A Critical Review of National Health Insurance Proposals

EVELINE M. BURNS, Ph.D., LL.D.

Dr. Burns is Robb visiting professor at Barnard College and professor emeritus, Columbia University. This paper is based on one she presented at the Group Health Institute, Honolulu, Hawaii, May 25, 1970. Tearsheet requests to Dr. Eveline M. Burns, Apt. 10A, 70 LaSalle St., New York, N.Y. 10027.

It is evident that within the next few years we shall see some major extensions of governmentally supported insurance against the costs of health services. Even the American Medical Association (AMA) and the insurance companies see the handwriting on the wall and are coming up with their own proposals. The mounting insistence that there should be further governmental involvement in this area stems from two major influences. First, the very existence of Medicare has demonstrated that public compulsory health insurance is feasible. Despite its many well-known weaknesses, Medicare obviously has brought considerable financial relief to, and broadened access to health services for, many millions of the aged, and it is popular. Inevitably, there is growing pressure to extend a similar service to those whose economic circumstances differ little, if at all, from those of the mass of the aged. If aged social security beneficiaries, why not disabled beneficiaries? If the disabled, why not survivor families?

We are already seeing, too, criticism of the limited scope of the types of health services covered by the insurance program. Why exclude preventive check-ups, or drugs, or certain other components of comprehensive care? If paid-up insurance is feasible for hospital and institutional care, why is it not equally applicable to physicians' services?

Even more influential in stimulating a demand for an extension of compulsory health insurance is the impact on all sections of the population, and not merely the aged, of the sharply rising costs of health services, so especially pronounced since 1965. These increased costs are reflected in a continuing upward trend in the premiums charged by private health insurers, both profit and nonprofit, or in some curtailment of benefits so that the contribution these institutions can make to moderating the financial burden on even middle-class families will inevitably decline. They may indeed be in danger of pricing themselves out of the market.

The result has been a flood of bills and proposals and plans. The AMA has made proposals (*1, 2*); so have the Equitable and the Aetna insurance companies (*3*). Governor Nelson A. Rockefeller has again introduced a health insurance bill in New York (*4*), and the Committee on Human Resources of the National Governors' Conference has endorsed a system of universal health insurance (*5*) following the general lines of the earlier Rockefeller bill. The AFL–CIO has made some proposals, now embodied in the Griffiths bill (*6*). The Committee for National Health Insurance (CNHI), formed by the late Walter Reuther, has been intensively working on a proposal for national health insurance, which, under the title of the Health Security Act, has now been introduced by Senator Kennedy (*7*). Among other bills are those sponsored by Representative Dingell (*8*), jointly by Representative Fulton and Senator Fannin (*9, 10*), and by Senator Javits (*11*). Organizations such as the American Public Health Association also have committees working on a program for national health services.

It is obvious that space alone will preclude a detailed consideration of each and all these numerous schemes. In any event, a detailed comparison of their features would be extremely repetitious and boring. I propose instead to discuss some of the more crucial features and problems of any health insurance system and to examine how these are dealt with by some of these plans.

As we consider them, it is well to bear in mind the objectives to which almost everyone gives lip service. What we are seeking, I assume, is a program that assures universal access to comprehensive and continuous health services of high quality, delivered under circumstances that are convenient, comfortable, and dignified and in a manner that is efficient and economical. Several features of current propos-

als bear directly on the attainment of these objectives.

A Voluntary or Compulsory Plan?

A number of proposals, notably those of the AMA as embodied in the Fulton bill, the earlier Fannin-Fulton bills, and those of the insurance companies, envisage a vast expansion of voluntary insurance through the use of tax incentives. These incentives would take the form of a tax credit—the amount would vary either with the level of adjusted gross income or, as with the Fulton (AMA) bill, the level of tax liability—equal to some percentage of the costs of purchasing a qualified insurance policy. Receivers of very low income would get Government certificates enabling them to purchase such a policy.

In contrast, the proposals of Governor Rockefeller and the National Governors' Conference, Senator Javits, the AFL–CIO (Griffiths bill), the Dingell bill, and the Kennedy (CNHI) bill provide for a compulsory system whereby both employers and workers would be required to pay social insurance taxes to support the system. There is also an element of compulsion in the proposals of the Aetna insurance company, which relies on an extension of fringe benefits to cover a large proportion of workers. They would penalize an employer for not broadening existing health benefits plans to the required extent by cutting in half the tax deduction he could claim for his contributions to his existing plan. The Griffiths, Kennedy, and Javits bills envisage a contribution from the general revenues toward program costs, while the governors admit the possible necessity for such a contribution if employee and employer taxes are not to exceed some reasonable ceiling.

