Health Insurance in the Medicare Years

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As we examine the experience of the past 10 years, the Medicare years, seeking to discover and evaluate what we have learned, what we have accomplished, where and how we have fallen short of achieving what we might have done, it becomes apparent that the events of these rich, turbulent years had their origins in the preceding decades. Thus, Medicare would not have come into being had it not been for the vaulting technological and economic expansion of health care resources and services in the 1960s. And, we would not have had the experiences of the soaring 1960s had it not been for the innovations in health services and health care prepayment and insurance in the 1940s and 1950s. These developments, in turn, were simply building on the inventive pioneering of the 1930s and the World War II years that followed, when the burgeoning technology of medicine spurred the specialization of medical practice and medical care and the newly discovered financing method, group prepayment, began to fuel the public demand for medical miracles as they became available. To understand the Medicare years, we need to keep in mind at least the milestone events of the previous decades.

The Groundwork

Group hospitalization, as it was commonly called in the 1930s, spread rapidly across the country during the depression years as people learned about this novel method of relieving the onerous burden of hospital costs, then a staggering $5 or $6 a day. By 1936 there were 15 prepayment plans in 11 States. The concept was anointed in the controversial recommendations of the prestigious Committee on the Costs of Medical Care. The American Hospital Association had become interested in the movement, recognizing it officially in 1936 with the organization of the first Committee on Hospital Service. Also, several of the large, group-writing insurance companies had begun to offer hospital expense indemnities along with group life insurance policies. Responding in the late 1930s to widespread public interest in group hospitalization, several of the large State medical societies organized physicians' service plans. The first joint offering of hospital and physicians' service prepayment was put together for an automobile industry group in Michigan in 1940—foreshadowing Blue Cross-Blue Shield and the insurance coverage of major industries, which later laid the groundwork for the nationwide intermediary system that was to administer eligibility, claims, and benefit payments for 20 million Americans in Medicare.

The early groups were organized and enrolled for the most part at places of employment, but at first without benefit of payroll deduction for payment of subscribers' fees. Most employers resisted this expense and involvement until some time after payroll deduction was sanctified by introduction of the Social Security Act in 1936.

During World II, the economic expansion of industry aided the growth of the group plans; employers began to offer payment of a portion of the cost of health insurance for employees. By 1945, more than 32 million people were covered under various prepayment and insurance programs. Of this number, 19 million were covered by Blue Cross and Blue Shield plans, 11 million by insurance companies, and 2.5 million by independent plans organized by employers, employees, unions, or other community groups. Benefits were focused mainly on hospitalization expenses, but Blue Shield plans and insurance companies covered surgeons' fees for 13

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million people. Home and office visits of physicians were beginning to appear in benefit schedules, and by 1945 almost 5 million people had this kind of coverage.

Perhaps more important than the level of coverage was the growing acceptance by industry and the population of a group or societal concept of security as a necessity of life, like nourishment and shelter. Along with health insurance, group life insurance and retirement plans had emerged as a fringe benefit package for employees and as an instrument of negotiation for unions. When the U.S. Supreme Court in 1949 ruled that employer contributions to health insurance for employees could be considered as wages and included in collective bargaining agreements, the question of whether to provide health insurance was virtually eliminated, and negotiations were resolved in considerations of what benefits at what cost.

The effect on enrollment was electric. By 1955, 101 million people had some form of protection for the costs of hospital care, 86 million were now covered for surgical expenses, and 53 million had coverage for regular medical expenses. To supplement the basic coverage, major medical insurance had been introduced, and enrollment stood at 5 million persons. All or most of the group insurance companies were offering health insurance by this time, and the competition was becoming intense within what had become a $2.6 billion industry.

