Coverage, Costs, and Controls in Voluntary Health Insurance

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TWO overriding problems confront voluntary health insurance today: Can group benefit coverage be expanded far enough, fast enough, and at a feasible price to meet, for the majority of employed workers and their families, the rising tide of demand? For those who cannot generally qualify for group insurance, notably the aged, and for whom government is already paying a substantial portion of total medical costs, what will be the future relation between public financing and private medical care programs? Although these problems are obviously interrelated, this paper discusses the first one only.

The central issue of group insurance—which means, primarily but not exclusively, employee insurance—can be summarized as the problem of the "3 C's": coverage, costs, and controls. This bit of shorthand indicates both the challenge and the solution. There are, of course, other important issues. For example, several million workers and their families are denied the benefits of group coverage simply because they work for employers with firms or with profit margins too small to have a systematic employee benefit program. Equity requires that some method be devised for bringing them under the umbrella of insurance protection. This can be done. One approach is already under study by the task force appointed by Governor Rockefeller of New York.

Numerically, however, and in terms of national policy, the overriding issue with respect to employee insurance is whether benefit coverage can be expanded far enough and fast enough, at a price which the average employer or employee, or both, are willing to pay, to prevent the mass purchasers of group insurance from following the lead of the aged and turning to the government for assistance. If so, how?

In the attempt to answer these questions, we shall review briefly the present state of the "3 C's."

Challenge of "Comprehensive" Coverage

What is the situation with respect to current levels of health insurance benefits? How well founded is the insistent demand for more? The most important single fact is that, after a decade and a half of continual pressure and tremendous activity on all fronts, health insurance is still meeting on the average less than one-fourth of our private medical care bills (the costs of physicians' services, dental care, nursing care, hospitalization, drugs, and appliances), whether measured in terms of total private expenditures for the Nation as a whole or total expenditures of insured families. These are disappointing statistics. Unfortunately, however, they are well documented.

The ratio of total health insurance benefits

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to total private expenditures for medical care (including the net cost of insurance) in 1958 was 23.6 percent (table 1). In that year, according to the Health Information Foundation and the National Opinion Research Center (HIF–NORC), insurance benefits averaged 24 percent of the total costs of insured families (*1*). In 1953, the ratio was 19 percent. The improvement has been much less than the frequent rises in insurance premiums would suggest.

The most disappointing fact, probably more significant than the actual current figures, is the recent slowdown in the rate of improvement. From 1948 to 1954, the benefit-expenditure ratio rose 10.5 percentage points, well over 100 percent. But from 1954 to 1958, the increase was only 5.2 points, or only 28 percent. While we cannot expect a constant progression in rates of increase, the relatively sharp falloff from what is still a small percentage base suggests a decline in the dynamism of expansion.

With respect to hospitalization alone, insurance coverage is, of course, far more adequate. Among insured individuals who actually received some hospital benefits, insurance appears to be meeting 80 percent or more of their hospital charges. And yet it must come as a shock to realize that only a little more than half of the Nation's total private hospital bill is met through insurance. Even in this area, where the most progress has been made, we appear to be reaching a plateau. In 1958, for the first time, there was virtually no increase, less than 1 percentage point, over the previous year.

Some advance is still being made with respect to benefits for physicians' services—there was an improvement of 1.6 percentage points between 1957 and 1958—but, in general, it seems that the drive for comprehensive coverage, about which so much is heard, is at the moment largely confined to rhetoric.