It seems highly doubtful whether, even as thus subsidized, the voluntary approach would insure universal coverage or effectively remove the financial barrier. Quite apart from the problem of reaching and enrolling those who normally pay no tax or are not employed, which is admitted by the sponsors, it seems unlikely that many millions of families who are not now insured or adequately insured could be induced to lay out the sizable sums necessary to purchase adequate coverage. Dr. Russell B. Roth (*2*), speaking for the AMA, has estimated that "a package providing minimal benefits which can justify a description of comprehensive protection will cost something like $700 a year for an average family." Yet to increase the share of the premium provided by the tax credit would vastly increase the cost of the program.

The Pettengill or Aetna proposal (*3*) places heavy reliance on an extension and liberalization of fringe benefits as the method of enrolling the vast majority of workers, and provides a second subsidized program for the long-period unemployed, the near-poor whose employers do not provide group medical coverage, and those who are uninsurable because of poor health. Incidentally, the groups not covered by employer fringe-benefit plans will be larger than this. For these groups it is proposed that Federal action should encourage the States to develop a system of uniform health insurance benefits to be operated by a reinsurance plan underwritten by all carriers and for which the poor would be covered free, the near-poor would make a contribution varying inversely with adjusted income, while the uninsurable would pay a fraction of a premium that would reflect their high claims costs. The difference between the needed premiums and those charged against these three groups would be carried by the State, which would receive between 65 and 90 percent reimbursement from the Federal Government. Yet when we recall the many claims on State resources and the unwillingness of many States to undertake further expenditures under Medicaid and existing health programs, it seems highly unlikely that any plan which relies on State action for the coverage of those not benefiting from fringe-benefit health programs can hope to succeed.

A further objection to proposals that aim to make it possible, through subsidies from the Government, for low-income receivers to buy insurance is that it perpetuates and indeed extends income testing. For the proponents of this approach recognize that a uniform subsidy for each insured person such as that offered under title XVIII B of the Social Security Act will not meet the problem. Many people need a subsidy of much more than 50 percent. Yet the alternative (namely, to vary the subsidy with the size of a person's income or, as in the Pettengill or Aetna proposals, to have separate and variable subsidies for the poor, the near-poor, and the uninsurable) is to perpetuate the kind of social divisiveness that is currently causing so much concern. It will also be far from administratively simple as people move from one classification to another (poor to near-poor to not poor, and vice versa) or as their incomes change or as efforts are made to avoid "notch" problems.

With the current euphoria about family assistance plans and negative income taxes, we are in danger of becoming a needs or income-tested nation. We already have means tests for subsidized housing, school meals, surplus foods and food stamps, educational grants, day care, and other services. The Heineman commission (*12*) has estimated that a guarantee of a poverty-line income today would involve income supplements to some 24 million households. Do we want to add to the millions who must individually contact government and undergo a means test to secure some financial assistance? One

of the most important questions of principle to be decided is whether any health services plan should involve income tests.

It should be noted, however, that the compulsory plans which take the form of a requirement to pay social insurance taxes also have to face the problem of coverage of those who either do not or cannot pay the specified taxes. The Griffiths, Javits, and Kennedy bills aim to minimize the deterrent to enrollment presented by a heavy wage tax by providing for a contribution to the scheme from the general revenues. The public assistance population can indeed be covered by requiring States with or without a Federal subsidy to take out insurance premiums on behalf of their caseloads, though with fluctuating loads due to turnover this will be no simple administrative task. But there still remains the problem of the millions of irregularly employed workers and of migrants and the like who are hard to catch for tax purposes.

The Griffiths and Kennedy bills, and apparently the Javits bill, provide what would seem to be the correct answer. They make all citizens and permanent residents of the United States eligible for the promised benefits, thus in effect separating the determination of eligibility from the financing of the program and leaving it to the tax collector to gather in as much revenue from the wage and payroll taxes as he can. This is a sharp break with the original insurance theory that the right to benefits should be dependent on having paid the necessary number of contributions or taxes, but it is questionable how far today we need to limit the right to access to health services by resorting to this ideology. Wage and payroll taxes can be defended independently as a rich source of revenue helping to support the program; they do not also have to be the determinant of benefit rights.

Role of Private Insurance Companies

The plans of the AMA, the insurance companies, Senator Javits, and Governor Rockefeller would utilize private insurance as the central agencies for developing and operating the programs. Even Governor Rockefeller's recent proposals for encouraging nonprofit medical corporations seem to assume that these corporations in turn will contract with insurance carriers.

In contrast, the Griffiths and Kennedy bills would bypass the private insurance system except apparently for the possibility, in the Kennedy bill, of their limited use as representatives of the providers of services.

It seems likely that in the immediate future no issue will be more central or more hotly debated than the role of private insurance in either a government-subsidized voluntary or a compulsory social insurance system. The advocates of the private insurers claim that their involvement is in keeping with U.S. ideology. It maximizes the freedom of choice of the consumer and offers the advantages of private initiative and competition. But the involvement of private insurance also commits the program to the ideology of private insurance with its understandable preoccupation with fiscal considerations and its concern about strictly defined and specified benefits and the use of deductibles and co-insurance. (Incidentally, the Griffiths bill provides for co-payment, as does the Javits bill for drugs.)