A major byproduct of this competition was a steady stream of new developments as the insurance companies sought means of coping with the nonprofit, community enterprise, and service benefit features of Blue Cross and Blue Shield plans. And, the nonprofit plans wrestled with the fact that insurance companies were able to offer nationwide employers a single contract with one schedule of rates and benefits for employees in all parts of the country. The prepayment plans countered with reciprocal arrangements for the integration of plan programs into a national system. The insurance companies met this challenge head on by offering "experience rating," or sliding scales of premium rates favoring large, stable groups with populations that had relatively low rates of illnesses requiring hospitalization. When experience rating began to make inroads on Blue Cross and Blue Shield enrollments, the nonprofit plans offered a variety of benefit packages and rates, as well as experience rating, while maintaining an internal "cross subsidy" for low-income groups. Interestingly enough, despite the protest from government against erosion in the community rate principle, State governments (for example, New York and California) and the Federal Government insisted on experience rating when they began to offer group benefits to their employees.

The ferment within the health insurance industry consequently served the public interest; benefits were liberalized, rates lowered, services improved, and enrollment continued to soar. By 1965, 139 million people had hospital expense coverage and 124 million had surgical expense protection. Coverage for regular medical expenses had nearly doubled in the preceding decade and now stood at 100 million people. Significantly, coverage for major medical expenses had increased fourfold, now reaching 53 million people. Total benefit payments for personal health care expenditures also had increased dramatically to $8.3 billion.

Despite the significant enrollment growth, by 1965 it was clear that the ability of private hospital and medical expense protection plans to meet the unique needs of the elderly and of low-income groups was limted. Both groups suffered from a congruence of extraordinary and unpredictable need and highly limited ability to pay. To a large extent, the question of whether government should be involved in meeting this need had been answered in the affirmative. In 1965, the essential debate focusd on the questions of how and when.

Public-private sector relations. As to the "how" of government involvement in program administration, there were several examples of collaborative efforts between government and the private insurance industry. In 1956, the Defense Department contracted with the Blue Cross and Blue Shield organizations and with insurance companies to administer the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which provided services of community hospitals and physicians near military establishments to supplement regular Defense Department medical services. In dealing with the Blue Cross organization, the Defense Department entered into a prime contract with the Blue Cross Commission (and in 1960 with the newly-established Blue Cross Association), which used the individual Blue Cross plans as subcontractors. This type of prime contractor-subcontractor relationship was later to be employed in the administration of Medicare part A. CHAMPUS contractual arrangements with Blue Shield plans and Mutual of Omaha also had many features that would be utilized in the carrier and intermediary contracts under Medicare.

An even more impressive example of successful joint enterprise combining the health insurance resources of the private sector in a publicly supervised health program is the Federal Employees Health Benefit Program (FEHBP), inaugurated in 1960. The FEHBP provides comprehensive health insurance coverage to the entire Federal work force throughout the country, including employees, dependents, and retirees. The program is underwritten and administered by Blue Cross-Blue Shield, selected insurance companies, and a number of prepaid group practices or health maintenance organizations, where these are available. Contracts are negotiated and monitored for the Federal Government by the Civil Service Commission. More than 5 million persons were enrolled initially; since that time the number has risen to 9 million. At recurring open-en-

rollment periods, employees are given a wide choice among several Blue Cross-Blue Shield benefit and rate options, insurance company plans, and prepaid group practices, with uniform support from the Federal Government. This subscriber choice gives employees repeated opportunities to make decisions concerning type of plan, benefits desired, rates to be paid, and dependents covered. The choice keeps competition alive among eligible carriers, all of whom are required to meet standards of service established by the Civil Service Commission.

The FEHBP is considered by some to be a model that could readily be mandated for the employed population in a national health insurance plan and for the low-income population in the long looked for "federalization" of Medicaid. By allowing the government to set standards for benefit and administrative performance of carriers and by allowing the consumer choice among approved private carriers and alternative benefit offerings, the FEHBP model effectively combines public standard setting, private flexibility and competition, and consumer choice in a manner that builds effectively on the strengths of all.

