Contemporary Public Affairs

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1970

NATIONAL HEALTH CARE

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NATIONAL HEALTH CARE

1. The Crisis

That the opening of the 1970's saw the American health care system in a state of crisis is an undeniable fact. Costs were rising. Personnel was poorly allocated. The quality of care was inconsistent. And, finally, very little possibility for self-improvement existed within the system. One of the most striking characterizations of that system came from Dr. Herbert Denenberg, Pennsylvania's State Insurance Commissioner:

> Our health delivery system is a Frankenstein monster, built on Rube Goldberg principles, and it is now confronted by a public with rising expectations...But it goes on its merry way, indifferent to the needs of the community in its limited ability to pay ever increasing medical and hospital costs.
>
> The system is basically run for the benefit of doctors, hospitals, the drug industry, and other providers of medical care.[1]

The extent of the problem is documented in many places. One of the most extensive is in the eleven volumes of nationwide hearings before the Subcommittee on Health of the Senate Labor and Public Welfare Committee. These hearings, held in a dozen locations from February through May of 1971 are entitled: "Health Care Crisis in America, 1971." The facts they reveal are not only interesting but crucial to the health of the nation.

The initial remarks of Senator Edward Kennedy (D. Mass.), subcommittee chairman, as these hearings began, provide an idea of the scope of the problem:

> In the United States today, health care is the fastest growing failing business in the Nation, a $70 billion industry that fails to meet the needs of our people. The American health care system is in crisis, and the crisis is deepening....
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> There are several major dimensions of the crisis. They are different, yet they are related.
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> First of all, there is cost....
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> Second, there is the acute and worsening shortage of all kinds of health personnel....
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> Third there is the problem of the system, the archaic and inadequate arrangements by which we organize and deliver health care....
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> Fourth, there is the problem of the quality of care....

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1. National Public Radio, "Report to Congress and the Nation: National Public Radio 'Health Care Hearings'," (transcript available: N.P.R. Suite 715, 1625 Eye St. N.W., Washington, D.C. 20006), p. 24.

These hearings will be both systematic and comprehensive. They will delve into every major area relevant to the way our health care system works. Over the coming weeks here in Washington, and later across the Nation, we will be examining many areas, including:

1. The President's Program;
2. The quality of health care;
3. The cost of health care;
4. The role of the health professions;
5. The role of the consumers of health care;
6. The private health insurance industry;
7. Health professions education;
8. Group practice of medicine and health maintenance;
9. Medical economies;
10. Biomedical research;
11. The role of private foundations in health;
12. Dental health care;
13. Preventive care;
14. Mental health and retardation;
15. Inner city health care;
16. Health care in rural areas;
17. Health needs of the elderly, the young, minorities, and other special groups;
18. Comparisons with health care systems in foreign nations.[2]

With the exception of the first and last items, the above list represents a good tallying of more than a dozen of the major problem areas covered by an umbrella title like "Health Care Crisis in America." Obviously we cannot begin to take apart the entire list in any detail. What we will do instead is to briefly describe the general crisis, and then focus in on solutions which have been proposed in the form of national legislation.

Let us look at some of the statistics of the problem in terms of the four major areas mentioned by Senator Kennedy in the early section of his remarks: cost, personnel, quality and the system itself.

<u>COST</u>: The quickest way to see what is happening to medical costs is to look at the indexes of medical care prices which are a part of the Bureau of Labor Statistics' Cost of Living Index.

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2. Subcommittee on Health of the Committee on Labor and Public Welfare, United States Senate, 92nd Congress, First Session, <u>Health Care Crisis in America, 1971</u> (Washington, D.C.: Government Printing Office, 1971), pp. 1-3.

Year	Total Medical Care	Drugs and Prescriptions	Physicians' Fees	Dentists' Fees	Hospital Daily Service Charges
1950	73.4	86.6	76.0	81.5	57.8
1955	88.6	92.7	90.0	93.1	83.0
1960	108.1	102.3	106.0	104.7	112.7
1965	122.3	98.1	121.5	117.6	153.3
1970	164.9	101.3	167.0	152.2	287.9

Source: Statistical Abstracts, 1970, p. 62; Monthly Labor Review XCIV (Feb. 1971) 110-111.

In this set of indexes the years 1957-59=100. That medical care costs are rising more rapidly than prices in general can be seen by comparing them to the overall cost of living: prices in general were up 35.3 per cent between 1957-59 and 1970, and medical care costs were up an average of 64.9 per cent in that same period. And, as the table indicates, the daily hospital charges have almost tripled.

But index numbers tell only a very impersonal story. One official of the California Teamsters Union told National Public Radio's health hearings that the union's research indicated that six out of ten personal bankruptcies in this country were directly attributable to health costs. A Los Angeles housewife told of her family's loss of dignity, as well as loss of money, in the struggle to meet the expenses of a child's chronic illness. And, finally, there are the thousands who never even start the health care process because, in the quip of one critic, "the cash register sits next to the appointment book."

Why have our health costs become so unmanageable? What factors in our health care system have contributed to this rise in costs? There are several: 1) increased demand for care, 2) increased labor costs, 3) increased technical costs, and 4) increased costs due to the inefficiency of the system.

There are a number of reasons why most Americans are asking for more health services than they did 20 years ago. In general, the average person in 1970 is better educated and simply knows more about possible health problems. He probably has a larger income and better insurance to encourage him to seek health services. He has different social attitudes which lead him to expect good health as a "right." He has seen medical technology grow and has come to expect more of the health care system. As a result, the health care system has to expand facilities and staff in order to provide those services.

An additional reason for increased medical costs, especially at the hospital level, in which the greatest rise in index has occurred, is increased labor costs. For example, nurses' salaries have increased from a time around 1950 when the annual average earnings were below $3,000 to the point at which their average salary now exceeds $10,000 per year.