The necessity to conform to private insurance principles has two major disadvantages. First, cost considerations prevent any private plan from underwriting the entire range of health services. The Aetna plan recognizes this weakness and proposes an additional governmentally supported program of catastrophic insurance. But this, apart from the unlikelihood that it would be everywhere effective since it depends on State initiative and financial support, carries with it such heavy deductibles that it is unlikely to be of much assistance to the middle-class patient faced with heavy medical costs. And the addition of yet a third program creates an administrative monstrosity.

Second, and perhaps even more important, the resulting inclusion of only some health services perpetuates the fragmentation of care, which is everywhere deplored, while the existence of deductibles and co-insurance discourages early utilization of health services, especially those of a preventive character.

Against the possible advantages of competition must be set the added costs of securing business, much of which will have to be written on an individual basis, and presumably an allowance for profit. These costs would be negligible or nonexistent in a compulsory publicly operated plan. Allowance must be made, too, for the lowered level of efficiency attributable to a multiplicity of plans and for the governmental costs of approving and policing the systems. Problems of accountability would be intensified, especially if the insurance carriers were permitted to offer a package of benefits different from those prescribed if "actuarially equivalent and equal in health value," temporarily in the Rockefeller plan, or "equivalent and at no greater cost," as in the Javits bill, which also envisages contracting out by employers who provide fringe benefits of a type and level superior to the national plan in terms of actuarial and health care considerations.

It is indeed somewhat surprising that the insurance companies have not had some second thoughts about involvement in a program that would inevitably bring about a considerable measure of public control of their activities. For, given the magnitude

of the expenditures and the public interest in medical care, Government would be compelled to exercise some control over the way in which the private insurance companies were administering the vast amount of subsidized business that was being thrown to them. Minimum requirements for an acceptable or approved policy, prohibitions of discrimination against certain types of would-be insurers, the permissibility of merit rating, control of the reasonableness of premiums both for legally prescribed benefits and, as in the Javits bill, any supplementary benefits and the like would seem unavoidable.

The use of private insurance agencies as intermediaries involved in the reimbursement of providers under Medicare gives little reason other than political considerations for continuing their use even in this more limited capacity. As many of us pointed out in 1965, it was not very reasonable to expect an agency competing for business from providers to develop a reputation for strict application of rules and regulations and keen secrutiny of charges and volume of service in the interests of keeping down costs, no part of which they had to pay. I submit that the mounting costs of Medicare have justified these gloomy prophecies.

Nevertheless, if the private insurance companies are not to be intimately involved in the organization and administration of the program, other more appropriate administrative bodies must be utilized. Here, differences seem to turn on the role to be assigned to the States as against new regional bodies. Failing the assumption of organizing and administrative responsibilities by private health insurance companies, the Javits bill provides for the creation of national health insurance corporations operating as agencies for the Federal Government and also permits the States to conclude agreements with the Federal Government to administer, as agents, all or part of the program. The Griffiths bill provides for administration of the Federal program through a group of regional administrations, which will be empowered to enter into contracts with providers of medical, dental, and hospital services and to carry out other extensive responsibilities. The Kennedy bill also contemplates a regional basis of administration under a Federal health security board, although the States are given responsibilities for planning and coordinating health services but, it would seem, without any effective powers to enforce their policies.

Some critics who fear that regions are artificial constructs with no solid base of political or financial support would prefer to see the program administered by the States on the basis of contracts with the Federal Government, which *inter alia* would provide for the setting up of regions. It is argued in further support of this position that the States are already involved in a variety of important health services and are the only entities in a position to develop services additional to those financed by the basic plan.

Even a compulsory publicly administered program faces the necessity of defining the services it will finance or provide. Given the present shortage and maldistribution of manpower and facilities and the high costs of some of the more exotic procedures, no system can guarantee the complete range of possible services to everyone. Even the Griffiths and Kennedy bills, which offer perhaps the widest range of services, limit dental care to young persons and, in the Griffiths bill, to some categories of the poor. The literature and the proposals are full of references to "the basic health services" that a national program would guarantee. But of what do the basic services consist? Is it possible to define them without running up against the problem of the item-by-item approach . . . the effect on comprehensiveness and continuity of having some services for which costs will be covered and some for which they won't? Is it possible to approach comprehensive coverage in stages, as the Javits, Governors' Conference, and Kennedy proposals (for dental services) suggest; if so, what should be included at each stage? Or should the policy rather be to make the distinction not on the basis of type of treatment or illness or timing but on giving priority for full service to certain population categories? Might it make more sense to aim first of all to cover all the health needs of children?

