AMA Congress on Socioeconomics of Health Care

Physicians, other allied health professionals, and Government representatives met in April in Fort Lauderdale, Fla., to discuss health services in the 70's, the theme of the sixth National Congress on the Socioeconomics of Health Care of the American Medical Association.

The conference theme was developed in a series of three in-depth explorations—the financing of health care, the structure of the health care delivery system, and meeting the challenge to improve services.

Topics included Government dollars for health care, changing role of voluntary health insurance, physicians and payment mechanisms, structure of health care delivery, Government blueprint for organization of health services, a consumer's view of the health system, health needs of the poor, a State society's involvement, community organization of health services, health of the aging, public accountability for health services, medical education's new look, expanding the health team, emergency medical services, and accomplishments in peer review. However, not all the speakers provided copies of their papers.

Of the copies available to *Health Services Reports,* 13 were selected for summarization.

Federal Dollars for Health Care

In discussing the relationship between medicine and the Federal Government, Congressman William R. Roy of Topeka, Kans., stated that during the next several years the role of the Government in financing health care will increase. As a result, he added, the Government will become increasingly concerned that services are provided efficiently and effectively.

According to Roy the Government's concern

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with the manner in which health services are provided stems from three dificiencies in the current delivery system: increasing cost of care; availability, accessibility, and continuity of care; and the quality of care.

If there is to be increased Federal interest in health care delivery, what direction will that concern take? Roy asked. Initially this concern has begun to evolve into two distinct patterns. One may be referred to as the regulatory approach and the other as the local system approach.

The regulatory approach is the most direct reaction to the deficiencies of the health care system. It will seek to deal with these deficiencies by monitoring the operation of the health care system and planning its future. Roy pointed out that direct cost containment and utilization review are among the regulatory-type proposals adopted by the Administration.

The local organization approach encourages the development of defined local units. These units, Roy explained, would provide comprehensive health services to local populations for a fixed, predetermined cost. Except for general Federal monitoring—to insure that the cost is reasonable, that services are actually being delivered, and that quality of care is satisfactory—the internal operation of the local unit would be left to the management, providers, and consumers of each unit.

Roy, who is an obstetrician-gynecologist, pointed out that the increasing costs of care have been of special interest to the Government since the inception of Medicare. The predicted cost of Medicare, established on what was considered to be a conservative actuarial basis, has greatly increased. In terms of Medicare alone, hospital insurance benefit estimates have risen sharply. The first effect of Government participation in the financing of medical care, therefore, is concern for inflationary tendencies in the medical industry.

Availability, accessibility, and continuity of service is the second problem area. Although this concern is less direct and less immediate than cost containment, Roy said that it is clear that Government financing will lead to Government interest in the actual delivery of services. For, he continued, Federal officials must be concerned with the actual benefits which result from a program. If financing is not the only barrier to the receipt of adequate care by citizens, then the Government will become concerned about the barriers which remain and which continue to prevent citizens from actually receiving services ostensibly guaranteed by Government financing.

As for quality of care, again Federal dollars will lead to Federal interest, Roy stated. The Federal administrators will be concerned that funds are being used properly to purchase quality services.

Whether the regulatory approach or the local organization approach will prevail is uncertain at this time, Roy said. This is proper, he went on, since it is uncertain which approach will lead to the more effective solution to the problems encountered. Until such evidence is presented, both approaches will likely coexist.

Federal Blueprint for the 70's

Substituting for Dr. Merlin K. DuVal, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, Dr. Ian A. Mitchell, his Special Assistant, outlined the basic philosophy behind the so-called Government Blueprint or National Health Strategy presented in the White Paper on Health Policy and in President Nixon's recent health message to Congress.

The Federal system calls for major reform. Yet, at the same time, it recognizes and preserves the strengths inherent in a pluralistic approach. The system is based on the conviction that the excellence which is characteristic of American medicine must be preserved and that no American should be denied health services because he cannot afford them or because they are inaccessible to him.

The Federal proposed blueprint for the 70's is predicated on five underlying principles, which Mitchell outlined as follows.

First, it recognizes that medical care can be delivered effectively through the private sector.

Second, the proposed strategy is designed to maintain high standards of quality and, at the same time, provide for an equitable distribution of health services so that the needs of all people can be accommodated. In this regard, Mitchell emphasized that the impetus for the strategy is to be found in the disparities in health status which exist among the various segments of society, and that the strategy represents an expression of confidence in the ability of the private sector to effectively meet the demands of the future.