Cost containment. During the pre-Medicare years, the lines were also being laid down for the cost containment initiatives that are now commonly grouped under the rubric "rationalization of the health system." The regionalization of health services, for example, was recommended in 1932 by the Committee on Costs of Medical Care and 10 years later by the Commission on Hospital Care. Regionalization, rather than expansion *qua* expansion, was the conceptual framework for the Hill-Burton Hospital Construction Act, although it was honored too rarely by the State plans that emerged to govern priorities in Hill-Burton operations over the years. Other elements of the health care rationalization complex—now a major concern of Congress, Federal and State departments of health and welfare, industry, many citizens, health professionals, and insurers—also had their origins in the earlier decades. For example, controls on utilization and quality of care have been a continuing concern of professional groups since 1914. Dr. E. A. Codman of the Massachusetts General Hospital was the first to report work on outcome measurement (*1,2*). Codman's goals were institutionalized in the hospital standardization program of the American College of Surgeons and continued to be developed by the Joint Commission on Accreditation of Hospitals.

Utilization and cost controls were also matters of concern to some as early as the 1950s, when the promotional ambience of the economy made growth a symbol of patriotic pride and the national mood was not notably friendly to any suggestion that more is not necessarily better. In 1958, an insurance commissioner, Francis Smith of Pennsylvania, became convinced that the coincidental growth of hospitalization insurance and hospital beds might represent elements of demand not wholly explainable as medical necessity. Smith's subsequent approval of a Blue Cross subscription rate increase was tempered with an order for hospital utilization review. Compliance for the most part was *pro forma*, and despite a variety of local programs employing differing techniques, the issue of utilization control remained out of sight until it surfaced again in the conditions of participation for providers in Medicare.

Occasional studies identified use of facilities and services as a key element in the hospital economy, however, and warned that underutilization was a threat to quality, just as overutilization was a threat to economic stability. Commissioner Smith may have been the first to adjudicate utilization review, but others were talking and writing about controls. In the early 1960s, results of studies suggested that group practice plans were reporting measurably lower rates of admission to hospitals than fee-for-service plans.

The results were noted by economists and a few health professionals and administrators, but they were generally disregarded by others. Instead, cost-containment efforts followed the more popular line of efficiency studies that resulted in adaptations of industrial techniques to health care institutions. Work standards and work measurements appeared, automation of business operations became commonplace; hospital associations and Blue Cross plans sponsored and supported methods-engineering services, cost-finding studies, and productivity incentive plans.

In the 1960s, too, the payment mechanism began to be used as an instrument of cost containment. Earlier, hospitals, Blue Cross plans, and others had experimented with flat rates for certain services such as obstetrics and tonsillectomies and in a few cases, with an all-inclusive per diem rate. Now, the idea emerged that hospitals and paying agencies could negotiate rates prospectively, permitting the institution to retain an agreed share of any savings that might be realized but also imposing a penalty for cost overruns—presumably an incentive for efficiency. Interestingly enough, some Blue Cross plans limited cost reimbursement price increases for a given year over the previous year to some stipulated percentage for peer groups of hospitals defined by geographic location and size.

Thus, throughout the pre-Medicare years, we saw the growth and development of prepayment and insurance coverage for health services, an expansion of administrative capabilities both in the private market and under contract with government, and a framework for the cost-containment efforts which would ascend sharply in importance in the early 1970s. Concomitant with the wide availability of health services and an acceptance of health care as essential to the well-being of the population was an identification of a social responsibility, shared by both the public and the private sectors, to assure access to care for all Americans.

The Years of Medicare and Medicaid

Public-private sector relations. The experience of CHAMPUS and FEHPB had demonstrated that whereas the government must set goals and establish standards for publicly funded health programs, the private sector with its flexibility and ability to deal with providers also had an important role. This experience shaped the intermediary-carrier function that has been performed by the prepayment plans and insurance industry in Medicare. Under part A of Medicare, provider institutions have nominated the Blue Cross Association and several insurance companies to be intermediaries with the Social Security Administration; a small number of institutions have elected to deal directly with the SSA. In part B, the SSA selected Blue Shield and insurance companies to play a similar role as carriers in the administration of benefits. In Medicaid, some States have used the private plans and companies as fiscal agents, while others have chosen to administer Medicaid directly. In a number of States, changes of fiscal agents have been made from time to time during the history of the programs.

