The Insurance Industry Looks Ahead at Health Care in the 1970's

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TO LOOK AHEAD at health care, and to attempt to anticipate the shape of things to come in the 1970's, is to confront an elementary fact: change. Change is upon us—on all sides and in all fields. Change is coming in health care. It will accelerate. It will be basic. Hopefully, change will be evolutionary because the needs, feelings, and aspirations of human beings are involved.

Change will be evolutionary and constructive only if leadership can emerge—if leadership can put forward relevant, effective, and accountable programs to meet this nation's crisis in health care. At present, this is a $60 billion crisis; by 1975 it may be a $100 billion crisis.

Today's health care crisis is compounded of an awesome conjunction of forces:

TECHNOLOGY—ever-new and ever-better "miracles" of medical treatment—more and more scientific, more and more complex, and more and more costly—sophisticated 21st century technology shackled to 19th century organizational patterns.

SHORTAGES of manpower and facilities—pressures on our professional schools and obsolescence in our professional workshops, the hospitals. Even now our professional and technical manpower and facilities are poorly distributed and used. The result is discontinuity of services with overlaps as well as gaps.

OBSTACLES in the way of getting medical treatment and health care—costs in time traveling and waiting, costs in time off the job, costs in ignorance of health information and of resources for care, costs in physical pain and emotion, costs in money, and costs in human dignity.

MINORITY GROUPS—increasing visibility of the problems of the poor—the blacks, the whites of America's Appalachias, the Indians and Eskimos, and the Spanish-speaking.

TWO-CLASS SYSTEM of health care, which often results in inferior care, and even the absence of care, for the poor and near-poor in the inner cities and rural areas.

ERODING QUALITY of care, not only for the poor and the near-poor but for many others more economically advantaged, for quality is more than better facilities and amenities.

CONSUMER'S increasing importance, and the rising stridency of his voice as his frustrations compound.

All of these forces are reflected in costs—persistent, accelerating increases—22 percent since the advent of Medicare. Leading are inpatient hospital costs, which account for about one-third of the nation's medical bill and about one-half of insured benefits.

In short, converging dynamic forces are pro-

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ducing rising demands, increasing public frustrations and expectations, and mounting pressures for affirmative action. It all adds up to crisis—in essence a political crisis building up inevitably to action and change.

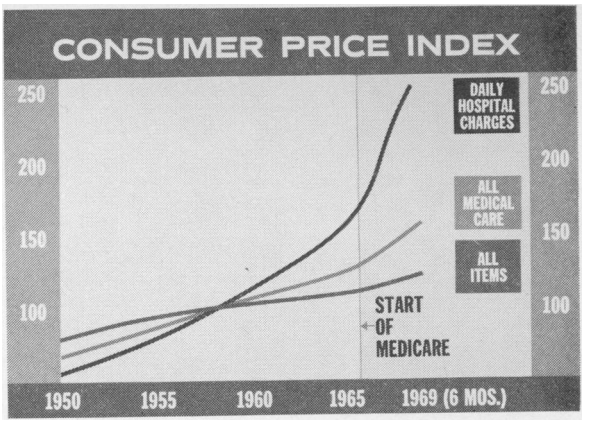
The question is: Will the action be in terms of constructive change to meet the underlying causes of the crisis in health care? Or will it be action for the sake of appearance that, consequently, fails to come to grips with realities and that undermines the possibility of evolutionary change?

Thus, the crisis which demands action and change is a fundamental challenge to this nation's capacity to deal with a basic human need. It is a direct challenge to the health industry and professions to re-evaluate their functions and prerogatives and to weigh their proper role in the public interest. The private insurance industry sees the health care crisis in these terms, and views it as a direct challenge to the industry that is a principal resource for health care financing—and we are moving to confront that challenge.

In recent years we in private insurance have been re-evaluating and experimenting with new forms and applications of insurance coverage. Some time ago, we became committed to and involved in comprehensive community health planning. More recently, we sought to encourage prepaid, as well as fee-for-service, group practice through active participation in a variety of projects—at Harvard, Yale, Columbia City, and St. Louis (with the Office of Economic Opportunity and the National Medical Association Foundation) to name a few.