Effect on Service Delivery

Government, despite its growing financial commitment, hitherto has been reluctant to become involved in the structure, organization, and administration of health services. In the preamble to title XVIII of the Social Security Act, any such intention was expressly disclaimed: "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the . . . manner in which medical services are provided . . . or to exercise any supervision or control over the administration . . . of any institution, agency, or person." Thus Government has deferred to the practices of private insurance not only by admitting them as intermediaries but also by adopting a reimbursement system on an item-by-item basis and such cost-controlling provisions as deductibles and co-insurance. It has deferred to the medical profession by making no effort to encourage departure from solo practice or a fee-for-service method of remuneration. It has, with the notable exception of New York and a couple of other States, made no effort to control the proliferation of unnecessary facilities and underutilized specialized equipment or their inappropriate location, though

encouragement has been given to voluntary planning . . . but without teeth, presumably in deference to the hospital establishment.

This timidity is unlikely to last much longer. First, the rising costs of health services are now, thanks to Medicare and Medicaid, highly visible, and we have a growing body of data on a nationwide scale that permits sophisticated statistical analysis and comparison. The political undesirability of having to increase both social security taxes and appropriations from the general revenues, or to curtail promised benefits by increased deductibles or reduced services, or to narrow the groups of eligible people is propelling Government into a concern for the causes of rising costs and a search for controls. On all sides today, it is admitted that a major cause of the costliness of health services is the nature of the delivery system itself. It is significant that the Administration's proposed addition of payments to health maintenance organizations under Medicare, which would presumably encourage a different type of delivery system, was put forward not as one might have hoped because it would improve the service received by the insured, but mainly because it was believed to save money.

In the second place, Government no longer needs to be afraid of and subservient to the providers of health services. The prestige of the medical profession is not as high as it was, and its influence on public policy is correspondingly weaker. A more literate and sophisticated public is less impressed by the mystique of the physician and more likely to question his views. The organized medical profession has contributed to this decline in prestige. Its prolonged opposition to any social health insurance program, even for the aged, where the gap between need for care and ability to pay for it is so obviously large, has left a nasty taste in the national mouth. Even more destructive of the old image is the unfortunate impression that the medical profession is greedy and has taken advantage of the reimbursement provisions of Medicare and Medicaid to enrich itself. The profession can rightly claim that such antisocial behavior is characteristic of only a small minority of physicians. Yet the profession should take a lesson from the welfare field: abuse of that system by a few recipients has been sufficient to damn the entire welfare population as lazy, improvident, greedy, and unscrupulous. The famous case of the "relief recipient with a mink coat" still influences the public image of the welfare clientele.

Nor need Government continue to be so squeamish about interfering in the way hospitals are organized and run. For with the growing dependence of the voluntary hospitals on public funds, the Government is in a powerful position to exercise strong-arm financial pressures and to claim that receipt of public money implies conformity with public policy.

Thus both the need and the opportunity for Government to become involved in the health services delivery system are much greater than they were even 10 years ago. What advantage do the various proposals now before us take of this situation?

All proponents of health insurance plans now proclaim their recognition of the fact that the problems besetting the health care industry cannot be resolved merely by making more money available for the purchase of care. They differ, however, in their identification of major problems, in the methods they propose for dealing with them, and in the extent to which they would use the health insurance system as a vehicle for bringing about change.

All proposals include provisions aiming to keep down costs. Some would limit charges by, for example, providing that fees cannot exceed the prevailing level of fees in the community (Aetna), or should not increase faster than the general price level (Secretary of Health, Education, and Welfare), or that hospital costs should not increase out of proportion to general payroll increases in given areas (Governors' Conference), or provide for setting a limit to total annual program expenditures (Kennedy), or require conformity with professional fee schedules set by official regional councils (Rockefeller), or prescribe that total costs may not increase more rapidly than average wage levels (Javits). Several suggest that institutional reimbursement should be on the basis of a predetermined annual budget instead of the present cost-reimbursement system.

Most plans envisage the development of incentive reimbursement formulas offering rewards for efficiency and economy and better utilization. Indeed one gets the impression that incentive plans are the "in" thing now.

Recognizing that costs are affected not only by unit charges but also by the number of units of service rendered, most plans also contain provisions aiming to insure economical utilization. The Griffiths bill would make the receipt of all professional services dependent on the order of a primary physician or dentist who alone would be directly remunerated. Aetna would require a review committee of qualified physicians passing on the necessity and appropriateness of services if a hospital were to be approved, and most of the other plans make provision for some form of peer review or utilization committee. In addition to the requirement of utilization committees in hospitals and skilled nursing homes, the Kennedy bill would provide for similar controls over the use of drugs and make only approved drugs reimbursable.

Space does not permit a listing, let alone an evaluation of the effectiveness, of the various cost-control measures. But a few doubts may be voiced. How feasible will it be to set limits to reimbursable costs by reference to general price or wage levels or prevailing fees? Haven't we tried prevailing fees already? How justified are the high hopes now being placed on incentive schemes? How much reliance can be placed on peer review of the professional performance of colleagues?

