A Government View

The Prepayment Challenge

By W. PALMER DEARING, M.D.

BEFORE BEGINNING a discussion of the prepayment challenge from the viewpoint of a Government official, it may be well to recall that in the United States all of us are the Government. Any presentation of a Government view, therefore, must undertake to reflect the composite view of all of society, the professions, the consumers, the farmers, the businessmen, and so on. The authoritative interpretation of this view is made by Congress, which finally sets the policies, provides the funds, and reviews the performance of those of us who serve the public.

First, I propose to offer a few comments concerning the current status of health insurance and some of our hopes for the future. Then I will review some of the current Government programs which will affect and, we hope, stimulate the growth and improvement of health insurance.

I think it particularly appropriate to point out that voluntary health insurance has both fiscal and health aspects. Insofar as insurance encourages our citizens to seek medical care early, without financial deterrent, and eliminates worry over medical bills by the sick individual, its fiscal aspect contributes to health improvement. The health aspect, however, needs specific attention if the potential contributions of health insurance to health maintenance and restoration are to be fully realized. This means attention to the type, quality, and efficiency of the health services which are available through insurance. Encouragement of comprehensive care, with proper emphasis on preventive services, and organization of service so that skilled specialty service is available when needed, but without waste, are examples of the health, as distinguished from the fiscal, aspect of insurance.

Dr. Dearing is Deputy Surgeon General of the Public Health Service. His paper was one of a series on prepayment delivered at the Western Conference of Prepaid Medical Service Plans, Sun Valley, Idaho, October 12, 1956.

Characteristics of Prepayment Plans

Turning now to medical service plans in operation, let us note and comment on several aspects as follows:

- Insurance for care of short-term illnesses rather than for major medical expense.
- Simplicity of administration.
- Nursing and convalescent services.
- Preventive services.

First, the benefit structure of present prepayment plans is designed primarily to provide protection against the cost of short-term hospitalized illness, the most frequent cause of unpredictable medical bills.

We need now to break down the problem of medical care costs further, to look at the components of the medical bill, particularly those which involve heavy financial burdens. Urban families, for example, on the average spend only 2 cents of their medical dollar for nursing services in the home or hospital, exclusive of nursing furnished as part of hospitalization. Urban families with large medical bills of $1,000 or more, however, spent, in 1950, 14 cents of their medical dollar for nursing services. Even these averages obscure wide individual variations. Some families spend 66 cents or more of each medical dollar for nursing services. Medical care costs to the individual differ, depending on the nature of the illness, family circumstances, entitlement to care under industrial and

public programs, and other factors. The items which make up the less usual, but frequently catastrophic, medical bill need to be reexamined with a view to providing benefits more nearly in line with medical needs and services.

Despite the brief period in which major medical expense insurance has been offered, more than 5 million people now carry this type of coverage (*1*). Another step toward more complete protection is the extended benefits proposed by Blue Cross-Blue Shield plans. Some of these plans have experimented with limited coverage of care in convalescent homes and chronic illness hospitals, of the cost of expensive drugs and of special duty nursing. A start has been made by prepayment plans toward coverage of dental services. Progress along all these lines is essential.

To meet the needs of the buying public, we also must have an administrative base for broader health insurance offerings. Physician and hospital service plans, for example, have developed methods for joint administration of enrollments and claims. Coverage of nursing home and convalescent care has been worked out within the administrative organization of some Blue Cross plans. If it were possible to extend hospital services to provide special nursing and other auxiliary services in the home as well as in the hospital, we would have a practical base for insuring the costs of these services. This kind of arrangement would not only relieve the hospital of many nonacute long-term patients, it would also be a most valuable aid to the family physician and would reduce the costs of care.

A few hospitals now offer organized home care services. To a considerable extent, these services now are especially adapted to the needs of the indigent patient. A program similar to the home care offered by hospitals, though not necessarily as elaborate, could assist the family physician to care for his patients at home and help include these services in voluntary prepayment arrangements.

Another challenge to voluntary health insurance is the development of preventive health services. This is sound insurance practice as well as beneficial for the health of the subscribers. Well over 150 plans now offer insurance for a wide range of physician services including diagnostic and preventive health services (*2*). These plans, like the Health Insurance Plan of Greater New York and the Permanente and Ross-Loos groups on the west coast, have proved it is feasible and practical to encourage the use of preventive service by insurance. Some of these plans carry on organized health education activities among their membership. Early detection and diagnosis of disease help to ease the burden of heavy medical care bills. Inclusion of diagnostic laboratory and X-ray services helps to encourage prompt attention to illness and early treatment.

Insurance carriers and the personnel who provide health services share with public health agencies the responsibility for preventive health activities. They also desire the development of health facilities and resources and their effective use for improving patient care. Some prepaid medical care plans now use the immunization, laboratory, and other services of public health departments, but many are not even aware of them. And there is also joint responsibility for health education of the public and for the development of new public health measures. We look to prepaid medical care plans for assistance in improving public health services so that they may better meet their own needs as well as those of the public generally.

