The Consumer and Prepaid Medical Care

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PRESIDENT KENNEDY recently said when defining the word "consumer" that "it includes us all." This definition is particularly apt in regard to medical services; indeed, we are all consumers. In my discussion, the consumer is any person who needs or may ever need during his lifetime preventive or therapeutic medical services from a physician, hospital services, rehabilitation, convalescent care, nursing home care, or any other medical or paramedical service.

Responsibility for obtaining the best and all the necessary medical services may be placed respectively or in any combination on the individual, the family provider, the employer, the union officer, the trustee of a consumer cooperative, or a program administrator, whoever is entrusted with this important task. Consumers are confronted with evaluating health insurance plans either when selecting a prepaid medical care program or when seeking to improve their medical insurance plan coverage.

The problems of any situation depend on the goal to be achieved. The goal for every individual should be all the modern scientific medical care available, when and as necessary, without any deterrents because of age, sex, creed, color, or lack of money, and whether employed, unemployed, retired, or disabled. Nothing less should be expected by any person in this nation for himself and for all others. The activities of organized labor and consumer groups in attempting to achieve this goal have been of benefit not only to their members but also to the entire nation. Each individual and organized group therefore should strive for this goal; anything less is inadequate.

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The Problems

Some of the questions which must be considered in order to obtain the broadest and best medical care services are:

1. What types of medical and hospital insurance plans are available in the area?
2. How many dollars are available for premiums?
3. Will the enrollment be on an individual or group basis?
4. How many in the group will be eligible for enrollment?
5. Are dependents as well as the workers covered? (Prebudgeting for the total family medical care assures availability of preventive and other required medical services and, by spreading the cost, causes fewer financial burdens arising from unpredictable medical needs.)
6. Will services both in the hospital and from physicians be completely paid for, or will there be partial indemnification with unpredictable balances to be paid by the insured?
7. Is the medical care comprehensive or limited?
8. What limitations, exclusions, deterrent charges, or deductible expenses may deprive the insured of comprehensive medical care?
9. Do the medical benefits include preventive, diagnostic, therapeutic, and rehabilitative services, or are they fragmented with the accent on inhospital care or diagnostic services only?
10. Does the plan provide physician services in the hospital, in the home, and in their offices, or are they limited to services in the hospital?

11. Do the benefits include prescribed drugs, psychiatric treatment, and dental care?

12. Are the physician services provided by medical group practice teams of general practitioners and specialists selected in accordance with professional standards and organized to provide modern, efficient, highly integrated medical care of high quality in a medical center?

13. Is there an administrator or medical social service counsellor with whom the beneficiaries may discuss problems affecting their health and welfare?

14. Is there a subscribers' health education program which will encourage and assist beneficiaries to make proper use of the medical program?

15. What voice does the beneficiary have in the choice of plan so that the "best" program can be purchased? If the "best" is not available, will it be possible to develop a program for the group or to join with others to develop a community-sponsored plan?

16. Will the benefits continue during periods of unemployment or after retirement?

17. Is there a clause in the contract permitting conversion from group to individual or family coverage when the worker separates from the contracting groups?

One can see from this list of questions that selection of good medical and hospital plans which will provide needed services requires thorough understanding and acceptance of the goal. Since most insurance programs are purchased in behalf of groups, persons entrusted with this important task also must become fully conversant with all the facets and possible flaws of this precious utilitarian necessity to maintain health and to eradicate or alleviate unpredictable illnesses. Advice and guidance should be obtained from persons who have experience in health and welfare programing, and this does not mean one's insurance broker or personal physician.

Available Information

In 1960 private medical expenditures for all medical care, including direct payments by consumers and health insurance benefits, totaled $19.6 billion, or three-fourths of the total national private and public expenditure for health purposes exclusive of research and facilities. This sum represents 5.6 percent of disposable income. It amounts to $109.82 per capita. The total includes $5.3 billion (27 percent) for hospital care, $5.09 billion (26 percent) for physician services, $2 billion (10 percent) for dental care, and $4 billion (20 percent) for drugs and sundries.

The index of medical prices at the end of 1961 compared with 1957, only 4 years apart, increased as follows: (*a*) all medical costs, from 135 to 163; (*b*) hospital daily service charges, from 185 to 247; (*c*) physician fees, from 132 to 151; (*d*) prescriptions and drugs, from 117 to 121; and (*e*) dental services, from 127 to 139.