The technology of medicine has had a heavy influence on the cost of care. It is not unusual for a hospital patient with even a suspected heart attack to have a bedside monitor costing $5,000, to have his blood analyzed by a machine costing $60,000; and to have his billing handled by a computer costing, perhaps, $100,000. Medical miracles may be possible via the laser, atomic medicine, and the computer, but these miracles do not come cheap. In addition, today's $60,000 piece of equipment may find itself in the scrap heap after only a very few years, because a new and improved variety of the same machine becomes available for $120,000.

Facts like this latter one lead us to the fourth cause of rising costs--the inefficiency of the system itself. Although it is unlikely that the population will reduce its demands for health care, or that health professionals and other health system employees will spontaneously cut their salary expectations, or that technological investment will diminish, it should be possible to make the health delivery system more efficient. Statistical data are not so readily available in this area, but many experts would agree with Herman M. Somers that:

> Once the glare [of public resentments due to cost] began to penetrate the many recesses of this complex field, it appeared to reveal an array of alleged difficulties: a delivery system...fraught with inefficiency, obsolete arrangements, inequities, and waste--all increasingly criticized by the professionals as well as laymen, but apparently intractable to quick or obvious reform...The two phenomena--high costs and a disjointed or inadequate delivery system--nurture one another."[3]

One very typical type of inefficiency which can exist in many local areas is the unnecessary duplication of facilities. Within the same medium-sized community, medical technological facilities and medical services are often repeated in several locations, while at each of these locations the facility or service is receiving only partial use. This unneeded duplication results in part from the competition which often exists between hospitals. The convenience of doctors and staff is another part of the reason.

PERSONNEL: Here the problem is not only one of simple shortage, but also one of maldistribution of our existing manpower. Although the problem is discussed in terms of doctors, it applies similarly to all health care professionals.

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3. H. M. Somers, "Health Care Costs." In the American Assembly, The Health of Americans (Englewood Cliffs: Prentice-Hall, 1970), p. 168.

First, doctors are poorly distributed in a geographical sense. As Dr. Leopold J. Snyder pointed out:

> ...doctors are not always located where they are most urgently needed. As examples of the disparity in distribution, let me cite some figures. Here in urban Washington, D.C. there is a physician for every 340 persons. In rural Arkansas, the ratio is one doctor per 1,400 people. There are some rural counties throughout the country with no private practicing physicians, some 136 by the last statistics I have seen.[4]

But even within the cities the distribution is as bad or worse. Gordon Chase, head of the Health Services Administration in New York City pointed out:

> You need only travel a couple of miles to find 150 physicians serving a population of 233,000 [one physician per 1,553 people] in central Harlem and contrast this with more than 4,000 doctors located on Park Avenue and its affluent side streets.[5]

Not only are doctors poorly distributed in terms of geography, but the same is true in terms of the specialties they practice. For example, Dr. John Stubbs of the Massachusetts Institute of Technology observed:

> ...there are too many surgeons, particularly far too many general surgeons. I think this claim can be made for many other branches of surgery as well. I take the example of neurosurgery, where there are more neurosurgeons in the state of Massachusetts serving a population just over 5 million than there are in the United Kingdom serving a population of over 50 million....
>
> And the other side of this oversupply of specialists in general, and surgeons in particular, is the way in which we have allowed to run down our primary care physicians--and by this I mean general practitioners, internists, and pediatricians.[6]

<u>QUALITY</u>: Dr. John P. Bunker of Stanford University addressed the problem of variations in the quality of medical care. Based on a four-year study of 34 selected hospitals, he concluded: "...a 40-year-old woman entering for an elective hysterectomy would appear to have three times as great a chance of surviving in one hospital than another."[7]

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4. <u>Ibid</u>., p. 1063.
5. <u>Ibid</u>., p. 1604.
6. <u>Ibid</u>., p. 1174.
7. <u>Ibid</u>., p. 1147.

Dr. Lowell Bellin, First Deputy Commissioner, New York City Department of Health, cites some figures bearing on the quality of health care. A study done on the care given Teamster Union members in the early 1960's showed that almost one-fourth of that care was inadequate, yet 80 per cent of those receiving this care were satisfied with the quality of the work done. Relative to dental work done on New York City Medicaid patients, Dr. Bellin revealed the following:

> Of the 1,300 patients examined about 120, or 9% showed evidence of fraud. In these cases there was no evidence that the dentist had performed the service for which he had billed the City. In another 120 patients, or 9%, the quality of dental work was execrable. The total of fraud plus poor quality was 18%....Of the 498 partial dentures our staff checked, only 333, or 66%, represented satisfactory craftsmanship. Of 295 full dentures...57%..."[8]

THE SYSTEM ITSELF: While most attention is focused on the problems of cost and quality, there is another and more basic level of difficulty--that "Frankenstein monster built on Rube Goldberg principles" that Dr. Denenberg talked about. As Dr. Peter Rogatz, associate director for patient care services, Health Services Center, Stony Brook, Long Island, State University of New York, phrased it:

> The problems I have mentioned cannot properly be laid at the doorstep of the physicians or the hospitals... I believe the difficulty resides more in the fact that all providers of health care--physicians, dentists, nurses, hospitals, departments of health--are functioning within an archaic system, recognizing the defects of the system but almost powerless to modify it significantly because its nature is determined by factors that are essentially nationwide in character.[9]

Dr. Rogatz indicates what some of these factors are by pointing to the reforms needed to create a rational health care delivery system. First, Dr. Rogatz suggests the elimination of unequal health care and different health standards for people of differing economic status. The present system provides private practice for the well-to-do and clinic care for the poor. A second reform in the system would stress prevention of illness rather than treatment of those already sick. In essence, the American system of health care is structured in such a way that it rewards illness: i.e., doctors receive pay for diagnosis and treatment of a specific problem, and hospital services are available to the sick. But relatively little attention or time is given to procedures and

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8. Ibid., p. 1625.
9. Ibid., pp. 1857-58.

tests aimed at preventing illness. Finally, Dr. Rogatz sees three tiers to this rationally structured health care system: primary care, designed to assure every person prompt, convenient access to the health care system through basic diagnosis and treatment of minor problems; secondary care, which would encompass diagnostic or treatment services of a more sophisticated nature, but within the reach of most community hospitals; and tertiary care, which would include only the most complex services not available in most community hospitals.