With some 20 million people becoming eligible for benefits at once, automated record systems to determine eligibility had to be established and maintained and systems developed for informing participants of their entitlements, recording payments, keeping track of deductibles, adjudicating and paying claims, and maintaining utilization records. For all these and other functions, forms and recordkeeping methods had to be designed and produced, personnel trained, procedures developed and manuals produced, and supervisory systems devised by the SSA and the participating intermediaries, carriers, and providers. The period of preparation just before the effective date of the program 10 years ago was described by President Lyndon B. Johnson as "the largest management effort this nation has undertaken, with the single exception of the Normandy invasion."

As it has turned out, the relative roles of the public and private sectors have evolved gradually over these years and are still subject to adjustment and realignment, such as the decentralization of the Department of Health, Education, and Welfare and the attendant shift of some program responsibilities for Medicare administration to the regional offices. Similarly, the private sector has had to improve its systems capabilities to be able to handle the increasing volume of claims and still sustain improvements in productivity.

Intermediaries and carriers processed more than 25 million claims in fiscal year 1975 as compared with 10 million claims in fiscal year 1967. Productivity improvements were dramatic, rising to 3,422 claims processed per man-year in fiscal year 1975 as compared with 2,650 in fiscal year 1970. The maturing relationship has presented an important opportunity for analysis and evaluation. In 1973, a Medical Panel under the National Academy of Public Administration (NAPA) reviewed the contracts between the SSA and its carriers and intermediaries. The panel noted the initial success of both public and private sectors in administering the monumental claims payment function.

The NAPA study group recommended that the SSA and its contractors develop a relationship which would enable the private sector to add its full capability to the administration of Medicare. Essential to that relationship, the study group believed, are a public sector that focuses on specific performance goals and a private sector that focuses on management against those goals. More specifically, the study group set forth several long-term recommendations that need to be observed by both public and private officials if an enduring successful relationship is to be maintained. These were:

- —Better understanding of one another's roles and responsibilities and improved management interaction through effective knowledge and communication.
- —On both sides, better understanding of the political process that results today in unprecedented demand on politicians for (*a*) more services and (*b*) more controls on government.
- —On the part of government, specific goals and performance yardsticks subject to audit following discussion with carriers and intermediaries.
- —On the part of contractors, acceptance of SSA as overall administrator and contractors as agents of the public interest in dealing with providers.
- —Willingness on the part of contractors to accept public disclosure of their performance records relative to standards.

In 1974, the Subcommittee on Medicare Contracting and Subcontracting (Perkins Committee) examined the administration of part B of Medicare and made a number of generally similar recommendations for management improvement, more effective communication, and realistic understanding of roles and responsibilities. Clearly, the wedding of accountability and independence is a sophisticated task. It is a major challenge to avoid the temptation to try to improve performance by issuing excessively detailed regulations rather than relying on standards. Similarly, it is difficult to find mechanisms that reward innovation and creativity while protecting the public interest and the public purse. The private sector and the SSA seem to be headed toward a relationship built on a record of improved performance and on trust and mutual respect. As the NAPA study emphasized, understanding on both sides is basic to the commitment to make Medicare more of a shared responsibility.

The importance of objective evaluation of relative responsibilities is underscored by the debate on roles envisioned under national health insurance. A major public policy decision will be made, and the Congress needs facts to judge wisely. The recent General Accounting Office report (*3*) comparing the performance of private intermediaries and the SSA in Medicare was less important for its specific results than for the debate

it generated in an attempt to achieve reasonably objective conclusions.