There are two major reasons for this situation: A much larger proportion of the consumer's medical dollar goes for uninsured types of medical care than we used to think, and most of the quantitative gains in benefit coverage in

Table 1. Amount of private expenditures for medical care and percent met by voluntary health insurance, selected years, 1948–58

Year	Total medical care expenditures		Hospital services [1]		Physicians' services [2]	
	Amount (in millions)	Percent met by insurance	Amount (in millions)	Percent met by insurance	Amount (in millions)	Percent met by insurance
	Net cost of insurance excluded					
1948	$7,391	8.2	$1,689	26.9	$2,360	6.4
1950	8,346	11.9	2,126	32.0	2,462	12.7
1952	9,709	16.5	2,602	41.3	2,702	19.6
1954	11,267	19.3	3,167	45.5	3,162	23.3
1956	13,679	22.0	3,905	51.8	3,590	27.7
1957	14,683	23.7	4,221	54.6	3,831	30.5
1958	15,777	24.6	4,761	54.4	4,011	32.1
	Net cost of insurance included					
1948	$7,647	7.9	$1,881	24.2	$2,424	6.2
1950	8,645	11.5	2,315	29.4	2,572	12.1
1952	10,098	15.9	2,834	37.9	2,859	18.5
1954	11,844	18.4	3,492	41.3	3,414	21.6
1956	14,288	21.1	4,251	47.6	3,853	25.8
1957	15,353	22.6	4,596	50.1	4,125	28.4
1958	16,397	23.6	5,102	50.8	4,290	30.0

[1] Includes hospital outpatient services.
[2] Includes some payments for services of nurses, dentists, and laboratories.
SOURCE: Derived from *Social Security Bulletin*, December 1959, table 7, p. 9.

the areas already generally insured, especially hospitalization, have been canceled out by the steady rise in costs. In the face of this dilemma, insurance negotiators and administrators are earnestly searching for ways of satisfying the insistent demand for broadened coverage which may circumvent the erosion of rising costs.

There are numerous encouraging experiments directed toward a change in the typical pattern of benefits so as to cover a larger segment of the total family medical care budget. Major efforts to achieve comprehensive coverage on a general basis have been made by the "comprehensive" prepayment group practice plans and by the insurance companies in their "comprehensive" major medical policies. Several million persons are enrolled under each of these experimental forms.

Thus far, we know practically nothing as to the actual effect of comprehensive major medical insurance on the benefit-expenditure ratio. The current study being made by the Columbia University School of Public Health and Administrative Medicine for the labor-management financed Foundation on Employee Health, Medical Care and Welfare—a comparative survey of four kinds of coverage including the GE–Metropolitan major medical plan—should throw some light on the comparative value of this type of insurance.

We already know, however, as a result of the work of HIF and NORC, what happens to the average benefit-expenditure ratio under a leading closed-panel plan, the Health Insurance Plan of Greater New York (HIP) and under a comprehensive prepayment plan with free choice, Group Health Insurance (GHI) of New York City (*2*). It came as a considerable surprise to many advocates of these types of organizations to discover that they covered only a little over one-third of their enrollees' total medical costs.

On the other hand, their record with respect to the insured portions of medical expense was excellent, especially in the case of HIP. This plan, together with Blue Cross, met 88 percent of the subscribers' average hospital costs and 92 percent of surgical costs. HIP covered 80 percent of the cost of all physicians' services; GHI, 59 percent.

The real surprise in this study is not the fact that drugs, dentistry, and other generally uninsured services pull down the overall benefit-expenditure ratio, but the extent to which they do so. The explanation for this phenomenon is complex and points up the extreme difficulty of achieving anything like comprehensive coverage. The fact that insured people utilize more medical care, including uninsured care, than uninsured people is now generally acknowledged. Less recognized is the effect of different types of insurance coverage on the distribution of family medical costs. This is clearly indicated in table 2 based on six separate surveys made by HIF–NORC between 1953 and 1957. The cost of physicians' services as a whole constitutes a relatively stable portion of the consumer's average medical dollar,

Table 2. Percentage distribution of total expenditures for medical care, by category of service, from various surveys of the Health Information Foundation and the National Opinion Research Center [1]

Service	Group Health Insurance (1957)	Health Insurance Plan (1957)	Birmingham Blue Cross-Blue Shield (1953)	Boston Blue Cross-Blue Shield (1953)	Aetna (1953)	Nationwide insured (1953)
Hospital	19	9	18	23	24	21
Physician	32	[2] 33	35	31	34	38
Surgery	8	4	8	8	8	8
Obstetrics	2	1	4	4	5	4
Other	21	28	23	20	21	26
Drugs	21	26	20	17	16	14
Dentist	20	26	16	19	18	17
Other	8	6	10	10	8	12

[1] Percentages do not always add exactly to 100 percent or to the sum of their components because of rounding.
[2] Based on unit charges to GHI subscribers.