Third, the strategy recognizes that there is a limit to the amount of Federal resources which

can be allocated to health. To obtain the most effective use of every dollar spent, major emphasis is placed on maintenance of health, control of unnecessary use of health services, and more effective use of scarce manpower through a strong emphasis on productivity.

Providing for the maintenance of health and the prevention of premature and unnecessary death is a major part of the health strategy. It is based not only on the premise that these services will eliminate a significant amount of human suffering, but also on the belief that the expenditures for prevention can be traded off economically with expenditures for treatment and rehabilitation.

Fourth, the strategy recognizes that continued inflation in medical prices can limit the ability of the health system to meet the demands of the future.

Fifth, the health strategy recognizes that continued research and development is a necessary prerequisite to maintaining excellence in medicine. Accordingly, plans are underway to expand the national commitment to biomedical research and to launch new or extended initiatives in heart disease, cancer, sickle cell disease, alcoholism, and venereal disease. Outlays for biomedical research will total $1.6 billion in 1973. Major research efforts are to be targeted to achieve critical accomplishments, particularly in cancer where outlays will reach $335 million this year, Mitchell reported.

These five points represent the basic rationale behind the health strategy. They are based upon the underlying thesis that although there is much in our system that requires reform, there is also much that is worth saving.

HMO Qualification Conditions

The form of aid and assistance offered in the leading Congressional bill on health maintenance organizations also sets conditions of qualification which, although desirable, are unrealistic in fulfillment, in the opinion of the president of Group Health Association of America. After examining the prospects of the proposals for HMOs in the immediate future, Dr. Ernest F. Saward of Rochester, N.Y., concluded that more flexible and practical qualifications are needed to achieve the goal.

While there are numerous bills that include the HMO concept, Saward considers the Roy bill of November 11, 1971, to be more detailed and specific, and, he said, it represents a more developed concept. Thus, he singled out some of the provisions of the Roy bill with a view to how, if enacted, they might promote HMOs and affect group practice.

All the provisions of the bill do provide assistance and encouragement for HMOs, Saward agreed. However, he continued, the statement of definitions as to the nature of a HMO is a set of specifications which raises a question of how realistic the offer of many types of aid is if the specifications are such that few would be tempted to try.

Medical care and its financing, both from public sources and private health insurance, now exists in a certain environment and set of circumstances. But the conditions under which present functions are carried out are far from being a single ideal design, according to Saward. And, he went on, although many advocate modifying these circumstances, few believe that a completely fresh start can be made.

The Roy bill sets forth an idealistic definition of a HMO to compete in the contemporary world of health care organization and financing, Saward said. It expresses the basic hope that, with assistance from loans and grants for disadvantaged areas to start HMOs, such organizations will be able to compete so successfully that they will spread and make this option available to a significant portion of the population.

One requirement of the Roy bill is that the HMO receive a uniform payment for all its members except social security beneficiaries. The intent is commendable, Saward stated—it is to truly mutualize the cost of health care. But, he pointed out, the difficulty is that this is not the nature of the health insurance world in which the best-risk groups pay the least money and the worst-risk groups are essentially priced out of the market or limited in coverage. Thus, the position of the HMO becomes untenable, for it is obligated to take all risks, in contrast to the prevailing insurance pattern.

Another requirement of the bill states that the HMO must demonstrate proof of ability to assure that comprehensive services are available and accessible promptly and appropriately and with continuity. However, experience has shown that this often-repeated ideal is unrealistic, Saward said. It is a standard to be sought, rather than a requirement to start.

Turning to the requirement that the HMO

assure its members a meaningful role in policy-making, Saward reminded that among those who have dealt firsthand with some of the issues of consumerism in the past decade, there has been no consensus as to how a meaningful role might be implemented.

In its requirement for quality assurance, the bill asks for a program "which stresses both health services processes and outcomes." According to Saward, this requirement projects the state of the art beyond that which exists. If one looks at populations served in different ways, he said, one finds not only great difficulties in distinguishing differences in health care outcome but also so many intervening variables that there seems to be little correlation between health care process and health care outcome. This is a most worthy field of research, he declared, not a requirement to start a new organization.

