National Health Insurance for the United States

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WHAT WE NOW DEBATE in the United States as the needed development of national health insurance had its roots in ancient societies. If space permitted, I would trace the emergence of various social inventions to provide for the sick and injured—from the beginnings of the industrial revolution in western Europe, the gradual development of voluntary and compulsory sickness insurance programs, and the prototype national compulsory program in Germany in 1883. But I can mention here only a few of the most significant developments in our own background.

Origins

From our colonial years onward, we had governmental provisions for protection of society against common risks (such as epidemic disease) and to meet essential needs of the poor and destitute (an inheritance from the Elizabethan "poor laws"). We also had the supports provided by religious and other charitable agencies, by early labor unions, and the self-help assurances of fraternal societies, lodges, and clubs organized by immigrant groups. Also, for nearly a century we have had growing reliances on prepayment plans, especially for people in geographically isolated industries (*1*).

The first major involvement of our national Government with illness and the provision of medical care for other than the armed services came almost immediately after our birth as a nation. It began with the Marine Hospital Service Act in 1798, to provide for the sick or disabled merchant seamen. Initially, it was in effect a compulsory contributory national sickness insurance program for a particular category of employed persons. In time, it came to be supported by Federal financing, and the Marine Hospital Service became the Public Health Service, charged with greatly broadened functions. The Service was first transferred from the Treasury Department to the newly created Federal Security Agency

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in 1939 and then absorbed into the new Department of Health, Education, and Welfare in 1953 (*2*).

The first major campaign for enactment of State-government sponsored health insurance was led from 1912 to 1920 by the American Association for Labor Legislation after a successful campaign for the enactment of workmen's compensation laws to provide protections for workers in cases of work-connected accidents and injuries. The association's proposal was to provide corresponding protections against nonwork-connected risks, services, and costs. This campaign ended in disaster after the American Medical Association and other early supporters retracted their previous support and blocked affirmative action in the legislatures of the 16 States that considered legislation (*3*).

The course of subsequent events was greatly influenced by developments which came not from social or political movements but from the world of science and technology. The scientific revolution of the decades from 1870 to 1900 had not led to modernization of medical education and training in the United States. The antiquated system of training physicians was demolished by the findings from a survey published in the Flexner report of 1910 (*4*), and reform and modernization of medical education and training then came rapidly, with momentous consequences for the medical care scene. Teaching and training became based on the newer developments in science, the teaching hospital, and the laboratory, and in basic and clinical research.

As the exploding mass of newer knowledge and the improving arts and technologies were incorporated into medical education and training, specialization became inevitable. It resulted quickly in fractionation of medical care, increasing complexity of the services, rising costs, and a trend toward outmoding the general practitioner and family physician. Thus, along with improvement in the quality of medical care came increasing difficulty for millions of people in knowing how to obtain care in the medical care system or to afford its increasing, increasingly uneven and—for the individual family—unbudgetable costs.

All these changes happened rapidly—first between 1912 and the World War I period and then at an accelerating pace after the war. Public hope and expectation of the capacity of medicine to prevent and to heal grew as the wonders of the then modern medicine became widely known in a nation that was relatively prosperous. These expectations led to rapidly growing demand for medical care and, at the same time, to widespread and increasing frustration about deficiencies in what, today, we call the "delivery" of medical care and about the threat of reductions in the availability and actual receipt of personal health services.

In the early 1920s, apprehensions began to be widely felt that the changes in the medical care scene were also bringing shortcomings and prospective dangers. By the mid-1920s, leaders in medicine, public health, economics, and sociology began to sense an urgency to assess the trends and the outlook and to consider what might need to be done and what could be done from such assessment and through leadership and guidance of the medical care system. This sense of urgency was the genesis of the Committee on the Costs of Medical Care (CCMC) in 1927.

The CCMC's Contributions

The CCMC came into being as a self-created, private organization of about 50 leaders from many interested fields. They came from medicine, dentistry, nursing, pharmacy, public health, hospitals and other institutions, the social sciences, banking and insurance, labor, and civic affairs. A former president of the American Medical Association, Dr. Ray Lyman Wilbur, then president of Leland Stanford University, was chairman of the committee (he was U.S. Secretary of the Interior from 1929 to 1932). Dr. C.-E.A. Winslow, who was professor of public health at Yale, was chairman of the executive committee.