These, then, are some of the most basic difficulties of health care in America. Because the system is powerless to correct these problems, there has been legislation proposed to aid in their solution. However, these legislative proposals vary in the extent to which they attack the problems. Some would simply aid in meeting the costs of a health catastrophy, such as $60,000 for kidney treatment and transplantation. Since approximately 20 per cent of Americans do not have hospital insurance coverage, some would provide that coverage directly for the poor, or give tax incentives for the purchase of health insurance. Others would regulate the health insurance industry or extend medicare to the entire population. Finally, some bills would actually attack the structural problems and begin to reshape the health delivery system.

In our next section we will begin discussing the particular proposals which have been made to the Congress.

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Discussion Questions: Section One

1. Over the years health care has been changing in this country. What changes have you noticed in your own experience?

   For example, you might think in terms of a particular incident: a child falling and needing stitches, an adult about to have major surgery, a woman's pregnancy and delivery, a case of polio. What differences would there be in the handling and treatment of that incident today as compared to ten, twenty, thirty years ago?

   Many of these changes have been for the good. Others have deepened the crisis faced by the system. Explore the implications of the changes you have noticed. What ones have had only the effect of advancing health care, or of retarding it? What changes have been basically to the good with a mixture of bad side effects?

2. Health care in this country has different standards for different economic classes. This is evidenced by the following facts: when compared to the highest income group, the poor have four times as many heart conditions, six times as much mental and nervous trouble, arthritis and rheumatism, and high blood pressure, three times as many orthopedic impairments, and eight times as many visual impairments; the non-whites have three times as many mothers die in childbirth and twice as many babies die in the first years of life; the life expectancy at birth for a White male is 68, for a Black male, 61, for an American Indian male, 42.

   To what extent should the elimination of this difference in standards be the primary goal of the health care industry?

   What other goals would you put ahead of the elimination of this difference?

   Discuss how the difference in standards might be eliminated. Begin by identifying the obstacles to its elimination. For example, you might go back over the four areas of crisis which have been discussed and ask in what way each of them contributes to the creation of such a gap.

   If left unattacked, what argument can you make that in the future this difference in standards will become greater? Less?

3. Most of the material presented in this unit deals with four problem areas: cost, personnel, quality, and the system itself. Since providing health care for the entire nation is a very complex issue, causes tend to overlap and be interrelated. In fact, it is often difficult to distinguish the causes of a problem from its symptoms.

   Discuss each of these four areas in terms of symptom and cause.

   Does it seem to you that some of the areas are more at the root of the problem than others? If so, which area(s)?

   Does it seem to you that any of the four areas are clearly symptomatic, that is, the difficulties of that area would simply fade away if the real causes were corrected? If so, which area(s)?

   We have discussed only four areas. What other factors, if any, are you aware of which might be causing the health care crisis?

4. Dr. Kenneth E. Lister, president of the Iowa Medical Society, in his testimony before Senator Kennedy's subcommittee in Des Moines, May 13, 1971, made the following points: no one in Iowa is over 30 minutes away from either a doctor's office or a hospital, enrollment at the University of Iowa medical school has increased 40 per cent in the last five years, 80 per cent of Iowans are covered by some form of private health insurance and an additional 16 per cent are covered by government programs so that 96 per cent have some form of health insurance, the state medical school has established a Department of Family Practice and is also establishing a model rural health clinic and a doctor's assistant program. Bernard M. Grahek, president of the Iowa Hospital Association, noted in his testimony that Iowa has a statewide ratio of one doctor to 841 persons, however, in several counties the ratio is one to more than 2,000. The problems this section has been discussing are largely national problems. Based on these figures and your own experience and reading, to what extent are they also problems that apply to Iowa or to your part of Iowa?

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II. Legislative Proposals

During the first session of the Ninety-Second Congress, 1971, several major pieces of health care legislation were proposed. They range in scope from attempts to restructure the health care system through attempts to aid individuals in cases of exceptional cost. Increasingly it is evident that some legislation will be passed in this area in the next few years. What may be less evident is that this legislation will be extremely influential on the whole future shape and quality of health care in this country. For that reason, some knowledge of the alternative proposals and the issues they raise is vital.

Thumbnail sketches of the bills, listed in order of their Senate bill number (in 92nd Congress, 1972-1973) and with the name of their major senatorial backer are as follows:

S.3--HEALTH SECURITY ACT, Senator Edward Kennedy (D-Mass.)

This bill aims at offering a national health insurance plan to cover all U.S. residents. It includes provisions for improving the quality and the efficiency of the health care delivery system. If it is adopted, Medicare would be eliminated. Medicaid would continue as a supplementary program.

S.191--NATIONAL CATASTROPHIC ILLNESS PROTECTION ACT, Senator J. Caleb Boggs (R-Del.)

This bill would provide for a federally financed re-insurance plan designed to allow the private health insurance industry to develop policies which would insure against the costs of a major health catastrophy.

S.836--NATIONAL HEALTH INSURANCE AND HEALTH IMPROVEMENTS ACT, Senator Jacob K. Javits (R-N.Y.)

This bill would gradually expand Medicare until the entire population is covered. In addition the benefits would also be broadened.

S.987--HEALTH CARE INSURANCE ASSISTANCE ACT, Senator Clifford P. Hansen (R-Wyo.)

This bill is usually called the "Medicredit" plan. It has its origins with the American Medical Association (AMA) and aims at giving income tax credits for the purchase of private health insurance. In addition, premiums for the poor would be paid by the federal government.

S.1376--CATASTROPHIC HEALTH INSURANCE PROGRAM, Senator Russell B. Long (D-La.)

