan (CHIP) and the Kennedy-Corman Bill.

The major participants in the present debate have been identified as the purchasers of care (the Administration and insurance carriers), the providers of care (physicians and hospitals), and consumers (the labor unions.)[8, 9] Each of these participants has an insurance plan—the Administration, the Health Insurance Association, A.M.A., A.H.A., AFL–CIO, and the UAW-sponsored Kennedy-Corman Plan. The three leading plans represent the three major parties at stake—the Administration Plan speaks for purchasers of care; the A.M.A. Plan for the providers of care; and the Kennedy-Corman Plan comes the closest to representing the consumers of care.

The purposes, costs, and effects on doctors vary in the three plans according to their underlying goals and objectives. Major priorities in the Administration Plan are economy and efficiency, and mandatory PSRO's and optional HMO's are designed to penalize waste and reward efficiency. The A.M.A. would prefer no plan at all, but if a plan is inevitable, then the objective is to assure income for treating indigents within the existing fee-for-service, private practice system. The A.M.A. Plan is strictly a financing mechanism, with voluntary employee participation and no change in the delivery system. Consumers are concerned about both access to care and costs. Labor unions, which are the best organized health consumers, are especially distressed by the increasing proportion of fringe benefits and payroll deductions eaten up by health insurance. Thus, the Kennedy-Corman Plan goes the farthest in overhauling of the existing delivery system, with built-in controls on costs and quality.

CONCLUSIONS

In addition to differences between these three plans that may be hard to reconcile, there is great uncertainty as to whether any of the plans could actually fulfill their stated objectives. Based on the disastrous experience of Medicare and Medicaid, there is good reason to believe that the modest Administration and A.M.A. plans would further shift medical manpower from poor to middle-class areas and that the more ambitious Kennedy Plan would bankrupt us. But it is not even certain that the Administration and A.M.A. plans would *not* bankrupt us or that the Kennedy Plan *would* assure quality for care and control costs.

These proposals can work only if effective price and mode of delivery controls of the three types already discussed can be implemented. There is no doubt that under "free" competition, subsidies for the medical care of families above the poverty level would result in further shifts of physicians from poverty to non-poverty communities, raise private practice fees, and force up medical insurance rates.

Federal controls on medical prices and delivery systems are justified even now with respect to the $40 billion expended on health care by government in 1974. They would become mandatory if the government were to increase its health budget to $50 billion by subsidizing National Health Insurance. Without these controls Federal subsidies would drive up medical expenditures to levels that would not be tolerated by Americans. Within three years health care could take 10 percent of our gross national product, hospital beds would cost $150 per day, a physician's office visit would cost $25, a diagnostic visit $100, and physicians would earn $80,000 a year on the average. If that day should come about, there is no doubt that the pressure on government to nationalize hospital and medical services would become overwhelming.

The challenge for American government is not to spend more but to spend better—to channel current annual expenditures of $40 billion into more efficient and accessible health delivery systems made possible by medical technology advances and national health plans. In other parts of the western world, indeed in parts of the United States covered by prepaid group practice plans, comprehensive care is provided to all the population for a fraction of what the American government currently pays for fractionated care for the nation's old and poor.

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[8] S. W. Olson, "Health Insurance for the Nation," *New England Journal of Medicine*, Vol. 284 (1971), 525–533.
the Light of Contemporary Policy Issues." *Inquiry*, Vol. 8, No. 2 (1971), 20–36.
[9] R. M. Battistella, "National Health Insurance: An Examination Leading Proposals in

The only thing preventing a workable National Health Insurance program for the United States is that our doctors would not accept it and our citizens would not dictate it on recalcitrant doctors at the present time. We must resign ourselves to an unworkable National Health Plan that will so exacerbate the present dilemma of poor access and runaway costs that either the doctors or the citizens will have a change of heart, and decide to join the rest of the western world in making health care part of the public interest.

Mr. ROSTENKOWSKI. Thank you, Professor.

We now will afford you an opportunity for you to have an interchange, if there is anything you would like to bring up.

Mr. BUTLER. I was going to suggest that perhaps we spend some time, if the members are interested, in the subject that seems to have run through all of the discussions here, not premeditated, because of course, we did not get together before this. That is the question of cost control.

I was going to ask Dr. Bellin something, his illustration of the significant savings on lab in New York is a good one, but I am going to ask him when you get past a tangible service like a lab, such as an X-ray or something else, how far do you think you can go with that device?

Dr. BELLIN. I think this device is a good device in a number of areas of health care services. It is worth keeping in mind that not all health care services are provided by physicians. We found abuse in private practice podiatrists working in nursing homes in New York City. We found one lining up the patients and clipping the toenails and simultaneously clipping the city of New York a substantial amount of money, charging per clipped nail.

We stopped that fee for service or fee for toenail and put the podiatrist in the nursing home for a specific amount of money for a session, at a savings of substantial sums of money immediately.

Similar types of approaches of putting services out on bid can be done with optometry and specific institutions. We have done that. We have done it with ambulance services to a certain extent. There are a variety of approaches.

There is always the question asked as to whether the money that is invested is worthwhile. "Are you not spending more money in carrying on the audit than you actually recover?" That has not been our experience.

I wonder if I could invite two members of my staff to sit on the front row, because I think I am going to be referring in the conversation this morning to them on a few occasions, and they can give some specific details,

I would like Mr. Philip Agree, a member of the office of the New York City Corporation counsel, and also Dr. Martin Paris, the Deputy Executive Director of medicaid, to please sit here.

Recently, for example, you are aware of the terrible budgetary problems we have in the city of New York. We are constantly struggling with the first deputy mayor to make certain that our staffs are not cut. What has been very helpful in medicaid is and we have been able to prove to the first deputy mayor of the city, who makes these decisions about cuts in staffs, that in getting back moneys through auditing we more than pay for the salaries of our auditors. We are the only agency other than the OTB, the off-track betting activity,

that is bringing back money in the city. We are accomplishing this by virtue of auditing. There are significant amounts of money that can be recovered.

So I hope that the Subcommittee on Health, as a result of all this testimony does not conclude that there is a need to be annihilistic about this. One can bring quality and costs under some semblance of administrative control. I hope this point of view is being communicated.

Mr. BUTLER. Do not let me ask all the questions, but I did want to talk of Mr. Heim about the experience in New Mexico. I have a sense that things can be done in New Mexico that maybe cannot be done in some other parts of the United States having to do with service and people knowing each other and all the rest of it.

Going past that point, there is no question that you had fantastic success with this PSRO approach that predated PSRO's particularly on drug costs, I gather.

People tell me when you really get down to writing out what good care would be, whether it is pediatric care or something else, you are going to find out that under the Medicaid program alone the physicians are not giving enough care, that is the problem is not overuse, it is underuse. So the PSRO mechanism, which was intended to cut costs, in fact is going to increase costs in that regard, because the standards of care are always set higher than your recent practices. They are set at a level of perfection rather than a level of common sense.

Do you want to comment about that?

Mr. HEIM. When we went into our program, we did not specifically set as the only objective to control costs. I think when we presented the program to our legislature we said we wanted to guarantee to the citizen of New Mexico that they are getting what they are paying for.

One of our very important objectives is to detect underutilization as well as overutilization. I will submit that not as much effort has been directed in this way. However, the same tools that are used to detect overutilization are also available for underutilization. That is the instantaneous production of a patient profile which can show the total care that a patient has received for the past 12-month period. Any inappropriate care, and inappropriate prescription of medications can be detected quite readily and the treating physician can be so notified.

Mr. DE VISE. I have a question about your paper, Mr. Heim. I hope your State's very commendable program of cutting costs is meant to serve as an example for a Federal program, rather than urging the Federal Government to give back to the States the decisions about benefits and participation in the programs—because, as I indicated in my own paper, States really cannot do the job.

We had, as you know, a forerunner of medicare in the form of Kerr-Mills between 1961 and 1965. After 4 years of Kerr-Mills it turned out that 90 percent of Kerr-Mills funds were going to five States, California, New York, Massachusetts, Michigan, and Pennsylvania. That is because in Kerr-Mills it was up to the States to decide how these programs would be administered. So the richest States turned out to get the lion's share of the Federal funds.

Similarly, of course, medicaid is a program in which States have a lot of leeway in defining who is eligible for what benefits, even though

they are supposed to provide a minimum of five basic services. We find today that three States, California, New York, and Massachusetts, get over half of all medicaid moneys, even though they count about a fifth of the Nation's indigents.

I do not suggest that these States should not be encouraged to have generous benefits, but, on the other hand, it does mean that half of the medicaid funds go to these three States in a program that is designed to help poor people and poor States.

Dr. BELLIN. I wonder if I could ask Professor de Vise a question. I would like some comments not only about the American Medical Association—which I would argue has become increasingly a paper tiger in the last 5 years. I think you already commented that there is only a membership of 200,000. As those of you who have attended meetings of local county medical societies are aware it is hard to get a quorum. Attenrance is poor, members do not show up unless there is a hot issue, leaving the organization to be run by a skeleton crew, at best.

Our experience has been that it is not so much the county medical societies that represent a substantial locus of force but, rather, the hospitals and their organization, the American Hospital Association.

Since you are from the Chicago area, that is "the territory," as they say in "Death of a Salesman," how do you analyze the hospitals and the American Hospital Association?

Mr. ROSTENKOWSKI. Professor, we will have to suspend for about 7 minutes. We have to answer a rollcall, and we will return for your answer.

[Short recess.]

Mr. PIKE [presiding]. The committee will come back to order.

It is my understanding that Dr. Bellin has just asked a question of Professor de Vise, and for the benefit of those who went over to vote in the meantime, would you repeat the question, please?

Dr. BELLIN. Professor de Vise gave a very instructional organizational analysis of the various forces and counterforces involved in this entire medicare/medicaid Kerr-Mills history. I felt there was one aspect that deserved significant emphasis and I am sure he agrees.

I commented he was from the Chicago area, so he ought to know what I am talking about. I am talking about the American Hospital Association and the force of the hospitals.

I think we tend to beat the AMA, and I think we like to use them as a kind of scapegoat for all kinds of impediments to social progress when, as a matter of fact, they really have not counted for that much, in my view, in the last 4 or 5 years. I think there is a psychological momentum that maintains interest in what they are doing. I think to a great extent the locus of the power and authority has shifted to the hospitals, the American Hospital Association.

This is what we have found in New York City, and I was interested in how Professor de Vise and my other colleagues here at the table see this as a potential problem.

Mr. DE VISE. In my long paper I do discuss some of the other pressure groups and, of course, the AHA is another example of an integrated group with considerable influence over national policies. Indeed, in that paper I say that the AMA is much more fearful of rival groups like the AHA than it is of the Federal Government. The AMA is con-

cerned about not only the Federal Government's role but it is also afraid the Federal Government will give another group like the AHA some piece of the action.

If you remember, there was a huge debate during the negotiations on medicare with respect to the reimbursement of hospital radiologist and anesthesiologists under part A or B. At that time the AMA came out with a statement predicting that medicare would result in the complete takeover of medical practice by AHA and the Federal Government.

While the AMA has considerably dwindled not so much in contrast to the emerging power of AHA and the other groups but because of the emergence of consumer interests, due to the inflationary effect of medicare/medicaid. What we have seen is more than a doubling of the cost of the health care in the United States and the Government's share of the health care bill go from 25 to 40 percent. As a result, the business community and the Federal Government now have parted company with the AMA.

In my analysis the Republican Party and big business were allies of the AMA until about 1967–68, when the first results of medicare came in, with costs going way out of control, as the demand for medicare and medicaid services rose way beyond expectations. The Nixon administration came out with health cost effectiveness amendments in 1969, which resulted in the social security amendments of 1972 permitting all States to do the kinds of cutbacks on services that Mr. Heim has been mentioning.

I see the decline of the AMA also signalized by the new AMA bill. The AMA gave up its medi credit bill and has now come up with a mandatory hospital insurance, national health insurance from the point of view of employers, although employees would still have the option. I doubt, though, that the AHA has gained any influence over the AMA because it too is faced with the revolt of the consumers, the Government, the business community, and labor. It is now the target, as you know, of regulatory legislation.

The AHA reacted against a common assumption of government agencies in a recent editorial on the question of "Are there too many hospital beds?", and they denied this. Hospitals actually are much more affected by the public utility types of reforms than doctors. Certainly nobody is talking about certificate of need for new physicians' offices.

Also, there is new legislation in three or four States imposing rate control for hospitals. Corresponding fee controls has not been discussed for physicians yet. So I would say the AHA, although it is certainly a strong rival of the AMA, has not eclipsed the AMA in political influence. I think the influence of both groups will be much less in new health legislation than in previous legislation.

National Health Insurance, I am sure, will see tremendous concessions made by the AMA, but also by the AHA, because both groups actually are targets of cost containment policies of consumers.

Dr. Bellin. Might I ask Mr. Heim a question?

Mr. Pike. I am going to at this point let Mrs. Keys ask a question or two, if she would like to, and I might even like to ask a couple myself. Dr. Bellin, I realize you are having a ball up there, but it is our turn to play.

Mrs. Keys.

[She nodded no.]

Mr. PIKE. Well, all right.

Dr. Bellin, I will ask you a couple of easy ones, and then I will ask you a tough one.

You suggest that one of the reasons that these costs go out of control is that there is no effective method of disciplining a doctor, a physician, in the present system. If the medical society kicks him out of the medical society, he may not belong to it anyway.

What would you recommend for a proper disciplinary procedure for a doctor?

Dr. BELLIN. Well, one would need a few elements of discipline. One element of discipline is to take his money away. That is the first thing you do.

Mr. PIKE. At what level is the judgment? Who is going to make the decision to take his money away?

Dr. BELLIN. I would argue that it has to be a review organization that is accountable to the public. I do not believe that the PSRO's will be sufficiently tough. Maybe they can be tough in a city like New York where it might at least be theoretically possible to have physicians from one part of town review the work of physicians from another part of town and these physicians do not know one another.

I would be interested to hear what Mr. Heim has to say from New Mexico. I was originally health commissioner in Springfield, Mass., and I was a practitioner there before I went into public health, and all the doctors know one another.

Mr. PIKE. I want you to know that all the doctors know each other up in Riverhead, Long Island, N.Y.

The question is, who is going to take away the money?

Dr. BELLIN. I would argue that it ought to be the health department or an agency like the health department.

Mr. PIKE. Is this going to be done without any judicial proceedings?

