Policy Decisions Facing the United States in Financing and Organizing Health Care

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LESS THAN A YEAR has elapsed since the Social Security Amendments of 1965 were passed. It is already evident that this law will go down in history as the most important piece of social legislation enacted in this century after the original Social Security Act of 1935. In the health field alone, the 1965 law can claim to be of first importance. Despite its limitations to the aged and to certain carefully defined categories of needy or medically needy persons, its impact on every aspect of the provision of health or medical care has already been tremendous. Its implementation is making enormous demands on the time and energies and sense of public spirit of the professions concerned, on organized suppliers of health services, on hospitals and other medical institutions, and on governmental agencies.

And yet I venture to suggest that we are only at the beginning of what may well be a revolution in our methods of organizing and financing health services. After a period of digesting what was enacted in 1965, I am convinced that we shall see further action bringing us closer to the achievement of the goal so well stated by the New York Academy of Medicine that "all people have the assurance of an equal opportunity to obtain a high quality of comprehensive health care." As we study the history of social legislation, one fact becomes very clear: If a new policy or program is found to be good, even though initially limited in scope, pressure will be exerted to extend it to other groups or problem areas. And this pressure will not be unduly weakened even if it emerges that a more comprehensive program costs much more than originally thought. If people are satisfied with a program, they are prepared to pay for it. In this respect and this respect only, I find myself on the side of the American Medical Association, which has always asserted that the enactment of even a modest social insurance program would be the thin edge of the wedge of further governmental action. However, we differ in our emotional response to this probability: They tremble and I rejoice.

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Major Policy Issues

While the 1965 legislation will surely be no end but rather a beginning, it is a very important beginning for it embodies policies that are bound to influence future developments for good or bad. We need to be very clear as to what these major policy issues are so that if

change is needed it can be accomplished before it is too late, or if a choice faces us we will be aware of the alternatives and their implications. In fact we have many choices, for the 1965 amendments embody many different, and even conflicting, principles.

Health care as a right or a concession. Perhaps the most crucial of all policy issues concerns the principle on which governmentally financed health services are to be made available to people. Last year we simultaneously adopted two different principles. On the one hand, under Title XVIII (Health Insurance for the Aged) specified health services became available to the aged as a right through the application of the social insurance principle. On the other hand, under Title XIX (Grants to States for Medical Assistance Programs) various categories of needy people will be provided health care on a means test basis. Which of the two approaches do we wish to promote in the future? Shall the social insurance approach continue to be limited to those 65 and over or should it be extended to cover some or all of those under that age? Should efforts be made to broaden the coverage of Title XIX, medical assistance on a means test basis, not only to provide Federal financing for the general-assistance recipients but also progressively to raise the income limits so as to include an ever larger segment of the population?

Comprehensive care or item-by-item provision through government. A second major policy decision is whether governmental financing of health services is to be made available only for specific types of health services on an item-by-item basis or is to cover all care needed by the covered population on a comprehensive basis. Here again two different policies are embodied in the 1965 law. In Title XVIII the item-by-item approach has been adopted. Only so much hospitalization or posthospital institutional treatment will be underwritten by Government. Only certain types of hospital services will be reimbursable. Ambulatory care in hospitals, extended institutional care, drugs provided outside the hospital, dental care, and many other items of normal health care are excluded. Similarly, in Title XVIII–B (Supplementary Medical Insurance Benefits for the Aged) physicians' services are to be financed on an item-by-item basis. In Title XIX, however, in principle, governmental financing is to be available for comprehensive health services although in the first instance the States are required to supply only five broadly defined types of care. As we plan for the future, which of the two principles do we wish to follow?

Respective roles for Federal and State Governments. So far I have discussed only major policy issues and the ends we wish to achieve. But important policy issues are also raised by the methods we have adopted to attain these ends. The first of these concerns the respective roles of the Federal, State, and local governments. Here again we have followed two roads in the 1965 law. On the one hand we have two wholly Federal programs: hospitalization insurance and supplementary medical insurance. For although the State health authorities and private intermediaries collaborate, they do so as agents of the Federal Government, which alone carries final responsibility for financing and policy formation. On the other hand, in medical assistance we have what is essentially a State, or State and local, program, where, although Federal financial participation is substantial with a set of Federal standards that for extensiveness surpasses those of any previous grant-in-aid program, the initiative and, within quite wide limits, the nature and extent of the program rest in the hands of the States.