SOURCE: Derived from reference 2, table 6, p. 21.

roughly one-third. By contrast, there is wide variation in the hospital, drug, and (to a lesser extent) dental components, as well as in the surgical and obstetrical portions of physicians' services. HIP represents the extreme of this variation, with hospital care accounting for only 9 percent of total expenditures compared with 18 to 24 percent under other types of insurance, whereas drugs and dental care each took 26 percent.

One could long speculate on all the implications of these fascinating data. Here we are concerned primarily with three separate but related facts which bear intimately on the drive for comprehensive coverage: (*a*) the urgent need for insurance of drug and dental costs in addition to the generally recognized need for coverage of regular physicians' care; (*b*) the potentially high cost of insuring these two items in view of the demonstrated elasticity of demand; and (*c*) the possibility of paying for at least part of the additional cost by savings in hospital and surgical expenses.

Several insurance companies and prepayment plans are already experimenting in these areas. Dental insurance got off to a slow start, but a breakthrough in that area may be imminent. Between 1958 and 1960, the number of prepaid dental schemes is reported to have doubled (*3*). This year some 200 plans are said to be operating, and the number of enrollees with comprehensive dental benefits has climbed to half a million or more.

The phenomenal rise in the use of drugs, even without insurance coverage, is enough to frighten the boldest actuary. And yet, here too, insurance history is being made. Most major medical policies now cover prescriptions; evaluation of this experience is urgently needed. Also, alongside the prevailing pattern of continuous increase in the use of drugs, a few modest experiments appear to indicate that they can be controlled and insured for reasonable premiums.

Group Health Cooperative (GHC) of Seattle, Wash., for example, covers in its regular prepayment plan most prescribed drugs except insulin, other hormones, and vitamins (unless there is a clinical diagnosis of a vitamin deficiency) for each separate condition for up to a year. In 1959, GHC reported an average of 3½ prescriptions per year per covered member and a total annual cost per member of $4.99. Contrast this figure with the $36 spent by the average HIP member for noninsured drugs in 1957! Despite the limitations in GHC drug coverage, the difference remains startling.

The key to this low cost, according to GHC officials, is a formulary which provides a limited number of products, and so avoids duplications and prescribing by brand name. The problem of avoiding wasteful duplication in drug manufacture without discouraging new research is difficult, but an increasing number of pharmaceutical leaders as well as physicians and consumers appear convinced that something will have to be done if government regulation of drug prices is to be avoided.

If substantial coverage of these two areas could be achieved in the next few years, a significant breakthrough toward meaningful comprehensive coverage could be achieved and a substantial victory chalked up for voluntary health insurance. But it will not be enough to insure final victory. This will require close and perhaps painful attention to the problem of costs, both in the newly insured areas and in the more traditional fields of hospital and surgical services.

Threat of Rising Medical Costs

The dramatic rise in the costs of medical care is well known. However measured—on the basis of national, per capita, or unit costs, in current or constant dollars, considering only medical services or all medical items, over the long run or the short run, as a proportion of gross national product or of personal disposable income—the rise has been far greater than for the cost of living as a whole. For example, average per capita expenditures for personal medical care increased more than 80 percent between 1948 and 1958. As a proportion of disposable personal income this represents a rise of 30 percent in 10 years.