Dr. BELLIN. There would have to be a quasi-judical proceeding within the health department.

Mr. PIKE. The health department will be both prosecutor and judge in this case?

Dr. BELLIN. That is correct.

Mr. PIKE. All right, that is a good hard line.

Assuming that this is the way to do it, assuming, as you say that you have the toughest enforcement operation in the country, the fact is, as I understand it, that the city of New York today gets 20 percent of all the medicaid money spent in the United States of America.

If I could believe the New York Times, New York has just undergone one of the largest scandals which has been seen in the health care operation in the form of nursing homes. Why?

Dr. BELLIN. One reason that you know about what goes on in New York City is because the national media, at least part of the national media, are in New York City, and the warts and blemishes of New York City are publicized for the world to see.

I would argue if one were to go to Dubuque or San Francisco or Phoenix, one could find analogous situations.

I have spoken around the country one the subject and it is very interesting. During the formal question and answer period that occurs

after this presentation and gospel is presented, people argue that this may happen in your part of the country in Sodom, but it does not happen in our part of the country, that this kind of behavior is too grotesque and would not occur here.

After the presentation there is a subsequent meeting that occurs, and it happens every single time. They come and talk with me and then they start saying all the problems that you have discussed generically exist over here only we do not talk about it the way you people talk about it, and it does not get publicized.

So I want to say that the evils of the country in medicaid are not localized exclusively to New York City.

With respect to the nursing home scandal, what happened in the nursing home scandal is that some years ago the responsibility for overseeing the medicaid program in the nursing homes of the city of New York were taken away from the New York City Department of Health and were transferred to the New York State Department of Health, and one of the areas of investigation right now by the Moreland commission in New York City is to find out why that was taken away.

I think that in itself is evidence that we were getting a little bit too warm for them.

Mr. PIKE. Are you indicating that the State department of health was their handmaid?

Dr. BELLIN. I am indicating that it was a less than adequate review of nursing home operations and other operations. I would argue that in a State the size of New York State, it gets exceedingly difficult for Albany to carry out appropriate quality and cost control for local territories and you really should assign it to a local department.

Mr. PIKE. Let's take the State of New York as an example. You would make the enforcing agency for a health care program the county department of health outside of the city?

Dr. BELLIN. Depending the way the government runs. In some areas we have stronger county health departments than elsewhere, and in some places we have stronger urban areas and in some areas we would use the State because the local health department cannot do it.

Let me share with you the following. I spoke before the American Public Health Association on this subject a few years ago, and the health commissioner of one of the States came to see me and said, "You know, you are doing the kind of job we would like to do in our State, and we would do it in our State but we cannot."

I said, "Why can't you?"

He said, "You have to understand our State public health department's board of health, for whom I work as health commissioner. On it are the medical societies, nothing but the medical societies, I work therefore for the medical society in our State, and I simply cannot do it."

The man cannot do it. His pension depends upon his appropriate behavior. So I would be loath to make a general rule about this. I would say it depends on what is the governance of the local agency. There would be many places where I would not use the health department.

I know too much about the blemishes of some of my colleagues in the field of public health and why they behave the way they do, or

why they cannot behave the way they should. Perhaps you have to have a parallel structure to represent the eyes and ears of the Federal Government.

Mr. ROSTENKOWSKI. One of our difficulties in trying to legislate is that we cannot legislate without having criteria that are going to be applied nationwide. As to whether you are going to use the State health department or the county health department or set up some parallel structure, I do not see how we can legislate along those lines.

Dr. BELLIN. One suggestion: Offer a number of options. Establish qualifications and criteria for that type of agency appropriate to carry out this kind of responsibility. The boat was missed in the PSRO legislation. If you are going to establish PSRO's, at least give an opportunity not only to the medical society to have the first dibbs on the PSRO, but assign the responsibility in some cases on a demonstration project to a State department of health, assign it on some basis to a city department of health, assign a few demonstration projects to a university, to a school of public health, to a department of urban studies.

Then in a period of 5 years you could compare to determine under which auspices the work is better. By assigning all PSRO's to medical societies you have essentially put all your eggs in one basket. Having assigned it all to the medical societies, you should not be too surprised about what you will find in 3 to 5 years.

Mr. BUTLER. I would like to respond to Mr. Pike's point.

One is quality control on nursing homes. That is a very difficult thing, although it relates to it, I think, more than cost control. If you just have filth, if you have people dying, that is a standard medical quality control problem. There are a lot of different ways to try to deal with it. None of them is perfect, and, as has been indicated here, you have a wide variety of skills, talents, ability, organization, and so on from city to city and State to State.

I am unclear as to how you would arrive at any one given solution to the quality control problem.

The second one has to do with corruption, just plain stealing. In nursing homes that is not much different than paving contractors or anything else. You never get rid of it. You find a lot of ways to try to deal with it, and it is a classic city-county-State problem, and I do not think it is unique to the medical care field.

The one that is unique to medical care, even when the nursing homes are clean and when nobody is stealing, is what is it they are supposed to be doing. It is unclear now 5 or 6 years later exactly what the people had in mind when the nursing home benefit was included in medicaid. Of course, the legislation was not seen as greatly significant at that time, medicare was the big thing. But presumably one of the theories was that nursing homes would be less expensive than hospitals and people could go into them and then they could come out.

Going back to the question about chronic care, I think the statistics are now that the average stay in a nursing home is 4 years terminated by death. This is one-third of all medicaid expenditures, so you are talking about $5 billion.

So our problem for the long range is what about a lot of chronically ill people, are we going to house them in a health institution which

is inherently more expensive than some other kind of institution? Then that gets us back to quality control problems, because you say you do not have to have registered nurses. Then what is this, a boarding house? And so on.

So that last problem is the toughest. My own view is we cannot deal with this problem of chronic disease through a medical model such as a nursing home. We have to have a whole new residential approach for that or put people back in their own homes, and that will take years to develop.

Mr. ROSTENKOWSKI. Mr. Duncan will inquire.

Mr. DUNCAN. Thank you, Mr. Chairman.

Dr. Bellin, how many enrollees do you have in medicaid in New York City now?

Dr. BELLIN. Currently 1.4 million now.

Mr. DUNCAN. You have increased that constantly each year?

Dr. BELLIN. No, sir.

What actually happened was in 1968 we achieved our zenith enrollment. It was about 2.4 million, as you are probably aware, there were many definitions of what constitutes medical indigency under the medicaid program. Initially the rule was, if you were in a family of four with $6,000 a year for the State of New York, you were defined as being medically indigent and the enrollment was close to 2.5 million with that rule.

But by 1968 the New York State Legislature redefined it to be $5,300 for a family of four, and then subsequently $5,000 a year later, and with each decrement there was a slicing off of people who were qualified to belong to the medicaid program, until ultimately we now have about half the number we had back in 1968.

Let me comment about that. To give you an example of the terrible abuse in this program, in 1968 when we had double the number enrolled that we have now, we were spending about $18 million a year in pharmaceuticals in New York City. With half that number enrolled, rather than half the expenditure of pharmaceuticals, we are spending close to $40 million a year in pharmaceuticals on the basis of increased drug costs alone.

Let me reiterate something that may sometimes be forgotten.

Costs of drugs have remained on a plateau for the last 5 or 6 years. They have not gone up that much. Price per prescription increase surely does not account for that kind of increase at $22 million. One can only conclude that either there has been significant physiological deterioration of the people in the city needing three to four times the amount of drugs they were getting back in 1968, or there is a tremendous amount of overutilization of pharmaceuticals.

I would opt for the latter explanation. One can give example after example after example for this escalation of costs.

I would plead with members of the subcommittee that it be very, very careful indeed to structure within the framework of national health insurance appropriate quality and cost controls.

Mr. DUNCAN. How many dollars are you spending on medicaid?

Dr. BELLIN. Close to $1.5 billion a year. This is a doubling. We were spending $750 million in that 1968 period when we had double the enrollment.

Mr. DUNCAN. I read a paper recently that you had given—and it indicated then a few years ago the money you were spending in New York City was 20 percent of all the medicaid expenditures in the Nation.

Dr. BELLIN. That is correct, sir.

Mr. DUNCAN. Is it more than that now?

Dr. BELLIN. I do not know what our percentage is right now, but it is double the amount that we spent in absolute dollars in 1968. I do not know what our percentage is of the entire Nation.

Mr. BUTLER. It is about 10 percent of the country.

Mr. DUNCAN. How much of that goes to the hospitals and how much to nursing home care, and how much to physicians?

Dr. BELLIN. If we put hospitals and nursing homes together, we would say that about two-thirds to three-quarters of that money approximately each year goes to institutions, and it is sometimes forgotten that the bulk of the expenditure really goes to the institutions.

Keep in mind that a per diem of hospital care in New York City can vary anywhere from $150 to $240 a day. That is a preview of coming attractions for other parts of the country.

Mr. DUNCAN. Does the other one-third go to——

Dr. BELLIN. The remainder go to private practitioners in their offices, to physicians, to dentists, to optometrists, to podiatrists, to pharmacists, to chiropractors.

Mr. DUNCAN. Mr. Heim, you restrict coverage I believe in your State, is that correct?

Mr. HEIM. That is right, sir.

Mr. DUNCAN. How many days would a person receive in a skilled nursing home?

Mr. HEIM. As I mentioned in my statement, this was done as a temporary expedient. We had restricted coverage for only 14 months. We have had an unlimited coverage for the covered services since July of 1972.

Mr. DUNCAN. Does that also include dental care?

Mr. HEIM. Yes, sir.

Mr. DUNCAN. When you first started it was emergencies?

Mr. HEIM. We still limit dental care to treatment of children and emergencies for adults.

Mr. DUNCAN. And does the person still have the right to select their own physician?

Mr. HEIM. Yes.

Mr. DUNCAN. Or their dentists?

Mr. HEIM. Yes, sir.

Mr. DUNCAN. Would anyone on the panel care to express themselves on the HMO's?

Dr. BELLIN. In New York City we currently have a contract with one HMO, that is with the health insurance plan of Greater New York, that is about 25 years old right now and has an enrollment of about 800,000 patients cared for by 1,000 physicians through 31 confederated HIP groups.

Now the contract we have with them is to give them a specific amount of money per patient per year. That actually represents a very small proportion of the total enrollment in the medicaid program. On a

nationwide basis there has not been the enthusiastic, at least, endorsement on the part of patients of health maintenance organizations. This represents a disappointment to many of us in the health care field.

We had hoped that more people would enroll from the standpoint of quality control and of cost control. As an matter of fact, the marketing ability of selling this plan to people has not kept pace with the growing population of the United States. Most people evidently prefer their own physicians. I guess that is understandable, and they are reluctant to break away from the previous physician and join what seems to them to be a strange method of providing services.

Some of my other colleagues may have some opinions about that.

Mr. DUNCAN. I understand some of the HMO's are in financial trouble today.

Mr. BUTLER. That is correct.

I would say I was responsible for the preparation of HEW's HMO initiative, and I will take some of the blame and maybe some of the credit. They are like most undercapitalized industries right now in the United States, that is the new ones. High interest costs kill them, and that is why they are undercapitalized, because they can not borrow enough money.

Also, the HMO legislation, so-called enabling legislation, in fact, was a little bit disabling and it is now being amended to try to make it more possible for fledgling HMO's to get started. They were actually put at a competitive disadvantage to existing providers of care. They had to do more things and offer more benefits.

You see, they were going to require that employers give their employees an option of joining an HMO or continuing with the regular employee plan, and that really has not worked out under the Federal legislation yet, and that needs to be changed.

There are some basic problems, again problems that I think we underestimated when we first worked on HMO's. Dr. Bellin referred to one of them and that is a quality control. If you have an HMO, and this has been a problem in Los Angeles over the last few years, you have to make sure that people are not shorting on care, because, just as the doctor with fee for service has an incentive to provide for more care than is needed, the HMO sees itself getting a flat sum and has an incentive to do as little as possible. There are problems on both of those.

So quality control becomes an issue.

Even if you have good quality control mechanisms, which they did not have in the case of Los Angeles and they are now trying to institute in California, there is another fundamental problem and it goes back to this question about technology and how important do you think medical care is.

For example, we have done studies on coronary bypass operations, and you find out that in the fee-for-service system, that is with a lot of surgeons who are very skilled at this, that you may have from 2 to 4, up to 10 times as many coronary bypass operations performed on a given population of people as you will have in a controlled organized system like an HMO.

In those situations the HMO's will say, we are very conservative, we do not think those operations do a lot of good, we are waiting to see the evidence come in, sure it helps with angina and so on.

Maybe some of you have seen the article in the Wall Street Journal in the last few days about bypass operations. They are growing enormously in the last few years. Here is where HMO will do a lot in controlling costs.

Now which standard of quality are you going to use to determine whether the HMO is good or not? You see, they are operating really on very different assumptions, for example, in the case of that one operation. That is why I think that HMO's are always going to be at a comparative disadanvtage as long as you have an unlimited insurance system, because they will always look as if they are not doing enough compared to the fee-for-service system.

Mr. DUNCAN. Professor de Vise, I think in the past you have expressed some reservation about the HMO's?

Mr. DE VISE. I have, Congressman. It is partly based on the validity of the models we had of HMO's, the prepaid group practice organizations like Kaiser-Permanente. These are mostly found in areas which have a surplus of physicians, the west coast, New York City, Hawaii, but they are not found in places like Chicago because in places like Chicago you cannot hire a doctor at $30,000 or $35,000 a year.

So in a way you are looking at the areas where you had sufficient physicians and where an HMO could hire doctors at $30,000 or $35,000 a year, who would be willing to work for a salary.

Of course, most States do not enjoy a surplus of physicians and in these States you have to either get the doctors involved in the medical care foundation kind of HMO, where the doctor gets a fee for service, or else you have to rely on FMG's or else you have to pay physicians $60,000 or $70,000 a year to join.

So my position was that HMO's will actually turn out to be more expensive than no HMO's especially if they have to compete with the dual option of the private sector, and I guess we are committed to the option. If there is a dual option, then indeed the HMO's will have to bid resources away from the private sector at the going rate, so they would have to meet the competition of $70,000 or $80,000 practices and what the hospitals can get from third party payers.

In that sense the HMO's, since they have to provide complete health care, are going to charge more than the private sector.

Mr. DUNCAN. Thank you.

Dr. Butler, you mentioned something about we would have to go to something besides fee for service, and I did not quite understand what you meant by that. Would you care to explain further?