A major policy question for the future thus is whether to increase the role of the Federal Government or that of the States. And it is a decision that must take account of existing Federal and State responsibilities in health areas other than those affected by the 1965 amendments, where the trend appears to be toward a growing Federal responsibility for construction, research, education, and more recently the treatment of specific diseases.

Role of private enterprise in governmental programs. A second issue raised by the implementing methods we have adopted concerns the role of private enterprise in what are essentially governmental programs. Here again we have started out on two paths. On the one hand, in Title XVIII the legal structure provides for, although it does not require, the use of private intermediaries to perform many of

the administrative functions of the programs. On the other hand, Title XIX makes no provision for intermediaries unless the State decides to "buy into" the supplementary medical insurance for its aged needy persons.

It seems likely that the use of private intermediaries in the social insurance programs was a political concession designed to overcome some of the opposition to Medicare on the part of organized medicine and the profit and nonprofit insurance companies. But what may have been politically expedient to obtain enactment may or may not prove to be socially desirable once a program is established and in operation. Already some serious questions have been raised about this policy decision. As the program moves into operation it will be of the utmost importance to study experience and evaluate the wisdom of using private organizations in the administration of a governmental program.

The private enterprise concept is also evident in the methods adopted for the remuneration of professional personnel. Here, the policy of paying for professional services on the basis of the "reasonable charge for the service rendered" perpetuates the fee-for-service method of payment so dear to our private-enterprise-oriented medical profession. So long as we conceive of the physician as a private enterpriser, selling his services for the best price he can get to whoever can afford to pay for them, the fee-for-service method of payment may make sense. However, one might then wonder what justification there is for governmental action to assure minimum collections, and, if the physician decides to bill the patient directly, to make possible the collection of more when the traffic will bear it. The question that has to be decided in the future is how far this concept of medicine as a private enterprise undertaking is appropriate to a governmentally financed and operated program.

The private enterprise character of the market for health services has also permeated another feature of the insurance programs. The provisions for deductibles and co-insurance, to the extent that they were not inserted as political strategy to keep initial cost down, can only be justified on the assumption that the buyer looks on health services or medical care as he looks on automobiles or any other commodity. If it is cheap he will buy or use more of it, so deductibles and co-insurance are utilized to keep demand to a minimum. Is this parallel exact? Or do we have to recognize that to the buyer health is not like other commodities and that the money barrier of the deductible may prevent some people from seeking care when they need it, especially preventive care or early diagnosis, while co-insurance will still leave some patients with a sizable bill or the unfortunate necessity of foregoing some types of treatment or care.

Administration by health or welfare agencies. A third major policy issue in the implementation of the new programs concerns the allocation of administrative responsibilities among State agencies. Once again two roads have been simultaneously opened. In Title XVIII, the various functions delegated to the States in connection with the social insurances are to be carried out by their departments of health. In Title XIX, the States can designate whatever State agency they wish to administer the program although the determination of financial eligibility must be done by the welfare department. At the Federal level, administrative responsibility for Title XIX is lodged with the Welfare Administration, and the Public Health Service serves only in an advisory and consultative capacity. The question of whether health or welfare agencies shall have administrative responsibility for the enormously important Title XIX programs must not be viewed merely as a struggle for power between two governmental agencies. The decision, as I shall try to show later, has far-reaching consequences for the future development of our health services.

Determinants of Policy

Time does not permit the enumeration of the many policy issues we face. I have chosen five that seem to me to be crucial to the future development of health services. I am no better prepared than anyone else to forecast what answers we shall give 25 years hence. But I am sure that what happens will depend on the importance the American people attach to certain values and objectives. Specifically, I shall try to show how the importance attached to the concepts of health care as a right, to the equality of access to health services, to the high

quality of care, to orderly organization for the provision of health services, and to economy in the use of resources devoted to health will influence our policy decisions, not only on the five major issues as I see them but also on others as well.