These are not unrelated or casual developments. In essence they are but outward manifestations of our industry's increasing cognizance of the underlying reality that financing is conditioned by the organization of services, and that, in turn, the organization of health services is markedly influenced by financing methods. The mutual and interdependent purpose of financing and organization is to effectively deliver health care to people who need care, when and where they need care, under acceptable conditions.

With the present health care situation it seems painfully obvious that new approaches and affirmative proposals are needed for the



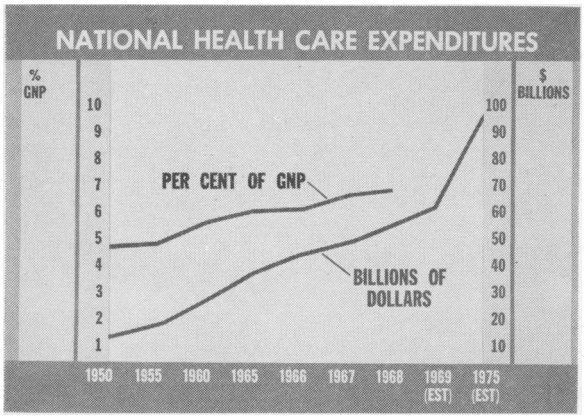
health care financing system of the nation. And, of course, any rational system of financing should enable all persons to enter the mainstream of health care on an equal basis and with assurance of a reasonable level of quality care. This means, simply, that financing systems have to be developed concurrently and in balance with delivery systems.

This simple idea also alters considerably the role of those who have been concerned for many years principally with financing of health care benefits. For the insurance industry—traditionally cautious, consciously concerned that its activities be strictly appropriate to its basic functions, and reluctant to intrude into professional preserves—to accept the implications of this idea requires a considerable shift in attitude. Even so, that shift is well along.

Health Care in the Seventies

In April 1969, a task force from the insurance industry was asked to describe health care in the 1970's. This was not an academic exercise, for clearly we needed to have a reasonably accurate concept of the future if our financing services were to be made relevant—and especially if we were to act on the idea that financing is a critical leverage mechanism in shaping delivery.

Our task force proceeded not only to review the literature and talk with insurance colleagues, but—in what might be called an ecumenical spirit—through a series of informal interviews across the nation, consulted with a cross-section of persons of recognized knowledge, experience, and stature. We presented to them some of our tentative formulations and sought their candid views and suggestions.



In November our report and proposals were presented before the Health Insurance Association of America. (The association represents 313 companies which account for about 80 percent of private health insurance and cover more than 104 million people.) Our report was unanimously approved by the association. The findings of the study include a statement of objectives which we believe provide sound criteria for measuring our efforts and the efforts of others in approaching the problem of providing personal health care for the people of this nation. From these objectives flow a concept of the shape of health care to come in the seventies and then some proposals for action by the private insurance industry.

We proposed four objectives, and stated the first as follows:

> Health care delivery systems should be *responsive and relevant* to the continuing health needs of the people rather than only to their episodic medical needs. Systems should be oriented to the whole person and his needs for disease prevention and health maintenance, rather than primarily to medical treatment and management of disabling conditions.

These systems, we feel, should seek to maintain the health and well-being of the individual, the family, and the community. Emphasis should be placed on prevention, health maintenance, and ambulatory care.

Systems should be organized so that each family unit has easy access to them and, when practical, may choose from a number of equally appropriate points of entry. This would presuppose family-centered health care that encourages continuity in both treatment of disease and maintenance of health, a refocusing on family practice, and a re-evaluation of the roles of the varieties of health manpower.

Our second objective is that:

> Health care delivery systems should *integrate and interact* with other social and environmental systems that serve in the public interest, including employment, education, housing, transportation, communications, recreation, etc.

It is evident, we believe, that the health of the individual, the family, and the community affects and is affected by the nature and quality of the physical environment and the social context of the community—such things as employment potentials, educational levels, food and nutrition, and cultural and behavorial patterns of day-to-day living.

Health care delivery systems functioning in harmony and responsiveness to these other elements relating to the living circumstances of people would (*a*) provide services within a cultural framework that is compatible with the values held by those in the communities served, (*b*) cooperatively assess the overall needs of the people and the community and encourage improvements or needed changes in such areas as education, employment, housing, and so forth, and (*c*) consciously and dynamically interrelate with the other social and environmental systems.