The CCMC was committed to a comprehensive 5-year program "to study the economic aspects of the care and prevention of illness." It was supported by contributions from eight foundations and by collateral studies undertaken by other professional organizations and by official agencies, including the Public Health Service, State and local health departments, and others.

Over its 5-year lifespan, the CCMC staff prepared 26 reports and many miscellaneous papers on such topics as resources for health and medical care; actual availability and receipt of care; costs, expenditures, and their impacts; standards for the measurements of adequacies and applications for evaluations; the resources and needs for improvement of organization to assure ready and effective service; and the needs for better coordination of services within the personal and communitywide services and between them (*5*).

The committee produced its final report with recommendations in 1932. It had no authority to compel any action, and its appeal was to reason,

responsibility, and the public interest. Thus, from beginning to end, CCMC was an undertaking to achieve social progress mainly through voluntarism.

The final report presented five main recommendations, each based on large volumes of supporting data; and all five were intended to be considered together (*6*):

1. For better organization of personal health services, especially through comprehensive group practice;
2. For strengthening of the public health services;
3. For group payment of the costs, whether through nonprofit insurance, taxation, or combinations;
4. For more effective coordination of the services; and
5. For improvement of professional education, with increasing emphasis on the teaching of health and the prevention of disease.

In the aggregate, the recommendations constituted a first formulation of a national health program.

The committee's members were not, however, all of one mind. The principal minority report voiced strong objection to some of the majority's recommendations—especially to the two that recommended gradual development of and reliance on group practice and on group payment. Instead, this minority report advised continuing reliance on solo practice, fee-for-service payment, and the leadership and guidance of the professions, and it objected to governmental or other intrusions into medical care.

This minority report was formally endorsed by the American Medical Association (*7*) and, since there was no adequate or even substantial countervailing force in our society at that time, the committee's proposals appeared for a while to hold little promise of serving as a basis for useful action. This lack of support assured the death of a massive experiment to deal through voluntarism with the health and medical problems that were ahead.

An unfortunate turn in the national economy changed the fate of the committee's recommendations and preserved them from the "innocuous desuetude" to which they had been consigned by the editor of the JAMA (*8*). The committee had begun its work in 1927 when our economy was climbing toward a high level of prosperity, but it completed its work at the end of 1932 when the nation was already in severe economic depression, with health and medical care needs far beyond the resources or capacities of private charity, voluntary agencies, and of State and local governments. Efforts to deal with national needs—including the needs for welfare, health, and medical care—moved to Washington in March 1933 when President Roosevelt was inaugurated and Federal explorations for dealing with critical national distress were begun.

Proposals of the 1930s

The first measures to deal with national economic depression were emergency programs in 1933. In mid-1934, however, President Roosevelt appointed the cabinet-level Committee on Economic Security (CES) to devise permanent programs for the protection of society against common causes of insecurity, including the risks deriving from wage loss and costs of care arising out of illness.

The CES staff proposed a broad national health program embracing the personal and the communitywide health services, a program that was generally acceptable to the committee. But owing to storms of protest to the White House and to Congress from medical professions, the insurance industry, and others, and reflecting political timidities in high places, only a preliminary report was made to Congress "for study," and proposals for Federal grants to support State programs of health insurance and of medical care for the poor and near-poor were filed away. Nevertheless, in the Social Security Act of August 1935 we did achieve, in Title V, Federal grants-in-aid to the States for maternal and child health and for crippled children's programs and, in Title VI, the first permanent authorizations to the Public Health Service of funds for grants to the States for public health work and an authorization of funds for intramural research and studies by the Public Health Service.