Importance attached to health care as a right. In a recent policy statement, the New York Academy of Medicine stated: "The availability of health services, as a matter of human right, should be based on health needs alone, not on a test of ability to pay." This is what the social insurance technique, as opposed to medical assistance, achieves, and it is of the utmost importance that we understand the implications of the two approaches. The essence of social insurance is that whatever benefits are included in the program are made available as a right, subject only to proof of insured status and the existence of the condition calling for health care. The economic status of the claimant at the time he is in need of care is not questioned. Proof of insured status in turn involves the application of the objective tests specified in the law which apply to all covered persons. They typically leave little room for argument or the exercise of official discretion in the individual case.

It is this objective, nondiscretionary method of determining eligibility that accounts for the great popularity of social insurance among our independent self-respecting citizens and that, incidentally, justifies the prevailing terminology. For we always speak of social insurance claimants, whereas those whose eligibility is based on passage of a means or needs test are referred to as applicants, and no one likes to be an applicant.

Still less is the position of the applicant an enviable one when we look at the reality of the means test as it is typically applied in the United States to applicants for public assistance. Detailed reporting of all income and other resources and of expenditure needs; verification of all statements by house visits, confirming reports from relatives, employers, landlords, and often neighbors; coupled with the exercise of wide discretion in the withholding or granting of specific items that are not included in the basic budget and, in far too many instances, the arbitrary application of additional eligibility criteria relating to the behavior of the applicant: All these explain why the means test as the door to social services is so heartily detested, not only by those who have to undergo it but also by all observers of the effect on human dignity and morale of submission to this kind of treatment.

It is true that the 1965 legislation contains a number of provisions designed to make the needs test, as applied to eligibility for medical assistance, less offensive and deterrent. The responsibility of relatives has been greatly narrowed. Only resources actually available rather than presumably available are to be considered. Arbitrary income limits that would exclude people, regardless of the size of their medical bills, have been ruled out. Resources must be "reasonably" evaluated. Furthermore, the Federal Welfare Administration is urging the States to simplify the needs test and the verification process. And in theory there is no legal barrier that would prevent a State which so desired from setting very high income limits, using income tax returns or simple affidavits for verification purposes, and with predetermined eligibility wherever possible, in effect, turning its Title XIX program into a full-fledged State health service, available to practically everyone. It could do this and still claim Federal matching for all those whose age, family composition, or physical disabilities identified them as persons who but for the size of their incomes would be eligible for federally aided, categorical public assistance.

I emphasize "in theory," for it is highly unlikely that this would happen on any large scale. However, if there are no further extensions of the social insurance principle to other age groups, we are likely to see very extensive liberalization of medical assistance in this direction in some of our wealthier and more progressive States in the next few years. Realistically, we must expect that for the vast majority of States the means test for health care, apart from the statutory restrictions already referred to, will be administered in a manner and spirit not very different from that applied to the applicant for public assistance.

This is the more likely in view of the unfortunate provision in the 1965 amendments

to the Social Security Act that the financial eligibility requirements must be administered by the welfare departments. One would have thought that our best chance of developing a nondeterrent, liberal, and nonoffensively administered income test for health services would have been to lodge its administration in the hands of agencies not identified with a long tradition of deterrence, namely the health departments. After all, many of our social programs, such as housing or educational scholarships, involve the application of an income test, but its administration is not for that reason lodged in the departments of welfare.

If we desire to move toward the objective of medical care as a right, we shall surely push for further extension of the social insurance approach and change our administrative arrangements in medical assistance. We shall also have to reconsider our policies on deductions and co-insurance. For if, as indicated by administration spokesmen, the two parts of Medicare will cover only between 40 and 60 percent of the individual's medical bill, many of the aged will discover that all that has happened is that they now have to go to the welfare department to meet 40 to 60 percent of their bills instead of 100 percent as previously. They will not have been spared the necessity of contact with a means test system, and they will have the added disadvantage of having to deal with two agencies.

At the same time we must not forget that social insurance is only one way of implementing the right to needed health services. It is a useful social invention that has made it possible for societies, troubled about the possible effect of free payments or services on initiative and self-dependence, to accept the idea of conferring rights freed from any needs-test requirement. Its contributory character supported the parallel with private insurance and made it possible to argue that people had earned their rights because they had contributed toward their benefits. But by the same token, those who had not contributed or had not made a sufficient number of contributions for whatever reason, within or beyond the individual's power to control, are denied benefits under social insurance systems. In other words, insured status as the door to rights to service inevitably excludes some people. Exclusion from benefits may under some circumstances make sense in a cash-payment program, but do we want to exclude anyone from needed health services?