Stimulating Voluntary Insurance

Now, let us turn to some of the things the Government is doing which will affect and help extend and improve voluntary medical service insurance.

One of the major health goals of the Administration is to help encourage and strengthen voluntary health insurance. Accordingly, the Administration has urged legislation which would authorize Federal reinsurance to stimulate improved coverage and expanded protection for more people. It has also sought legislation to permit small insurance carriers to pool or share their risks in developing better protection.

The Federal Government has acted in another respect to stimulate the development of sound voluntary health insurance. People have suffered from misleading advertisements, cancellation clauses buried in policies, special

riders providing for various types of exclusions, and limitations that policyholders did not understand when they paid their premiums. Action has been taken by the Federal Trade Commission during the past 2 years to correct misleading advertising. Under this stimulus, insurance companies are examining the fine print in their contracts and improving their practices from the viewpoint of the consumer.

In addition to these roles of stimulation and regulation, the Federal Government has embarked on other programs designed to improve medical services for the American people. Among these are medical research, aid to States and communities in the construction of health facilities, fellowship and training programs to relieve shortages of professional manpower, and factfinding and analysis relating to health problems, needs, and resources. In addition, the Government is working with hospital, nursing, and other groups to explore methods of reducing the costs of care. And finally, the Government is developing new methods of providing coverage for special groups such as members of the armed forces and their dependents and Federal civilian employees.

Several of the programs mentioned are new or have been recently expanded. Congressional appropriations for medical research funds were increased markedly in 1956. About half of the total national budget for medical research is financed by Federal funds, mostly distributed as grants to universities, medical schools, hospitals, and other nongovernment research institutions.

Medical research has already paid enormous dividends in reduced costs of institutional care. The savings that have accrued as a result of the discovery of antibiotics, for example, can hardly be estimated. Although it was only a short time ago, relatively few remember the exorbitant costs of care for chronic osteomyelitis, or for chronic bladder infection, or for the paretic patient. On every hand, research has paid dividends far beyond its cost.

At the same time, application of research results changes the pattern and the cost of the service which voluntary insurance undertakes to provide. Early ambulation and better control of infection shorten the period of treatment but increase the per diem cost of hospital care as compared with the days of long convalescence with little need for expensive procedures and drugs.

The local-State-Federal program of hospital construction was broadened 2 years ago to include Federal aid in the building of chronic disease hospitals, nursing homes, diagnostic and treatment centers, and rehabilitation facilities. This program encourages flexibility in community health planning and more efficient use of manpower and resources. At the request of the Administration, this program was extended in 1956 for an additional 2 years.

Congress, also in 1956, enacted legislation to provide financial aid for the construction of medical research facilities. The Administration's recommendation for aid in the construction of medical training facilities, however, was not enacted. The Secretary of Health, Education, and Welfare has stated that the Administration will continue to press for legislation to authorize grants for teaching facilities so that the supply of badly needed research scientists and physicians may be increased.

Congress, at the recommendation of the Administration, in 1956, also authorized a program of traineeships for professional public health workers and for graduate nurses, to help prepare more nurses for supervisory and teaching positions. This legislation, in addition, authorized grants to the States for the extension of practical nurse training. The funds appropriated for the National Institutes of Health of the Public Health Service furthermore will permit a substantial expansion of fellowships and traineeships to promising young research scientists and physicians throughout the country.

Better Use of Facilities

In working toward reducing the practical barriers to medical services we need to look toward a more rational utilization of facilities and personnel, with patients cared for in the facilities appropriate to their illness. Wider use of home care, outpatient facilities, and nursing homes offers great promise, both as a method of improving the use of health manpower and facilities and of reducing the cost of care. We also need to study such innovations as the

"minimal care unit," the "hospital hotel," and the "day hospital" for the care of patients during that portion of the 24 hours when families are unable to provide care.

The Department of Health, Education, and Welfare, in September 1956, initiated a cooperative study of various types of hospital units to develop recommendations on the organization of facilities more closely related to the specific needs of patients. To assist in this task, the Secretary has appointed an advisory committee composed of physicians, hospital administrators, and nurses. Dr. Russell Nelson of Johns Hopkins University is chairman. The primary objective of the committee is to help hospitals improve care and reduce costs, particularly for patients who need only limited services. The committee, in addition, may wish to consider the problem of extension of extramural hospital services as a base for insurance against the costs of special nursing and other auxiliary health services in the home.

There are longstanding programs for complete care of personnel of the uniformed services and medical benefits for civilian employees injured at work. Care has also been provided for dependents of uniformed personnel but only to the extent that facilities of the particular service are available. Modern industrial health care for civilian employees, however, is provided only on a limited basis. The Administration's proposals for a voluntary health insurance plan for Federal employees, participated in by the Government as an employer, have not been enacted into law.