In part this was due to increased use of medical goods and services. Our calculations, based on Department of Commerce and Social Security Administration expenditure data, indicate that utilization rose about 27 percent during this period (*4*). To a larger degree, however, the rise is attributable to a 43 percent advance

in medical prices, which were spiraling upward far more rapidly than other prices. Indeed the most disturbing aspect of the price rise is its acceleration and the increasing disparity with general price trends. Between 1947–49 and 1959, medical care prices rose twice as much as the general cost of living. But during the last year, 1958–59, when general prices rose less than 1 percent, medical prices continued their lively pace with an increase of more than 4 percent.

This persistent rise is the major factor in the ever-increasing loss ratios of which all carriers and plans complain and in the extreme financial difficulties of many Blue Cross plans. It threatens both the comprehensive major medical and comprehensive prepayment plans with retrenchment, at a time when both should be expanding, and has generally made it more difficult to expand benefits, not to mention being a major cause for increasing government intervention in the problem of the aged. For all these reasons many experts feel that costs have become the greatest single issue facing voluntary health insurance today.

Not everyone agrees with this view. Some take the position that there really is no cost crisis as yet—at least so far as group insurance is concerned. In spite of all the rate increases, they say, health insurance still represents an insignificant item in industry's overall budget, perhaps no more than 2 to 3 percent of total labor costs, and less than pensions. Furthermore, they say, as costs rise, it simply means that employees will take a little less of their next pay increase in the form of direct wages and a little more in the form of medical benefits. And since the total cost can be spread so easily and painlessly throughout the consuming public, so runs the argument, nobody really has to worry.

Indeed there seems little doubt that Americans are destined to, and probably should, spend more than they now do for medical care. Not only is scientific advance making more and better health protection available, but rising living and educational standards and the aging of the population are making the demand larger and inexorable. A greater proportion of the gross national product and the corporate dollar for this purpose could easily be justified.

But if the price of medical care continues to rise at its current rate of 4 percent a year, and health insurance even faster as it must to keep up with the greater rise in hospital prices, still the major component in insurance benefit payments, then we may find that all the additional money is absorbed in maintaining the present level of benefits. In fact, premiums could continue to rise substantially while benefits actually decline.

Moreover, there are increasing indications that management and labor really are concerned about the cost problem. An example is the high-level National Conference on the Rising Costs of Medical and Hospital Care, held at Arden House, Harriman, N.Y., in March 1960 under the sponsorship of the Foundation on Employee Health, Medical Care and Welfare. Another is the new steelworkers' agreement. The steel employers have agreed to pay the full cost of their employees' health insurance, but there is a unique clause which permits management to deduct any rises in the cost of insurance from cost-of-living escalator raises which the workers would otherwise get. This should have the effect of making the individual worker extremely conscious of, and probably resentful of, any future rises in health insurance costs.

The price of health insurance is primarily, of course, a problem of medical, not insurance, prices. In 1958, the net costs of all health insurance amounted to less than 4 percent of the total private medical bill and about 14 percent of total premiums (*5*). The fact is that group health insurance has become largely a "cost plus" operation, and when we talk about the rise in cost of health insurance we are inevitably talking about the rise in cost of medical care.

The matter is not quite that simple, however. It is increasingly recognized that the presence of insurance is not a neutral force in the medical marketplace however much its proponents may wish it to be so. The influence of various types of insurance on subscriber utilization and expenditures has frequently been noted. Consider, for example, the effect of the HIP type of coverage in reducing hospital use and, therefore, costs (*6*). Blue Cross of Philadelphia has found that hospital use is consistently higher

for subscribers with Blue Shield medical and surgical coverage (*7*). At one point, before it undertook necessary reforms, the United Mine Workers medical care program faced financial disaster, so great was the increase in the costs of hospital and surgical services by its beneficiaries (*8*).

It seems clear that health insurance, originally designed to ease problems of medical costs, has actually contributed, by its effect on utilization and on prices in a scarcity market, to intensification of the problem. This is not to deny, in any way, the great good which insurance has already accomplished. However, if it is to continue to play a constructive role in the easing of medical costs for consumers and in the stabilization of income for producers, it must acknowledge, more forthrightly than heretofore, its influence on costs and be prepared to accept the corollary responsibilities.