Throughout the pages of definition in the bill, the general tenor is as outlined for these few particulars, Saward said. He considers it an act to aid and assist, through grants and loans, the creation of a medical utopia. One cannot quarrel with the aim, he stated, but it is clear that something quite different is required to gain the Administration's aim to have this form of medical care available to a majority of the population as an option within the next decade.

Private Insurers' Changing Role

The changing role of private health insurers is clearly only one piece of a much broader issue. The total health care system is under close public and political scrutiny. Whatever emerges from all this attention will determine the future of the industry, in the words of William W. Keffer, senior vice president, Connecticut General Life Insurance Company, Hartford.

Basically, Keffer remarked, we have a sound health care system which is serving the majority of Americans well. In order to preserve it and eliminate its admitted weaknesses, however, he advised that physicians, hospitals, and insurers revise and broaden their traditional roles in the delivery system.

The health insurance industry, according to Keffer, has identified certain basic criteria necessary for a good health care system. These criteria are a pluralistic health care system, equal access to quality medical care for all Americans, opportunities for the patient to choose alternatives of medical service, quality standards throughout the nation, and greater integration of the components of health care for improved delivery of service.

Keffer urged all health care deliverers to resolve their differences and launch a massive educational effort to tell the American people why a pluralistic system is best for both their health and their pocketbooks.

If we can achieve this consensus among health care deliverers, said Keffer, private insurers will have the following important roles to play:

—sharing in planning the necessary changes in the system

—helping to bring together the parties concerned with change, including physicians, hospital administrators, government officials, and consumers

—sharing in the process of review and control of cost and quality

—participating in several constructive ways to organize new modes of delivery of care

—developing better and more complete prepayment financing.

These roles, Keffer pointed out, carry the insurance industry far beyond its traditional mission in the health care system. Historically, for instance, insurers have not considered it appropriate to be concerned with minimum health standards. They left this up to their customers—the employers and employees who decided how much group health protection they wanted to buy. And, Keffer went on, traditionally insurers dealt with health care providers—physicians and hospitals—at an arms length basis. "We felt it was best to represent the consumer exclusively in the financial aspects," he said.

This freedom from involvement with other parties in the health care system leaves insurers in the advantageous position of catalyst, Keffer said. "We are in a unique position to bring the parties together, offer them the assistance of our skills and resources, and help them develop new approaches to health care delivery. And we are determined to fulfill this mission of catalyst today without losing the very important values of our present impartial and unbiased position."

Keffer said that the prepayment system can be extended to protect the uninsurable or those unable to purchase insurance. In partnership with Federal and State governments, health insurers propose to establish State insurance pools to cover health care needs of the poor. Private insurers,

including the "Blues" would contribute to these pools, which would also be subsidized by public funds. People unable to afford to purchase all or part of their health insurance would have their premiums paid by a pool. They would then have equal access to all benefits defined in the national health standards.

The insurance industry also proposes a tax incentive program—as an alternative to Government mandate—to encourage employers and employees to obtain health protection which meets the Federal health standards. If employers chose not to provide coverage that meets the minimum standards, they would receive only 50 percent instead of 100 percent tax deduction on the premium outlay.

It will be the responsibility of the private insurers, the Blues, and the emerging prepayment plans to meet the demand spurred by this tax incentive, according to Keffer. And, once again, the laws of the marketplace will dictate that insurers keep premiums as low as possible and service as high as possible.

Blue Shield Plans for the 70's

Looking to the role of Blue Shield in the health care system by 1976, Dr. Ira C. Layton, chairman of the board of directors, National Association of Blue Shield Plans, Kansas City, Mo., foresees three major factors in health care financing during the upcoming years:

- The nation will retain its basically voluntary and pluralistic system of health care.
- Federal involvement in health care will be greater. But, generally, direct financing by Government will be limited to programs beyond the practical fiscal capabilities of the private sector.
- The private insurance and prepayment sector will continue to underwrite health care programs for the employed population. It will also continue to act as fiscal agent or administrator for almost all Government-financed health care programs for general populations.

We believe, said Layton, that the private sector will continue to be a vital and major factor in the financing of health care. The private sector will be called on to administer or underwrite interlocking health care programs tailored to meet the need of defined segments of the population—for example, the poor, the catastrophically ill, and the employed. It will also be involved in other programs attempting to solve the problems in bringing health care to rural and inner city populations, to reduce the cost of care, and to improve cost effectiveness.