This program, as S.191, would attempt to cover the costs of a health catastrophy for those under Social Security. The existing machinery of Social Security would be used to administer the plan.

S.1490--NATIONAL HEALTH CARE ACT, Senator Thomas J. McIntyre (D-N.H.)

This plan would give financial assistance to state health care insurance plans. It would allow persons on public assistance to be covered at no expense. Low-income families and those in poor health could enroll for a small premium. The bill also aims at changing some aspects of the health care delivery system, especially by providing planning for health care at the state and national levels.

S.1598--HEALTH RIGHTS ACT, Senator Hugh Scott (R-Pa.)

This bill would provide financial assistance for both inpatient and outpatient care. The inpatient assistance would absorb additional costs after a family's medical expenses reached a certain ceiling level. The outpatient assistance would cover most of the costs of certain health maintenance and sickness prevention programs.

S.1623--NATIONAL HEALTH INSURANCE PARTNERSHIP ACT, Senator Wallace F. Bennett (R-Utah)

This is the Nixon administration plan. It would set health insurance standards and then require private insurance coverage of all employed persons and their families. Medical care benefits would be provided for low-income families through a separate Family Health Insurance Plan.

Before considering aspects of these plans in more detail, it may be worth noting that legislative enactment is not going to be the solution to all the problems that plague the American health care system. As Basil J. F. Mott observed in Public Administration Review:

> Because of certain basic characteristics of our political system, it will not be easy to solve in the political arena the problems that the health community itself has been unable to resolve. For government to act in any fundamental way to alter our health system, as, for example, the private practice of medicine, requires commanding political support and thus broad public agreement about what is wrong and what needs to be done. However, the lack of consensus within the health field on the nature of the problems and what to do about them has its counterpart on the political and governmental scene. The radical differences between Senator Kennedy's proposal for a

national health service and the Administration's plan is a case in point.[1]

This collection of eight bills can be simplified somewhat by using Somers and Somers classification of the proposals.[2] They see four basic approaches:

1. Proposals for tax or other incentives which will stimulate the voluntary purchase of private health insurance:

   The best example of this approach is S.987, the AMA's Medicredit plan. The Hospital Insurance Associate of America (HIAA) takes a similar approach in S.1490. One other plan using incentives, but which was not introduced into the 92nd Congress, is the American Hospital Association's (AHA) Ameriplan.

2. Proposals for the mandatory purchase of private health insurance by employers for their employees:

   The only example of this approach is the Nixon administration's proposal, S.1623.

3. Proposals calling for a unitary and all-embracing federal program to provide coverage for the whole civilian population:

   Two proposals are of this type. They are the Kennedy-Griffiths plan, S.3, and the proposal of Senator Scott, S.1598.

4. Proposals calling for a strengthening and extending of Medicare to the entire population:

   The two catastrophic illness plans, S.191 and S.1376 are of this type. Senator Javits proposal, S.836, would also fit under this category.

There are three levels of purpose which run through this body of legislation. The first and most basic level is to prevent the kind of medical expense which can destroy a family's financial structure. This level of purpose is represented by the catastrophic illness plans of Senators Boggs (S.191) and Long (S.1376). For this purpose it seems to be enough to provide some form of extension of the Social Security Act which presently includes the Medicare program. The two senators have approaches which differ somewhat, but the aim is to provide aid in what are clearly the most difficult

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1. "The Crisis in Health Care: Problems of Policy and Administration, The Changing Health Care Scene," XXXI (Sept.-Oct., 1971) 505.

2. H. M. Somers and A. R. Somers, "Major Issues in National Health Insurance," The Milbank Memorial Fund Quarterly, L (April, 1972; part 1) 179-180.

situations arising in the present health care structure--families and individuals totally swamped with medical bills. The classic example, which has come to the attention of many people through fund drives in their local communities, is a kidney transplant. The thousands of dollars needed for this life-saving operation are beyond the means of all but a very few.

The second level of purpose involved in these bills is to provide greater access to health insurance which would aid the insured not only when faced with a catastrophy, but also in the payment of routine medical bills. Five additional bills (S.836, S.987, S.1490, S.1598, and S.1623) aim at achieving this purpose. They attempt to do this in all the various ways mentioned: incentives, mandatory employer purchase, a unified national plan and extension of Medicare.

Several issues of concern arise from these various approaches. One is voluntary vs. mandatory insurance. This difference clearly exists between the incentive plans proposed by the AMA, HIAA, and AHA, on the one hand, and the employer purchase approach of the Nixon plan, on the other. The relevant question is one of goals. If the goal of the program is to ease the cost of health insurance, then the incentive approach would be sufficient to do that. If the goal is to assure ourselves that at least a very large segment of the population will have health insurance which meets certain minimum standards, then a voluntary program will not be sufficient. There is obviously a significant minority of people in the country for whom no incentive would be strong enough to get them to part with money destined for the more immediate needs of food, clothing and shelter. In addition, there are many others who perhaps could afford the insurance, but would never seek it out on their own initiative either through lack of information or disinterest. Indeed, if the aim of the nation is to have a health care program giving universal coverage to all citizens, then even a mandatory program which provides insurance for all full-time employees through their place of employment will miss many thousands of persons such as farmers and other self-employed, part-time workers, and multiple-employer workers.

Another issue on which these bills differ is whether the private health insurance industry, "private carriers" as they are called, will have a role to play and what that role may be. The AMA's Medicredit approach, for example, would see the private carriers as having an almost exclusive role in financing health care for those under 65. Short of a list of minimum benefits which must be a part of any policy, no effort would be made to regulate the industry or shape its approach. The Nixon administration would give the private carriers a large role, but would allow room for other options as well. A bill such as Senator Javit's extension of Medicare, however, would leave little or no room for the private health insurance industry.