Objective three is that:

> Health care delivery systems should be *reflective of consumer and professional interests*, operating not only to provide the quality of care needed and desired by the citizen-consumers, but to assure that the means of delivering services are in keeping with the professional concepts and standards of the providers of service.

The development of systems for delivery of health care should be an active partnership process involving consumers and providers throughout all stages of planning and operation. In structure and procedure, systems of delivery should reflect respect for the dignity and equality of opportunity of each individual, each family, each community. Equally important, all systems should be compatible with the human needs and professional standards of those who provide the services and who implicitly carry responsibility for life and death.

Our fourth objective deals specifically with the shape of things to come:

Health care delivery systems should be adaptively structured and interrelated so as to provide *access to quality health care* to all residents regardless of geographic location, economic resources, or other cultural or social variables.

In the years ahead, no monolithic method for the delivery of health care, nor its financing, can be practicable in our pluralistic society. What may be feasible are numerous and diverse "systems" that interrelate multiple methods and varying approaches to a common goal of "equality health care for all."

Such systems would be self-adapting to social needs, to scientific and technological developments, and to varying local conditions. They would provide access without delay to optimum care of acute and major health-threatening problems, but would shift the focus of concern from the extraordinary to the ordinary, emphasizing prevention of disease, health maintenance and education, and early diagnosis and treatment.

Equality health care systems would encourage effectiveness and quality but eliminate or minimize duplication of effort, unproductive fragmentation, and inefficiency in services to people. They would thus seek to avoid the impact of unrealistic costs and minimize confusion for patients and families as to how, where, and when they can enter into the systems. They would be characterized by conscious and continuing efforts to facilitate entry by providing counsel and initial care as close as possible to the persons needing care. The patient would proceed through such systems progressively in terms of his particular needs, with access to and use of whatever services and facilities are appropriate and necessary.

Systems for equality health care would involve interrelated networks of institutions, facilities, and services. They would be consciously designed to provide primary, specialized, intensive, convalescent, rehabilitative, and custodial care. Emphasis would be on ambulatory approaches—perhaps the key immediate need. The viability of such systems would depend significantly upon effective communication and transportation facilities. And crucial, we feel, is the partnership involvement of citizens and professionals in the planning, development, and management of the systems.

To sum up, health care delivery systems for the 1970's, in our view, should (*a*) be responsive and relevant, (*b*) integrate and interrelate with other social and environmental systems, (*c*) reflect consumer and professional interests, and (*d*) be structured to provide quality health care for all.

We think these four general objectives provide valid tests of health care delivery systems for the 1970's.

The private insurance industry has accepted them as guiding principles to help shape our response to the health care crisis.

Scope of Action

The nature and scope of our concern for action is evident from the following partial list of topics dealt with in our report: medical and allied manpower, facilities, State and local laws, hospital costs, comprehensive health planning, group practice, ambulatory care, capital financing, insurance coverage, records systems, quality of care, hospital staff privileges, outpatient diagnostic testing and surgery, prevention, health education, rehabilitation, consumer involvement, problems of the poor, public health, occupational health, and safety.

For each of these topics we already have or are planning activities and position shifts of consequence. For example, throughout our explorations, the idea repeatedly surfaced that as a nation we simply have to reverse the order of priority from inpatient to outpatient care. Obviously, this will require changes in emphasis of coverage patterns. And, more emphasis on ambulatory care will require new methods of organization so that care is accessible, continuous, and coordinated.

Group practice. Naturally, also, the various forms of medical practice were discussed extensively. While it seems clear that the solo practitioner will not vanish overnight, it does seem that he will gradually disappear. "Organized service" is the order of the day.

Even today, it is common for physicians in the same specialty to practice as a group in order to gain more regular hours, more time off, and greater income through lower operational expenses. We assume that these single-specialty groups, particularly those in fields such as radiology, will continue to exist in the future and

will have agreements with ambulatory care centers and hospitals to provide their specialty service when needed.

We anticipate, also, that multispecialty group practice will continue to grow since, in theory at least, this approach is an effective way to organize medical practice. A practical problem, which may be slowing this development, is the scarcity of the able management talent needed to give physicians and other personnel ample financial incentives and time for self-development.