Mr. BUTLER. Dr. Bellin said that he did not agree, and I think he and I are in more agreement than we think.

I think from the standpoint of Government payments, that if you really are interested in putting a lid on medical care expenditures in the United States—and that may not be something you want to do, you may say medical care is important enough that we are going to let costs inflate and go to a 8 or 9 or 10 or 12 percent of the Gross National Product—but if you do not want to do that, if one of the prime concerns is to put an absolute lid on those expenditures, then I do not see any way to do that with the fee for service system.

Mr. DUNCAN. What would you suggest?

Mr. BUTLER. Then I think you have to pay somebody so many dollars per person per year for the care of that person, but it does not

have to be an HMO. The most extreme form of that is in the Kennedy bill, which essentially puts an absolute lid on expenditures, allocates them all out by regions, and says, "All right, you in the fee for service system, you only have so many dollars and you have to perform the services within that amount of money."

I think we have to experiment with a number of variations of capitation payments out to the regions, although I do not favor that particular one.

Then the doctors within the region—and, of course, the so-called medical foundation does this to some extent—the doctor in any given area may be paid on a fee for service basis. That is, if the Federal Government put out let's say $600 for a family of four people to some institution in that area, then it would be very possible for that institution, be it a hospital or anything else, to hire doctors on a fee for service basis or to do whatever they wanted to, provided they stayed within that overall ceiling.

Mr. DUNCAN. My time has been up for some time and I apologize to the rest of the subcommittee.

Mr. ROSTENKOWSKI. Mr. Cotter will inquire.

Mr. COTTER. Thank you very much, Mr. Chairman.

Dr. Bellin, you have painted a pretty gloomy picture of abuses in the medicaid program in New York City. Let me ask you this. Do you think this is peculiar to New York City, or do you think it is common to other parts of the country as well?

Dr. BELLIN. I would argue that there is a random distribution of immorality throughout the United States, and it is not localized exclusively in the city of New York. We just flagellate ourselves better perhaps and publicize it better.

I would argue that if you put me into a similar post in any part of the country, possibly with the exception of your part of the country, sir, I would be able to find the same proportion of scoundrels there as we have in New York City.

Mr. COTTER. What I was getting at, really, is the medicaid expenditures in New York City are about 20 percent of the total in the country.

Dr. BELLIN. Ten percent is a better statistic.

Mr. COTTER. By multiplying it five times, the savings we could accomplish would be that much greater.

Dr. BELLIN. You see New York City is a peculiar area in that we have 5 percent of the Nation's population, but we argue we have at least 15 percent of the Nation's social problems and other parts of the country send their social problems to us, and we are compelled to absorb them.

Mr. COTTER. You pointed out these abuses in the labor field. Are there any other areas within the medicaid program?

Dr. BELLIN. I could regale you with story after story after story, and statistics in every single one of the areas, any area you care to mention. I can give you dentistry where we did a review of patients' mouths where we had paid for false teeth, we had paid for extractions, and we found no evidence of false teeth, we had paid for. We had paid $300, for example, for a bridge and the bridge was evidently an invisible bridge. We paid for extractions of teeth and

when we examined the patient's mouth we found a third set of desiduous teeth had grown back into the patient's mouth. That is the only explanation we could dope out other than one of fraud.

We found situations of poor quality of podiatry. Because we were accused in our department as not being totally objective, I said, "OK, I will tell you what we are going to do. We are going to develop a protocol of quality. We are going to turn this over to your alma mater. We are going to have the schools check their own alumni."

We developed a protocol with the College of Optometry in New York City and with the College of Podiatry in New York City, and they checked the podiatrists and the optometrists in New York City. About 95 percent of their graduates work in that area. They found about 20 percent of the optometry as professionally unacceptable by their own professors. There were similar statistics in the field of podiatry.

I think we are deceiving ourselves if we conclude that this is necessarily something unique to medicaid. The studies are yet to be performed in this depth for middle-class health care services, and it would be a very useful thing indeed if we would have some objective analysis of the quality of care that is being rendered in private offices.

I would argue that we might fiind that there is some trouble down in River City.

Mr. COTTER. Do you think it is possible to eliminate these abuses or to police them in such a way that the Government is not going to be cheated in this fashion?

Dr. BELLIN. We use two words in public health. We use "eradicate" and "eliminate" with somewhat different meanings. Eliminate means to bring it down to reasonable proportions, and eradicate means to extirpate it from the planet Earth. I think we can bring it to better proportions than we currently are.

Right now there is a heyday going on out there, and the reason why there is a heyday is the local and State and Federal Government has been assigned the responsibility that it cannot carry out, because it has not been given the wherewithal to carry out these responsibilities.

I can understand the poignant plea that Mr. Heim has made, and I certainly agree with it, to remember we are mortals and keep in mind whatever program you promulgate in health insurance that you are going to be dealing with mortals. We may be extraordinary mortals, but we are mortals anyway.

Mr. COTTER. I wonder if the Government has a capacity to administer a national health insurance plan.

Dr. BELLIN. I think the Government has the capacity. I think up to the present time the Government has been reluctant to use that capacity. The Government is not without power or authority, but there are going to be some hard decisions that have to be made.

You know there is an old Chassidec legend about when the Messiah will come. There is a theory that the Messiah will come only when things get bad enough on Earth. I think that we will get the legislation here only when things get bad enough, and maybe it is $200 a day in the hospitals now, and maybe we have to see $350 to $500 a day before the message is communicated.

Mr. COTTER. Thank you very much.

That is all, Mr. Chairman. Thank you.

Mr. ROSTENKOWSKI. Mrs. Keys?

Mrs. KEYS. Thank you very much.

Gentlemen, I would like to hear each of you on the advantages or disadvantages of a truly comprehensive NHI program which would bring under one umbrella all the varying programs we now have, including service to veterans, et cetera.

Mr. BUTLER. I guess the first thing I would say refers to the administrative problems which are not insurmountable, and the need for facing such in problems in testing and figuring out the role of the States. That would apply to any system.

Then you are dealing with basic value choices which only the Congress can make on behalf of the American people. There is no such thing as one health insurance system that is better than another, given any set of values. It depends on what it is you are trying to do.

So when you talk about a comprehensive system, if you mean by comprehensive in benefits, what you are saying there is that, well, if we add as full medical benefits as we can, dental care for kids, nursing homes, and so on, the Congress is making a decision that it wants to buy that kind of thing on behalf of the American people and not put the same amount of money into, let's say, income maintenance payments through social security or public assistance or some other program. So there are very fundamental choices like that to be made at the start about national health insurance.

Mrs. KEYS. I am speaking specifically about the administrative problems. That was the question I really wanted to ask.

Mr. BUTLER. I did comment before a little bit about that. I happen to think that the issue is not whether the private sector or the public sector runs the program. That is a question, but there is no clear choice in that.

Mr. Cotter, I think, suggested something like that. Is that one of your questions?

Mrs. KEYS. Would not administration of health programs be significantly simpler if there were not so many duplicating and overlapping administrations?

Mr. BUTLER. I am not sure exactly what you mean.

Are you thinking about the Veterans' Administration?

Mrs. KEYS. I am talking about programs within the Federal Government. There is a great deal of controversy about whether or not we should move ahead and leave medicare, medicaid, veterans health care, alone or whether we should have absolutely one health insurance program—one program that would abandon all of these separate jurisdictions and be administered as one.

That is what I wanted your comments on.

Mr. BUTLER. I think it is possible to have single administration and multiple programs, given benefits and so on.

Taking those one at a time, certainly medicaid and medicare have to be integrated into any national health insurance system. There is no question about that. That does not mean you may not have different provisions for the elderly and for other kinds of people.

One of the major problems, for example, with the old Nixon national health insurance proposal, which I had prepared, was that

it deals with people at their place of employment. When you get into high rates of unemployment and people are shifting into jobs and out of jobs, they run out of the health insurance, people fall through the cracks. That is one of the difficulties in any plan you work through the place of employment.

So I think you have to deal with that in any national health insurance system. In the case of the Veterans' Administration, you have to address that problem, but it is not essential that be integrated; that is, veterans could have dual eligibility. They could vote with their feet and decide if they wanted to go to a VA hospital, and if they did not, the VA system would begin to dwindle.

The Public Health Service hospitals are just an anachronism. There are only six or eight left for merchant seamen. That is crazy. They ought to go. But the VA is a separate question.

Certainly the military is going to have its own system but for military dependents that are covered now, undoubtedly you would want to integrate with the national health insurance.

Dr. BELLIN. With respect to the question of simplification, I would certainly urge that there be simplification, as much merging as possible. I think the best way of explaining how Gresham's law operates in the field of health care services one could give the example of medicaid, medicare.

I recall in 1966, 1967, when a nursing-home owner in New York City, or anyplaace else in the country, could receive more money for a medicare patient than for a medicaid patient. On a per diem basis, even if there was no more than a $2 a day difference, if an individual had a 100-bed hospital that represents $200 per day, and that is over $1,000 per week.

What happened was, the nursing-home directors were kicking the medicaid patients out and putting medicare patients in their place.

Subsequently, a few years later when the Social Security Administration began cracking down on medicare and was retroactively holding back money for nursing homes for services they had already performed, nursing-home directors responded as anyone in the room would. They said, "We are not happy with the way medicare is treating us," so now they replaced their medicare patients with medicaid patients. So this ping-ponging back and forth must occur as long as there are two different Federal systems with two different fee schedules.

We have this in fees for service as well. Suppose a physician can sell 15 minutes of his time and receive $25 from medicare and only receive $8 from medicaid. The only thing he is selling is his time. Therefore, he is going to prefer the medicare patient to the medicaid patient, and the medicaid patient does not have access to the system.

I think it is important to take a look at these anomalies—and, after 8 or 9 years these anomalies are known to all of us in the field—and to attempt to do something about them.

There is one comment that none of us has made. In order to make any system work, we are going to have to have physicians.

Professor de Vise has already mentioned the question of surplus physicians, and the only way you can have an HMO is with your surplus physicians, and I think that is absolutely correct. In order for Government to be in any kind of a bargaining position, it is necessary

that something be done about the sellers' market in physicians which currently is operative, where the physicians and the dentists are calling the shots. We simply need more physicians, more dentists out there, and we need a better distribution of physicians and dentists and other health care practitioners.

In Great Britain you simply cannot go into practice where you want to go. You have to put in a certain amount of time in a lesser-served area. Unless you have something like that in the United States you are going to be in a situation where you are going to pass a piece of legislation which simply cannot be carried out by any of the administrators out in the field, because the physicians in their paucity and mal distribution have us by the throat.

Mrs. KEYS. Would you agree with Professor Butler that the veterans hospitals should remain as an optional choice?

Dr. BELLIN. I think what is going to happen is, with the passage of national health insurance, the veteran is going to decide, for example, in New York City whether he is going to go to Harkness Pavilion of the Columbia Presbyterian Hospital or to the Bronx VA hospitals.

I think in most cases they would opt for Harkness Pavilion of the Columbia Presbyterian and something would have to be done about the VA hospitals.

Certainly we have heard through the grapevine that the VA hospitals are very, very concerned about the passage of national health insurance. In New York we hear there is an increasing interest on the part of the VA to get involved with the community. There had not been that degree of reaching out historically.

Mr. BUTLER. Could I explain, Mrs. Keys, what I meant by that. I hope I did not say "should." I think what I tried to say is the veterans' system could be kept separate for political or other reasons. I do not think that is an inherent defect and exactly the kind of choices Dr. Bellin talked about would be made.

Mr. HEIM. Since I am not confronted with the same level of administrative problems that Dr. Bellin is, I think I am much more optimistic about the ability to develop the administrative capacity to have a comprehensive national health insurance program take over most of the Government programs that serve the people today.

I think there is an absolute necessity to cut down on what presently I feel is some ridiculous duplication. Just to mention one example, family planning services are contained in at least three titles of the Social Security Act that I know of, and maybe there are some stashed away someplace else, all of which we have to administer.

I should like to think that you could bring in such programs as CHAMPUS and maybe the services to veterans in a total program, but I would throw out this caveat that again we do not try to do it all at once, that we have plenty of lead time, that we do it on an incremental basis and, for God's sake, that we do not cut off services to a certain category of recipient before it can be picked up simultaneously by the comprehensive program.

Mr. DE VISE. Let me summarize the advantages and the disadvantages of a single health care program for the Nation. I see them more as financial and economic than in terms of the simplification of administration.

The great advantage of pooling all 300 health programs in one agency I have suggested in my paper as combating medical inflation, and that is simply to match the interest of doctors in Government health programs which now adds at least 10 percent to their income. There is only one consumer with 10 percent of the national income that would be affected, and that would be the Federal Government. So you would concentrate all payments in one Federal program that would in effect have a consumer monopsony empowering it to bargain unilaterally with organized medicine.

There are other important financial aspects and aspects having to do with equity. I mentioned earlier that extreme inequities in the State programs, the fact that in some States medicaid spends about 10 times per capita more than in other States, because some States are more willing and able to finance the 50 percent local share.

Also, I mentioned the inflationary effect of the 300 Federal health programs. They are all vying for money. Institutions and physicians can play the game of tapping in several programs.

In Chicago there are some physicians who are tapping different Federal programs and make as much as half a million dollars just from Federal health programs. This could probably be avoided if there were just one payment agency. At this time we cannot even match medicare/medicaid payments to individuals vendors.

The disadvantages of a single health umbrella organization are that we do want to maintain flexibility. We do want to maintain the opportunity for local government and local vendors and local organizations to participate in decisions and, also, we want to have competition. We do want to have as much competition as possible and to the extent that this might be discouraged by one comprehensive national health system agency, we should be wary.

Another issue, as we mentioned before, is the cottage industry versus the larger scale hospital as the mode of health delivery. There are many advantages to the cottage industry organization of medical care both economically and in terms of psychological needs. So we have to be wary about the possible effects of one large umbrella national system on competition, on small local institutions, and the cottage industry versus the teaching hospitals.

Mrs. KEYS. Thank you very much. You have been most helpful.

Mr. ROSTENKOWSKI. Mr. Waggonner will inquire.

Mr. WAGGONNER. Thank you, Mr. Chairman.

Professor Butler, in the assumptions that you set forth with regard to several aspects of medical care, you said that it was not so, that more medical care will make the Nation healthier, that there were other influencing factors, and you listed a number of them such as nutrition, for example.