We have discussed health care's two levels of purpose so far - helping with catastrophic costs and helping with routine costs. There is a third level of purpose, as well, which the Kennedy-Griffiths bill (S.3) adds to these two. It is the aim of

this bill to begin restructuring the system for delivering health care. Although the specifics of the Kennedy-Griffiths bill will be discussed in the next unit, there is one concept which is almost always a part of discussion of new structure and it would be well to consider it here. It is the H.M.O.--the Health Maintenance Organization. The HMO is, in effect, a new model for health care.

However, when most of us think of medical care, we usually conceive of it in terms of the solo-practice model. We assume that most doctors are in private practice and see their patients on a fee-for-services-rendered basis. Like all mental models, however, this is a simplification of reality. Other models do exist and new ones, like the HMO, are being brought into existence. By and large, the solo-practice model is health care as it was received by the middle and upper classes a generation ago.

Another model of health care, one which most of us do not carry so readily in our consciousnesses, is the clinic-care model. Its users are frequently poor. They often move through an anonymous maze of health care professionals with none of the personal relationship we associate with solo-practice. These clinics exist at all levels: the general clinics of an urban ghetto, the welfare clinics of the community hospital, the highly specialized clinics of a medical research facility. Still another model might be the intensive, specialized group practice of a place like the Mayo medical complex in Rochester, Minn.

HMO attempts to create a new model - that of a prepaid, comprehensive group practice, which will hopefully remedy some of the failings of the other models.

There are three basic conditions for a Health Maintenance Organization, as that concept is spelled out by Saward and Greenlick in an article on "Health Policy and the HMO." They begin their description with a comment on the name itself:

> Considering the state of the [medical] art, it must be considered a politicized euphemism. The vast majority of the work of any such organization that fulfills the requirements being laid down will be sickness care; and, indeed, on the assumption that man is mortal, it will probably remain so into the future. However, with that caveat, the HMO is intended to provide the inherent motivation for any prevention and cost-effective disease detection that exists.[3]

What, then, are the requirements laid down for an HMO? The first is that there be an organization capable of offering comprehensive medical services, with the understanding that members are assured access to those services for which they have

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3. Ernest W. Saward and Merwyn R. Greenlick, "Health Policy and the HMO," The Milbank Memorial Fund Quarterly, L (April, 1972; part 1) 149.

a medical need. The second condition requires that this organization will serve a specified population of members who are enrolled. Ideally, these members will have had a choice of systems of medical care (such as the private-patient system, the clinic-care system, the HMO system, etc.) and they will have voluntarily chosen to become an HMO member. Finally, HMO requires that costs of all care be distributed among the whole membership on a flat fee-in-advance basis, similar to our present health insurance premium payment.

It is probably not correct to infer that HMO is a completely new concept or that not many people are involved. More accurately it is a concept in a new phase of application. As William A. Regan points out:

> At present, eight million Americans belong to some type of prepaid group practice plan. For example: 1. Kaiser Foundation Health Plan, 30 years old, has 2.1 million members in California, Oregon, Hawaii, Ohio, and Colorado, with 2,000 doctors participating. The Kaiser Foundation owns and operates a string of hospitals in areas it serves. The cost is $420-$600 per year for a family of three. 2. Health Insurance Plan of Greater New York has about 750,000 members. HIP contracts with Blue Cross for hospital services and it offers a total package similar to the Kaiser Foundation. The cost is $565.56 per year. 3. Group Health Co-op of Puget Sound is the largest health cooperative in the United States. This HMO-type Co-op in Seattle is owned and operated by patients themselves. It has 145 physicians and it operates one large hospital and several small clinics. The cost is $530 per year. 4. Harvard Community Health Plan was established in 1969. It serves Boston and 39 communities; has 23,000 enrollees; and the cost is $51 per month.[4]

By comparing the financial structures underlying the different health care systems, we note that in the present fee-for-services system, there is a very real sense in which the system is rewarded for keeping people sick. This is not, by any means, to infer that this is done. It is only to observe that the financial organization of health care is such that the more persons who are sick, the more medical services are rendered to patients, causing more money to flow into the system.

On the other hand, Saward and Greenlick noted that the organizational form of an HMO allows it to capitalize on "any prevention and cost-effective disease detection." Under the HMO form of organization the patient becomes a liability in the sense that there is a total budget for the organization which comes from

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4. W. A. Regan, "HMOs: Implications for Catholic Hospitals," Hospital Progress, LIII (Sept., 1972) 64-67.

the membership fees. If disease can be prevented or detected at an early stage, the number of services rendered to patient-members can be reduced. Since the total budget comes from fees-in-advance, any reduction of required services represents a financial savings to the organization. A part of this savings may, in turn, be passed on to the members in terms of lower membership rates, thus making it more attractive for new members to join. The hope of this structure is to make the financial dynamics of the system biased in favor of the member's health, rather than being biased in favor of his sickness. As President Nixon put it: "Under this arrangement, income grows not with the number of days a person is sick but with the number of days he is well...economic interests work to reinforce...professional interests."[5]

Even though the HMO is not the panacea that some advocates would seem to indicate, it may well offer a healthy alternative model to complement other, already existing models.

Of the eight bills with which we began this unit, most experts would agree that three are politically more important. They are: Kennedy's Health Security Act (S.3), the AMA's Medicredit plan (S.987) and the Nixon administration's National Health Insurance Partnership Act (S.1623). These will be discussed separately and at more length in the next section.

5. U. S. Congress, House Document #49, 92nd Congress, "Health Message from President of the United States Relative to Building National Health Strategy," February 18, 1971.

NATIONAL HEALTH CARE

Discussion Questions: Section Two

1. Three possible goals of national health care legislation have been spelled out. They are: 1) to aid the individual or family with a medical catastrophy, 2) to aid individuals and families in the payment of routine medical expenses, 3) to begin a restructuring of the health care delivery system.

   What other goals do you think might be added to this list, if any?

   Which of the possible goals do you think should be most actively pursued?

   Why?