There is considerable opinion today that the combination of prepayment with multispecialty group practice offers a possibility of bringing about significant improvement in health care delivery by more efficient use of available manpower, by more expeditious use of less costly forms of care, and by minimizing the inevitable increases in the overall cost of care.

I believe that few persons would argue that prepaid group practice is the be-all and end-all method, but it certainly is a promising avenue toward better delivery of health care.

We strongly feel that insurance companies must keep abreast of developments in prepaid group practice and should be prepared to conduct experiments—as indeed we have begun to do—to determine the proper relationship of insurance companies to this concept. Where feasible, for example, there should be arrangements for a viable system of dual choice within each insurer's program.

Furthermore, we need more hard data on group practice and its impact on quality of care, on access, on hospital use, and on costs. For example, we are impressed by the "two beds per 1,000" potential of group practice in contrast to the generally-accepted four per 1,000, but feel that this potential should be better documented, as should other data on hospital usage and related aspects touching on costs and quality.

We are conducting a feasibility study to determine the practicability of evaluating and comparing utilization of hospital facilities for different forms of medical practice—solo practice on a fee-for-service basis, multispecialty group practice on a fee-for-service basis, and multispecialty group practice on an enrolled prepared basis.

Although group practice is but one area of our current activity, it points up the fact that we actually are taking a new look at what makes sense in health care delivery systems for the entire population—that we are striving for equality health care for all.

General goal. The general goal of equality of health care was stated in action terms which were recently voted by the board of directors of the Health Insurance Association of America. The board urgently recommended to its 313 member companies that they:

1. Continue to inform themselves of evolving developments in health care delivery.
2. Become more involved in health care delivery developments and exert their influence to bring about soundly conceived changes in present systems.
3. Formulate programs for, and exert leadership to achieve, a pluralistic system of health economics for this nation which will assure all citizens access to needed health services on an equal basis and regardless of the personal means for payment—making maximum use of private health insurance but recognizing that some use of government funds is necessary for persons of limited income.

Future Directions

Change indeed is in the wind! I think I can assure you that we in private insurance shall be putting forward plans, projects, and proposals for direct and affirmative action. To put it bluntly, we are aware that change by us—action by us—is crucial if we are to remain relevant or if we are even to survive.

But I would caution you not to underestimate another motivation of the private insurance industry—namely, the important fact that affirmative action is obligatory on us as citizens of this nation if the nation is to utilize constructively our unique expertise and hard-earned resources to help meet the pressing health care needs of the American people.

Already there is evidence of direct and affirmative action. Recently, for example, one of our peer companies presented to the House Ways and Means Committee a six-point program "to improve the availability, acceptability, and financing of health care for all in the United States."

The proposed program would strengthen the responsibilities, authorities, and financing of comprehensive health planning agencies as principal instruments in the development of more effective and accountable health care delivery systems.

The proposals would coordinate and expand efforts to meet growing health manpower needs for medical and allied personnel and put forward a new loan-grant scholarship and service program to foster inner-city, rural, and family care. Cost controls are proposed which aim to give primary weight to ways and means of assuming quality of care. As a central thrust it would promote the development and use of comprehensive ambulatory care.

A series of proposals are outlined to stimulate immediately the process of making health insurance available to the entire population, building on the present wide base of coverage, focusing on ambulatory care, and aiming to achieve as rapidly as possible our national goal of quality health care as a right and responsibility of each citizen. Finally, it is proposed that the Federal Government needs an integrating and guiding group to oversee the multitude of efforts in health care delivery. To this end there is suggested the establishment of a President's Council on Health Care.

In short, the so-called conservative insurance industry is on the move, guided by a sense of fundamental social responsibility and accountability, and in a spirit of open partnership. It is beginning to shake off blinders and break through stereotypes with the result that it is discovering resources of vitality and innovation that are truly remarkable.

The insurance industry is documenting anew the statement of Abraham Lincoln in his second message to the Congress in 1862: "The dogmas of the quiet past are inadequate to the stormy present." We are taking seriously also the more recent commonly used remark: "If you're not part of the solution, you're part of the problem."

Truly, the goal of equality of health care for all requires a new and open look by all of us and a sense of partnership and mutuality that challenges the best in each of us.

Tearsheet Requests

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