In summary, Layton sees the role of Blue Shield by 1976 as that of a major underwriter of health coverage and as a fiscal agent for a Government-funded program for the poor. Blue Shield will also be the administrator of other Government-funded programs such as Medicare, Medicaid, a catastrophic illness program, and it will be actively involved in developing prepaid group practice and, specifically, health maintenance organizations.

Blue Shield will become more public oriented, Layton predicted, and it will work closely with the medical profession to fulfill its public and professional service obligations. It will be developing and experimenting with methods to promote cost containment and cost effectiveness. These efforts will be in the areas of plan-based utilization review, professionally organized review mechanisms, and foundations. And, he added, there will be greater uniformity among plans in such areas as contract design and scope of benefits.

Thus, Layton concluded, Blue Shield will be working to provide coverage for the poor, to develop a program to meet the needs of the catastrophically ill, to improve the quality of health care contracts, and to develop alternate delivery systems and better cost-control measures. Toward these ends, he urged the understanding and cooperation of both the medical and lay communities.

Health is a Community Affair

The success of the Capital Area Health Planning Council, Baton Rouge, La., in planning for health care was attributed by the president of the board of directors of the Louisiana State Health Planning Advisory Board primarily to the leadership and drive emanating from an active, dynamic, and responsible medical society in East Baton Rouge Parish.

Dr. Page W. Acree, describing his agency's 6 years of "intense involvement in this fascinating experiment in intergovernmental, interprofessional, private-public relations in matters pertaining to health" concluded that his community now feels that health is no longer a hospital affair or a medical affair—it is a community affair.

There is no real organization of what is now being called the health care system, in Acree's view. The independent units of specialization do

not think as a system, do not act as a system, and do not lend themselves to becoming an identifiable system, he said, in most of the areas of Louisiana and probably most of the nation.

Areas within which most medical problems are generally solved can be identified and organized, Acree proposed. Once organized, institutions and individuals begin to view community problems from a different perspective, and decisions are made more in the interest of the common good.

An organization capable of influencing powerful personal and institutional interests must be soundly constructed, professionally staffed, and led by those who are trusted by the medical profession, hospitals, nursing homes, and the public at large, in Acree's opinion.

There is absolutely no substitute for sincere, informed medical leadership, Acree declared. At every committee level, such physicians are invaluable, and they are usually elected to be chairmen of committees. He noted that the chairman of every standing committee of the Capital Area Health Planning Council is a physician. And, he added, by the very nature of the inborn needs that prompt most physicians to train themselves to care for the sick, they are interested in the medical needs of their communities as well as their patients.

In the past, Acree said, his area had no organization designed to consider total community needs in health matters. In Louisiana, only two component medical societies have full-time directors, and they simply carry out the customary functions within the societies.

The planning agency's experience has shown that as individual physicians understand and trust the intent of the planning council, more become interested in serving on committees than the council can accommodate. However, Acree said, the fact that the council functions under the Department of Health, Education, and Welfare was a strong deterrent to many physicians until they understood its purpose more fully and found that they could trust it because of its leadership and makeup.

The evolving concept of health planning can do at the local level what the State and Federal governments are incapable of doing at the central level, Acree stated. The diversity, the affluence, and the intelligence of this country, each State, and each community, he believes, will demand optional systems of health care.

Acree stated further that, over an extended period of time, the evolving comprehensive health planning concept, properly led, can help individual communities work out what is best for the country. This concept, he went on, embraces the attitude that health is now a community affair. Once this attitude is adopted, he said, the consumer gets into the action. And, when properly led, the consumer's contribution for the common good can be enormous.

If the provider and the consumer cannot evolve together the medical care they need at a price they can afford, Acree sees a system of one source of funds and one source of controls as inevitable. And, he concluded, such a system would be the most costly, the least efficient, and least responsive system of medical care in the world.

Keep the Aged Employed and Wanted

Except for the trials imposed by retirement, the health problems of people older than 65 are the same as those of any other age group, in the words of Dr. Frederick C. Swartz of Lansing, Mich., chairman of the AMA Committee on Aging. He said that his committee, after some 15 years of study, could find no disease entity or physical or mental condition that resulted from the passage of time. Nor was there any prophesied picture or condition that could reasonably be expected to occur in anyone after the passage of time.

Citing passages from the literature which indicate that older persons have a happier health situation than most people imagine, Swartz said that this probably represents more specific advances in the care and treatment of persons with chronic disease.