Of the total U.S. population in 1960, 132 million people (73 percent) were covered by insurance: 73 percent were insured for some hospital care, 67 percent for some surgical benefits, and 48 percent for physician services, mainly inhospital. Total premiums for all insurance were $5.8 billion: $3.8 billion for hospital services and $2.0 billion for physician services. Total benefits paid were $5.0 billion: $3.4 billion for hospital and $1.6 billion for physician services.

Of the total $19.6 billion private medical costs only 25.5 percent was covered by insurance; of this 25.5 percent, 57.5 percent was for hospital benefits and 30 percent for physician benefits. Obviously insurance coverage was inadequate, and when this inadequacy is coupled with unpredictable extra fees both for physician services and for hospital services, there is reason for beneficiaries to criticize their insurance plans and to take steps to obtain more adequate coverage. Comprehensive insurance is particularly important to our ever-increasing number of retired citizens because their income has been sharply reduced and their need for medical attention and hospitalization has increased considerably.

Under the auspices of group practice, for example, in the Health Insurance Plan of Greater New York (HIP), the Kaiser Foundation Health Plans, and the United Mine Workers Welfare and Retirement Fund hospitals, and affiliated medical groups, the number of hospitalizations and operations was reduced, in some instances from 30 to 50 percent, as compared with the rate of hospitalization and sur-

gery under Blue Shield, Blue Cross, and other plans where services are provided by physicians in solo practice. HIP also found that its group practice units had a considerably lower rate of prenatal mortality than the New York City population outside these groups.

Dr. I. S. Falk in a survey for the steelworkers stated: ". . . of the $125–$150 million a year spent for health insurance benefits for the steelworkers and their dependents, some $30–$50 million a year are being used ineffectively and wastefully. . . . The main faults lie with prevalent patterns of medical organization and insurance" (*1*). Practically none of the steelworkers are receiving group-practice medical care.

In 1959 enrollment in independent plans (plans other than Blue Cross, Blue Shield, or those of profit-motivated insurance companies) was 9,876,000, of whom 3,929,000 were in group-practice plans. Of those in group practice plans, 3,837,000, 40 percent of the total membership in independent plans, were insured through industrial plans (unions, employers, or the like). Labor had 3 million of its members in medical groups with services ranging in scope from diagnosis only to comprehensive care.

Premiums and expenditures for hospital and physician services among independent plans were $336.8 million and $318.3 million respectively.

In 1959 there were 1,809 medical groups with 16,500 physicians, an increase of about 300 percent in the previous 14 years; 1,154 of the groups were multispecialty groups, but not all conformed to the concept of a total medical team as described above. The greatest number were in the north central States.

Trends

The following reasons may be cited for the increasing trend toward more group practice:

1. Medicine as a science and technology is becoming more and more complex, far beyond the ability of one physician to encompass. It requires the dovetailing of many different knowledges and skills.

2. The shortage of physicians and paramedical personnel requires the most efficient use of those available.

3. Medical equipment is becoming more complex and costly for hospitals and certainly for the solo physician. There is need, therefore, to decrease duplication and costly waste of money and technicians' skills.

4. The trend is toward full coverage and away from fragmented care. There will be a slow but definite increase in dental and drug benefits under insurance plans.

5. Physicians are beginning to learn that there are greater professional and personal advantages by working in a well-organized group, for themselves and their patients, whether insured or not.

6. Industry and labor are becoming aware of the advantages of group practice for their beneficiaries and are urging the purchase of medical care from medical groups.

7. As labor and other consumer groups obtain more dollars for their health and welfare benefits, the trend will be toward community-sponsored, nonprofit, comprehensive group practice medical service plans such as HIP, the Labor Health Institute in St. Louis, and the Community Health Association in Detroit. If this is not practical or feasible, consumer groups may develop their own plans affiliated with a hospital, as for example, the Group Health Cooperative of Puget Sound in Seattle, the New York Hotel Workers medical plan now being established for its members and dependents in the New York Flower-Fifth Avenue Hospital, and the AFL–CIO hospital now being built in Philadelphia.

8. The number of persons insured under voluntary programs probably will not rise much higher.

9. There will be closer integration of industrial inplant medical services with medical services outside the plants.

REFERENCE

(*1*) Falk, I. S., and Senturia, J. J.: The steelworkers survey their health services—a preliminary report. Am. J. Pub. Health 51: 11–17, January 1961.