Administrative Controls

Fortunately, the same insurance mechanism which has aggravated the cost problem also appears to contain the possibility for an equitable solution: an administrative mechanism for reconciling the three great objectives of economy, quality, and free choice.

As already indicated, the closed panel is one reasonably effective method of controlling some forms of medical cost. The HIP record, for example, which, even in this decade of inflation, has not raised its premiums since 1953, is impressive. This fact, made possible by the plan's capitation method of payment to affiliated groups, has undoubtedly resulted in some hardship to individual doctors, especially the best and most dedicated of them. But in the general shortage of medical personnel, it is not likely that it could have held together an organization of 1,000 physicians, with the reputation they have established, if any inordinate economic sacrifice had been required. The HIP experience, of course, is not definitive; not all closed-panel plans have such a record.

It is not necessary, however, to confine the discussion to closed-panel practice. There are examples of effective cost controls among doctors in solo fee-for-service practice. Among those that come readily to mind are the San Joaquin County (Calif.) Foundation for Medical Care and two Canadian plans, Windsor Medical Services and the Saskatchewan Swift Current program. Let us sketch briefly the functioning of the San Joaquin program.

The foundation is not a carrier. It is the brainchild and a legal subdivision of the San Joaquin Medical Society. It was organized in 1954 partly as a countermeasure to the success of the Kaiser Foundation Health Plan. Its officers are appointed by the county society, and it is housed in the same building as the society in Stockton. The relations between the foundation and the society could hardly be closer. Nevertheless, in practice as well as in philosophy, it has construed its role as a protector of consumer interests as well as those of the physicians.

The functions of the foundation include the setting of benefit standards for all policies marketed as foundation approved, the review and payment of claims, and the establishment of maximum fee schedules for physicians' services. The actual underwriting and sale of policies is left to insurance companies which are willing to accept the foundation's liberal benefit standards and vigorous claims procedures.

Participating physicians, about 98 percent of all in the county, practice on a solo fee-for-service basis, but they agree to accept the foundation's fee schedules as full payment, thus guaranteeing service benefits and certainty-of-costs to the insured and eliminating the whole problem of income limits which plagues Blue Shield. The physicians must reapply annually for membership.

The key to the foundation's control is its insistence on handling all claims itself. Each one receives a twofold review—a contractual review by specially trained clerks and a medical review by a rotating committee of physicians who give an hour a week to this work and who, as members of a committee of the county medical society, have the authority to call up a colleague and insist on an adjustment, if necessary. This review is directed as much at the quality of care as the price. It represents an extension of the principle of internal medical audit, familiar to most accredited hospital staffs, to outpatient care. The results, according to foundation officials, are generally educational rather than

disciplinary. But enough discipline has been applied, including refusal to readmit one physician, to act as a powerful influence on the whole program. The San Joaquin experiment has received the compliment of imitation by 13 other California counties.

Another illustration, from the hospital insurance field, is Blue Cross of Philadelphia. This plan, one of the oldest and largest of the Blue Cross group, has experimented over the years with numerous institutional devices for exercising some discipline over the rising costs of hospital care and hence its own subscription rates. One is a negotiated hospital reimbursement formula, which does not pay on the basis of the individual hospital's costs or charges, however discounted, nor on the basis of a flat community rate, as was done originally. The present formula is a complex one which attempts to incorporate the best features of all these approaches. Its aim is to build in incentives for more efficient hospital operation by rewarding, within limits, the more efficient institutions and penalizing the less efficient.

One especially interesting feature divides the affiliated hospitals into 10 categories according to their patients' average length of stay and then adds within these categories differential payments, varying from 200 percent of the basic rate for the first day to 75 percent for all days over the average in the appropriate category. The purpose is to create a financial incentive for the hospitals to discharge patients as soon as possible. To try to cut down possible misuse of hospital services by consumers, this plan has also introduced a deductible contract, outpatient diagnostic benefits (now carried by about 60 percent of the enrollees), and visiting nurse services for older subscribers.