The committee feels that its proposed program, originally intended for oldsters, of periodic health appraisals, daily physical exercise, daily mental exercise, good but not excessive nutrition, participation in preventive medicine—such as vaccinations—and elimination of harmful habits, should now be started earlier in life. With this program and the proper motivation for living, the length of life and the depth of living for the older population can be increased, Swartz said.

Since the health of the oldster depends to a varying degree on his employment as well as his environment—housing, recreation, and religion—the committee is deeply concerned with the policies which call for arbitrary retirement based on chronologic age, without regard to individual desires or capabilities. This concept, Swartz reported,

has now been accepted as one of the planks in the program issuing from the White House Conference in 1971. Additionally, it was recommended that there be no age discrimination in employment.

Swartz pointed out several medical aspects of the problems of unemployment and retirement. For example, when a man is completely separated from his job and must spend the remainder of his life at home, he is likely to have only 2½ more years to live. Also, the suicide rate is higher among men over 65 than in any other age group. Additionally, Swartz said, the nonworker soon becomes a "complete medical problem, portraying most of the real or imaginary symptoms that the flesh is heir to."

Medicine has a vital stake in the solution of this situation, Swatrz declared. It seems almost insolvable when one views the various positions taken by labor and management and the increasing unemployment figure for the nation. Somehow, he concluded, we will have to find some way to keep the aging employed, motivated, and wanted.

A State Society's Involvement

Among recent efforts of the Illinois State Medical Society in health care was the development of the Foundation for Medical Care, a separate corporate entity, according to the society's president-elect, Dr. Willard C. Scrivner, of Belleville. He defined the foundation as an organizational expression of the practicing physician's intent to assume leadership responsibility for the State's health needs.

To help save an estimated $25 million annually in the State's Medicaid program, the foundation created an Illinois State organization known as HASP (Hospital Admission and Surveillance Program). Under HASP, Scrivner said, every Medicaid hospital patient is certified for length of stay, as determined from statistics of the Professional Activities Study for Illinois. By December 1972, HASP will be in operation in 85 percent of the State's hospitals which admit Medicaid patients and in skilled and intermediate care nursing homes.

Since HASP will directly affect every physician who treats public aid recipients, Scrivner gave a detailed explanation as to how the program will be structured and operated.

The Illinois Foundation for Medical Care will establish a State HASP committee to determine policy and oversee the affairs of the program. The committee will be composed of four physicians, two hospital members, and one consumer. The foundation's executive vice president is the senior administrative officer of HASP; he will appoint a State project director for HASP to be responsible for the statewide program. The composition of the State committee will be duplicated at the regional and local levels, Scrivner said.

The responsibilities of the State HASP committee include making all administrative and policy decisions and approving the appointment of all regional administrators. The regional committees will make rules and regulations not prohibited by the State committee, and they will make all policy and HASP medical decisions in their areas. They will also be advisers to their regional administrators.

Local HASP committees will nominate a physician adviser to the regional committee. They will advise regional HASP of changes and standards and criteria for local needs, serve as courts of first appeal for grievances, monitor activities of local physician advisers, and monitor local hospital utilization review committees.

All hospitals in the State will be assigned program coordinators who will assign length of stay to each Medicaid patient admitted, using the physician's diagnosis as the basis. The State HASP committee will approve all length of stay standards. HASP's initial certification for length of stay will not exceed the 50th percentile. As the program gains experience, Scrivner said, this percentile may be modified.

The responsible physician must authorize the hospital admission. On all elective admissions (any procedure the physician considers nonacute or nonemergency), certification will be given at the time of admission.

HASP will certify, according to the patient's physician, continued stay every 30 days for skilled care nursing homes and every 90 days for intermediate care facilities, and it will designate the level of care required in the nursing homes.

Utilization review will follow previously established standards, structures, procedures, and activities of utilization review committees set down by the Department of Health, Education, and Welfare, Scrivner reported. Other services under this phase of HASP will include (*a*) education and training of hospital utilization review committees, (*b*) provision of sample surveys for eval-

uation by utilization review committees, (*c*) evaluation of extended care facilities, (*d*) monitoring and followup of the implementation of utilization review committees' recommendations to hospital administrators and medical staffs, and (*e*) certification evaluation of hospital review committees for forwarding to the Illinois Department of Public Health for Medicare and Medicaid.