Rights to services can be conferred without making eligibility depend on insured status. In this country we already do this for veterans with service-connected disabilities. Some other countries—Great Britain is the most prominent example—have extended this right to all people who need medical care while in that country. They treat health services, in other words, as we treat elementary and high school education. Is there any reason why health services should be less universally required than education?

Thus if we are really committed to the idea that health services should be available as a human right based on health needs alone, perhaps we should raise our sights and move toward a free health service for at least some sections of the population. Children suggest themselves as the obvious target for such a service.

Importance attached to equal access to appropriate health services for all our people. A second major determinant of future developments in the organization and financing of health services will be the importance we attach to equality of access on a geographic basis. Because of the limited scope of Title XVIII in terms of persons covered, types of health service insured against, and the presence of deductibles and coinsurance, it is Title XIX that we shall have to rely on as the main instrument for insuring that no one who needs health services is denied them. And Title XIX only deals with that part of inability to obtain needed care that is due to financial inability to pay for it. It does not deal with such obstacles as the nonavailability of personnel or facilities.

Even as a means of solving the problem of financial incapacity, I fear that Title XIX, despite its high potential, will result in great geographic inequalities in care. Its full implementation will involve large additional expenditures by the States, which are already finding themselves under heavy pressure to finance growing educational and other State-supported services. More important is the great variation in per capita income in the different States. Even with the best will in the world and with

83 percent Federal matching, some States will be unable to raise the necessary sums. In addition, State attitudes vary greatly. Not all the States are convinced of the importance of making health services available under self-respecting conditions to everyone, especially if a large number of the beneficiaries are likely to be nonwhite persons or persons held in social disesteem such as unmarried mothers.

As a result we are likely to find variation from State to State in the Title XIX program—just as we did, incidentally, in the Kerr-Mills Act, of which much of Title XIX is an extension and broadening. The range and quality of services offered and the income limits that will determine how many people benefit from the program will be vastly different. We may even find that when some States realize all the conditions they have to satisfy to benefit from Title XIX Federal grants they may prefer not to participate at all. And as 1970 approaches, the date when States can no longer obtain grants for vendor payments under the old public assistance formula, and it is compliance with Title XIX or nothing, we shall probably find great political pressure to postpone the deadline.

Inequality of access to health services on a State-by-State basis may be regarded by some as the inevitable price we pay for our much-vaunted Federal form of government and our desire to leave maximum freedom to the States. But if growing importance becomes attached to insuring equality of access to high-quality health care for all our people, we are likely to see a much greater degree of Federal involvement. Because it will be difficult to pretend that the program is really a State program if Federal matching goes much above the already high 83 percent, I suspect that Federal involvement will take the form not of additional Federal matching but of the assumption of additional wholly Federal responsibility for certain categories of people or for certain types of disease or for certain components of health services such as medical education or construction of hospitals, nursing homes, or health centers.

If we are to select certain categories of people as the beneficiaries of new Federal programs, we need to weigh our priorities carefully. So far we have selected the aged. Children, unless crippled or retarded or suffering specific handicaps, have been given no priority although one would think that a rational society would give them the highest preference. It is true that under Title XIX all children under 21 must be covered under medical assistance if they meet the financial eligibility criteria, but as I have just indicated, these criteria and the scope of services are likely to vary greatly from State to State. The task in the years ahead is to redress the balance in favor of children wherever they may live.

Importance attached to the objective of high-quality medical care. A deep concern for high standards of service would surely have led us to lodge administrative responsibility for Title XIX clearly in the hands of health departments rather than welfare departments (with a provision for appropriate consultation and cooperation with health agencies). At best, administration by welfare will lead to a parallel organization, the creation of an almost wholly health administrative unit within welfare departments. At worst, it will create the danger of perpetuating a two-standard system, one for the means test population and one for the rest of us. Even if as envisaged in New York the responsibility for standard setting and control of quality is delegated to the health department, we are creating a most difficult situation in which one agency calls the tune and another pays the piper. Given the well-known proclivity of legislators at both State and Federal levels to be more liberal in granting funds for functions labeled "health" than for those labeled "welfare"—which typically seem to have the lowest appeal to appropriating bodies—it is unfortunate that the vast new medical-assistance program was not clearly identified as a health rather than a welfare program.