In any event, certain observations can be made about all these cost-controlling proposals. First, more attention is paid to controlling charges and volume of service of institutional providers than of practitioners. Second, in most plans—the Kennedy bill is perhaps an exception—the control of quality is given much less attention than the control of costs. For the control of quality, reliance usually is placed on the setting of standards for participating institutions and professionals—the Kennedy and Griffiths bills devote much attention to these—though it would seem that only the Javits and Kennedy bills provide for stricter relicensing provisions to offset obsolescence of professional knowledge and, in the Javits bill, for the possibility of national licensing standards. In some instances peer review is cited as a device for controlling quality. Third, all these cost-control measures are directed toward the performance of the individual provider. They could operate with no change in the existing costly and inefficient delivery system.

At this point we come to a major difference between the proposals; namely, in the extent to which measures to improve the delivery of services are envisaged as an integral part of the health insurance system itself. On the one hand the AMA and the insurance companies see any such measures as calling for quite independent programs. The AMA expressly states that it "would surely make no sense" to burden the insurance program with these responsibilities. Their disregard of the delivery problem is evident in the fact that they propose to perpetuate the present unsatisfactory dual program now found in parts A and B of Medicare. The Aetna proposals recognize the need for more and better arangements for ambulatory care and for teamwork and group practice, but suggest only a separate program of Federal grants to train physicians in primary care and in managing teams of professional and allied personnel together with a Federal program of loan guarantees for construction of ambulatory care centers and loans (grants in poverty areas) for "set-up" costs.

In sharp contrast, the Javits, Kennedy, and Griffiths bills would use the financial leverage of the insurance system to bring about change. The Kennedy bill devotes much attention to the promotion of health service organizations stressing health maintenance and ambulatory care, which will undertake to provide, or arrange for, complete health care, or at least the complete range of health security services to an enrolled or local population. This care is to be provided through prepaid group practice or an approximation thereto. To this end, a health resources development account, financed ultimately by 5 percent of the sums in the trust fund, would be set up to administer a program of grants and loans for expansion or establishment, which would be available for both existing (up to 80 percent of costs) and new such organizations (up to 90 percent). In addition, there are to be loans at 3 percent, in the same proportions, for capital construction.

Starting-up costs will be subsidized for the first 5 years. Additionally, special improvement grants will be made to public or other nonprofit agencies to assist them in establishing improved coordination and linkages with other providers of services, while organizations providing comprehensive ambulatory care would be given grants for improving records, establishing information retrieval systems, and purchasing equipment for various purposes. Reimbursement of the costs of certain services, such as those of nutrition personnel or social workers, would be made only if rendered by comprehensive health service organizations. The bill also provides that Federal law will supersede State laws which restrict the development of prepaid group practice.

Concern about the delivery system is also seen in the duties and powers given to the health security board to strengthen health planning throughout the country, with emphasis first on the special needs for personnel, facilities, and organization that will be necessitated by the new service, and second on the continuing improvement of the capabilities for the effective delivery of health services.

The Javits bill also makes specific proposals for changing the delivery system. Title IV of this bill, subsequently introduced as a separate bill, includes a series of measures to encourage the development of local comprehensive health service systems based on primary service areas. Grants equal to 80 percent of the cost of planning and developing such systems would be offered, together with technical assistance, assumption of the difference between income and operating costs during the first 5 years, capital grants up to 80 percent of the non-Federal contributions under title VI of the Public Health Service Act, a 50 percent grant plus a loan at 3 percent if no other assistance is given for modernization, rehabilitation, or construction of ambulatory centers, and a subsidy to keep interest down to 1 percent for the development of facilities operated as part of

a group practice system. In addition, such systems would be permitted to retain up to two-thirds of the difference between their actual costs per member and those of comparable groups in the community.

Finally, under the Javits bill, all providers entering into agreements or contracts to provide services must undertake to make continuing studies of the organization and delivery methods in their geographic areas and of possible improvements, and to take action, or to recommend action to the Secretary of Health, Education, and Welfare, calculated to provide greater continuity and comprehensiveness and to control unnecessary utilization.

The Griffiths bill, to promote continuity of care and presumably economy, provides that all agreements between the administrators and professional providers shall be limited to primary physicians or dentists. Their remuneration, on a per capita basis, would be sufficient to permit them to provide or arrange and pay for the needed services of specialists and other licensed health professionals, who in turn could be remunerated on a salary, capitation, or fee-for-service basis. Similarly, agreements between short-term hospitals or groups of hospitals would provide sufficient reimbursement on a capitation basis to permit them to pay for skilled nursing home care, home health services, and rehabilitation services.

Part B of the Griffiths bill also provides for grants from the health insurance funds to hospitals, medical groups, nonprofit organizations, and consumer cooperatives—up to 75 percent of the cost of planning and developing comprehensive health service delivery systems. To assist in staffing the new comprehensive health service delivery systems, a small revolving loan fund is provided, while title VI of the Public Health Service Act is to be amended to give priority in authorized loans and grants for construction to such comprehensive plans.