In the years between 1935 and World War II, discussion continued around a newer formulation of a national health program that had been developed by an interdepartmental Technical Committee. This committee was composed of Dr. Martha M. Eliot of the Children's Bureau, the chairman; three officers of the Public Health Service (Dr. Joseph W. Mountin, Dr. Clifford E. Waller, and George St.J. Perrott); and I.S. Falk of the Social Security Board. Their formulation was utilized as the agenda of a national health conference in 1938, and the outcome of the conference was that the program was incorporated into Senator Wagner's bill, S. 1620, the National Health Act of 1939. The plan still rested mainly on Federal grants to States. Despite extensive hearings on the legislation in the Senate, the result was only a Senate Committee report and a promise of further pursuit.

Developments in 1940s, 1950s, and 1960s

In World War II and the post-war years, the congressional discussions and national debates were focused mainly on a series of annual Wagner-Murray-Dingell (W-M-D) bills which went through an evolutional process. They started with a national health program based mainly on Federal grants-in-aid to the States; but, beginning with the 1945 bill, they incorporated proposals for national health insurance in the pattern of the national social insurance. These bills generated extensive national debates, but they also evoked strongly organized oppositions that lobbied the congressional committees, and they led to no enactments.

President Roosevelt had permitted the Social Security Board to continue to propose national health program developments during the war years, but he did not press for enactment. When President Truman came to the White House, he inherited a Roosevelt intention to go forward in this field. He acted on his own strongly held views along the lines of the then current W-M-D bill and expressed them in a succession of Health Messages to Congress (1945, 1947, and 1949), but he could not overcome the oppositions. There was a continuing legislative stalemate.

Except for the 1946 enactment of the Hill-Burton program to support hospital construction, inaction had persisted while needs had been growing and intensifying. In 1950 I suggested, as a way of breaking the stalemate, a tactical retreat to a national insurance for the aged and the survivor beneficiaries of the national social insurance system, instead of for the eligible covered population of the system (*9*). This would provide paid-up health insurance for those who needed it most, who generally had less-than-average resources for health care or private insurance, who were not fiscally important to providers, and who were a severe burden on the costs of the insurance carriers. Except for the brief interlude of the ill-fated Kerr-Mills medical care assistance program of 1960–65, this retreat eventually served its purpose: thus, after about 13 years of further intense debate, conflict, and compromise on the limited proposals of 1952–65, Medicare, Medicaid, and broadened maternal and child health care were enacted on July 30, 1965.

Consequences of Medicare and Medicaid

Within a few years it became evident that the Medicare enactment was making large contributions on a prepayment basis to the medical care of millions of older persons and that the Medicaid enactment was augmenting medical care for the means-test assisted poor and medically indigent. It also became evident that the dominating compromises with the status quo that had been built into those newer public programs had brought them into difficulties that they had been intended to avoid—flagrant and steepened price and cost escalations, inadequate services and cost protections for the populations served, exploitive and even fraudulent charges by providers, and pervasive corrosion of the medical care system generally. By July 1969, even a conservative President was constrained to say that America's medical care system faced a "massive crisis."

The most evident reason for the growing crisis in medical care has been persistently rising costs. In the final CCMC days (1929–32), we had been spending as a nation $3.7 billion for all health services, about $29 per capita per year—about 3.6 percent of a gross national product (GNP) of about $100 billion. By 1969 national expenditures for health services were up to $61 billion per annum, $295 per capita, and 6.7 percent of a GNP of $899 billion, and expenditures were increasing at a rate 50–100 percent higher than for other necessities of life, with no end in sight for the escalation (*10*).

But cost was not the only major reason for crisis. A broad consensus was emerging that resolution of the problems required not only better financing but also improvement of the system itself and that effort to achieve either would be futile without the other. With this perspective, a Committee for National Health Insurance, organized in November 1968 under the leadership of the late Walter P. Reuther, president of the United Auto Workers (UAW), undertook to develop a comprehensive proposal for medical care for everybody (*11, 12*). Its major objectives were an improved system for the availability of medical care through the private resources for service but with national public financing; the total funding was to be determined by national policy, and annual cost escalations would be restricted to those of the economy as a whole. Since Reuther's death in an airplane accident, the committee has been led by Leonard Woodcock, his successor at the UAW.