I am second to none in my admiration for the welfare departments of our country, which have shown a commendable concern for the well-being of their clients and are carrying out, often with conspicuous success, an important and difficult task and one for which they receive little public recognition and much abuse. And there is much justice in the claim of the spokesmen for welfare that in the country as a whole

the health departments are not as highly developed as the welfare departments, that they have taken a very narrow view of their functions, and have resisted involvement in programs of direct service to people that might create for them difficult administrative relations with the medical profession. Yet I venture to suggest that this is a short-range view and one that disregards history. For the short run, I agree that under the vigorous and imaginative leadership of the Federal Welfare Administration and of some of our State welfare departments, the new programs will get off to a quicker start, and administrative interpretations will display more knowledge and concern for the needs of the clients, than if the administration had been lodged in the health departments. Yet for the long run, a necessary condition for bringing some order out of the present medical chaos and for the development of policies that do not involve one set of standards for the assistance patient and another for others is the creation of strong health departments.

What the welfare spokesmen forget is their own history. Before 1935 welfare departments with experience in making cash payments and administering services connected therewith did not exist in many parts of the country. Those that did took a narrow view of their responsibilities. It was the Social Security Act of 1935 which, by providing Federal funds for public assistance including its administration, coupled with the requirement that they be administered or supervised by a single State agency and accompanied by Federal standard setting, stimulated the development of the great welfare departments that we know today. It is sad to think that we missed the opportunity to do the same for State and local health departments in 1965.

Importance attached to orderly organization for the provision of health services. An orderly organization for the provision of health services would include coverage of all health needs from prevention to rehabilitation, the elimination of gaps in services, the assurance of continuity of care, the avoidance of duplication or overlapping, and the prevalence of knowledge as to what is available and where to get it.

The more importance we attach to this objective, the more we shall surely move away from the item-by-item approach where separate units or types of care are identified and paid for with public funds while others are not. No word has appeared more frequently in medical literature and in health conferences in recent years than the word "fragmentation," and it is used as a term of abuse. The item-by-item approach adopted in Title XVIII can only intensify that fragmentation.

More is needed, however, than avoiding the intensification of fragmentation through our public programs. Given the existence of both public and private operation of a great variety of health programs and services, a crying need exists to create a structure whereby some central health-planning agency or council at the community, State, and Federal levels is given the responsibility for looking at the provision as a whole, is given authority to do something about it, and is adequately financed to do the job. Of all the innovations contained in the British National Health Service Act, none in my judgment has been more far-reaching in effect than the implementation of the first sentence of the administrative proposals in the famous White Paper on Health Policy of 1944; namely, "If people are to have a right to look to a public service for all their medical needs, it must be somebody's duty to see that they do not look in vain." It has been this centralization of responsibility for looking at the structure as a whole (lodged in Britain in the Minister of Health) which more than anything else has stimulated critical inquiry into all aspects of the health services and has led to the many improvements which, as all students of the health service know, is slowly transforming what was a 19th century system of services into one more appropriate to the needs and scientific knowledge of the 20th century.

Concern with the nature of the overall provision can hardly be expected of the administrators of a social insurance system, even with as dedicated and public-spirited a leadership as we fortunately have in the Social Security Administration. More especially is this so when social insurance is concerned only with meeting the costs of specific items of care. But even with more comprehensive social insurance systems the social insurance agencies have typically been concerned with structural organization

only when existing structure leads to cost escalation or when the lack of facilities and personnel to provide the specific services contracted for is so glaring that the program is in danger of falling into disrepute. Perhaps we shall see something of this kind happening to the supply of nursing homes and medical personnel as Title XVIII goes into full effect.

