Fundamental Concepts of National Health Insurance

☐ Over the next 12 months, the number one health issue facing this nation and its health care community is likely to be national health insurance. Several bills are already pending in the Congress. President Carter has announced his intentions to send a health insurance proposal to Congress early in 1978. Indeed, an advisory committee appointed by Secretary Joseph A. Califano, Jr., Department of Health, Education, and Welfare, is already hard at work on the key issues that must be resolved in the coming debate.

With the recent surge of public and professional attention to the issue, it is important to remember that the debate over national health insurance is not of recent origin. It has, in fact, spanned most of the 20th century. Dr. I. S. Falk, in the first article in this issue of *Public Health Reports*, reflects on this debate and comments on the various proposals. Forty-five years ago, the report of the Committee on the Cost of Medical Care provided an incisive and comprehensive discussion of most of the issues which still surround national health insurance. While a perusal of this report might cause a cynic to conclude that thinking about national health insurance has stagnated for nearly a half-century, I would submit that there can be no stagnation of a fundamental concept; in this case, the concept embodied in an interpretation of the general welfare clause of the Constitution—that all Americans should have the right to pursue good health. That notion is still true today, and it is the goal of national health insurance to protect that right by removing obstacles of one's inability to pay and the inaccessibility of services.

If there has been stagnation, it is in the public will to remove these obstacles for all Americans. True, there have been attempts such as the Murray-Wagner-Dingell bill of the 1940s and the Kerr-Mills programs of the 1950–60 decade. Enactment of Medicare and Medicaid in 1965, a form of national health insurance for some of our people, eased the pressures for a while. But rising health care costs and the continued unavailability of services and insurance for many millions of people have renewed public demands for improved equity in financing and services, which only some form of national health insurance can bring.

This need for national insurance now appears to be more universally accepted in our society, even among the health professions that in days past opposed the concept. To me, this broad public and professional recognition and expression of need has been the missing ingredient necessary to enact a health plan.

As the Administration and the Congress now begin to develop the specifics of national health insurance, it is timely to remind ourselves of some of the objectives that an insurance scheme should help achieve as part of its broad purpose.

1. EQUITY. Any federally financed or supported health plan must assure equal access to services for all. This means:

2. REDISTRIBUTION OF SERVICES. We will have to redistribute resources to central cities, rural areas, and geographically remote places where services currently are scarce. The distribution of manpower by professions and specialities will have to reflect service needs, as well as help to upgrade the efficiency and quality of health care.

3. TRAINING. Financing of health professions training is important, but it is equally important that training reflects patient needs. We must find effective methods to assure this.

4. QUALITY OF SERVICES. We are already moving to develop methods and systems for assuring that services are of proper quality. There is certainly no justification today for providing funds to qualitatively inadequate services. We should be able to assure quality relatively simply and without a vast new bureaucracy.

5. PREVENTION. We need more effective disease prevention efforts to apply the knowledge we now have.

6. BIOMEDICAL RESEARCH. Our research efforts must be nurtured and strengthened by national health insurance and must increasingly be aimed at prevention and early
tection.

7. RESOURCE PLANNING AND C
TROL. We see about us the co
results of excess hospital capacity a
duplication. As Health Systems Ag
cies evolve, we must move quickly
develop national health resou
planning guidelines and assure t
they are applied with equity a
common sense.

8. ORGANIZATION AND DELIVERY
SERVICES. Medicare and Medic
experience showed that reimbur
ment mechanisms are potent in
ences over the organization of delive
systems and use of manpower. Dev
opment of health maintenance or
nizations has been slow; we still
not reimburse physicians' extende
under Medicare and some Medica
programs. Some services, althou
necessary, experience difficulty getti
adequate financial support. All
these deficiencies must be addres
through a comprehensive health ca
financing system, as well as by dire
measures.

9. ADMINISTRATIVE SIMPLICIT
The more funds that are diverted
operate administrative machinery, t
less that will be available for delive
of services. We obviously need
countants, bookkeepers, and adm
istrators, but they do not care
patients.

☐ Let me add a word about eli
bility requirements. As soon as th
are met, a very heavy administrati
burden—and considerable risk to
dividual dignity—is imposed. A
tional health insurance progra
should be available to all, and
should bring those in need into t
system without complex eligibili
requirements.

☐ A health insurance system that
simply a financing mechanism can
turn out well-trained manpower
place people where they are need
It cannot even assure that servi
are available to all in need. T
heart of the program must be
assure the actual provision of servic
their appropriate use, and their
livery in a humane and cost effecti
manner.

Julius B. Richmond, MD
Assistant Secretary for Health
U.S. Department of Health,
Education and Welfare