In 1958, a physicians' review board was created with the backing of the Philadelphia County Medical Society to check on practices of physicians that might lead to unnecessary admissions, overuse of ancillary services, and unnecessarily prolonged stays. The board is composed of 34 outstanding local doctors, with a leading surgeon and an internist as co-chairmen and an advisory council of six which includes such eminent men as Dr. I. S. Ravdin and Dr. John H. Gibbon, Jr. The doctors, divided into seven groups, are continuously engaged in review of hospital records. The plan's new electronic equipment makes these available in detail for every case admitted to every hospital.

It is impossible to measure precisely the results of these various efforts at cost regulation. They have certainly not produced anything like a price freeze. They were not intended to do so. Two large rate increases took place in Philadelphia in 1958 and 1959 to the accompaniment of widespread consumer objections, public hearings, and an adjudication by the insurance commissioner which has become part of health insurance history (*9*). The point is to illustrate that measures are available for exercising some discipline over medical care costs, even hospital costs. As a result, all the plans cited have been able to maintain service benefits and assured coverage for their enrollees, even the repetitively ill and other high-cost risks.

The cases mentioned are, of course, conspicuous exceptions to the general policy of laissez faire—of allowing the seller to charge what he will. Indeed, even these plans have encountered bitter opposition. A portentous policy conflict is currently taking place in Philadelphia over the Blue Cross reimbursement formula. In 1959, about half the affiliated hospitals refused to renew the existing contract. This issue is currently being investigated, at the request of Blue Cross and most of the hospitals, by a committee of the American Hospital Association. Meanwhile, eight Catholic institutions served notice, in January 1960, that they would cancel their Blue Cross affiliation on March 31, if their demand for reimbursement based on individual charges was not met.

The nature of their demand, while complicated by secondary factors, goes to the heart of the control issue. They insist that Blue Cross' function is solely to pay the bills of its subscribers. They deny that it should have any favored position on rates, or the right to negotiate terms and conditions, or to check their books, records, or administration.

Blue Cross maintains that capitulation to such a demand would remove incentives to more efficient cost-conscious hospital administration and would inevitably lead to higher hospital rates. This would force a further rise in Blue Cross rates and result in the loss of subscribers. Some of these would switch to indemnity contracts;

others would lose coverage altogether. In either case, the hospitals would have to carry a larger proportion of nonpay or part-pay patients. In brief, the plan maintains that by exercising reasonable protection of subscriber interests through attempts to keep prepayment rates within bounds it is also serving the best interests of the hospitals.

In a statement to the press, the "lay representative" of the disaffiliated hospitals—a Philadelphia insurance broker—accused Philadelphia Blue Cross of a "conflict of interest." The plan is acting in a dual and conflicting capacity, he claims, as a seller of hospital insurance and "as a social agency with power to dictate the administrative procedures of hospitals" (*10*). Herein is the heart of the issue: Overlooking the political hyperbole in such debating terms as "power to dictate," are these two functions really in conflict or are they complementary? Was Philadelphia Blue Cross going beyond its proper function or discharging a necessary duty? Does the plan, which provides about 70 percent of patient-days in Catholic hospitals and serves 70 percent of the city's population, have the responsibility to represent its subscribers as well as the hospitals or not?

Officials of the Philadelphia plan believe that if they can establish this broad authority it will mean a notable victory for the entire voluntary health insurance movement. It will mean that it has the authority to keep its house in order, balance its books, and tackle with some assurance of success the problem of extending benefits. If the authority cannot be established, if the majority of providers and subscribers do not sustain it in this challenge, an important test case for the future of voluntarism will have been lost, including the possibility that the plan may have to abandon its traditional responsibility for the aged. A big step will have been taken toward abdication of responsibility by the voluntary agencies and the likelihood of public intervention.