The Illinois Department of Public Aid remains the actual fiscal agent, Scrivner said. It will pay only claims for services that any participating provider gives to an eligible beneficiary who is hospitalized which are properly certified as approved by the HASP committee or its authorized agents. According to the HASP contract, the State will pay the Illinois Foundation for Medical Care up to $15 for each Medicaid hospital certification of admission and up to $3 for each admission for the utilization review function.

Speaking for the State society, Scrivner concluded that it is better to create new facets of health care systems to match the scientific sophistication of present-day medicine and attempt to make it accessible to everyone, rather than to adopt rash laws which can only overwhelm the present system and drain fiscal resources without providing worthwhile alternatives.

Expanding the Health Team

With the rapidly changing patterns of health care delivery, the old question of who should "quarterback" the health team is meaningless unless asked in terms of a specific physician, a specific team, and a specific patient during a specific phase of his care episode, proposed Dr. Malcolm C. Todd, Long Beach, Calif., chairman, AMA Council on Health Manpower. It is wiser, he reminded, to think in terms of pluralistic patterns of teamwork rather than a monolithic concept of a uniform health team. Because the primary team unit of a physician and nurse is no longer adequate to cope with recent technological advances, the need for effective communication and teamwork becomes more obvious.

The physician, it is hoped, will always exercise the primary responsibility in medical care, because he alone has the breadth of medical knowledge necessary to make the initial decision as to whether services of an allied health professional are needed for his patient, Todd remarked. There will be times during the spell of illness, however, when the services of other health professionals assume the forefront, depending on the design of the system and the individual circumstances.

To exercise his authority effectively, Todd stated, the physician must be familiar with principles of effective management, supervision, and delegation of responsibilities. He must also be aware of how the various categories of allied health manpower are prepared to help him in the care of his patient. More emphasis is needed in this area in both undergraduate and continuing medical education, as well as a greater interrelationship between training programs for medical and allied professions, including common courses for some or all of them.

Contrasting opinion argues that there is an unclear division of duties and inappropriate use of skills within existing health teams, Todd pointed out. Also, that job analysis and task reallocation within these teams does offer significant potential for increasing productivity even in the present tight labor market. Todd feels that this difference of opinion misses the main point, which is the need to increase the supply of health services. Whether this can be done immediately by reassigning tasks to existing personnel, or over a longer period by education, we need to determine who should be doing what to whom, he declared. This precedes everything else.

The AMA Council on Health Manpower and other groups have encouraged and cooperated in analyzing health teams in different settings. The aim, said Todd, is to refine this kind of procedure to the point where guidelines can be developed that can be adapted by other medical service areas for their own application.

Todd pointed out that the basic worth of the task analysis approach to increasing the supply of health services has been questioned because the shortage is not just of physicians but of all types of health manpower, and thus there is little chance of increasing productivity by having the physician delegate more duties to someone else.

One approach to increasing productivity applies the techniques of industrial engineering and job analysis to the health care delivery process. While specific techniques and methodologies vary, Todd said that the essential elements common to most approaches include the following:

1. The selection of a health subsystem or "health team" to be studied, whether it is defined by a medical specialty, by a type of patient need, or by a specific care setting such as a hospital or outpatient department.

2. Compilation of an inventory of all tasks performed by each member of the health team, with frequency and time duration obtained for each, and the physical facilities used.

3. Assignment of task performance capabilities to all present or potential health team members; that is, identifying the tasks or services best performed by the physician and those best performed by other personnel, with specified levels of training or competency, using professional judgments.

4. Development of a model identifying the combination of personnel, facilities, and the agreed-on task allocation needed to achieve the desired health care "output" (usually measured in terms of patient volume, number of patients served, or similar indices). Sophisticated computer simulation techniques are being used increasingly to structure this model so that a fairly precise representation of patient flow and volume can be made for a number of different personnel-space-task configurations.

Health Services and Phase II

A member of the Price Commission's Committee on the Health Services Industry, Dr. Francis C. Coleman of Tampa, Fla., summarized the regulations developed by the committee and their present and future implications as they apply to non-institutional providers. The Commission is part of President Nixon's phase 2 effort to stem inflation, and the committee was appointed to deal specifically with prices and wages in the health sector of the economy.

The committee considered physicians, dentists, medical and dental laboratories, and convalescent and rest homes to be noninstitutional providers and hospitals and extended care facilities to be institutional providers. The committee's objective was to reduce the inflationary rate for both types of providers by 50 percent, Coleman explained. Regulations were adopted to achieve this objective.