2. The issue of partial or universal coverage was also raised. Again there were, broadly, three choices: 1) a voluntary program, as at present, but with incentives to encourage participation, 2) a mandatory program which would include many more citizens, 3) a universal program including all citizens.

   Which of these three levels of participation seems best to you? Why?

   If you choose anything less than total coverage, would you make any provision for those who are not covered? Would you be able to prevent the situation of having different levels of health care for different groups of people in the country? How? Would you want to prevent such different levels from developing? Why or why not?

   If you choose total health care coverage, is there any way to keep the private health insurance industry as a part of the system? How? If so, would its presence result in differing levels of health care for differing groups?

3. What changes might be made, assuming any should be made at all, in the structure of the current private health insurance industry to make it more responsive to the health care crisis? Discuss such points as:

   Should benefit schedules, especially as they relate to non-hospitalization payments, be revised?

   Can private carriers play any useful role in cost control or quality control?

   Could they have a role in affecting the numbers of medical personnel or their distribution?

4. There are those who feel that the whole approach of this body of legislation is oriented in the wrong direction, with the result that the wrong problems are being attended to. Dr. S. J. Axelrod, professor of medical care organization at the University of Michigan, has observed that "private commercial health insurance dominates the field, and this kind of dominance results in considering health insurance not so much as a means of providing adequate service but rather a means of paying bills...And in general the whole coloration of the health insurance industry takes the view that health insurance should be a mechanism for exchanging dollars...." We should, in the words of some critics, talk about "health assurance" rather than health insurance. Their point is that rather than orienting us toward a discussion of the financing of the health care system, this whole body of legislation should be oriented toward assuring adequate health care for Americans. Only then, should the questions of financing that care enter the picture.

   Discuss the merits of this criticism. To what extent would you agree with them that the emphasis is misplaced? How could it be changed, if it should be? To what extent do questions of finance seem to limit the questions of real care? To what extent is it possible to discuss real care without simultaneously discussing how to pay for it?

5. The unit discussed the models (or methods) for organizing the delivery of health care.

   What was the model(s) of which you were most conscious before reading this unit?

   How do you think most Americans would respond when asked: "What is the right way to organize health care?"

   What advantages or disadvantages do you see following on the various ways of organizing health care?

6. Discuss the HMO model.

   Would you yourself be willing to receive your health care under that sort of a plan? Why? Why not?

   To what extent does it hold promise for helping change the nature of health care in America?

   Would you agree that it is a healthy alternative model which should become part of the health care system? Why? Why not?

   Should it become the dominant model for health care in this country? Why? Why not?

NATIONAL HEALTH CARE

III. Proposed Legislation--The Major Bills

As was indicated in the last section, three of the health care proposals have received wider public attention than the others. They are: S.3, the Health Security Act of Senator Edward Kennedy; S.987, the Health Care Insurance Assistance Act proposed by the American Medical Association through Senator Clifford P. Hansen; and S.1623, the National Health Insurance Partnership Act proposed for the Nixon administration by Senator Wallace Bennett.

The Kennedy bill is the most extensive of the three. Research on it began in 1968 when Walter Reuther, late president of the United Auto Workers, announced the formation of the Committee of One Hundred for National Health Insurance. Senators Kennedy, John Sherman Cooper, William Saxbe and Ralph Yarborough were members of that committee. After two years of study, a bill was introduced into the 91st Congress through these four senators (S.4297) in August, 1970. At the same time in the House, Michigan Congresswoman Martha Griffiths had introduced a very similar program (H.R. 15779) which had the endorsement of the AFL-CIO. By late in the year it was decided to pool these two efforts when the new Congress met in 1972. S.3 was the result of the combined programs. The bill itself is meant to be comprehensive, and the text of the bill, longest of any of the eight pieces of legislation we are considering, is over 130 pages.

The Nixon administration proposal is S.1623. In fairness to the President's plan, it should be noted that the National Health Insurance Partnership Act is only one part of a broader plan. In President Nixon's message to Congress on health, February 18, 1971, he included several other points which are to be worked on as well. These points are:

1. Reorganization of the delivery system. The President indicates his purpose to foster the growth of HMO's through legislation, allowing Medicare recipients and private insurees to join such groups.

2. Meeting the special needs of scarcity areas. The President proposes to make funds available through the Department of Health, Education and Welfare (HEW) to locate HMO's in such scarcity areas. Federally funded health education centers would be located in underserved areas, and the Emergency Health Personnel Act would provide a sort of VISTA volunteer for health care.

3. Meeting the personnel needs. A program of "capitation," or per capita grants, would be established to reward medical schools in proportion to the number of graduates they produced. This would encourage both larger numbers of graduates and shorter curricula. In addition,

financial aid would be given to low-income medical and dental students. Training of paramedical personnel and professional medical assistants would be encouraged.

4. Malpractice suits and malpractice insurance. Since this problem is causing a climate of fear among medical professionals and is also significantly increasing doctors' costs, a special research and analysis commission is being set up through HEW.

5. Prevention of illness and accident. The President is recommending greater funding of medical research, particularly cancer research. Additionally, there exists a need for a national program of health education which would include the whole area of accident prevention, with special emphasis on automobile accidents.

Many of the matters covered by these five points are of the type which can be accomplished through executive order. However, one area in which a major, detailed legislative program is needed is in the President's sixth and final point--national health insurance. This, then, is the role of S.1623. The bill contains two major approaches. The first is called the National Health Insurance Standards Act. It would require all employers to provide basic health insurance for all their full-time employees including their dependents. The second approach is referred to as the Family Health Insurance Plan (FHIP) and is aimed at aiding low-income families which are not part of an employer plan.