The more we are concerned with a rational organization of health services, the more we shall question the wisdom of using the private intermediary, especially the profitmaking insurance companies. Unless their functions are narrowly confined to the mechanics of paying bills—and it does not look as if they will be—their existence as an integral part of the administrative structure can only complicate the task of community planning. They are not community-based or oriented. As fiscal agents paying on an item-by-item basis, they are unlikely to be concerned with the appropriateness and adequacy of available services. At best they create yet one more agency that has to be brought into the planning process.

Importance attached to economy in the use of resources devoted to health care. It is obvious that the implementation of the policies and programs to which we are even now committed will require the allocation of a greater proportion of our national resources to the health services. More people will be entitled to claim the services of professionals and to utilize medical institutions. The quality of the institutional care for which they are eligible will be superior to that previously received because the aged can now claim semiprivate rather than ward care and because, as a condition of participating in the program, hospitals and nursing homes will be held to higher standards. The funds devoted to the health services will also be increased because of the payment to suppliers on the basis of reasonable charges or costs. No longer will services to the indigent be paid for at submarket rates.

Thus costs, in the sense of the volume of resources devoted to health services, will inevitably rise. How high they go will depend on the priority people attach to health services as opposed to other things they could have bought with the same amount of money. I should like to disabuse those who think costs can be kept down by fixing, as a matter of policy, a maximum sum that can be spent on health services. For as I stated earlier, if people want something badly enough they will if necessary give up other things to get it. All this only emphasizes the importance of economy in the use of resources devoted to health care, and I was glad to see that the policy statement of the New York Academy of Medicine emphasized "the importance of using the nation's resources in the most effective and economical manner consistent with the enhancement of individual dignity and high standards of care."

If we are really concerned about economizing resources, would we have adopted what is essentially a major medical type of insurance in Title XVIII–B? All experience has shown that this method of reimbursement tends to escalate costs by making it easier for suppliers to raise prices. Would we have fragmented our governmentally financed services, thereby running the risk that people may have to use costly hospitals because there is no provision for reimbursing hospital-based ambulatory care? Would we have envisaged the involvement of private intermediaries in control of utilization? Even now the effectiveness of utilization committees run by the professionals is very uneven. How much more concern for the public interest in economy of use can we expect when assistance to hospitals and related agencies "in the application of safeguards against unnecessary utilization of services" is placed in the hands of competitive profitmaking concerns whose orientation will surely be primarily toward what makes life easy for their clients and themselves attractive to them as administrators? A concern for economy in the use of resources would surely have induced us to make provision for more effective representation of the public interest on the many committees that are setting policy in the application of the "reasonable cost" provisions. It might have led us to make arrangements for the separate organization of consumers of the health services, who are also taxpayers, to counter the pressures of organized medicine and the insurance companies on the Federal agency.

The short time elapsing between passage of the 1965 Act and its coming into effect means that many major policy decisions and interpretations had to be made in a hurry. Inevitably under such circumstances, existing organizations exert what in retrospect may well come to be seen as undue influence. No aspect of our new programs is more in need of study and reconsideration than the provision made for proper representation of the public interest, for publicity and accountability.

Waste, in the sense of more resources being devoted to a particular service than is really necessary, occurs not only when patients are kept in costly facilities because equally appropriate but less costly methods of caring for them are not available or reimbursable, or when suppliers, through monopoly powers, are able to charge an excessive price for their services. It also occurs when procedures that could be performed by less highly trained personnel under professional supervision are carried out by expensively trained professionals. It occurs when unnecessary tests or procedures are applied. It occurs when too many hospitals are built in a community, when there are too many acute general beds or hospital laboratories, or when for prestige considerations individual hospitals create specialist departments, such as for brain surgery or cobalt treatments, totaling far in excess of combined community need.

A concern for economy in these respects will, I am convinced, ultimately lead to a reconsideration of the status and independence of the voluntary hospital. Given the large proportion that hospital costs form in the medical bill; given the many possibilities of reducing costs, of which the hospitals could take advantage but have not; given the importance of assuring a uniform accounting system to permit effective interhospital cost comparisons; and given the crucial importance of the hospital in the total organization of health services, we cannot much longer permit the voluntary hospital to operate as a purely private concern, answerable only to its own governing board. The recent so-called Folsom Law in New York, which introduces a measure of public control over hospital expansion and operation, is a significant "straw in the wind."