Are you saying or are you suggesting or do you have an opinion as to whether or not national health insurance should be comprehensive enough to include aspects of these matters such as nutrition?

Mr. BUTLER. Of course a lot of them national health insurance inherently could not deal with.

For example, there are people's personal habits. You cannot legislate that. There is a marvelous analysis done by Vic Fuchs on the comparisons between Nevada and Utah. They are really identical in their

population statistics and so on, but, of course, the personal habits of people in Utah and Nevada are very different, and you come out with very different health indices. So some things are way out of the reach of legislation.

Some of the prevention is, too, in the sense that if you are dealing with problems of emphysema stemming from air pollution, presumably you are not going to cover that in national health insurance. That has to come under a clean air act and auto pollution controls and things like that.

One of the major health measures we have had in the last 12 years has been the 55-mile-an-hour speed limit which has cut down auto deaths by 10,000 a year.

Mr. WAGGONNER. Another one of your conclusions dealt with noneffectiveness, and your conclusion was that it was not as effective as you would hope, even though it is highly scientific.

Have we been on the wrong track a little bit when we try to apply in the instance of medical care too much in the way of cost effectiveness? Is this not really impossible?

Mr. BUTLER. I think we have expected too much of medical care. I think people outside of the profession like myself expected too much of it and did not realize that there are certain fundamental things such as, we are all going to die some day of something.

Beyond that, I think that the enormous successes with infectious disease—here we are, everybody was dying of tuberculosis and pneumonia, 30 or 40 years ago, and we were so enormously successful with that I think there was a sense on the part of some of us that future breakthroughs would come as those did, that there was a cure for cancer, and it would happen quickly, and with the heart problems.

We are now—and doctors should talk about this—but we are now in a stage where I think it is clear that those big breakthroughs are not going to happen as soon as we would hope, and that means we have to take a look, if we are spending all this money, at what our priorities are.

To me the coronary by-pass operation is a very good test of that because we do not know enough about its results yet. We know that it does some good. The quality is such that I think we could probably control that so that the dangers of death from the operation are limited. But then we have to decide whether we want to spend that much money on whatever it does, and since we do not know enough about its long-term results, because it has not been going long enough, what will we do in the 10 to 20 years we are waiting for the research?

Mr. WAGGONNER. Dr. Bellin, you spoke of HEW's refusal or nonconcurrence at least, with your efforts to provide, on a county basis, single providers of such things as laboratory service, and your bids are something like 50 percent of what the cost had been in times gone by.

Has there been any pressure on the part of HEW to try to require you to develop that in-house capability rather than contract it for that service?

Dr. BELLIN. What has happened during the past few weeks is there has been some dialog that has begun between HEW and ourselves about this subject, and they are making some recommendation that perhaps this might be done either (a) on a demonstration project and put this

out on bid in one of the counties and see how it works out, or (b) let the low bidder come in in each of the counties and permit other laboratories to participate in the program at the same low bid as the other low bidders.

We are very gratified that there has been this kind of response, at least a beginning of this kind of response, and we hope it continues, and we hope it gets translated into a program.

I can give other examples of frustrations that administrators face in attempting to effectuate what seem to be reasonable cost controls and quality controls. These channels are extremely educative.

Let me give you another example. I do not want to say that HEW is a villain. We work very closely with them and occasionally we have a disagreement. Let me share one with you under the State Department of Health in New York that occurred some years ago.

I agree with Professor Butler's disillusionment about what medicine can accomplish and I am a physician myself. But we do know that if you perform a Pap smear every year on a woman over the age of 35 or 50 and you pick up early cancer of the cervix, that is, the neck of the uterus, it is possible to intervene at that moment and have an enormously successful effect at preventing cancer from spreading.

We have found in New York City that very few physicians were performing Pap smears on medicaid patients. In other words, they would do a complete physical examination of the woman, or tell us they were doing a complete physical examination of a woman, and not perform a pelvic examination and a Pap smear. When we checked into the reason for this, they felt it took too much time and it was not worth while to them, and they skipped it.

Some did say, in order to justify financially the performance of the Pap smear, that they would invite the patient to come back the second time so that could be billed as a second visit, and the patient would not return and so never had the Pap smear.

So I communicated with the State Department of Health. I said it is a lot cheaper to pay for a Pap smear now than to pay for advanced pelvic surgery and radiation in the future in case, God forbid, this becomes widespread cancer.

From a cost-benefit analysis it is clear we ought to do what we can to encourage the physicians. Let's pay them extra so while the patient is on the table the physicians will do the Pap smear.

Let me tell you the response I got. The response was "No dice." "If we let you pay extra money for this part of the physical examination, within a short period of time you will be asking extra money to palpitate the right breast, to do a blood pressure, and you will financially fragment various pieces of the physical examination."

That was the response I got about 5 or 6 years ago. I would urge that there be a significant review of just what we are paying for, and when we have something like this which makes a difference.

Now, on coronary bypass, that is up for grabs, and maybe we will know in 10 or 20 years, but in the Pap smear example we know it makes a difference and that is where we ought to be putting the public dollar.

Mr. WAGGONNER. What has been your experience in the 19 municipal hospitals that you administer or have some authority over with regard to malpractice in a relative way?

Dr. BELLIN. I am afraid I can't give you any comparative data. There have been malpractice suits against house staff and physicians practicing in the in-house hospitals. There have been some suits.

I can't give you anything more.

Mr. WAGGONNER. You raised some question about administration and you mentioned some possibilities of National Health Insurance programs, whether it should be Federal or joint Federal and State, and that sort of thing.

You didn't come down in any particular place yourself, but as a layman with the experience you have had with the bureaucracy here in the legislative branch of government and now with the executive of your State, what is your personal opinion? Should it be a federally administered program without regard to the States? Should it be a jointly administered program or what?

Mr. HEIM. As I mentioned, I don't have any hard suggestions to make at this time, Congressman. But I am assuming that there will be State involvement in whatever is passed, and my appeal was that this State involvement be clearly spelled out in the legislation and that the State processes, their political legislative appropriating processes, be given sufficient time so the States can react to whatever is required.

My personal view is that the closer you can get government to the people, the better it is. But in a vast program like this we are talking about a lot of money and about uneven performance by a number of States and this, indeed, may not be practical.

Mr. WAGGONNER. Professor de Vise, on page 7 of your statement, the last paragraph, I don't know whether this is a bad choice of words or exactly what your intent was. But in the last paragraph, page 7, you say: "The inexorable progress toward the welfare state is the result of long-term processes of industrialization and urbanization."

You are not saying movement toward a welfare state is progress, are you?

Mr. DE VISE. This is my wife's choice of words. I had another word. But she said, "No; that is not positive enough," and she changed it. My original wording for that was "The inexorable ascent or descent, some would say, to the welfare state."

Mr. WAGGONNER. I have one other question and I am through. You are not by chance either advocating that the Government involve itself in the assigning of doctors to specific areas as a matter of policy, are you?

Mr. DE VISE. I have not advocated that here, but I have testified before the Kennedy committee and the Rogers committee last year on the health manpower bills in which I commented on the proposals with respect to the medical schools contracting with students to serve in medically unserved areas.

I think it is indispensable that we find some way for the Federal Government as a payer of services to start encouraging doctors to not go in even larger numbers to glamorous areas like California, Massachusetts and New York.

Mr. WAGGONNER. I agree with you that we have something in the way of a problem with regard to maldistribution of these abilities. I just don't know how in the hell we are going to resolve it.

Mr. de Vise. I don't know either, and I am not an advocate of the current proposals being considered by Congress.

Mr. Rostenkowski. Mr. Crane will inquire.

Mr. Crane. Thank you, Mr. Chairman.

Looking at the testimony, is it safe to say that all of you either are supportive of the concept of national health insurance or else feel it is inevitable?

Mr. Butler. I would like to comment on that. I think we have national health insurance now.

Mr. Crane. Are you saying that because about 40 percent of health dollars are now spent by the Federal Government?

Mr. Butler. That's right. I would not necessarily support increasing that amount, but I think the point is that most of the problems we have been discussing we have now, because we have a very, very high percentage of the Nation's medical bills now being paid by health insurance and we have a national health insurance policy, a tax policy certainly in the sense we permit employers to give the health fringe benefit to their employees and we don't tax it the same.

So we have a national health insurance policy now and are we going to change it and are we going to fill in the gaps for those people in the country remaining who have no insurance or something less? I think we will have to have less of some kinds of health insurance for some people. I think the packages are far too rich and far too tax-subsidized in industry now, and I think we need something more for some others, such as low-wage earners in the South who don't have anything.

Dr. Bellin. I find myself in substantial agreement with Professor Butler about this. I think that significant attention has to be paid to what steps you are going to take, whether you are going to have catastrophic insurance first and test that out and work the bugs out before you go to a more comprehensive package or whether you are going to do a comprehensive package on an incremental basis.

I would urge that you proceed incrementally, that you not make the same error that was made in 1965, where some States respond with extraordinary generosity in taking advantage of the medicaid legislation and then had to live to regret it about 9 to 12 months later, but found that they were stuck.

I think that the whole situation is too complex and beset with all kinds of imponderables that you simply cannot predict to do anything but adopt a sensible public policy of going at this in incremental steps, small incremental steps, try it out and see how it works and then move on to the next step.

I would think that one of the areas you should concentrate on are those areas where we know there would be a payoff and lives saved.

Mr. Crane. Mr. Heim.

Mr. Heim. Yes, I believe it is inevitable and I think desirable. I, of course, agree with Dr. Bellin. As is contatined in my statement, I think we ought to move into the program in an incremental way.

Mr. Cane. Professor de Vise.

Mr. de Vise. Also on page 7 of my report I have a word which you may take exception to. The word is a Frankenstein monster, as I call medicare, and I suggest that what now impels us to national health

insurance is the need to control what I call the Frankenstein monster of medicare-medicaid and that is because we have got this monster by the tail and we have to bring it under control. It is not enough just to control costs in the public sector, but with the private sector as well since the public cost is determined in the private market, reimbursible fees are based on what is the ongoing market.

Unless the Federal Government can come to grips with the factors that are responsible for medical inflation in the private as well as the public market, then I think we are going to go bankrupt even with just medicare-medicaid.

My own State of Illinois had to cut back 6 percent across the board on the State budget because of uncontrollable programs in which medicaid is a major factor as indicated earlier by some of the panelists.

Mr. CRANE. Don't you see, Professor de Vise, the danger that in attempting to control the Frankenstein monster which was created in medicare-medicaid with yet another program more far-reaching, that we might be compounding error?

Mr. DE VISE. In the last page of my statement I say we will indeed aggravate the problem if we make the same mistakes of the medicare legislation and that is by greatly increasing the demand for services within the existing framework of supply, and market conditions such as the fee-for-service. I indeed assert that we will be aggravating the problem if we have national health insurance which does not have effective controls on costs.

Mr. CRANE. On the subject of costs, under the British National Health Service, they are paying 5.5 percent of their gross national product for health care. When one talks to hospital administrators, physicians, and staff within their system, they all say the same thing. There is an insufficiency of money being allocated for health care in Great Britain.

Mr. DE VISE. But at least the British can decide, the government can decide how much of its income will go to health care. This is what we cannot do. I am sure an individual in this country would not decide to spend 9 or 10 percent of his income on health care, but we are forcing him to do this collectively by buying medicare-national health insurance. I think the British figure of 5 percent is too low. Sweden is up to about 7 percent like we are. But at least the British people do have the option of deciding how much of their income they will spend on health care.

As Mr. Butler indicated, other things than health care make for good health and these other things are much more important and as individuals we can decide this, but as a government individuals lose that freedom.

Mr. CRANE. The problem some of the health administrators and physicians mentioned to me is that when you have political medicine as they have in Great Britain, health care becomes increasingly a low priority item when contesting with other budget priorities that are a lot more glamorous to the electorate.

For example, building housing is a highly visible, presumably highly desirable political thing. Mass transit systems, education, highways what-have-you are competing for limited resources and unless you as an individual are sick and need care, it is difficult to get the public aroused to demand that more than, say, 5.5 percent of their GNP be spent in health care areas.

I mean, the people who are with it day to day preach the need for greater funding, but the public-at-large has not raised a political clamor. To an American looking at the system it is puzzling why with the extensive waiting periods for surgery you don't have a great hue and cry, a great public indignation over this failure on the part of the politicians to allocate more money to the system.

Mr. BUTLER. Could I comment, Mr. Crane, a little bit about that?

Mr. CRANE. Yes, sir.

Mr. BUTLER. I think a lot of what you say is very true, but it has to be seen in terms of the British economic sphere even right now. If you look at any particular government expenditure, of course the level of affluence is so much different there than here, the rate of inflation is so high, the country is so close to national bankruptcy anyway to single out the medical care system may lead us to some conclusions that are probably not to the United States. It might be more instructive for us to look at the Canadian experience with all of its merits and disadvantages, because the level of affluence in Canada is so much closer to ours, the population and all is so much like the United States. That is a very instructive experience for us.

By no means do I imply that it is all rosey. Costs have gone up considerably, they have still not solved problems of maldistribution, physicians' earnings have gone up by 50 percent, some cases 100 percent, and they have now a national health insurance system.

By looking at that system I think we can get a fairly good idea of what might happen in this country under a similar kind of approach. I don't think we should go the way the Canadians went, because I don't think we can afford it. They have 20 million people. We have 200 million. I don't think we can afford the kind of cost overruns that they are going to experience before they get it under control.

Mr. CRANE. I think still this does not answer the question of the dilemma as perceived by the medical people in the profession over there. Admittedly the country is in dire financial straits right now, but that has not been the situation through the entire history of the Health Service. And yet medicine has not been the highest priority item so far as the expenditure of the public dollar there.

Dr. BELLIN. Ultimately public decisions have to be made through a political process and if that is the decision they have made, we can only conclude that is the decision they have made. If the people have not protested, presumably we have to presume they are reasonably content with that level of priority they are receiving from the Government.

Mr. CRANE. They may not know any better.

Dr. BELLIN. I don't think the British population is less intelligent than the American population.

Mr. CRANE. It might be what they have become accustomed to. The passivity and tolerance of the British patients you would not find in the United States, because Americans have not been accustomed to that. So the current condition may not be totally novel with the British people. They may have experienced it through most of their lifetimes.