A much less complicated type of plan is S.987, submitted by Wyoming Senator Clifford Hansen. This "Medicredit" approach of the AMA aims to provide equality of access to good health service independent of a person's ability to pay. Any one of several avenues would be available to reach that goal: a sound private health insurance policy, membership in a prepaid group such as Blue Cross-Blue Shield, subscription to a group practice such as an HMO, or personal payment of medical costs to later be claimed as an income tax deduction. The individual could choose the approach best suited for his situation. To stimulate use of these options, a pro-rated tax credit would be given. The rate would range from 100 per cent to 10 per cent. Those who have no tax liability, presumably because they are the poorest, would receive a 100 per cent credit. The credit rate would diminish as one's tax bill rose until only a 10 per cent credit would be given on an $891 tax bill. Provision is also made to provide insurance for those unable to purchase such coverage.

Senator Hansen notes that his bill alone provides only a partial answer to the nation's health care problems:

> Unlike some of the other proposals before this committee, my bill is concerned solely with the financing of health care. But, after all, that is what national health insurance is all about. This bill is designed to solve the problems of financial access to health care.

> There are, of course, other problems in health care delivery. I recognize these problems and support programs to overcome them. However, I believe these programs should be proposed through separate pieces of legislation. There are many different problem areas but let us look at them individually and not lump them together in supposed cure-all omnibus legislation.[1]

The following table adapted from an article by John M. Glasgow furnishes a more specific comparison of these three bills. You will find them compared under six major categories. Perhaps the best way to approach the table is to read it twice. The first time through, read the columns vertically in order to get an understanding of the nature of each bill. Then go back and read horizontally in order to compare the three proposals for each of the six categories mentioned.

A few preliminary reminders may be of some help. Medicare is, of course, a program to provide basic protection against hospital costs and some post-hospital costs for those individuals over 65 years of age who are eligible to be a part of that program. Medicare is a federally based program. Medicaid is a state based program, through which federal and state funds for needed medical assistance can be channeled primarily to families whose bread-winning members are receiving public assistance, or are aged, blind or disabled. The federal legislation allows any state to establish a Medicaid program, but whether or not a particular state actually develops such a program depends on the state's own initiative. Iowa acted during the 62nd General Assembly (1967) to make such funds available to Iowans.

Coinsurance and deductibles are mechanisms for keeping the cost of a health program at a reasonable level. For example, a 25 per cent coinsurance provision stipulates that a patient would have to pay 25 per cent of the customary charge for use of any medical service. Alternatively, one might have a flat $5 deductible for any service used. The idea is that if a certain part of the cost has to be borne by the patient, he will not be tempted to overuse the medical services available.

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1. National Health Insurance, Hearings of the Senate Finance Committee, 92nd Congress, First Session (Washington: Government Printing Office, 1971), p. 68.

Category	S.3 Kennedy Health Security Act	S.1623 Bennett (Nixon) Natl. Health Insurance Partnership	S.987 Hansen (AMA) Medicredit
Population Coverage	All U.S. citizens, plus aliens admitted for employment and employed within U.S. while within the U.S. certain non-resident aliens such as embassy personnel could be included under reciprocal and "buy-in" agreements.	Mandatory employer-provided plans should cover all but the self-employed, federal employees, and those outside the labor force. These would be covered by existing plans; through purchase of insurance at group rates from state pools of private insurers; or, in the case of the poor, by federally subsidized plan.	Total population would be eligible to purchase private plans. Government would pay full premium for low income groups having no income tax liability, with varying amount of premium cost for other poor.
Benefit Pattern	Comprehensive personal health care with limitations on nursing home care, psychiatric care, dental care and drugs. Intent would be to remove most limitations over time. No cut-off dates, no coinsurance, no deductibles, no waiting periods. Benefits would not take effect until two years after law enacted.	Minimum plan which employers could buy would provide a range of hospital, ambulatory and preventive services which meet federal standards. Medicaid would be replaced by a Family Health Insurance Plan with total federal financing of part or all of cost of private insurance or capitation charge of prepaid group practice. Benefits under employer provided plans would not be subject to limits; those provided to poor under FHIP would be. Beneficiary responsibility for deductibles and coinsurance, would vary with income of eligible family in case of FHIP. Coinsurance and deductibles would be waived for all after individual receives $5,000 of covered services in a benefit year.	Includes two benefit packages. Basic policy would offer 60 days in-patient hospital service plus full range of out-patient and physicians services in hospital, home or office. Catastrophic plan would include hospital, extended care facility, in-patient drugs, blood, appliance and other services. Patient responsible for deductibles and coinsurance plus corridor between basic coverage and catastrophic illness coverage.

	(S.3)	(S.1632)	(S.987)
Administration	Health program administered by 5 member Health Security Board within HEW. National Advisory Council, including consumer representatives to assist in development of policy. Field administration by regional, subregional and local units with strong discretionary power.	Private insurance companies, with federal regulation of their organization and costs, would administer employer provided plans. FHIP would be a federally administered program.	Medicare would continue to be handled by intermediaries; private insurers would handle their own participants under age 65. Federal Health Insurance Advisory Board would establish standards for insurance carriers and develop programs to maintain quality health care and effective use of health resources. Advisory Board would be appointed by President with Senate consent.
Financing	Employer, employee, self-employed and federal government would share in costs: 50% from general federal tax revenues; 36% from 3.5% tax on employers payrolls; 12% from 1% tax on wages up to $15,000 per year; 2% from 2.5% tax on self-employed income up to $15,000 per year. Employee share could be paid by employer if called for by union negotiations or employer-employee arrangements.	The employer provided benefit plan would be paid for primarily by the employer with payments deductible for tax purposes. Changed Medicare program would be financed by increases in both the tax rate and the base taxable under Social Security. The FHIP would be financed out of general revenues. Tax credits would be given for private purchase of insurance plans.	Income tax credits would be given for cost of private insurance, with percentage of allowed credit based on personal income tax liability. Tax credit ranges from 100% for those with no tax liability to 10% for tax liability in excess of $891. Those eligible for full payment of premium by Federal government would be issued a certificate enabling purchase of private insurance plan. Others could elect between tax credit or a certificate.