The Griffiths bill assigns to the regional administrators the duty of making studies of the ways and means by which the quality of health care and the efficiency of its delivery may be improved in their regions. They are also required to allocate funds so as to "reasonably assure" the availability of needed services in all areas. Provision also is made for the appointment of regional consumer advisory committees, to be concerned with the delivery system in their areas, which are to be staffed by professionals who are competent in medical care administration and organization, planning, public health and epidemiology, statistics, and health education.

Two other health insurance proposals aim to deal with the delivery system. The Administration has recently proposed the addition of a new provision in title XVIII of the Social Security Act under which the aged can elect to join a "health maintenance organization," which will provide in the form of a guaranteed package all the promised Medicare benefits plus preventive services. These health maintenance organizations will be reimbursed on a capitation basis, and any savings through efficiency consistent with quality will go to the organization and the consumer. The Rockefeller bill aims to encourage group practice by permitting the formation of profitmaking professional health service corporations to render specified professional services, and to stimulate the growth of prepaid comprehensive care programs by providing for the formation of nonprofit medical corporations. The corporations would be empowered to provide medical services and to provide or arrange for any health service, including hospital service, on the basis of contracts with carriers for payment in advance or periodic charges. In both instances, however, the Rockefeller plan appears to rely on the removal of legal and technical barriers rather than the offer of positive inducements to form such corporations.

I suppose most of us agree that to the extent the health insurance system can use its buying power to improve the delivery system, it should do so. Perhaps the only area where doubts arise concerns the desirability of using the insurance reimbursement system to control the proliferation of facilities. Some proposals, such as the Kennedy bill, suggest that reimbursement of capital expansions or depreciation allowances should occur only if the planned expansion is certified by a State or local planning agency as being necessary or of a high order of priority. But it may be better to exclude capital costs entirely from the health insurance reimbursement formulas. Separate provision would lend itself more readily to implementing overall planning of resources, local or national. Instead of the health insurance administrator negotiating hospital by hospital to determine whether new capital additions are justifiable, needed resources would be allocated by a separate agency making allocations as indicated by the determined needs of the community or region.

But aside from this, the vital question is in what ways the health insurance plans can influence delivery systems. It is clear that great reliance is placed on "financial and other incentives." Reimbursement formulas and grants such as those proposed in the Kennedy, Javits, and Griffiths bills could increase the financial attractiveness of prepaid group practice, though it is by no means certain that the main hindrance to this form of organization is financial. But the main problem today is surely one of assuring adequate and appropriate linkages between the various types and levels of service and between primary physician care, secondary care based on community hospitals, the super specialist care of

the medical center, and the supportive health services of the community.

How is this to be brought about and to whom are the incentives to be addressed? Even the Griffiths bill, which aims to assure continuity of professional treatment on the one hand and institutional care on the other, still appears to do nothing to insure that the two hands will meet; and it is doubtful how far groups of physicians will be capable of arranging for the whole gamut of professional services. Nor is it clear how enforceable is the Kennedy requirement that institutions and individual providers of care must establish working relationships with others.

Something can be done about linkages by standard setting. Thus it can be provided that any participating physician must have a hospital affiliation. But what if the hospitals refuse to accept him? Both the Griffiths and the Kennedy bills provide that any participating hospital must not refuse affiliation for any reason other than lack of professional competence. But how can the hospitals be induced or forced to take action to raise the levels of competence of the physicians practicing in their catchment areas? How can they be induced or forced to assume some leadership in developing the community health services or to align themselves with prepaid group practice units? And if not the hospitals, what agencies or groups of people would seem to offer leadership potential?

All current health insurance proposals appear to concentrate mainly on physicians' services, broadly interpreted, and on institutional providers. But what about what might be termed the health infrastructure? By that I mean the supportive community health services on the one hand and on the other the underpinning services and procedures needed by large numbers of providers and patients and which can most effectively be provided on a large scale. I am thinking of centralized data bank and retrieval systems, multiphasic screening facilities, a comprehensive transportation system, or certain types of laboratory services. How are these to be brought into being? Should provision of such facilities be the responsibility of the health insurance system or should they be provided otherwise? And where should responsibility for assuring an adequate volume and appropriate types and distribution of medical manpower be placed?

Sooner or later, too, a decision will have to be made about the compatibility of a fee-for-service basis of professional remuneration and a system that assures comprehensive and continuous care. The AMA, the insurance companies, and Governor Rockefeller appear not to question the fee-for-service principle and propose no changes in the status quo. The Kennedy and Griffiths bills evidently regard fee-for-service as a barrier to the development of a desirable system. Griffiths proposes from the first the reimbursement of groups of providers serving defined populations through a capitation system based on a national capitation rate modified by local adjustments. The Kennedy bill encourages capitation and sometimes salary payment, but permits continuation of fee-for-service for independent providers. However, in the event of a shortage of funds, only those paid on a fee-for-service basis would suffer reductions in reimbursement.