As a "health security" bill began to emerge from this committee's studies and as it was first introduced in Congress in 1970 and 1971, a veritable flood of alternative proposals began to appear. This led to an oft-repeated cliché that they reflected "an idea whose time had come"—even if only with "all

deliberate speed" after nearly half a century of public discussion.

As the national elections of 1976 approached, polar positions appeared in the platforms of the two major national political parties: the Republican party expressed opposition to compulsory national health insurance and support for extension of catastrophic illness protection mainly through private insurance; and the Democratic party advocated a comprehensive national health insurance system with universal and mandatory coverage, financed by a combination of employer-employee shared payroll taxes and general tax revenues.

In the course of this campaign, Presidential candidate Carter frequently expressed his commitment to advocate mandatory national health insurance of broad scope. Soon after taking office, he sent a message to the Congress (on April 25, 1977) transmitting proposals for improving the nation's health care system (*13*). The message proposed the Hospital Cost Containment Act of 1977 as a preliminary to phasing in a workable program of national health insurance. The message also proposed a Child Health Assessment Program (CHAP). Bills on both proposals were promptly introduced and congressional hearings are underway. (*14, 15*). Also, Joseph A. Califano, Jr., Secretary of Health, Education, and Welfare, appointed an Advisory Committee on National Health Insurance Issues, and it is already holding public hearings in various parts of the country. We are now waiting for the Secretary's recommendations and the President's decisions promised for early 1978 and how they will be related to fiscal and other elements in his legislative program.

If, as many are now saying, we have a general national health insurance in our future, it is not so much because it is "an idea whose time has come"—its timeliness came half a century ago—but more because the costs of health services and medical care have already risen to nearly intolerable levels, because they are still escalating at unacceptable rates, and because there is no sign or outlook for moderation of the steep upward climb.

Cost Control and System Improvement

Health care expenditures are climbing this fiscal year of 1977 above $150 billion, approaching 9 percent of a GNP of more than $1,700 billion, and they are proceeding toward $200-250 billion or more a few years hence (*16*). This outlook compels undertakings that will bring the costs within manageable bounds. Since "rollback" of costs and expenditures may not be feasible, decision is urgent because the longer delayed, the more heroic and drastic the action will have to be.

There was a time when many thought that we could deal with the several causes of medical care deficiencies separately and discretely. All recent experience now supports the CCMC perceptions of 1932 that the major causes are interrelated and do not stand alone, and that they demand simultaneous attack. Any program with reasonable promise of success must achieve both cost controls and system improvements, since neither one can be durably effected without the other.

My reference to system improvements extends to a long list of failings—to weaknesses from solo practice and fee-for-service payments, largely unrestricted practice of surgery, excessive fragmentation of services from specialization gone rampant and resulting in insufficiencies for primary and coordinated care, inadequate support of better organization and excessive use of hospitals, geographic maldistributions resulting in too much here and too little there, self-serving professional resistances against effective controls over quality and ethical performance, professional control of price and expenditure levels, and so forth.

Further, system improvement should end the complacency with one system for the poor and medically indigent and another for the self-maintaining—a complacency that has bred near disaster for both. Proposals that would engender more multiplicity—for Medicaid, Medicare, the employed, the self-employed, and the nonemployed—would assuredly render impotent all efforts to effect real improvements. The need for both cost control and system improvement compels, I believe, one system serving everybody through a design that rests on national resources.

Phasing National Health Insurance

At the moment, it is popular in some quarters to argue that a national health insurance should be developed in steps and not all at once; this counsel goes by various names—phasing, staging, incrementalism, gradualism, and so forth. To the extent that gradualism is advocated by reason of alleged lack of resources for, say, comprehensive dental care for everybody and the need for growth of needed resources that cannot be created quickly, it may be an unavoidable policy. But there is a basic disregard of both the lessons of history and the objectives of a good program to the extent that gradualism refers to the magnitude and complexity of requirements for the initiation of a comprehensive program and

argues for step-by-step additions of "categories" (*17*).