Dr. BELLIN. I would like to make a comment about other things being important in achieving health in a large population other than medical care and this may sound strange coming from a physician. I can reecho what Professor Butler has to say. I remember in medical school we were shown statistics over what was the annual mortality

rate of TB throughout the planet starting during the early 1800's when there were the early statistics available and to the early 1940's and 1950's.

There is a slope of that curve, the TB is declining each year and it continues to decline, and the first antibiotics against TB were only available in the 1940's. When streptomycin and PAS para-amino salicylic acid first appeared, the curve didn't change, the slope continued to go precisely the way it was going before. This tale is not meant to be therapeutically nihilistic.

What was taught to us was that many, many decades before there was the first antibiotic, because of better housing, because of better nutrition throughout the whole planet, TB was already declining. One, therefore, could identify TB not only as a bacterial disease, but also as a nutritional disease, and that this should not be forgotten.

Similarly, I remember at the Harvard School of Public Health at one time receiving a lecture about Syria where a decision was to be made. There was a disagreement in the Syrian Cabinet as to whether to build more roads for military roads or to build more prenatal clinics.

The argument was that you ought to build more prenatal clinics in order to lower the infant mortality rate. But they built more roads instead of more prenatal clinics, and do you know what happened? The infant mortality plummeted because with the roads their people could get to Damascus and get to medical care.

There are all kinds of public health byproducts of other governmental activities that are taking place. I am not at all certain even as a public health person that much more of the gross national product should be put into health services. I think there ought to be a redistribution of the percentage of the gross national product that we already are in health and that it ought to be more wisely spent.

I advocate national health insurance, but again incrementally. I think a piece of this national health insurance ought to pay for health education, which is an idea that should get started. We could save a lot of lives if we got people at the proper weight and exercise and cutting out smoking. I am not referring to anybody in this room, but that is far more important.

Mr. ROSTENKOWSKI. Mr. Vanik will inquire.

Mr. VANIK. I would just like to follow along on the discussion. I am so much concerned as to what we can really do about the problem in light of our costs of economic recovery and the cost of energy and all of these other things that are confounding our lives. When you talk about an incremental movement into health care, what are you talking about? How do you propose that we should legislatively to it?

I think it was you, Professor Butler, that talked about it. You all talked about it. Do you have a comment on it? Or are you like the House of Representatives on energy when we have 435 different plans?

Mr. BUTLER. At the risk of speaking before the others, it does seem to be on common thread and that is, the first increment would be to deal with the medicaid program. My view is that it needs to be federalized, and frankly States like mine ought to be talked about. California has made off with most of the money and you have to have a move in the other direction.

The rich don't need to get richer. That does not do New York City much good, but we ought to start with the medicaid program. In

starting with that we ought to take a look at what about people who are not categorically eligible for medicaid now.

You have a lot of working poor people who do not have health insurance and are we going to include them? That includes the bill this subcommittee has been considering about unemployment compensation.

Mr. VANIK. Do you concur in that, Mr. Heim?

Mr. HEIM. I do not entirely disagree, but I had something a little different in mind when I was talking about developing a program incrementally. I think we ought to look at where the needs are the greatest right now which are not being met.

In my opinion I think this is in catastrophic coverage. My recommendation is that we should provide assistance to the citizens of this country where they are going to be hurt the most, and that is, you know, if a true medical catastrophe strikes that could take $40,000 or $50,000 or more, that it should begin there.

I was thinking more in terms of——

Mr. VANIK. Does that meet Dr. Bellin's test of saving most of the lives, because catastrophic coverage doesn't mean you save most of the lives. It means you save most of the costs in a castastrophic situation?

Dr. BELLIN. If I could respond to that, it does to some extent meet one of my criteria, because I am concerned about the lives of the surviving members of the families, and I am not being facetious when I say that. I have seen families' lives ruined because of somebody living who it would have been better for the family, callous as it may sound, for the person to have died a week or two earlier.

There is the old moral delimma of who pulls out the plug. The plug is pulled out when the family faces the financial catastrophe.

Mr. VANIK. I did a little bit of research and there is an interesting correlation between the incidence of death and the termination of medicare coverage. This is just a statistic we can measure.

Regardless of the philosophical or moral issues involved, there seems to be a correlation that when they get near the end of coverage, that suddenly somehow the medical scientists exhaust their capacity to maintain life.

Professor de Vise, how do you feel about this?

Mr. DE VISE. I realize the incremental approach has been the way the Federal role in health care has been. Every bit of past health legislation has been incremental. There has not been a single revolution in legislation. Perhaps national health insurance will be no exception, although I may imply in my remarks that I see nothing short of a revolution in cost control as a solution in national health insurance. There is a way to reconcile that approach with an incremental approach and that would be to lay out what might be an ideal system that might be achieved after 10 years, that after 10 years of national health insurance this is what the delivery system ought to look like and begin incrementally by saying that the first year 10 percent of NHI money will go to this ideal system, the second year 20 percent, and 30 percent.

If we decide that capitation is the best way to go in the long run, we should incrementally reach that 90 percent or so in a space of so many years.

Mr. VANIK. It is awfully difficult to develop legislative language that would approach your suggestions. I think we have to deal with

more definitive points when we administer a service. But would you agree or is there some consensus that if we were able to combine the medicaid problems somehow with modifications of a catastrophic coverage plan, that we would take care of a tremendous problem in a manner in which it would be more universally accepted, or where we could make some reasonable estimate of costs based on the State experiences in which there is a measurable program?

Mr. DE VISE. I have a very uneasy feeling that if we are to reform medicaid not just from the point of view of costs, but from the point of view of access and quality of care, that we will actually result with a more expensive medicaid program. Many of the abuses that we have heard about have been because of the fact that the medicaid program in many jurisdictions invite such abuse, because of low and uncertain payments, redtape, and other obstacles. Typically physicians can only make about $6 per physician visit, which is about half what they can make in private practice.

So actually very few physicians are involved or participate in the program. So in a way the public gets a bargain because it discourages widespread participation by physicians in medicaid. We do have a few hundred individuals who make a mint, who have learned to provide mass production medicine where they see a patient every 3 minutes, but on the whole medicaid is cheaper today than it would be if there were comprehensive medicaid.

So if we just look at the cost containment on medicaid, we are not going to get it and also improve the program and have all States participate on the same basis.

Mr. VANIK. Here we have a political problem and it deals with the problem of those who contribute most to support the country. I am talking about the working people, the mature workers who are complaining, and perhaps rightfully so, that they are "locked out." They see the tremendous programs for the senior citizens. We have yet to talk about any really decent programs for the young people, the people whom we don't really do very much with from the standpoint of preventive medicine. But this group is one that is insisting, and rightfully so perhaps, for a really effective program because they are the ones who are supporting the entire existing system.

Medicaid doesn't really mean very much to them because this is a group of workers and self-sufficient people generally who are contributing through work and taxes during their working years. Do you think that catastrophic coverage, for example, would be enough of an inducement for them to contribute more money to support the medicaid system?

Dr. BELLIN. I would say yes to that question. I have been thinking myself the last number of months how do you translate the concept of incrementalism into real programs that can be legislated? I think one piece has to be catastrophic insurance. I can understand the growing irritation on the part of the working middle class with respect to what has been called the notch effect. If you are in the appropriate notch, you get the service and if you are above that, not much. The only way you can get to it is to spend down and make yourself broke.

If you make one buck more than that, you are out of the program completely. I don't know of any better kind of social policy to render

the country apart than that kind of policy. In order to give something to everybody, and appropriately certain catastrophic insurance ought to be one part of it. There is intrinsic merit to it anyway aside from the political utility.

The other aspect to this, and it gets back to the question of maldistribution, you cannot run any kind of program without physicians and whereas in New York City we have bombed out areas where there are no physicians accessible. There are other parts of the country, rural areas, and indeed cities, that don't have the proper number to a great extent because of maldistribution.

I think a responsible public policy cannot look at manpower separately from insurance. I think that error has been made and we have suffered grievously because of this error. I think part and parcel of the package must be the redistribution of physicians and there is no need for the Congress of the United States to feel defensive about studying this matter.

Anyone who goes to medical school today and is paying his or her way is being subsidized to the tune of 70 and 80 percent and that is without exaggeration, and when they get out of school and internship and residency, they are going to make a nice bundle for the rest of their lives and there is no need for the Congress to feel defensive about saying, "All right, you have been supported this amount of time. You owe something to your country. During war we send you abroad, during peacetime you put in 2 years of service in an appropriate area."

Mr. VANIK. I yield.

Mr. ROSTENKOWSKI. Yesterday we had testimony that even in Russia you can't direct the doctors where they are going to work. How would you do that in this country?

Dr. BELLIN. I am not so certain about the Russian experience. All the doctors want to practice in Moscow and Leningrad to be sure, but they do put in their time. In Turkey and in Israel people put in years in other undesirable areas. I think there is no reason for us to consider this is a hopeless problem. It is a problem that can be dealt with.

If we don't do it with the stick, we have to do it with the carrot. If we don't want to use the carrot, we have to use another method.

We have to adopt as a policy that we will flood the market with physicians. We could double the number of medical schools, have medical schools that operate at night as well, graduate twice the number.

Mr. VANIK. Now you have a little bit of that awareness in the Latin American countries now. They say the quality of medicine isn't very good, but the shocking thing is you can go to Mexico and see doctors around in even the remotest areas. The costs are very low and they complain about not having a chance to make a good living.

In the Philippines, for example, and throughout the Spanish-speaking countries where they have created a lot of doctors, they seem to have been able to hold costs down. Doctors creating doctors is not quite as difficult as creating oil because it takes hundreds of generations to create oil, but it should not take that long to create doctors. But where there is a sufficient number of doctors, we at least find an availability of medical care.

Now I live in northern Virginia here and the only way I can get to a doctor is go into an ambulance and get to the hospital. Of course,

there are some clinics nearby that I can go visit, but they are just as tough to get into as the hospitals. They audit me and get a report from Brinks or Dun & Bradstreet and decide what the fees should be. So much of the doctor's time is lost in shuttling between hospitals and in management of their own affairs.

I talked to some young doctors over in Sweden. This may not be a good example, but I said, "How do you like your system?" They said, "We love it." I said, "Why?" "Principally because we work 53 hours a week."

They thought that was a great privilege to have that kind of a short workweek as a doctor. It was an accomplishment. They liked the easy access to consultation with colleagues, which was not always available in an individual practice. And they felt that they were really spending most of their time in medicine instead of other things that are a source of distraction.

I can just tell you that in my community when I visit the sick in hospitals, I sometimes walk in with a Wall Street Journal and they say, "Well, that is the new surgeon." Other times I walk in with a Baron's, a Financial World, and they say, "He is the new neurosurgeon" or something else, but they judge my eligibility to enter the hospitals by what kind of financial paper I carry.

I thought at one point we might improve the efficiency of hospitals if along all the screens that monitor the heart we have the Dow-Jones averages put right on the screen so they could with convenience look at my heart and also at their stock fluctuations, so that they could consolidate their time and not have to run out to call the broker so often.

But in any event I do feel that our system is wasteful of the doctors' energies. Somehow we don't get all the efficiency we can out of the system. Even in comfortable areas it is very difficult to find a doctor to give you medical care—you know, you go to the hospital to get a tetanus shot and it costs you $42. You may want a prescription for a biotic and you just can't get it.

I think we lose more lives by denying standard medical care than the lives we save from complicated medical procedures. We should probably have a more open health care system.

In Mexico I had an accident some years ago and I remember buying some penicillin that was 50 cents a unit. When I got to the United States and had to continue my prescription the same medication was $7.50.

So these are some of the problems. I think Mexico ought to be studied. I don't know whether it is a good example, but I feel that in those communities even in remote parts of the country there is more medical help available. I don't know about the quality, but medical care certainly is available. Most of the time we don't need the sophisticated high-level judgment that is always important. Sometimes it is just a cut or a small illness that needs treatment. I feel that this kind of medical need is almost impossible to satisfy under the present system.

I thank you very much. We appreciate your tremendous contributions. We would be happy to hear from you. If you get any other ideas how we can develop an incremental plan which we can get through this Congress and get the President to sign—the latter point will be more significant than any other. We have this incredible burden of satisfy-

ing all of us and then having two-thirds plus one to be able to insure that we can put the program through.

Thank you.

Mr. ROSTENKOWSKI. Mr. Vanik, maybe after this week's announcement, the President next year will feel the National Health Insurance is a priority item and will sign it.

Professor Butler, you are so sure that we should get rid of the fee-for-services program, and yet yesterday in most of the conversations that we had this was one of the aspects that the panelists felt was going to remain, if by negotiation or some other workable arrangement.

Why are you so sure that we should get rid of the fee-for-services?

Mr. BUTLER. I guess I must not have said it very well the first couple of times. I happen to think there are a lot of good things in the fee-for-service system. What I realy meant to say was that system functions inherently in such a way that costs are hard to control. For example, if you limit fees for costs for a hospital-day, you may get more hospital-days.

If you set the fees for a physician visit, you can get more physician visits. It has that inherent characteristic. So really what I meant to say was if you want to have an absolute control over costs, you can't do it by the Government or through its intermediaries paying out on a fee-for-service basis. It may still be possible; for example, take the foundation movement in California. It is conceivable that the Federal Government could pay so many dollars to the San Joaquin Medical Foundation to take care of all the people in that area and then that foundation would pay the doctors by whatever way they wanted to pay them, including fee-for-service.

But the point is that the total bill to the Federal Government or to whatever level of government was paying it would be fixed on the basis of number of dollars per person year year. All I really meant to say was unless the Government reaches the point where it can do that, it cannot have any real assurance that it is going to control costs.

You may think that the advantages of fee-for-service is such that you don't care that much about cost control and then all I would say is then you are inevitably looking at the kind of inflation that we have had.

So it is really a choice.

Mr. ROSTENKOWSKI. Would you like to comment on that, Dr. Bellin?

Dr. BELLIN. There is a terrible dilemma here in how you are going to pay physicians. The advantage of fee-for-service is it encourages enormous productivity. Doctors work long hours many, many days during the week. They are really not that much out on the golf course, as has been accredited to them, particularly with malpractice rates being what they are. They have to work another day in the office to pay the malpractice fees.

But you can get enormous productivity. At a time when you have a shortage or maldistribution of physicians, I think it is important to decide what price you may pay by abandoning a type of payment which produces productivity. The obvious other side of the coin is overutilization.