Many hospital officials, in addition to spokesmen for the Catholic institutions, see the issue quite differently. Addressing the American Hospital Association in 1959, one of Philadelphia's ablest administrators said (*11*):

"Do any of you believe that Blue Cross is better versed in the complexities of hospital administration than trained hospital administrators and that Blue Cross should be given dictatorial powers to compel hospitals to follow their instructions concerning ways and means of operating hospitals more efficiently? . . . If he (Insurance Commissioner of Pennsylvania) attempts to utilize his alleged power it will drastically limit the control of these hospitals by their administrators and their boards of trustees. The commissioner apparently intends to delegate his policing power to the several Blue Cross plans of this State."

In this view, opposition to controls apparently extends to any form of "outside interference." Supervision by private agencies is condemned in virtually the same terms as public regulation.

Discussion

In summary, there are two trends which, if allowed to continue unchecked, seem to threaten the future of voluntary health insurance. These are the slowdown in the rate of improvement in benefit coverage and the persistent rise in the costs of medical care.

Potentially, ways to offset both these trends are available—partly through the extension of insurance to the major uncovered areas of medical costs, especially outpatient physicians' services, dental care, and drugs; and partly through the voluntary application of cost controls, preferably by the vendors themselves but, if that proves unfeasible, by the health insurance carrier or plan. The first of these developments is likely to come about more or less automatically; the major problem here is speed. The second, however, requires a conscious policy decision on the part of the major interest groups with a stake in voluntary health insurance.

The argument for private health insurance rests primarily on the presumably greater ability of private management to consider equitably all the interests in question, to design local solutions to local problems, and to combine resilience with toughness, as circumstances require. If health insurance is to be purely a fiscal operation, a mechanism for converting premium dollars into automatic payments to the vendors at whatever price they set, or into simple indemnity payments to the insured, it is

hard to see why the government cannot do it as well and at less expense. Here, it seems, is the real challenge to the survival of voluntary health insurance today. Are the providers of care willing to merge their separate interests sufficiently to permit the development of this type of private leadership and aggressive management?

It is a truism in this country that the government is generally permitted to do only what private enterprise cannot or will not do satisfactorily. The initiative still rests with the voluntary movement. But it may not indefinitely. It is inescapable that public financing, in one form or another, will increase in the medical care field. That the government will continue the trend toward meeting all or part of the costs of certain categories of prolonged illness and certain categories of high-cost, low-income patients is a settled issue.

There are, however, at least two big questions which are far from settled. One involves the future boundaries of public financing; the other, the relationship between public financing and private administration. At this particular juncture of affairs, one would expect the medical profession and the health services industry as a whole to be enormously concerned with strengthening the voluntary institutions, not only to make sure that they can discharge their own responsibilities effectively, but in order to enable them to play a responsible role in the administration of the new public programs.

This cannot be accomplished without responsible, community-conscious leadership and strong management. It also calls for determined support from the majority of the providers and consumers of medical care. The ability of voluntary health insurance to meet successfully the challenge of the "3 C's"—coverage, costs, and controls—and hence insure its own survival, will probably be determined as much by the leaders of the medical profession and other health services as by the plans and carriers themselves.

NOTE: Since this paper was written, the two Blue Cross disputes have been at least temporarily resolved. A fact-finding committee of the American Hospital Association recommended that the Philadelphia reimbursement contract be based on the "full and equitable audited cost of each individual hospital." Reluctantly, the plan agreed "in principle" and the new contract is being hammered out with the 37 hospitals involved. In late September Blue Cross and the eight Catholic institutions reached a compromise settlement calling for reimbursement to the hospitals on the basis of uniform charges, agreed to among themselves, thus avoiding Blue Cross or other external audit. However, they accepted a ceiling, $24 per patient-day until December 31, 1961, guaranteeing that they will not receive more than Blue Cross pays to other hospitals of like size and character.