In our concern about economy in the use of resources devoted to health care, we must never forget that in the broader sense waste occurs when we continue to treat as exclusively medical problems conditions that might be prevented by appropriate policy and program changes in other areas such as housing, the reduction of poverty, or the improvement of education.

Agenda for the Future

I have tried to suggest that how we organize and finance medical care has by no means been answered by the Social Security Amendments of 1965—important as they are. Even in the limited areas with which the Act is concerned (essentially the aged, the indigent, and the medically indigent), a number of highly questionable and sometimes conflicting policies have been adopted. But this action has started us on a road from which there can be no turning back. Governmental involvement in the financing and organization of our health services is here to stay, and there is every indication that it will increase. Resolution of the policy issues at stake provides an agenda that will make the greatest demands on our ingenuity and resourcefulness for the rest of this century. It will also make great demands on our courage and our sense of public responsibility. Above all, it will be a crucial test of the strength of our conviction that all people should have the assurance of an equal opportunity to obtain a high quality of comprehensive health care under self-respecting conditions.

HIGHLIGHTS OF THE HILL-BURTON PROGRAM

ON AUGUST 13, 1966, the Hill-Burton Program marked its 20th anniversary.

The program was the culmination of action on several fronts in the 1940's when hospital shortages attracted national attention during postwar planning. A survey of the nation's hospital needs by the Commission on Hospital Care, organized in October 1944 under the sponsorship of the American Hospital Association with staff assistance from the Public Health Service, revealed that 195,000 more general hospital beds were necessary for the maintenance of good public health. Meanwhile, in January 1945, legislation authorizing a hospital construction grant program was introduced in Congress. The legislation, signed into law by President Truman in August 1946, embodied the principle of Federal-State action endorsed by the Commission.

Since the beginning of the Hill-Burton Program, nearly 8,300 projects providing more than 353,500 beds in hospitals and nursing homes and nearly 2,400 other health facilities (including public health centers, diagnostic and treatment centers, rehabilitation facilities, and State health laboratories) have been approved. These facilities were built at a total cost of $8.1 billion, of which the Federal Government contributed over $2.5 billion. More than two-fifths of these projects are completely new facilities. While 59.4 percent of the general hospital bed need was met in 1948, 83 percent of this need was met in 1965; while 10 million people lived in 600 hospital service areas which had no acceptable general hospital beds in 1948, currently only 2 million people live in 100 such areas.

The tremendous increase in hospital construction which has taken place in every section of the United States is not the sole accomplishment of the Hill-Burton Program, however. Of equal importance has been its influence in upgrading the nation's health facilities. This has been achieved through consultation services which have been an integral part of the program since its inception, the development and publication of guide materials, and the stimulation of research and demonstration projects. The research and demonstration program has funded 175 projects with nearly $33.4 million since 1956.

Areawide planning of health facilities has been advanced and approximately 50 communities are receiving Federal assistance for planning projects. Of the 24 metropolitan areas with a population over 1 million, only 2 have not yet organized planning agencies. Continuous statewide planning for additional health facilities has been encouraged and physicians and board-qualified specialists have been attracted to many rural areas because of the Hill-Burton facilities there.

As the program's scope has broadened, facilities for long-term care, diagnosis and treatment, and rehabilitation have been built, and obsolete facilities have been renovated or replaced. While the original emphasis of the program was on the construction of hospitals in rural areas, more recent legislation has stressed the nation's changing needs. Modernization grants, authorized in 1964, permit a shift in emphasis to give special consideration to the renovation and replacement of obsolete facilities in urban areas.

Through the years, Hill-Burton has contributed to improved design, functional relationship, and overall efficiency of health facilities through the establishment of minimum standards for health facility construction and the dissemination of related guidelines. Operations in all health facilities have been improved because States are required to adopt standards of maintenance and operation for facilities constructed under Hill-Burton, and most have made these standards applicable to all health facilities through licensure requirements.

The State agencies, in turn, have given leadership to communities and joined forces with Federal staff and voluntary groups in assuring that facilities are built where the greatest need exists. One of Hill-Burton's sources of strength has been the partnership between Government—Federal, State, and local—and voluntary groups to improve the nation's health facilities.