	(S.3)	(S.1632)	(S.987)
Payment Mechanism	Given amount of money would be allocated for health annually. Board would allocate to sub-areas. Of funds in a given area, amount sufficient to pay physicians receiving salaries and for the professional services component of institutional budgets would be first priority. Hospitals and other institutions would be paid on the basis of approved prospective budgets. Independent practitioners could be paid by various methods which they would choose.	Predetermined per capita amount would be paid to HMO's. Present methods under private insurance would continue to be used. Other cases first would be subject to federal review and criteria standards.	Continuation of present methods under private insurance would be used.
Effects on Health Care Delivery System	Provides financial levers to restructure health delivery system. Strong emphasis on development of group practice programs and preventive health measures. Substantial grants available to develop innovative health systems and assure availability of care in local communities. High national standards for participating providers and facilities, including Board standards for major surgery and other specialist services; requirements for continuing medical education, national minimum licensure standards. Financial support provided for systems which (continued)	Major financial push to development of prepaid group practice concept through provision of planning grants and loan guarantees. Financial support for training and utilization of new types of health manpower or increased supply, with special emphasis on increased opportunities for disadvantaged students. Funds for the development of new organizational forms such as consortia and area health education centers. Special support to encourage location of physicians in areas where there are few or no M.D.'s.	No changes in present system proposed although a peer review mechanism is to be submitted as a separate legislative proposal.

(S.3)	(S.1623)	(S.987)
efficiently organize and utilize all levels of medical manpower. Special funds available to subsidize the training and initial utilization of new types of professional manpower and paraprofessional personnel with special emphasis on programs for training poor or minority groups. Special support for location of increased health personnel in urban and rural poverty areas. Prospective budgeting for institutional services. Consumer participation in health care system encouraged.		

Adapted from John M. Glasgow, "Special Report: A Comparison of Six Major Proposals for National Health Insurance," Connecticut Medicine, XXXVI (February, 1972) 75-79.

One issue remains to which none of these bills has directed itself very explicitly. That issue is consumerism. Samuel Wolfe in an article entitled "Consumerism and Health Care" holds that:

> there is every reason to assume that the new consumerism in the health field is not a fad, but the wave of the future.[2]

Earlier in the article he had defined consumerism as:

> the various forms of participation by the users or potential users of service, on the boards of private and public agencies concerned with either the organization, financing, provision, planning, coordination or regulation of health care services.[3]

There is a critical and yet not too openly discussed issue in all of this:

> The question of consumer control is part of the larger question of who is to govern the health system, and thus how it is to be governed. Answers to the issues of financial sufficiency, the redistribution and quality of services, depend importantly upon whom the system responds to. The voices of consumers in the health field typically have been pre-empted by other actors who have held the reins of governance tightly; particularly the medical profession, hospitals, insurance giants (including Blue Cross and Blue Sheild), universities, and various government bureaucracies.[4]

The Medicredit proposal gives virtually no room to the consumer at all. Control would be left mainly in the hands of the health care provider professionals. The Nixon plan would probably have the overall effect of enhancing the influence of the health insurance industry as controllers of the system. Under the Kennedy plan there would be little room for consumer choice since there would be almost no competition among providers. However, that plan does call for consumer majorities on advisory councils at the national, regional and areawide levels. William Flash observes: "This extraordinary administrative and advisory framework is probably the most far-reaching aspect of the Kennedy proposals."[5] However, Dr. Oliver Fein of the Health Policy Advisory

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2. Public Administration Review, XXXI (September-October, 1971) 535.

3. Ibid., p. 528.

4. William S. Flash, "National Health Insurance, Responses to Health Care Issues," Public Administration Review, XXXI (September-October, 1971) 514-515.

5. Ibid., p. 515.

Center disagrees: "The Kennedy proposals will likely leave control of the system unchanged, or shift it toward control by the corporate forces, such as the big hopsitals, medical centers and insurance companies."[6]

As Basil Mott observed in a statement quoted earlier, it is difficult to achieve a legislative solution to a problem such as the health care crisis when there is no broad consensus on what should be done. A part of the difficulty in reaching that consensus is the seldom vocalized, but very real question: to whose pressure will the system respond? Who will have the power? Will the system be shaped for the convenience of the government, those training medical professionals, those who work professionally in the system, those who insure it, or those whom the system serves? This series is meant to help you think constructively about the issues involved in answering such questions.

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6. National Public Radio, "Report to Congress and the Nation" (Washington: 1971), p. 27.

NATIONAL HEALTH CARE

Discussion Questions: Section Three

1. There are several questions which can be raised about these three major plans:

   How does each of them relate to the private insurance industry?

   Which bills, if any, among these three get beyond the fiscal view of health insurance, i.e., beyond the view of exchanging dollars?

   To what extent do any of them work toward a "health assurance" system?

   To what extent do the plans mentioned in this section attack major problem areas: cost, personnel, quality, the system itself?

   Rate these three plans according to your preference and discuss the reasons why you made your choices. How do these three plans compare with the previous five? In your opinion are they better or worse? In what respects? Which plan out of the entire eight do you favor most? Why?

2. Beyond the contents of the bills themselves, this section raises the issue of the consumer's participation in the system which serves him. With that, it raises the larger question of who should control the system.

   The text gives five possibilities for such control: government, universities and medical school faculties, health care professionals (doctors, hospital administrators, drug companies, etc.), the private insurance industry, or the consumer. Are there any other possible groups? What part do each of these groups presently play in controlling the system? What are the real possibilities for some sort of balancing of power among the various groups?

   Looking more specifically at the consumer's role, what part should he play? Most health facilities today have a board of directors, many or most of whose members are not health care professionals. Is it possible that the consumer is already represented? Why or why not? Given the present structure of the American health care delivery system, is it even possible to talk about "the consumer"? What possible groups are there? How well represented is each likely to be?

3. Reviewing the entire topic, ask the question whether and to what extent any of these legislative proposals will actually begin to solve the crisis in American health care?

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