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Program Notes

Prepay Pharmacy

In San Jose, Calif., the bricklayers' union with 600 members is participating in a test run of group insurance for prescription drug costs, along with local members of the California Pharmaceutical Association, representing retail druggists, and the Pacific National Life Assurance Company of San Francisco. Encouragement and unofficial cooperation have come from members of the Santa Clara County Medical Society. Premium for the coverage is $1 monthly per family, paid by the union's health and welfare fund to the insurance company. Prescriptions are filled at a participating pharmacy which sends a copy of the prescription and bill, at the going retail rate, to Prescription Service, Inc. This service checks the legitimacy of the claim, and forwards approved bills to the insurance company which pays the druggist directly.

Self-Care Patients

A do-it-yourself wing, with cutrate prices, has been established at the Overlook Hospital in Summit, N.J., for patients able to care for themselves. The patients, who pay half of the regular $20 to $28 daily hospital charge, wear street clothes, eat in the hospital cafeteria, and visit nurses' stations for medication. Two nurses attend the patients in this wing, instead of the five nurses who usually attend a comparable area.

Nonprofit Drug Stores

Plans of nine New York City unions to set up a chain of nonprofit cutrate drug stores for their 900,000 members and families are opposed by six associations speaking for 3,400 retail druggists and by the Drug and Hospital Employees Union representing their registered pharmacists and clerks. The New York Retail Druggists Association claims that the manufacturers' profit after taxes ran from 6.5 percent to 16.8 percent compared with 2.8 percent for retailers. Unions could lower drug prices more effectively by investing in their own drug factory, advised Leon J. Davis, president of Local 1199, Drug and Hospital Employees Union. The pharmacists asked Mayor Wagner to form a permanent pharmaceutical service committee to explore ways of lowering drug costs without putting retailers out of business. The Nassau Physicians Guild questioned the quality of the drugs that would be provided in the union nonprofit drug stores. A board made up of professors of pharmacology would supervise quality standards of the union drug stores.

Alcohol and Ataraxics

A combination of a small amount of alcohol and of the tranquilizer meprobamate can make a person too intoxicated to be a safe driver, according to a report in the August 20, 1960, issue of the *Journal of the American Medical Association.*

Lead in Paint

Chicago health authorities plan to recommend passage of an amendment to the Illinois hazardous substance act which would require that paint containing more than 1 percent of lead be so labeled.

Homemaker Services

A task force created by participants of the 1960 Conference on Personal Care in Homemaker Services underscored as personal services a homemaker might perform:

- Helping the patient with bath, care of mouth, skin, and hair, and helping him to bathroom or in using bedpan.
- Helping him in and out of bed, in learning to walk with crutches, and with prescribed exercises.
- Assisting him to regain his speech, relearn household skills, and with eating.
- Preparing a special diet for the patient.
- Applying heating pad or hot water bottle.
- Giving prescribed medicines.
- Giving hypodermics, under some circumstances and if there is no alternative.

Fluoridation Report

Tooth decay among 6-year-old Baltimore school children has decreased 75 percent since 1955, according to a report by Dr. Huntington Williams, Baltimore health commissioner. Dr. Williams attributes this decrease to the fluoridation of the city water supply beginning in 1952.

Benny Traffic Hit

Since the Food and Drug Administration began its drive to curb illegal sales of amphetamine drugs (bennies) to truck drivers and motorists in the fall of 1959, 85 criminal prosecutions have been completed, 31 additional criminal prosecutions have been instituted and are now pending in Federal district courts, and in eight separate actions 1,837,000 tablets and capsules of amphetamine drugs were seized.

Education for the Retarded

The Connecticut State Legislature in 1959 made mandatory public education for both trainable and educable retarded children. It also created an office of mental retardation within the Connecticut State Department of Health.

Nursing School Admissions

Schools of professional and practical nursing admitted an estimated 71,297 new students in 1959, compared with 68,851 in 1958, according to the National League for Nursing.

Ohio Legislation

The Ohio State Legislature in 1959 gave the Ohio Department of Health authority to form a radiation advisory council and to adopt regulations for radiation, prohibited the sale or delivery for sale of any misbranded package of a hazardous substance, and granted funds to enable the division of industrial hygiene to conduct atmospheric research.