All proposals make obeisance to the principle of free choice on the part of the patient. To the AMA and the insurance industry, this seems to mean free choice of individual physician, specialist, hospital, or insurance company. Yet increasingly today it is recognized that what is needed is free choice between systems. Now a system, as I understand it, is an articulated structure, an entity in which the various essential and functionally related components are appropriately linked. Hospital-based or connected prepaid group practice is an example of such a system. But do we have any others? If not, and the alternative is to allow free choice to select any provider, personal or institutional, to render the basic services guaranteed, does this not commit us to a reimbursement system on an item-by-item basis and to a perpetuation of fragmentation and lack of continuity?

In any event, if we really mean a choice between systems, we must ask ourselves how many systems we need in any given community, State, or region? Can we afford unlimited proliferation of competing health delivery systems any more than we can afford unlimited proliferation of facilities and costly equipment? And who is to determine how many are needed? Should this, too, be the responsibility, as appears to be envisaged in the Javits bill, of our emerging health planning agencies, which have hitherto concentrated mainly on planning for facilities and supply of personnel? The Kennedy bill specifically gives the health security board the power to require providers to expand, modify, or curtail covered services.

Given what would seem to be the obvious advantages of prepaid group health systems to the consumer and patient, in most respects to the practitioner, and to society at large in terms of economy, does one not have to ask why this system has not been able to enlist a more powerful constituency? Some of the reasons are clear: legal barriers in some States, opposition of organized medicine enforced by sanctions such as refusal of hospital affiliation to participating physicians, inability of group health organizations to own and control their own hospitals, problems of covering setting-up costs, difficulty of offering salaries competitive with pri-

vate practice, a medical education system that builds in the emerging professional the image of the solo practitioner as the ideal to emulate and neglects the teaching of community medicine, and the lack of effective consumer education.

Probably all these have played a role, and to the extent they have we have some clues as to the steps, financial and otherwise, that have to be taken. But we also must ask why the public, which in the end always seems to get what it is really determined to have, has allowed these barriers to persist. Are there perhaps some features of current plans that repel or at least are not attractive to those who use or might use the services and to the participating professionals? Are there some obstacles to the expansion of prepaid group practice that lie within the control of the movement itself? Do they, for example, make adequate provision for a role for the consumer?

The Role of the Consumer

These various plans differ considerably in the role they allot to the consumer. The AMA appears to see little place for consumer involvement. The proposal does indeed provide for a national health insurance advisory committee of nine persons but gives no specification as to the characteristics of the seven non-ex-officio members. The stress laid on developing programs to assure quality and effective utilization "through measures which provide for participation of carriers and providers" clearly reflects the AMA view, as stated by Roth (*2*): "it is generally agreed by all authorities in the field that any adjudication in respect to the quality, quantity, or price tags for medical service must be made by the process of peer review. Perhaps the outstanding single advantage of our plan is that the providers of service—the only ones with the capacity to pass judgment on its equity—are maximally motivated to accept responsibility for the success of its operation." In such a philosophy there is little place for the consumer.

The Aetna proposal also includes a national advisory committee of nine persons, mainly experts but including a consumer representative. However, the plan assumes the formation of local comprehensive health planning agencies in which consumers would presumably be represented and provides that proposed institutional budgets and charges should be reviewed by a body composed of consumers, insurers, and health-care institutions.

The Rockefeller bill envisages considerable consumer involvement. The program is to be administered by a State health insurance corporation of 12 trustees, at least three of whom are to represent consumers or purchasers of health services and are to receive a salary. This body will appoint nine regional councils similarly composed. The plan also provides for public hearings on proposed premium rates and specifies that 75 percent of the directors of any hospital or health service corporation and 60 percent of the directors of a medical expense indemnity corporation must be representatives of broad segments of the subscribers covered by the contracts and other persons qualified to act in the public interest.

More explicit provision for the consumer is made by the Kennedy, Griffiths, and Javits bills. The Kennedy bill provides for a national health security advisory council of 21 members, of which a majority are to be consumers, and similarly constituted councils are envisaged at the regional and subregional levels. These bodies, which are to be assisted by technicians and secretarial staffs, are to report on all aspects of the program. The report of the national council must be submitted to the Congress by the Secretary of Health, Education, and Welfare, together with a statement of his reasons for any disagreement with its recommendations. In addition, comprehensive health service organizations are required to consult periodically with enrollees.

The Griffiths plan would be administered by a 10-member national health insurance board, with two members representing management and labor. There would also be an advisory health benefits council of 21 members who are "familiar with the need for personal health services in urban and rural areas as well as among the working population, the poor, the aged, children, and various minority groups." At the regional level there are to be regional consumers advisory committees of 12 to 14 persons—representatives of minority groups, the poor, the aged, labor, farmers, and consumer cooperatives—who are to be given their own professional staffs. The Griffiths and Javits bills appear to be the only ones that provide machinery for dealing with the complaints and grievances of patients or would-be patients.