There is a lot of that productivity that occurs that should not occur, services that are unnecessary, unjustified, and sometimes perilous to the patient. The alternative is to put doctors on a salary, to pay them

capitation, which is essentially a disguised form of salary. If you do that, it is true that you can predict with some assurance how much you are going to pay because you are only going to pay a certain amount of money per patient per year.

On the other hand, the obverse side of that coin is underutilization, the number of people who are not getting service who ordinarily could.

I faced a problem when I was in the U.S. Air Force. There was a small group of physicians on the base who refused to work. They were hanging around the officers club all the time. The rest of us carried the hospital by ourselves. Why were they hanging around the officers club? Because they got the same salary we did.

I thought it might be an interesting experiment to put everybody on a fee-for-service basis on that base and maybe some would leave the officers club and help us out at the hospital. Whether it is fee-for-service with the danger of overutilization or whether it is capitation and salary payment with the danger of underutilization, it is necessary that you have the appropriate administrative controls.

Those administrative controls differ. I would argue that wherever you find different systems in the United States, either one or the other, you find inadequate administrative controls. People are very bright when they figure out a way how to beat the system.

Mr. ROSTENKOWSKI. Mr. Heim, would you like to comment?

Mr. HEIM. Yes, Mr. Chairman.

Of course, in New Mexico we started out by saying, we trust you doctors, we want you to come in and work with us to try to develop the control system that Dr. Bellin was saying was absolutely necessary.

We feel that the record we have accomplished shows that this has been a successful approach. We feel that by involving the physicians in developing the control system, by involving them through the PSRO concept and actually monitoring the necessity and appropriateness of care, that the fee-for-service problem should not be a significant one.

I am not at all convinced that fee-for-service cannot be retained if there are proper methods of control that can be imposed throughout the country.

Mr. DE VISE. I oppose fee-for-service because it is a monopoly profit. I am very much intrigued with the idea of the economists that fee-for-service is here to stay as part of the market economy except that medical care is not competitive. I indicated in my paper that organized medicine has acted in many ways to restrict the supply of physicians, to restrict the entry of physician substitutes, and to hamper effective controls of costs. They will continue to do this as long as they have the incentive, that incentive being fee-for-service.

In all the factors we see in explaining the skyrocketing costs of medical services I don't think you can justify the doubling of physician income in the last 10 years. The physician was earning on the average of $30,000 in 1965 and he now earns $60,000 a year largely because he has charged all that the traffic can bear.

So that is a very special kind of inflation. It is not inflation of hospitals where the costs have to go up because they have to pull resources from other sectors, because of increased personnel, because minimum

wage laws make them pay a living wage to the people. I think that there are same ways to reconcile the dilemma presented by Dr. Bellin, that is, the dilemma that you may lose productivity in the capitation or salary scheme, and that is the compromise worked out by Kaiser-Permanente which has a combination of salary and bonus based on productivity.

So I think there is a way doctors could be reimbursed on the capitation or salary base and still assure their productivity. My main objection to fee-for-service is that it is a monopoly profit and that in other aspects of economic life our laws say that monopoly is illegal.

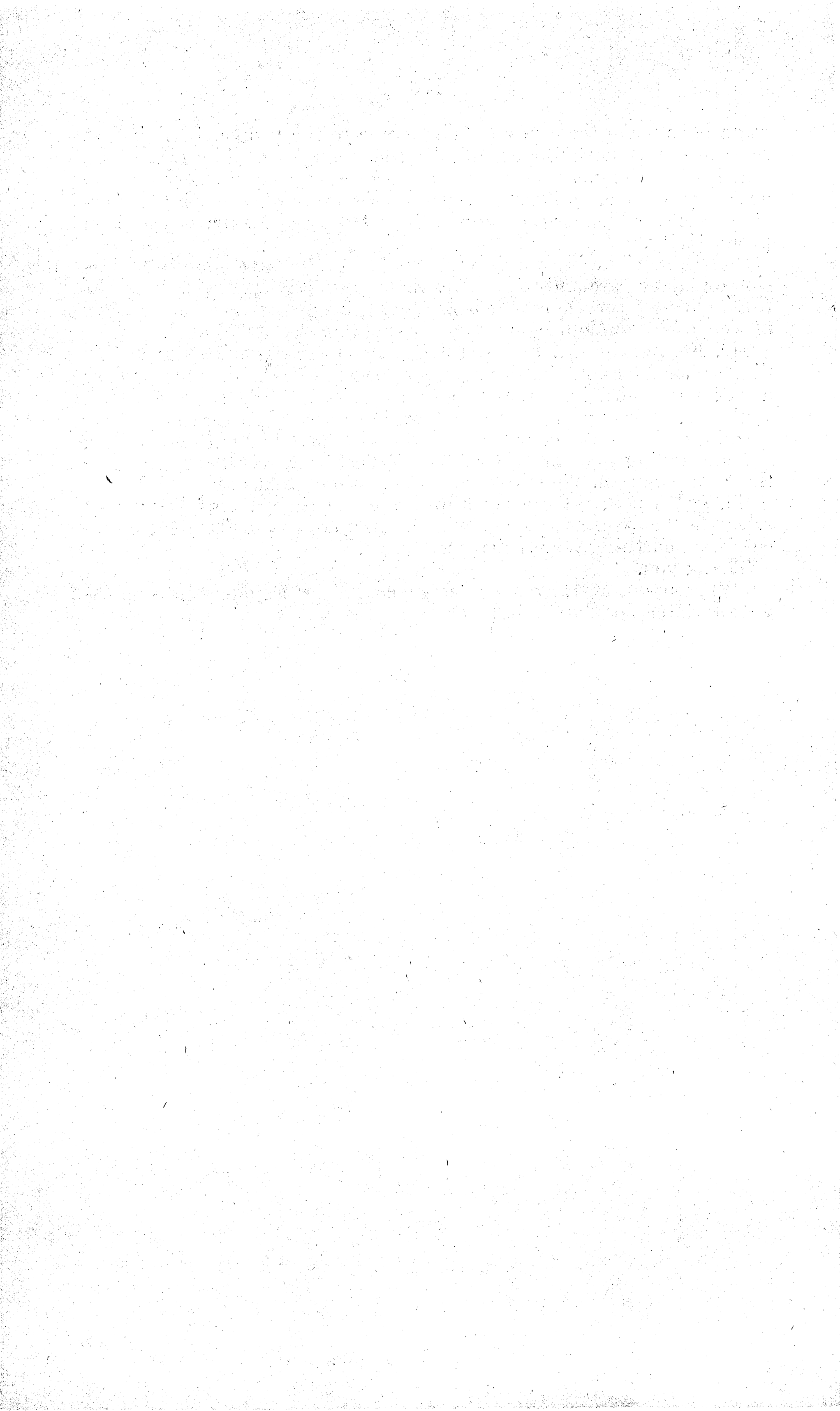
Mr. ROSTENKOWSKI. I want to thank you for participating in this discussion. We know that it is going to be a tedious job to put together a national health insurance program that it is going to be fair and equitable. It is a proposition that we have not taken lightly and we certainly will think about the discussion we have had with you today.

I am hoping that on July 17 we will have the private sector make their contribution. We will be meeting again on that day.

So, gentlemen, we greatly appreciate the time out of your busy schedule that you have spent with us. We hope that from these discussions something very fruitful will come.

Thank you.

[Whereupon, at 12:20 p.m. the subcommittee adjourned, to reconvene at the call of the Chair.]



NATIONAL HEALTH INSURANCE

(Private Sector Role in American Health)

THURSDAY, JULY 17, 1975

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The subcommittee met at 10:05 a.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski, chairman of the subcommittee, presiding.

Mr. ROSTENKOWSKI. The Subcommittee on Health will come to order.

The Chair would like to make several announcements before we proceed to the panel discussion.

It is the intention of the Chair to work through lunch and adjourn the committee at 2 o'clock because we have to surrender the committee room to the full committee. And if the panelists will bear with us, we will undoubtedly be interrupted on one or two occasions with rollcalls or quorum calls. However, this should not discourage the conversation to continue principally because of the fact that your contributions are for the record so we can use it in our judgment at a future time with respect to writing national health insurance legislation.

I would like to welcome the panelists. I might say that to date our meetings with the panels have led to very informative discussions. We usually allow panelists to make an opening statement, but would like it as concise as possible.

After the concluding panelist makes his contribution, we will have a discussion among the panelists if there are any diverse views that someone would like to make. Then we would go to a discussion with the members of the subcommittee asking questions.

If the panelists would introduce themselves as they make their statements, we would appreciate it very much.

Mr. Herman Somers, you begin the discussion.

A PANEL CONSISTING OF HERMAN M. SOMERS, PROFESSOR OF POLITICS AND PUBLIC AFFAIRS, WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS; NATHAN J. STARK, PRESIDENT, UNIVERSITY HEALTH CENTER OF PITTSBURGH; ROBERT G. ENGLAND, M.D., CARLINVILLE, ILL.; LAWRENCE M. CATHLES, JR., RETIRED SENIOR VICE PRESIDENT, AETNA LIFE & CASUALTY; AND JOHN LARKIN THOMPSON, PRESIDENT, BLUE SHIELD OF MASSACHUSETTS

Mr. SOMERS. Thank you, Mr. Chairman.

I am Herman Somers. I have been working in the health field for some 25 years. I am a former member of the Health Insurance Benefits Advisory Committee and of the Advisory Council on Social Security. I was on President Kennedy's Task Force on Health and Social Security, and I have been a consultant to HEW for many years. I am on the board of trustees of the College of Medicine and Dentistry of New Jersey, and of Blue Cross of New Jersey, and the author of four books in the health field.

I have been asked to discuss briefly the role of the private sector. I will in these introductory remarks, for the sake of brevity, confine myself to generalizations and if anybody asks, I will be glad to develop them later.

Mr. ROSTENKOWSKI. Professor Somers, I might make the observation that your full testimony which you submitted will be entered into the record.

Mr. SOMERS. Thank you.

The boundaries between private and public sectors have become pretty murky. The distinctions present difficult definitional problems. The statistical data usually are not illuminating on the real relationships and can be quite misleading.

For example, of the $104 billion reported as the Nation's health expenditures for fiscal 1974, about 40 percent is shown as coming from public funds.

Such expenditure figures do tell us the source of funds, but they are not descriptive of the relative roles of the public and private sectors. Government, of course, typically purchases directly or indirectly from private providers the health care it finances.

The great bulk of Government payments is made to privately owned and operated institutions and privately practicing professionals. Even the Government payments themselves are in large measure funneled through private insurance instrumentalities.

Further, the private institutions, particularly hospitals, receive a variety of Government subsidies for construction, research, and other purposes. Thus, there is considerable ambiguity in the data.

When Government merely pays for services rendered by and controlled by private providers, should the figures present that phenomenon as public or private sector activity, or both? And how much should be attributed to each? In practice, the figures are often inconsistent.

Should we wish to complicate the matter further, we could note that a large portion of the private sector is represented by not-for-profit institutions of a quasi-public character. One could argue that

the nonprofit sectors should be classified as part of the private sector, or the public sector, depending on the emphasis given to the concepts of profit or nonprofit. Some have argued that we should really think and classify in three separate categories—Government, private profit, and private nonprofit.

In short, our health system is now a marble cake mix of a pluralistic multitude of enterprises; the private and public enterprise activity overlaps are great and clear distinctions usually are difficult, if not impossible, to make. This seems to trouble some people who believe in tidy packaging. I am not one of them.

The health care industry has been the subject of an increasing volume and range of criticism in recent years, due, I believe, primarily to the rapid inflation of costs and the uncertain access to adequate care by large segments of the population.

The growing discontent is not due to the things having become generally worse, however. On the contrary, I believe any objective appraisal would show there has been substantial improvement over the years. To a large extent the discontents reflect the higher standards of expectation.

For example, the problems of the poor are not new and certainly are smaller in relative volume than ever before, but unnecessary discriminations are now no longer morally acceptable. Or, of course sickness has long been a menacing hazard for the middle-income family, but it is now seen as an avoidable financial hazard given proper social organization.

The private sector has contributed substantially to these dissatisfactions, but paradoxically, I believe, it has not been primarily its errors and omissions that have done so, but rather its successes that have helped generate rising expectations.

By making more people acquainted with the wonders of modern medicine, by opening wider the door of access to care, and by making the public aware of what is potentially available through improved financial and organization mechanisms, it has greatly increased impatience with remaining barriers and inadequacies.

That is one of the reasons there is widespread agreement on the need for better and universal protection.

Since the private sector has been the most dominant and visible factor in the health field, it is natural that it would be the focal point of criticism. The inadequacies of private health insurance are many and real. But, if we examine the specific criticisms, we generally find that the faults are at least equally attributable to Government in an interactive process.

Mr. ROSTENKOWSKI. Professor Somers, on that note we will have to suspend 5 or 6 minutes to answer this quorum call.

We shall return.

Mr. SOMERS. All right. Thank you.

[Recess.]

Mr. COTTER [presiding]. I think we can resume now, Mr. Somers, if you would continue.

Mr. SOMERS. Thank you.

I was at that point saying that if we examine the specic criticisms of the private health insurance sector, we find that the faults are at least equally attributable to Government and it is an interactive process.

Some examples. First, until recent years the health insurance industry showed little interest in developing effective controls over costs of care or pressing for more effective professional control of quality.

They used to say that their charters were merely to act as fiduciary institutions and that their role was simply to apply the magic of averages to spread risks and to ease the burdens of payment. Thus the industry was providing increasing resources to underpin a system that was progressively less satisfactory.

But exactly the same condemnation could be made of Government and probably more sharply. Government also did little about quality control or containing costs. For example, when in 1965 the National Government undertook to finance medical care for millions of additional persons through medicare and medicaid, the same omissions characterized those programs. Both private and public sectors were victims of knowledge lags which with the advantages of hindsight both now recognize.

Second, the fragmentation of insurance has contributed to the fragmentation of health services. Some of this was historical accident, some resulted from the obdurateness of the medical profession. The separation, for example, of Blue Cross, the hospital plan, from Blue Shield, the physicians' service, has obviously not contributed towards better integration of delivery of health services.

However, as late as 1965 when the insurance industry was beginning to move away from this pattern, Government adopted the same error in its major health insurance program, medicare, and set up two distinct financing and payment systems for the two types of services.

I have a list here of other examples which I will omit in the interest of time. The point of these simple examples is to suggest there are no automatic solutions to be found in doctrinaire formulas regarding preferability of public versus private operations.