For more than four decades since the CCMC we have been developing health services by categories, usually small, limited, and underfinanced; always they have had to conform to the existing medical care system. Similarly, we have had categories by population groups and with the same restraint. And both approaches have operated to preserve the system—bulwarking the status quo and breeding our current difficulties.

Nor is the decade of experience with Medicare itself without bearing on this subject. A broad (although not fully comprehensive) spectrum of covered benefits under Title XVIII of the Social Security Act actually came into being nationally on a single effective date, July 1, 1966, without phasing or staging, although surely requiring a large and skillful effort. It made services available to nearly all of its 20 million eligibles on the appointed day. The difficulties of the program that developed stem not from that nonincremental initiation but mainly from three political compromises and one failure of design in the legislated program. Among the compromises were—

1. Uncontrolled allowance to physicians, hospitals, and others to adjust their economic and practice "profiles" in the year before the effective date that might bring fiscal restraints on them;
2. Lack of provision for adequate and continuing quality and fiscal controls to moderate the guarantees of payments for provider-determined fees, prices, and reimbursable costs. The effect of this omission was to give signed blank checks on the Social Security trust funds to about 250,000 physicians and about 6,000 hospitals; and
3. Statutory negativism in the very first section of Title XVIII prescribing that the act conferred no authority to change the medical care system.

The basic failure of design was to develop Medicare primarily as a system to pay bills for services obtained by the eligibles on their own but with little concern for the availability of the right kinds of services of good quality needed by the aged.

Thus the mistakes in Medicare provide valuable lessons, but they bear primarily on the need to avoid crippling political compromises in the process of congressional enactment rather than on support for incrementalism.

Alleged Excessive Demand

It is also popular in some quarters to argue against an initially comprehensive national health insurance system by alleging that eligibility for services solely because they are needed—and without insurance contributions, ties to some particular employer, deductibles, co-payments, income or means tests—would precipitate an overloading of provider resources. And by extrapolations from limited experiences and observations, some writers support this view as an inevitable consequence of open-end eligibilities for care. It is as though, with health and medical services suddenly made price-free, 220 million people will rush to physicians' offices or demand inpatient surgery. This assumption is patent nonsense, witness that the imagined dash for services does not happen where services are made available without financial barrier—whether in private charitable provisions or in the public assistance programs —and that well-organized group practice prepayment plans, with open-end availabilities for primary care services and specialty services by referrals, function with substantially the same medical attendance rates as the population generally and with about one-half the inpatient hospitalization rates for the population under 65 (*18*). A notable exception to this remark is the large demand for frequent health examinations, reflecting decades of health education which encouraged it. Since this demand heavily burdens clinical staffs' schedules and is of doubtful productivity, there is a need for the design of a more effective substitute.

Also, in passing, I would invite those who advocate restraints on services, through phasing or through barrier payments in the form of deductibles and co-payments, to inspect the Canadian experience with its national program of substantially price-free services for more than 20 million persons. They will derive no comfort from that record (*19*).

Catastrophic Insurance

Another alternative to comprehensive national health insurance is the proposal for "catastrophic insurance" that will provide protection to persons needing extremely expensive medical care. In my opinion, such insurance would be no alternative at all, and it would quite surely lead to an increase and an intensification of what already ails the medical care system. Having to require large deductibles or prior expenditures as a precondition for eligibility to the benefits biases the program toward those who can afford or already have broad basic insurance or toward those of considerable means, thus greatly delimiting the potential reach of the program. For example, the "catastrophic" insurance benefits (like those in Medicare) in the program currently spon-

sored by Senators Long, Ribicoff, Talmadge, and others would be available to those who have already incurred medical expenses of at least $2,000 or have been hospitalized for at least 60 days or satisfy both of these requirements. Such a pattern would invite expensive surgical, hospital, or other services at least up to the qualifying deductible levels, further strengthening extremes of high-cost specialism and certainly contributing nothing to improvement of the system.