The basic regulations for noninstitutional providers state that prices may increase a maximum of 2.5 percent and then only to pass along increases of doing business, Coleman said. The 2.5 percent allowable maximum also must be reduced to the extent that any increased productivity has increased revenues to help cover the increased costs of doing business. Additionally, the price increase must not result in an increase in the noninstitutional provider's profit margin.

Institutional providers are subject to the same basic regulations, but are allowed price increases up to 6 percent before they must apply for consideration as an exception to the regulation, according to Coleman.

Noninstitutional providers must post a sign in a prominent place in their offices which informs patients as well as any member of the public that a price schedule is available for them to examine on request. They must have the schedule readily available for examination by any person who asks to see it. Coleman reported that Internal Revenue Service representatives who have appeared before the committee have emphasized that the IRS will be checking closely to see that these rules are observed.

Considering what the regulations allow the provider to do as well as what not to do, Coleman said that there are two basic ways for a provider to meet the increased costs of running his practice and to meet the rising costs of living. One way is to increase his prices, adhering to the rules that not only put a ceiling on the extent of his price increase, but also place certain restrictions on his profit margin and his productivity gains.

The other way is for the provider to increase his practice revenue by leaving his prices alone and increasing productivity through efficiency and cost cutting. While this may require more effort than simply increasing prices, it does not prohibit an increase in the profit margin of his practice. Hence, Coleman concluded, if there is room for efficiency measures and cost cutting in a practice, this approach may be more appropriate and successful than increasing prices.

Of course, Coleman went on, each practice situation is different and must be evaluated on its own merit. However, he believes that when price controls are in effect there is a tendency to become preoccupied with the controls themselves. This type of myopia, he said, may inhibit successful problem solving in the practice setting.

Emergency Medical Services

The challenge of the 1970s is to expand the experience of the 1960s in emergency health services into a comprehensive nationwide system, in the words of Dr. William T. Haeck, Jacksonville, Fla., treasurer of the American College of Emergency Physicians. The major task of this challenge, he said, is to educate the public about

the components of a first-rate system and the need for it.

Haeck suggested that what was learned during the sixties can be applied to the following components of emergency services:

Discovery and notification. A centralized emergency operating center is possible and desirable to receive notification of an accident or acute illness and to dispatch the necessary assistance. This avoids the confusion of multiple telephone listings and jurisdictional disputes, Haeck explained.

Notification has been accomplished in two ways. One is the plan used in Jacksonville, in which telephone call boxes are strategically placed throughout the city. The other is the more universally accepted form using the 911 emergency telephone number.

Dispatch of help. Central dispatch is essential to the proper management of emergency health service resources and follows as a corollary to a centralized or single notification number, Haeck said. This is the nerve center which insures that proper equipment and personnel will arrive at the scene in the shortest possible time with the least amount of waste and duplication. It is the control which links all the components together at the same moment through radio communication.

Onsite care. The public, which discovers 80 percent of the injuries and acute illnesses, can be trained to provide effective first aid and even to perform effective cardiopulmonary resuscitation, Haeck proposed.

Haeck agrees with the position of the American College of Physicians that cardiac resuscitation techniques, particularly closed-chest cardiac massage and mouth-to-mouth artificial respiration, should be taught to the general public as well as ambulance drivers, aides, nurses, firemen, policemen, and others. These techniques should be mandatory in schools' physical education classes. He also recommends that training be mandatory for ambulance drivers, using the training standards for emergency medical technicians.

Transportation. There must be mandatory requirements for the design of ambulances and their equipment, Haeck said. He mentioned the concept espoused by the Emergency Medical Care Committee for San Diego County. This concept proposes that all vehicles of all patrol agencies of each city and the county sheriff be manned by trained personnel and equipped with a basic module of sophisticated equipment, and that a portion of these vehicles be dual-purpose vehicles. This concept, Haeck added, greatly increases the odds that the first "public agent" on the scene will have the proper training and equipment to implement lifesaving measures. In effect, each vehicle can become a mini-rescue unit.

Initial emergency care. Haeck said that standards must be set for emergency department physicians and facilities. Residency training programs and review boards, departmental status for in-hospital facilities, and education of the public about correct use of the emergency department should be mandatory.

Definitive care. The sixties have shown that speciality areas of the hospital—coronary care units, intensive care units, respiratory care units, and trauma centers—can save lives that formerly were wasted, Haeck pointed out.