More analysis, such as that of John Krizay and William Hsiao, is needed. Krizay, an economist in the Department of State and former research director of the Twentieth Century Fund, examined the operating cost performance of Medicare and that of the Blue Cross and Blue Shield-administered portion of the Federal Employees Health Benefit Program (FEHBP). He stated: "It is clear that one cannot make a persuasive case for a public-sector operated universal health insurance program on the theory that its operating costs would be lower" (*4*). Hsiao, a professor of economics at Harvard University and a former actuary for the Social Security Administration, recently completed a study commissioned by the Blue Cross Association. Like Krizay, Hsiao compared administrative performance under Medicare—as an example of a program administered by the government—with administrative performance under FEHBP—as an example of a large, privately insured program with many characteristics similar to Medicare. Hsiao's findings suggest that private administration is highly efficient and also that available evidence does not support the assertion that the public sector is necessarily more efficient and less costly.

The administration of Medicaid has also been the subject of several major studies over the years, including one by the Task Force on Medicaid and Related Programs. The task force noted in 1970 the complexities, problems, and inequities emerging from the variations among the States in Medicaid benefits, eligibility requirements, and administrative procedures (*5*). Its first recommendation was that the program should be converted to one with a uniform minimum level of benefits financed by Federal funds, with further Federal matching with the States for supplementary benefits. The task force study and other studies also emphasized the difficulties of making valid measurements of performance because of fundamental characteristics of the program—chiefly, the welfare environment resulting in constant and drastic shifts in the eligible populations, the lack of administrative expertise in many of the State governments, the complexity of regulations drafted and administered in the States, and inconsistencies resulting from lack of uniform and representative participation by providers.

The health care climate and the private market. The past decade has been a period of restless transition toward a more formalized health field. These years have seen public policy controversy and outright strife rooted in varying political and economic ideologies. There have been dramtic increases in the cost of health care fueled by double-digit inflation in the economy as a whole. An economic recession has seen a substantial increase in the rate of unemployment, unequally affecting geographic areas and population groups. The consumer movement has moved to the fore, based on a desire for involvement in decision making beyond the economic marketplace. A "revolution of rising expectations" has been waged on the strength of a burgeoning technology and widespread awareness of its potential. Collective bargaining within the health industry has accelerated the process of "catchup" of wages for health workers. Recently, sharply rising malpractice premium rates have led to physician "strikes," unheard of a decade ago.

Despite the turbulence of these years, the health insurance industry has continued to expand. Since 1965, enrollment has continued to increase. As of December 31, 1974, the latest data available, 163 million persons were covered for hospital expenses; nearly 13 million were over the age of 65 and had purchased coverage which complements the benefits available under Medicare. In all, 77 percent of all consumer expenditures for hospital care were being met through insurance and prepayment mechanisms. For surgical expenses, nearly 160 million persons had coverage, and 150 million had coverage for regular medical expenses. Coverage for major medical expenses jumped by 70 percent in 9 years, reaching 91 million by 1974. The steady broadening of benefits under private health insurance also continued in those 9 years. For example, there was an increase from 3 to 33 million in the number of persons covered for dental expenses and an increase from 53 to 141 million in the number of persons covered for out-of-hospital prescription drugs. Total benefit payments by insurance and prepayment plans approached $25 billion in 1974 and rose to $27 billion in 1975.

Currently, however, the health field is beginning to face what may become the starkest of all economic realities. Fringe benefits in total and payroll taxes such as social security have become a heavy burden to U.S. employers. Typically, fringe benefits amount to about 30 percent of basic wage and salary expenses. Consider the fact that the three largest suppliers of the General Motors Corporation are, in order, Blue Cross and Blue Shield, Metropolitan Life Insurance Company, and United States Steel. Nor is this situation unique to private-sector employers. Federal, State, and local governments, too, are confronted with sizable expenses for fringe benefits, including health insurance.

In this context, flexibility and innovation within and without the health insurance industry assume critical importance. Other essential ingredients include a focus on underlying problems rather than on short-run solutions, an understanding of the relative roles of the public and private sectors apart from Medicare and Medicaid administration per se, to the end of building on that which each does well, and a commitment to persevere. Within the past decade, the needed tools forged in the pre-Medicare era have continued to evolve—in many cases taking on greater specificity, with progress measured in small increments. Also, an

improved understanding is emerging of the interdependency of funding mechanisms and other health actions such as planning and utilization control.