Observers of the current debate on National Health Insurance can, however, readily perceive that the symbolism of old ideologies remain a potent force and may interfere with what ought to be a pragmatic search for answers in terms of workability and practicality.

On the one hand, we have proposals that would completely preclude any form of private participation in financing or administration. On the other hand, we have proposals such as the old administration—Nixon—plan which, in order to avoid Government financing, abandons the major objectives of National Health Insurance. Years of intensive effort by some very bright young men at HEW demonstrates that it is not possible to achieve universal coverage and to avoid means tests under a mandating program.

Both approaches seem to me to pay more obeisance to so-called principles than to realities of finance and administration. The fact is that for the vast task at hand we need the resources and special strengths of both Government and the private sector and they need each other. Our best protection against inadequate public accountability—of which we have seen a great deal recently—lies in diversity, a spreading of functions and power centers.

Historically, Government has been most effective at picking up and advancing ideas and programs that have started elsewhere and won support, or that need assistance against sluggish responses in the private sector.

The cutting edge of a new movement is usually in the venturesomeness of relatively small and often new organizations.

Right now, for example, the most prominent organizational reform being advocated is the nationwide development of health maintenance organizations based largely on the success of the Kaiser Foundation health plan. But it should be recalled that Kaiser emerged from very small beginnings more than 30 years ago in the private sector and persisted against the impediments of governmentally created legal restrictions as well as the opposition of organized medicine.

Had a unitary system existed in the 1940's, it seems highly doubtful that a Kaiser scheme could have gotten off the ground. Good as the Kaiser idea is, it will undoubtedly not prove to be the final word in health organizations for the indefinite future. From whence will the next generation's innovators, the potential Kaisers, get their launching leverage in a unitary plan?

The ponit is we don't have to abandon private initiative to obtain the advantages of governmental financial strength, social equity, or democratic control. Government undoubtedly must assume responsibility for financing health care if universal and equitable access are to be assured, because there is no other way. But that does not mean that Government must itself directly carry out the policies and administer all operational aspects to effect the execution of governmentally determined objectives.

Some time ago in a discussion of the administration's plan and his own, Senator Kennedy was quoted as saying:

> The most basic difference is that the administration relies on the private health insurance industry while we rely on the social security approach. I don't see how there can be compromise on that issue.

Probably the private insurance spokesman would utter similar sentiments.

But the fact is that social security financing can be reconciled with the use of private instrumentalities. In fact, with good will an approach can be developed that borrows significant elements from all the major proposals that have been submitted to the Congress.

For illustrative purposes Anne Somers and I developed and published one such program several years ago. It was built on the general model of the Federal employees health benefits program, a significant practical experience with an effective public-private mix.

I am not here to peddle any particular program, so I need not describe the plan here nor is there the time. The point of the exercise was to illustrate that Government financing and policy initiative can be reconciled with the advantages of private management.

There are undoubtedly other ways.

Finally, I again say that on the one hand Government merely mandating the purchase of private health insurance—which has been erroneously called public-private partnership—would leave the essential health care problems just about where they are now, perhaps exacerbate them. On the other hand, I doubt that there exists in this country the managerial competence to administer a unitary all-inclusive system of diverse and continental dimensions dealing with such sensitive personal services. I doubt that the political system could withstand the strains of the inevitable multitude of complaints, dissatisfactions, demands and misfortunes of the entire enormous and complex health system heaped on it alone.

To achieve the objectives of national health insurance, Government needs help from the private sector. It needs the managerial expertise and experience of the private sector for effective decentralization and exposure to varied administrative alternatives.

It needs the diversity and incentives for efficiency that capacity for risk-taking, innovation, and experimentation make possible. It needs the political protection of a spread of responsibility and blame for mishaps. It needs the involvement of large portions of the private sector to promote broader understanding and tolerance of the immense difficulties of running such a system. It needs the support of such groups as a counterforce to the tendency of Government budgets to become unduly restrictive.

It is, of course, equally true that private health insurance needs Government to provide the necessary financial strength and stability and to insure universal and equitable coverage if it is to survive.

The traditional demarcations between private and public sectors are obsolete. The fabric of a democratic society requires that Government not be considered the sole vehicle with a public welfare mission. Public service is not antithetical to private or voluntary auspices. The concept of community involves something broader than strong government alone.

Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Thank you, Mr. Somers, Mr. Stark?

STATEMENT OF NATHAN J. STARK

Mr. STARK. Mr. Chairman, members of the committee, I am Nathan Stark. The role of the private sector in planning for national health insurance is of paramount importance. Unless there is deep insight and understanding of the private sector, designers of health insurance legislation could structure a program that would not assure the full cooperation needed. Without this cooperation a program could fail to get off the ground. It is encouraging indeed to see the interest and concern of this committee in examining with great thoroughness all of the complex issues involved here.

First, let me correct what may be an understandable but erroneous assumption of my position in this discussion. My titles at the University of Pittsburgh obviously identify me as a health professional. This is a new role which I have had for less than a year now.

Prior to that—literally for a quarter of a century—my vocation was private industry. My interest in the health field was strictly an avocation. As a business executive my primary concern was industrial planning and development. But like many industrialists there was secondary concern for community improvement. This led me progressively into the health field—as a hospital trustee, chairman of the board of an urban regional planning agency, and on into the development of a new school of medicine and a major medical center.

It was this experience in the health field and my commitment to it that less than a year ago led to changing from a business career to an academic health center. So in addressing the issue of national health insurance you will understand that I speak from a long experience in industry, as well as a health professional.

I suppose also being from Missouri, originally, I have the right to quote Mark Twain, who in talking about these various experiences said: "He who swings a cat by the tail learns things that one can only learn by swinging a cat by the tail."

[Laughter.]

Mr. STARK. Now, health insurance is not a new concept for me. After the enactment of Public Law 89–97 in 1965 I was appointed to the first Health Insurance Benefits Advisory Council, along with my colleague to my right, Dr. Somers. There we wrestled with the myriad problems of implementing medicare.

Prior to that I had served as a member of the corporate board of our local Blue Cross plan. But now the Congress, and especially this committee, is faced with the awesome responsibility of deciding what this Nation wants or needs in the way of health insurance. Or indeed, even whether such a program is really wanted or needed.

Few people ever questioned the need for medicare. Health services for the elderly was such a towering need and one that could not be met by the limited financial abilities of the aged. Without adequate financing services could not be delivered by the health providers. Local and State governments were unable to cope with the problems short of the indignity of the means test and some highly inadequate welfare programs.

Kerr-Mills had helped, but it was obviously not the answer. So the health field and the public were ready to accept a Federal program of health insurance for the aged. In good part, through the wholehearted cooperation of hospitals, this new program moved fairly smoothly into action.

There is an important lesson to be learned from medicare which bears close examination as far as health insurance for the total population is considered—the clash between expectations and reality, as was pointed out earlier. The public, and even the field of health, saw medicare as the answer to all the unmet needs of health care for the aged.

Congress, of course, did not intend it to be a panacea, a total coverage insurance. But the public, unused to the fine print and stilted language of the legislative package, chose to believe it met all their expectations. The health providers made similar assumptions. They simply believed that they would deliver services and be reimbursed their costs. They never realized that the program would be hedged in with increasing limitations and an endless maze of regulations and controls that they now feel threaten their very existence.

Medicare reimbursement, as you know, is used to encourage compliance with accepted standards. I don't think there is anything wrong with using financial approaches of that sort in those ways. In fact, such uses are tangible acknowledgment of interlocking relationships between components of health care.

However, I do not subscribe to the viewpoint held by some that a national health insurance program should be seen primarily as a method of modifying the health care system. At the same time I do subscribe to the fact that while the primary objective is underwriting the cost of illness, that objective can only be effectively achieved through a modification of the present health care system. In other words, we must give close attention to determining that the financial

mechanisms support rather than determine desired steps toward an improved total health system.

From the private sector viewpoint any extension of Federal health insurance will be met with a closer and more sophisticated scrutiny than was ever given to medicare. This calls for complete honesty and a rational presentation of all the facts.

Pertinent questions are beginning to surface in the private sector. Is the push for NHI an emotional idea hedged about with slogans and clichés and impassioned utterances? Or are there some hard, solid facts on which to build a case?

It is clear that the health care field today is undergoing tremendous economic, political and technologic change. Although the forces pushing these changes have been around for a long time, there is a quickening of the pace resulting from increased expectations and a phenomenal rise in costs.

Today many, if not most, of us find that we can no longer meet the cost of a major illness. I am reminded of Oscar Wilde's statement, "I am dying beyond my means."

Now access to quality health care is not readily available to many of our citizens. There are inequities caused by a geographic maldistribution of physicians. There is also a deficiency of primary care and family practice physicians, a maldistribution of specialists. Consumers want to be partners in decisionmaking and everybody agrees there must be increased accountability in the expenditure of funds.

Who supports the national health insurance program? Organized labor does, of course. But they support a program of total coverage. Some people are wondering whether the United Automobile Workers would yield its fine private health insurance program for a Federal program if it were anything less than total coverage paid. Or would Federal employees give up their excellent insurance coverage for national health insurance?

State governments would press for a national program in the expectation it would relieve them of the medicaid burden. Academicians can theorize with intellectual fervor on the practicability of national health insurance and compare this country unfavorably with other nations. And yet almost all of these groups base their positions on a program of total coverage. Some even ask what the cost would be, or question what would happen if the Congress were to enact a less than total coverage program.

The last question is worthy of careful study. If a program of modest proportions were enacted—less than all needs met and all costs paid—is it not possible, or even probable, that labor and industry and the general public would find it necessary to carry supplemental private insurance to give them as good an insurance program as they already have?

Many health providers are asking this question, and visualizing the incredible chaos of having to deal with dual coverage on a large proportion of their patient load. They find it extremely difficult now to deal with the tie-in insurance with medicare and may well shudder to think what it would mean if the covered population jumped from 23 million to over 200 million.

While it is recognized that many special groups in this country are vocally advocating national health insurance, a question is raised

about the great "silent majority" who speak through no organized groups. What does John Q. Public think or what would he think if all the facts were logically presented? The architects of national health insurance should study this diligently.

The health delivery system is undergoing a health process of change and development at the present time. Some very real progress is being made. Would the massive demands of a national program impede or speed up this progress? Or would the demands exceed the capabilities of the system to produce services now? We should carefully analyze our priorities here.

I have saved to the last that all-engrossing factor of program cost, a cost in hard dollars that will be paid by the American taxpayer for any program enacted. As a businessman I must think in terms of return on investment, of yield versus expense. Will a national health insurance program, bringing health care within reach of those who may not have had it available before, bear tangible results in health outcome?

For example, how much improvement in the Nation's health status is likely to result from an insurance program? I won't attempt long comments on this, but a look back over the past 15 or 20 years shows little increase in life expectancy in the United States and there is presently no reason to believe that increased resources spent on health care will alter this appreciably. When one examines the major causes of morbidity and mortality in the United States for people over the age of 40, one finds the leading causes of death—heart disease, cancer, and stroke—are all affected by behavior characteristics—lack of exercise, smoking, weight control, and alcohol habits.

As a matter of fact, the highest return on additional investment in health services is really a subjective one—albeit very important—that it results in an improvement in the quality of life. This relief of severe pain and the alleviation of anxiety are two examples, but they are difficult to quantify in terms of value and magnitude.

Which then is more beneficial to our Nation? Dollars spent to teach nutrition to ghetto mothers, to buy more research into low-cost housing, to develop and operate a coronary care unit in a hospital, to spend more on research in new therapies affecting major causes of death? Should our priorities be aimed at modifying human behavior related to health in the broad realm of public education? What about biomedical research or research related to health care delivery systems?

Obviously we do not choose between priorities. We arbitrate among them, we harmonize and balance them.

I was impressed with a statement made just a couple of weeks ago by Dr. Theodore Cooper, Assistant Secretary for Health, DHEW, in addressing the AMA. Dr. Cooper said:

> Let us be frank with the American people, with their lawmakers, and with ourselves. When it comes to influencing health status, health outcomes—even probably the results of health care—there are a great many determining factors over which medicine has effectively no control.
>
> It is one of the great and sobering truths of our profession that modern health care probably has less impact on the health of the population than economic status, education, housing, nutrition and sanitation, and the impact of changing technologies on working conditions and the environment. Yet knowing that, I think we have fostered the idea that abundant, readily available, high quality health care would be some kind of panacea for the ills of society and the individual. That is a fiction, a hoax * * *

The question is: What will the billions of dollars of our public's money buy? Will it be a good return on our investment? I am not opposed to the idea of national health insurance. But I hope it can be studied with a clear, logical, analytical process that is not based on emotion, or long espoused theories, or bland assumptions or political expediency. It is too expensive and too important to be based on other than cold, hard facts.

Finally, about the health crisis. It has always been with us. Simplistically, we might say that polio vaccine was developed as a response crisis. Perhaps an NHI program will be developed as a response to a perceived crisis. Many of us are on diets as a personal reaction to a crisis. Perhaps an NHI program will be developed as a response to a crisis in health care. I hope that this committee, the Congress, the people of this Nation will not fear the word "crisis." Without crisis we will not have the slight edge that gives impetus to change, to growth, to development.

It is paradoxical that when the Chinese write the word "crisis" they do so in two characters, one meaning "danger" and the other "opportunity."

Thank you.

Mr. ROSTENKOWSKI. Thank you, Mr. Stark.

Dr. England?

STATEMENT OF ROBERT G. ENGLAND, M.D.

Dr. ENGLAND. Mr. Chairman, members of the committee, I thank you for the opportunity to be a member of this third panel session on national health insurance. I have to apologize for my delivery because the climate in Washington doesn't seem to be satisfactory with my sinus and my upper respiratory tract is in bad shape.

Further, I reorganized my statement last night, some of it is pasted together with Maclean's toothpaste and although it is fragrant, it may make the going a little bit rough.

I am Robert G. England of Carlinville, Ill., and I am engaged in the practice of private medicine. My time is devoted to and my income is derived from the practice of private medicine. These are the only credentials I claim. I am not employed by any organization whose existence is dependent upon Government grants or subsidies and, therefore, of course, neither is my existence dependent upon subsidies. I am not part of any insurance interest whose profits or nonprofit income depends upon the legislative process. Nor do I represent any lobby appealing for Government subsidy.