The most significant action in the field of health care for Government employees is the dependent care law, which will make full use of the Government's plant by opening hospitals and outpatient clinics of any uniformed service to dependents of any other. It will also remove discrimination against the estimated 800,000 dependents to whom suitable service facilities are not available by authorizing payment for hospitalization and medical care for hospitalized illness of dependents by nongovernment physicians in nongovernment hospitals.

Since 1950, the Federal Government has participated in the financing of direct vendor payments for medical care of recipients of assistance under the Federal-State welfare programs. A new program enacted in 1956 authorizes a special earmarked grant for medical care for these recipients. The program will facilitate more adequate payments to hospitals, physicians, and other personnel for services to the indigent and thus have an impact on health insurance financing.

Health Status Survey

Finally, the Federal Government has an important role in collecting information on the extent of sickness and disability and of the use of health services. These are the facts with which voluntary health insurance plans must work in expanding and extending protection. The 84th Congress provided for a continuing national survey of sickness and disability to provide comprehensive information on national health problems. In carrying out this program, it is essential that the needs of prepaid medical care plans be taken into account. The active cooperation of voluntary plans will improve the usefulness and value of the survey. Advisory committees now being set up will assure that the data will be of maximum benefit to various groups.

The national survey will yield current information on the health status of the general population. For factual data on the special groups covered under individual health insurance plans, more information should be obtained by the prepayment plans. Much of the information now gathered is not brought together. Much of what is compiled is not comparable from plan to plan. These specific data would be helpful in planning broadened coverage and in reviewing administrative organization.

Consideration should be given to an expanded research program on the economics of medical care. Establishment by the Blue Cross-Blue Shield plans of a clearinghouse for information about utilization and costs would stimulate greater uniformity in data collection and would be an important step toward improving our knowledge of the problems to be solved.

Great progress has been made and is in prospect to improve prepaid medical care and to help more American families budget against the costs of care. All of us have a stake in this job. All of us are faced with the challenge.

It will take the combined efforts of the health professions, of insurance plans, of industry and labor, and of Government to carry us closer to the goals.

REFERENCES

(*1*) Health Insurance Council: The extent of voluntary health insurance coverage in the United States; Preliminary report on annual survey as of December 31, 1955. New York, 1956, 15 pp.

(*2*) Brewster, A. W.: Independent plans providing medical care and hospitalization insurance in 1949 in the United States; 1950 survey. Social Security Administration Bureau Memorandum No. 72. Washington, D. C., U. S. Government Printing Office, 1952, 122 pp.

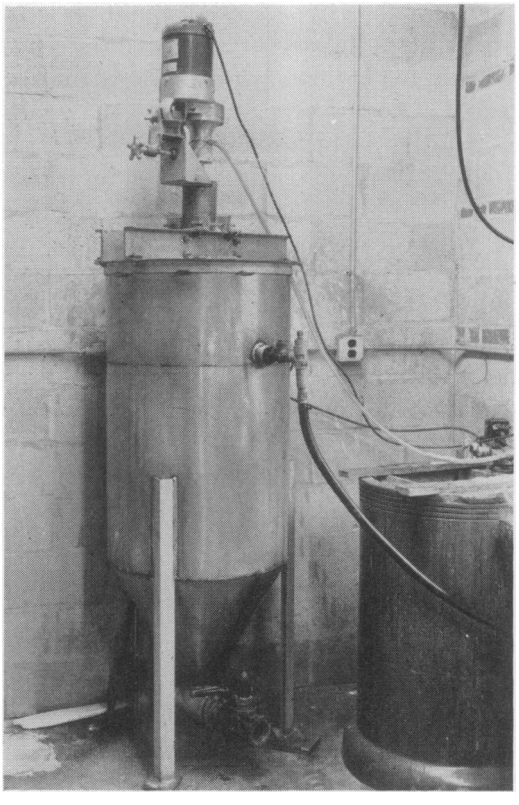
Invention Reduces Fluoridation Cost

A device which will lower the cost of adding fluoride to city water supplies has been developed by two Public Health Service scientists.

The new dissolver makes it possible to use fluorspar, the most inexpensive form of fluoride, which is used in preventing tooth decay. The cost per pound of fluoride ion in fluorspar is 4.3 cents. The cost per pound of fluoride ion in other compounds used in fluoridation ranges from 44.5 cents for hydrofluosilicic acid to 12.5 cents for silicofluoride. In the larger cities, the use of fluorspar can mean substantial savings; the estimated cut in costs for Washington, D. C., for example, is about $50,000 annually.

The apparatus was developed by F. J. Maier, sanitary engineer director, and E. Bellack, both of the Division of Dental Public Health of the Public Health Service. Six months of testing preceded release of the device.

Previously, fluorspar was impractical for use in water supplies, because it does not dissolve readily. When this compound is used in the tanklike dissolver, an alum solution is fed into the device and an agitator keeps the fluorspar in suspension to help the dissolving process. The resulting solution is drawn off and fed into the water system.



Manufacture of the equipment by private industry is expected to begin in the near future.