A Role for the Private Insurance Industry

One of the most contentious subjects in the debates concerns the place of the insurance industry in any new program. A national health insurance, adequately financed through budgeted national funding, would abolish the fiscal "risks" that are the usual basis for private insurance or re-insurance. Whether there is a place in this pattern for the insurance industry—to serve certainly not as carriers of risk but even as claims-takers or fiscal intermediaries—is not a question of logic or necessity but of political tradeoffs. Massive national experience shows that the insurance industry adds billions in cost and distorts sensible patterns of service and expenditure, while contributing little in administration and less in quality and cost control that could not be done at least as well and probably better and at lesser cost by public administration.

Financing

The costs of national health insurance and their financing precipitate endless discussion and dispute, especially when the premises are not first made clear.

In my opinion political debate, but not national interest, is served by pointing to the relatively low demand on the Federal treasury a particular proposal generates while ignoring the fiscal burdens that proposal would leave on State and local governments or on employers, employees, the self-employed, the nonemployed, the medically indigent, and the needy poor. Also, I think that the national interest is not served by criticizing a program that would rely mainly on public financing without referring to the corresponding reductions it would bring to State and local governments and to private financing within the global national costs for medical care (*18*).

Nor are actuaries' estimates the better if they use plus signs generously for increased utilizations, prices, and costs from so-called induced services to be expected for a program but use minus signs ungenerously for reductions that may be reasonably expected from cost controls built into a program proposal. This practice obviously leads to a relative cost overestimate for a program that makes provision for cost controls in comparisons with programs that do not (*20, 21*).

The real problem with respect to incrementalism, as I see it, is in part political, but otherwise it is fiscal and economic. Every major proposal that would involve transfer to the Federal budget of health care costs and expenditures that are presently in the private sector must, of course, be inspected quantitatively. It is not enough to say that a proposal would increase demand on the Federal general revenues. What matters is by how much, net of the amounts by which the Federal Treasury outlays would be reduced for otherwise committed expenditures that would be absorbed by the new proposal, and in relation to the capacity of the expected national budget. If such considerations compel incrementalism, great care must still be taken to devise a design under which the fiscal objective of incrementalism does minimal damage to the objectives of improving the system and controlling costs.

In this connection, I would emphasize that while procrastinating debates about prospective costs continue, prices, costs, expenditures, and inadequacies escalate not merely on crisis levels but toward disaster levels that will invite more drastic proposals than are already before the Congress. Witness the proposal for a salaried public national health service recently espoused from within the American Public Health Association (*22*).

A Better Lifestyle Alternative

I would like to make only passing reference to a newer confusion that has been recently introduced into discussion of national health insurance. It takes the form of proposing that what we need is less emphasis on medical care and more on so-called better lifestyles for health and greater emphasis on preventive services—as though these are real alternatives. Surely we can be of one mind about advocating healthier living styles, controlling occupational and environmental hazards, and favoring wider applications of promising procedures for prevention of accidents, infectious diseases, or of the onset or progress of chronic disease. But we should not act as though we are uninformed of their limited capacities to substitute for medical care in injuries, disease, or disability that cannot yet be prevented.

In light of the views I have been expressing, it must be no surprise that I do not subscribe to the

designs for national health insurance that have been sponsored by former President Nixon, former President Ford, or by past spokesmen for the Department of Health, Education, and Welfare. And it must come as no surprise that instead I advocate the health security program which I believe can serve better—for both the organization and operation of the system and for financing. It proposes a partnership of the private sector to provide health and medical services by all who are qualified to participate and of the public sector to finance those services. The health security program would make all who need care eligible for the services they need without contribution, income, or means tests and without deductibles or co-payments, lest any of these serve to impede receipt of needed care or to ration care by ability to pay. And it would support the improved availability of services through financing that is earmarked for needed new resources, for organizational improvements, and for further development of quality assurances (*23, 24*).

Conclusion

Finally, I can refer to the pride we all take in what is good in our medical care system and to a determination in which we all can share to preserve and nurture what is good. But it seems to me that the good in the present system is not all the good that is needed now and for the future. The health security program that many of us have labored to design can help this system to serve us better, and—with whatever further improvements can be made in the design of that program—I hope it will soon provide the pattern of a national enactment, so that the good in the present system will not continue to be an enemy of a better system for the future.

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