Areawide planning. In view of the primary importance of the capital structure in the health sector to both the cost and the availability of services, the National Health Planning and Resources Development Act of 1974 was enacted to upgrade the capabilities and the information base of planning agencies while maintaining local and State control over the decision-making process. These efforts are reinforced by Medicare and Medicaid through capital expenditure review provisions, by Blue Cross plans through conformance clauses in provider contracts, and by State certificate of need laws.

Utilization review and quality assessment. Declining hospital admission rates and length of stay in recent years are related to many factors, but no one would deny the potential contribution of increasingly effective utilization review techniques. Improved claims screening systems, better data, and the growing commitment of institutional utilization review committees have added to the positive result. In an era of preoccupation with costs, utilization review and quality assurance are in a delicate state of balance today; revitalization and redirection of current efforts are needed to realize the full potential of utilization review and quality assessment as an energizing force for behavioral change as opposed to cost control.

Reimbursement. The provider payment method provides an important opportunity to establish incentives for proper capital investment decisions and employee productivity. As with utilization review, the temptation is to use the payment method to impact cost, without recognition of the long-term inequity and the destruction of opportunities to influence provider behavior positively. Many good examples of effective payment methods are now under evaluation. The wise course would be to use these evaluations to approve workable methods, even if it should result in a wide variety of acceptable systems.

Alternative delivery systems. The Medicare years have seen a great deal of progress in the initiation of changes in the delivery of health care aimed at providing more rational incentives for improvement and economy. Technical difficulties with the Health Maintenance Organization Assistance Act of 1973 slowed down but did not thwart the development of alternative modes of delivery across the country. The HMO represents a valuable mechanism for consumer choice and thus has a meaningful role in stimulating change in the health care system. The HMO movement was ignited with the spark of commitment by the private sector, and growth in new HMOs and HMO enrollments in recent years has been dramatic. There are now approximately 200 HMOs in the United States, but we must do much more to make the HMO option available to a larger segment of the population. Blue Cross plans in one way or another are involved as owners, sponsors, or contractors with more than 100 HMOs, and many insurance companies are also offering HMO options to their health insurance policyholders and groups. To avoid abuses that have occurred where unqualified HMO entrepreneurs have seen contracts with paying agencies as profit opportunities, regulation is essential. However, regulation must be applied only to insure sound fiscal management and reasonable benefits—it must not be the kind that stifles innovation and incentive.

Opportunities for the Future

Whatever the strengths of the private and public sectors of the health care industry today, more is required of each to meet the major challenges facing us—to assure universal access to needed care for all Americans, to moderate the rising costs of care, to improve the overall productivity of the health establishment, and to articulate an overall national health policy.

Whatever the specific solutions sought, it seems likely that we will continue on the path of moderated pluralism, making productive use of the private as well as the public sector and capitalizing on what each one does best, while minimizing the excesses and fragmentation that have marred performance in the past. The rise of consumer organizations and representatives demanding accountability of health care providers for their performance has been felt strongly in the private sector as well as in the public programs. Employers spending huge sums for health care of employees have joined organized labor in exerting increasing pressure on health insurers as well as providers. Prepayment and insurance are responding with expanding outpatient and home care benefits; requirements for consultations in elective surgery; organizational, underwriting, and marketing support for HMOs; and other measures aimed at making structural changes in the system, in addition to utilization and cost-containment efforts aimed at economizing within the existing structure. It is a persuasive argument in favor of continuing the pluralistic approach that whereas the control of rising costs is a responsibility of both the private and public sectors, the solutions that go beyond changes in financing and regulation and contemplate reordering of the system itself must rely in part on the private sector, which is hampered differently by the constraints of legislative action and the bureaucratic setting.