The Javits bill specifies that the proposed comprehensive health service organizations must consult periodically with representatives of the membership and provide for user representation on their governing boards. In administering the loans and grants programs, the Secretary of Health, Education, and Welfare must enlist consumer and community involvement in the planning, development, and operation and insure "prompt response to local initiative." And in carrying out his mandate to develop new methods of compensation, the Secretary is required to consult with State and local representatives of consumers and, where none exist, to encourage and assist their establishment. In addition, he must hold hearings to obtain the views of users of the health services.

Everyone today, with the possible exception of the AMA, is talking about consumer participation and involvement. But there is a lack of agreement about what aspects of a health services program lend themselves to consumer participation about the form that participation should take, the levels of government at which different types of consumer involvement would be most effective, and about the types of persons who can represent the interests of the consumer.

It seems clear that the consumer has many roles, and the way these can be best performed (through the ballot box, the appointment of consumer-conscious administrators, representation on governing or advisory bodies, through public hearings or organized local community councils, and the like) will vary with the different types of consumer interest in the program. As the ultimate footer of the national bill, the consumer is interested in overall costs, efficiency and economy of operation, and financial accountability. As a member of a nation seeking to make a reality of the right to needed health services, he is concerned with overall policy and its administrative implementation; that is, with performance accountability. As a member of a local community, he is interested in the appropriateness of the delivery system to the special circumstances of his area. As an individual recipient of service, he needs some way of venting his dissatisfaction with the quality or adequacy of the service he receives.

The phrases "involvement or participation of consumers at appropriate points" and "appropriate representation of consumer interests" occur in the literature with maddening frequency and a baffling lack of specificity. Identification of the different types of consumer interests and discovery of effective devices for making the consumer's voice heard and influential are major pieces of unfinished business in the development of health insurance plans.

* * * * *

It is evident that there will soon be major extensions of something called health insurance. The question is not "whether" but "what kind." In 1965 those of us who were concerned with the health services were caught napping. Next time we shall have no such excuse, and we have now experienced the unhappy results of our lack of preparedness. It is now generally recognized that the problem is much broader than the mere removal of the financial barrier. Study and comparison of the provisions of the various bills now before Congress, only the major features of which this article has been able to touch upon, should reveal the issues and alternatives. It should help to sharpen our thinking on two essential points; namely, the characteristics of an efficient and socially acceptable health services delivery system and the nature of the organizational structures, financial arrangements, and administrative systems most likely to bring it into effect.

REFERENCES

(*1*) Roth, R. B.: Statement on behalf of the American Medical Association. *In* Hearings on Social Security and Welfare Proposals before the Committee on Ways and Means, House of Representatives, 91st Cong., 1st sess. U.S. Government Printing Office, Washington, D.C., Nov. 3–6, 1969, pp. 1419–1457.

(*2*) Roth, R. B.: Medicredit: A national health services financing proposal. Paper prepared for discussion at the National Health Forum, Washington, D.C., Feb. 23–25, 1970. Mimeographed.

(*3*) Pettengill, D.: Statement on behalf of Aetna Life and Casualty. *In* Hearings on Social Security and Welfare Proposals before the Committee on Ways and Means, House of Representatives, 91st Cong., 1st sess. U.S. Government Printing Office, Washington, D.C., Nov. 3–6, 1969, pp. 1824–1836.

(*4*) State of New York: Health insurance bill. Albany, 1970.

(*5*) National Governors' Conference: System of universal health insurance. Colorado Springs, Colo., Aug. 31–Sept. 3, 1969.

(*6*) U.S. House of Representatives: Bill to provide a program of national health insurance and for other purposes. H.R. 15779. 91st Cong., 2d sess. U.S. Government Printing Office, Washington, D.C., Feb. 9, 1970.

(*7*) U.S. Senate: The Health Security Act. S. 4297, 91st Cong., 2d sess. U.S. Government Printing Office, Washington, D.C., Aug. 27, 1970.

(*8*) U.S. House of Representatives: A bill to provide a program of national health insurance and for other purposes. H.R. 24. 91st Cong., 1st sess. U.S. Government Printing Office, Washington, D.C., Jan. 3, 1969.

(*9*) U.S. House of Representatives: A bill to provide for medical and hospital care through a system of voluntary health insurance. H.R. 9835. 91st Cong., 1st sess. U.S. Government Printing Office, Washington, D.C., Apr. 2, 1969.

(*10*) U.S. Senate: A bill to provide for medical and hospital care through a system of voluntary health insurance. S. 2705. 91st Cong., 1st sess. U.S. Government Printing Office, Washington, D.C., July 28, 1969.

(*11*) U.S. Senate: A bill concerning Medicare benefits, extension and improvement. S. 3711. 91st Cong., 2d sess. U.S. Government Printing Office, Washington, D.C., Apr. 14, 1970.

(*12*) President's Commission on Income Maintenance Programs: Poverty amid plenty. U.S. Government Printing Office, Washington, D.C., November 1969.