Once the patient is stabilized in the emergency department, he can be transported to these special units for definitive care. Since not all hospitals can support such facilities, Haeck suggested that hospital facilities will have to be consolidated and categorized to get the most effective emergency services for each dollar spent.

Delusions About the Future

Taking to task the "delusion-peddlers" who would have the public believe that there is a quick, easy, and painless solution to the nation's health care problems, Dr. Max H. Parrott of Portland, Oreg., chairman, AMA Board of Trustees, urged the conferees to help destroy this delusion.

How do we expose the fallacy that a sudden, massive, monolithic, monstrously expensive Federal health program will solve the problems? Parrott asked. Obviously, he said, one of the first things to do is to set the factual record straight every time a delusion-peddler sets it askew. He suggested to the conferees that they and their county or State executives meet with representatives of the press in their communities to discuss the complexity of developing any health care system.

Success in reforming, modifying, or improving any system of medical care depends basically on balancing three strong and competing dynamics: making medical care available to all, the control of costs, and the provision of high quality care. When a system of medical care emphasizes any two of

these three dynamics, Parrott said, the two tend to work against the third. For example, he pointed out that a system which combines universality of access with very tight cost controls can easily affect the quality of care. This combination reduces quality of care mainly because it causes a shift in medical priorities; it diverts a finite number of medical man-hours away from the sick to the well and worried well.

Parrott believes that the search for a perfect health care system—an ideal harnessing of the three dynamics—is not impossible, although difficult. No one, he said, has melded all three dynamics harmoniously and applied them successfully to a broad, across-the-board population base to the satisfaction of all—consumers, physicians, and cost accountants.

No one has devised a system which satisfies the consumer, who wants easy access to a physician; which satisfies the physician, who wants the best scientific capability there is; and which simultaneously satisfies the many who foot the bill, whether it is in terms of a fee, an insurance premium, or a bill.

It is for this reason that we have evolved a pluralistic system of medicine in this country, Parrott concluded, and we should continue this pluralism until there is clear evidence that something else will work better.

Physicians and Payment Mechanisms

Four broad principles that stand out in the policy pronouncements which the American Medical Association has made over the years in adaptation to the ever-changing circumstance of insurance coverages and Federal programs for the provision of medical benefits and welfare programs were highlighted by the speaker of the AMA House of Delegates.

Dr. Russell B. Roth of Erie, Pa., said that the first principle is that financing should be based chiefly on available dollars from the private sector and supplemented by Federal tax funds only as necessary. Roth believes that the mechanism of extracting dollars as taxes to return them as benefits is the most wasteful, least efficient approach. To illustrate this point, he said: "If John Doe owes me $1 and pays it to me out of pocket, I have $1 of income and he has $1 of expense. If, instead, in order to receive my dollar, I need to send an invoice to an intermediary to process, review, and pass on to government to process and pay for from funds which have been processed and collected by a taxing authority, and to support two or three bureaucracies along the way, John has to be taxed closer to $2 than to $1."

On the other hand, Roth said, when the dollar goes from John Doe to an insurance company as a premium and returns to him as a benefit, even though there is a shrinkage due to the cost of insurance company administration, this is the amount which he pays for the virtues of sharing his risk through the application of the insurance principle.

The second principle is that monitoring and control of the expenditures for medical service, in order to insure that a dollar spent is a dollar well spent, can be done only by the medical profession. It cannot be done, Roth declared, by insurance adjusters, consumer groups, or county commissioners. Moreover, it cannot even be done equitably by physicians unschooled in the kind of service in question. Roth feels that true peer review implies that urologists are evaluated by urologists, pediatricians by pediatricians, and so forth.

In Roth's view, the third principle is perhaps the most important—that the commanding necessity is to support and reinforce the competence, integrity, and proper motivation of the nations' physicians rather than to transfer their responsibilities to the State, leaving them as technicians in a public utility. He believes that good peer review can identify those physicians who are not competent, not well motivated, and not endowed with integrity.

Finally, Roth concluded, there is the need to keep the practice of medicine attractive to oncoming generations of outstanding young Americans. He feels that the training of physicians is being hampered by regulations appended to the government financing mechanisms. And he attributes this partly to the lack of progress in separating the costs of personal medical services from the costs of medical education and research and to a failure of regulatory authorities to understand the problems of medical education.