A reordering of health values in the society, and not solely within the health system as it exists, will be required to achieve the goal of a healthier population, and not just more medicine for more people. The needed reforms must not be limited to universal access to care for the sick and the injured from all walks of life and increased productivity and economy within the health services. They must also include a broader concept of health focused on lifestyle, attuned to the environment, and comprehending that the major responsibility for maintaining and improving health must lie not with the government nor with the health pro-

fessions but with the entire population. Ultimately, the individual person's attitude and behavior determine the status of his health. What is needed to support this concept is not a new national health insurance scheme but a new national health policy. In essence, we must stop throwing an intimidating array of technological processes and systems at lifestyle problems and equating more health services with better health.

For all the scientific knowledge we continue to accumulate, the technological breakthroughs we achieve, the heroic measures we are prepared to apply—and do apply, often with spectacular success—millions of people are not yet getting the coaching, the care, the support, the information, and the direction they need and must have if we can expect to make measurable improvements in the health of the population. The minimum requirement for achievement of this goal is that the people must have the capability and the will to take greater responsibility for their own health. We have been talking for some years now about the need for added emphasis on primary care, social medicine, preventive medicine, environmental medicine, and health education of the public. Yet while we talk, we keep right on concentrating our resources on specialized, sophisticated technological medicine.

The imbalance is related in part to the fact that our health resources are controlled and allocated excessively by the professionals, and to a more limited extent by the users. The health field has emerged as a technocracy in the precise meaning of the term, in that the goal is not so much the profit of its owners and managers as it is maintaining use of the system at the limits of its capacity, without a corresponding regard for the value of its output. Thus, it may be said that in a sense the system is going one way and the health needs of the society another. We are now reminded that health status is a compound of heredity, lifestyle, social and physical environment, and all kinds of emotional stimuli, as well as medical care. Yet, we continue to feed our money and manpower resources into one component, to the practical exclusion of all the others. When the imbalance has obtruded, we have generally turned our backs and considered that redressing it is somebody else's job.

We have learned over the years through Medicare and other public and private programs that we cannot get a healthier population simply by trying to help hospitals operate more efficiently, as we have done, or by encouraging and supporting regional planning of health care resources, as we have also done, or by paying for out-of-hospital health services, or promoting and supporting new organizational concepts like health maintenance organizations. More than that needs to be done, and if we can find out how to design and manage constructive interventions in the social and environmental factors influencing health, and how to inform and teach and motivate people to take better care of themselves, then government and private health insurance will find ways to support and pay for these activities too. Already, carriers have started to support and pay for such things as patient education services and psychological counseling.

As we look ahead to the next decade, the Medicare years and before give testimony that the present system is not bankrupt. It has strengths worth building upon. Certainly the experience of the Medicare years has taught us that if we are to have full access to the medical care we have been striving toward for so many years, any form of national health insurance must be accompanied by mechanisms relating financing to utilization and by controls aimed at rationalizing health planning and holding down health costs. We should have learned also that controls cannot be laid on a layer at a time, like coats of paint, or injected like medications at points where the health economy is hurting. Rather, they must be interwoven and orchestrated to keep the parts moving together at the same tempo—government, the professions, and institutional providers, health insurers, patients, and the public. We should have learned, at last, that public participation is meaningless when it is restricted to token representation in planning and advisory groups where consumer members sit like children at a grownup's party, silent until they misbehave. When we do accept the public members as full partners because we have come to understand, finally, that it is their health we are concerned with, some groups will grumble that we are letting the passengers fly the airplane. It is possible to understand this disaffection for the kind of change that is coming, but it is far more realistic to consider that the passengers are going to do some of the flying, at least, and we had better begin teaching them how. If we have really learned this lesson, it may be the most important one of these eventful years.

In retrospect, the Medicare program, an amalgam of the Department of Health, Education, and Welfare and the private sector, can take pride in improving significantly the health benefits of the aged and in giving new dimensions to concepts of productivity.

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