Legislation and regulations emanating from the Federal Government create such obstacles to the provision of quality medical care that it is apparent that opinions of physicians in the private practice of medicine have been largely ignored by the Congress. Surely only by failure to consider what the private practitioners know would Congress have promoted the existing situation.

Glancing at the list of members on other panels, I am not sure that one of me from the private practice of medicine is enough to provide a balance against the others who are outside the private sector.

I am singularly impressed with the fact that there seems to be a tremendous amount of academic personnel on these panels, many of

whom have been ardent advocates of compulsory politicalized medicine for many years; whereas, there seems to be a dearth of private physicians who are not committed to Government intervention and control.

Mr. Chairman, in your letter to me of June 30, 1975, you made two statements that I think are pertinent to this discussion. The first item I refer to is your statement that "My intent in conducting these panel sessions is to launch that vital educational and exploratory process that must precede the construction of a legislative proposal by this subcommittee."

The philosophy underlying this statement troubles me. Does every complaint, every alleged social need constitute a demand for legislative remedy?

I submit such is not the case in a country of free men. To the extent legislation is used to provide such remedies, the liberty of free men is diminished. Once one accepts the legitimacy of such legislation as the answer to all human problems, the information fed into the legislative process is easily organized to impel further legislation, and, consequently, further diminished liberty.

Unwittingly some who as short as 13 days ago hailed the free enterprise system as the bulwark of the Nation's liberty can now be found participating in an attack upon it. There is a mountain of unexplored evidence on the case of national health insurance which, if reviewed in the light of the historical development of freedom and the history of this country, will cause any group of legislators to pause before going ahead.

For example, the situation of the Indians in this country should be thoroughly explored. What role has the private sector had in caring for their health and what role has the Federal Government had?

The record appears to be that this group of citizens was more paternalistically cared for by Government as far as medicine was concerned than any other sector of this economy. Yet the morbidity and mortality rates of Indians is one of the most unfavorable of any in the country.

The second point I wish to comment on is your statement that:

> Consequently, the aim of these first sessions is to undertake a broad assessment of such fundamental matters as the historical development and current status of our health care system. The respective roles of Government and the private sector as they have evolved over time and the critical and economic organizational issues involved in the delivery and financing of health care.

With respect to this point, we should take a good hard look at medicare and medicaid from the standpoint of patients and the doctors who take care of them. Also we should evaluate the result of similar socialized medicine programs in other countries.

It is my hope that this committee will rise above partisan politics and look at what is good for patients in general and not what is good for labor union leaders or what would divert tax money to insurance companies, medical societies, the bureaucracy, or whatever.

In this connection the historical development of freedom in the United States did not come about by Government interfering in the minutest detail of everyone's life. As a matter of fact, everyone here knows that this country was founded by people who were trying to get away from Government dictation and control. It doesn't make

sense to me to develop the greatest country on earth with the greatest medical care under the system of individual responsibility and liberty and then adopt a pattern of Government intervention and control which our forefathers escaped.

An honest critical look at medicine in the United States and other countries with socialized medicine makes it obvious that government intervention and control is not the route to optimum medical care.

The most objective, complete, and factual study available on what has happened in countries that have socialized medicine is in the book "Medicine and the State" by Lynch and Raphael. This is a concise source of reference as distinct from a work based on emotion, political theories, or whatever.

It was carefully written and it expresses the conviction that it is more than likely that the medical profession of North America will find themselves in the frontline of the ideologic battle between the planned and the free societies.

In this book specific claims of the Socialists and Communists are unemotionally set forth in a deliberate manner and a comparative analysis is made of the government promises versus performance.

This committee should know that this book, which appears to be carefully avoided by promoters of socialized medicine, starts out by discussing the search for an ideal situation, enumerates the criticisms of the private practice of medicine, sets forth the advantages claimed for socialized medicine, then explores in detail what happened in Germany and Austria.

It explains in the first half of the book what the legislators and the government promised the people, how the medical profession was deceived into believing the political promises, what came out in the way of a legislative program and, finally, how it worked in practice compared with the promises. The truth it portrays is not a pretty picture. It details the same type of information for the Union of Soviet Socialist Republics, the British, New Zealand, Australia, and Sweden. I think every Member of Congress would be enlightened if he would take the few hours necessary to read this book and study the message it contains. It explains a system different from our basic system. It is a system of government subsidy and control with bureaucratic redtape and patients treated on an assembly line basis. It does not compare favorably with that part of our system which remains on a willing exchange basis.

Another question with needs investigation in this connection is if socialized medicine is so good, why has it been embraced by such as Lenin, Stalin, Hitler, and Mussolini? A detailed study of why this is so should go a long way to cause representatives of free men to be very careful.

The British system has been held up as an example by many people as to why we should adopt socialized medicine here. The man who knows most about this and is in a position now to speak freely without coercion is Enoch Powell, who is the former British Minister of Health from 1960 to 1963 and now a Member of Parliament. He has a profound understanding of why government medicine doesn't work and it was attained from experience.

He started out thinking it could be made to work if it were approached properly. He came to find out that inherent in the nature of

government medicine is the seeds of its own failure. It goes back to some very fundamental questions.

When a patient chooses his own doctor and pays for the services of that doctor, he generally gets what he pays for. A willing doctor providing a service to a willing patient who pays for that service results in satisfaction. The minute a third party, such as government, starts paying for the service, all kinds of problems result. The patient has a different attitude toward the doctor and vice versa. This is why even here in the United States the attitude of a doctor who is working for the Government toward his patient is basically different from that of a doctor who is on a fee-for-service basis.

Mr. Powell said it this way: "America taught the world that you get what you pay for." He also said, "There are two inherent evils of socialized medicine: (1) Centralization of decisionmaking, and (2) damage to the doctor-patient relationship."

We have seen under medicare and medicaid that decisionmaking is centralized and standardized against the best interests of everybody concerned. On the question of damaging the doctor-patient relationship, Mr. Powell pointed out that in Britain "it is often the case that the general practitioner who does a worse job, who serves more patients than he can properly attend, is paid more." He went on to explain, "You cut the direct link of service and appreciation between the doctor and patient by state medicine. Both the practitioner and the patient, instead of looking to each other, look to the State. It is an alibi for 'inadequacy'."

Mr. Powell decried the idea that is prevalent that a definable amount of medical care is needed and if that need is met, no more will be demanded. This is absurd. "Every advance in medical science creates new needs that didn't exist until the means of meeting them came into existence. Its demands are not only potentially unlimited, it is also by nature not capable of being limited in a precise and intelligible way."

Mr. Powell explains that waiting lists is the covert rationing device used in order to limit demand to the appropriations made by Parliament. Congress would do well to dig into this matter.

Congress should understand that medical school academicians have a stake in getting more Government money. They should also recognize that labor union leaders are not interested in good medical care as such, but are looking at the politics of how to get more power for themselves. They reason that if they can shift the medical costs of their labor contracts off the back of the corporation and on the general public, they will be able to get more salaries and fringe benefits from the corporations and, therefore, improve their position in the union.

A lot of shortsighted corporations think if they can cut the costs of medical care out of union contracts, they could increase profits. Further, there are in some corporate organizations individuals whose existence in that corporate structure is dependent upon the existence of a militant and demanding labor union.

Some medical societies, responding to the arguments of the academicians, who are interested in getting money out of the Federal Treasury, think they can get money out of the Federal Treasury for the organization. Neither the interests of the patients nor the doctors, whom they are supposed to serve, is their dominant consideration. Of course, a number of people are afraid that the Federal bureaucracy

is going to gain the upper hand and they had better make the best personal deal they can with it in order to lighten the bureaucratic blow.

With respect to the legislation now existing what has happened to medical care? Has it become cheaper?

Congress was forecfully warned before medicare and medicaid was enacted about their costs and the inevitable damage to the patient-physician relationship and to the economy. This was prior to 1965. Congress didn't pay any attention, but listened to the bureaucrats and labor bosses and others who had an interest in betraying the people. As a result we have medicare and medicaid programs, the costs of which are absurdly high and going higher.

Bureaucrats told Congress in a most solemn way that the costs of hospitalization the first year would only be $900 million, but the first year it turned out to be $2.7 billion, three times as much. They also said that in 1975 it would only cost around $1.7 billion. It cost $10.9 billion, six times what they said.

When costs skyrocketed, as every reasonable person knew they would, the answer was to publicly blame doctors for the bureaucratic miscalculations and to apply controls on the medical profession to force a reduction in costs. This, of course, was impossible and costs have continued to mount because demand is insatiable, particularly if the service or product is thought to be free.

In 1972 Congress passed the PSRO law, which puts all the power in the hands of the Secretary of HEW, who is a layman and who would have to act as a layman and politician even if he were a doctor. That law can be used to deny patients the right to choose their own doctor and the right of doctors to take care of medicare and medicaid patients. It denies the patient and the attending physician the right to decide what is medically necessary and medically appropriate. It denies the patient the right to have the kind of medical care the doctor thinks is best and denies the patient the right to talk to his doctor in confidence about his illness.

When the bureaucracy was challenged in a lawsuit in 1973 by the American Association of Physicians and Surgeons asking the Federal courts to declare PSRO unconstitutional, the reaction of the bureaucrats was to try to bring about the same result through utilization review committees. A Federal judge has issued a preliminary injunction against this abuse of power, but this type of bureaucratic control has been imposed in every country in Europe.

Again if you read "Medicine and the State," you will see that PSRO is not new here in the United States. It was introduced in every country in Europe that has socialized medicine and it resulted in poorer and poorer quality medicine. Of course, it injured the doctor-patient relationship. Police physicians were appointed there to look over doctors' shoulders similar to PSRO here.

In Russia, under a Communist dictatorship, where one might expect the most brutal control, agent provacateurs are created. Their job is to go to doctors, feign illness and when the doctor tries to treat the illness, the doctor is brought before the authorities as an enemy of the people. This degenerates into doctors looking at patients and wondering if they are enemies or someone who needs compassionate care.

Lynch and Raphael put it this way:

In such a climate the physician is placed in a hopeless dilemma. On the one hand his responsibility is to the patient with whom he must establish mutual confidence and trust if he is to diagnose and treat correctly. On the other hand, he is obliged to protect the state of which he himself is a poorly paid servant.

This is where we are getting in the United States with respect to medicare and medicaid even though section 1801 of Public Law 89-97 says:

Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

Has medicare under existing legislation become more compassionate? Does it have more dignity? Is it more personal?

I submit the answer is "no" and under the prevailing circumstances it never will be "yes." HEW regulations which must follow such legislation are hardly the substitute for the desires and needs of a patient or the personal knowledge and judgment of his physician. How can medical necessity be defined in a general way to apply in the particular in the case of an 86-year-old female who is a social security recipient, lives 30 miles from a hospital and is in need of a hospital service, such as a barium enema. What should be done for a 73-year-old female who becomes disoriented and combative at night, for whom a nursing home bed is not yet available and whose only other source of care is a daughter in her mid-fifties whose lower extremities were crippled by polio at childhood?

Is an extended stay in a hospital justified for an arteriosclerotic woman in her seventies, unsteady on her feet, but who must wait for her daughter's home to be cleared of throw rugs and carpeted. These patients should be hospitalized.

There is no way under the regulations that medicare administration will allow such extensions or recognize such medical necessity. Changing the regulations or even, as the AMA has done, obtaining an injunction against some of them, is not the answer. More will, and indeed must be promulgated. By its very nature the legislation now in effect and all others proposed demand such regulation.

Again, providing scarce services free to the consumer and creates unlimited demand. Some method to control demand and maintain some semblance of fiscal responsibility is needed and the bureaucratic response is rationing.

Along with the superinspection method needed to implement these devices there grows the notion that since everybody is being cared for by everybody's taxes, then everybody's care is everybody's business. From our record rooms in our hospital copies of records are provided to third parties at the rate of about 10 per week. This is in a hospital that has about 150 admissions a month.

Frequently I wonder how many of the consents to release information that are executed by medicare patients upon admission to the hospital are truly informed consents.

Has medical care become better? To the degree that medical innovation has manged to remain slightly ahead of bureaucratic regulation, I suppose so.

But this cannot be expected to prevail. To some it will not matter. If you are rationed out, the quality of care you don't get is irrelevant. Further, there is no way to judge the excellence of what would have been developed in the absence of smothering regulations from HEW. This, perhaps, is the most tragic result of the policies we are following. Comparisons of varieties of mechanisms of patient care soon become impossible. Any improvement becomes an unlikely dream.

Turning to the matter of cost, important because, today, we have the Government spending 48 percent of the income of all of its citizens. Surely there are statistics available to the committee which will indicate it is now more expensive to be sick.

It is also more expensive to eat, buy clothes or get a haircut. Popularly this is explained by saying, "Well, that is inflation." If one recognizes the true nature of inflation, I propose no further explanation is necessary. But opinionmolders—unhappily some Government figures are among them—have led people to believe inflation is the price at the grocery, the price on the gas pump, the light bill and the doctor's fee. Here though in this room we all know that only the Government can create inflation.

Further, the more the Government does for or to us, the more inflation there will be. The so-called crisis in health care is peanuts compared to the crisis created by ever-expanding and ever-expending government. The problems I face in trying to provide quality care to my patients are minuscule compared to the threat constituted by the rampaging growth of the Federal Government and what it represents to the liberty of Americans in general.

Yet there are panelists who will appear before this committee who have gone on record as favoring more subsidies and more controls. As a matter of fact, some of the panelists in other papers have talked about controlling the behavior of physicians. What kind of talk is this in America? Who gave Government employees or academicians in the universities the authority to control the behavior of anybody?

You had better take a good hard look at what you are buying when you substitute the European dictatorial system for the American system. Congressmen should not listen to the voices who say that Government employees have omnipotent wisdom and can decide better than ordinary citizens what they need in the way of medical care. We should not substitute a pattern of failure for the proven pattern of success based upon our willing exchange system.

One final word. The labor unions and the corporations who have collective bargaining contracts with them take the attitude that they are the ones who should dictate the kind of a system we should have for medical care in the United States. Labor unions only represent about 25 percent of the people gainfully employed in the United States. This being so, the big corporations that are unionized from top to bottom couldn't represent more than 25 percent of the workers. Who represents the other 75 percent? Should their best interests be betrayed to give power to the labor unions or provide temporary illusory relief to corporations?

In summary, I suppose my contribution to this educational and exploratory process we are engaged in would be this: Please, Mr. Congressmen, do nothing more and undo what you can.