

HEALTH CARE CRISIS IN AMERICA, 1971

HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON
LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
NINETY-SECOND CONGRESS
FIRST SESSION
ON
EXAMINATION OF THE HEALTH CARE CRISIS IN AMERICA

FEBRUARY 22 AND 23, 1971

PART 1

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HEALTH CARE CRISIS IN AMERICA, 1971

MONDAY, FEBRUARY 22, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE COMMITTEE
ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 9:37 a.m., pursuant to call, in room 318, Old Senate Office Building, Senator Edward M. Kennedy (chairman) presiding.

Present: Senators Kennedy, Pell, Nelson, Mondale, Eagleton, Prouty, Dominick, Schweiker, and Beall.

Committee staff members present: LeRoy G. Goldman, professional staff member to the subcommittee; and Jay B. Cutler, minority counsel to the subcommittee.

Senator KENNEDY. The subcommittee will come to order.

In the United States today, health care is the fastest growing failing business in the Nation, a \$70 billion industry that fails to meet the needs of our people. The American health care system is in crisis, and the crisis is deepening. The reality of this crisis, which affects almost every citizen, is no longer denied.

The crisis presents both a danger and an opportunity. The danger is that we may shrink from the magnitude of the effort required to reform and improve the health care system. We may shrink because of the pressure of powerful and parochial interests, whose principal concern is their own private interest, not the public interest.

The opportunity which the health care crisis presents is that, if we have the courage and the wisdom to diagnosis the substantive, economic, and political dimensions of the crisis, we will be well on the way to the reform we need. If we don't know where we want to go, any road will take us there.

There are several major dimensions of the crisis. They are different, yet they are related.

First of all, there is cost. Each of us knows that doctor bills, hospital bills, the cost of drugs, nursing home care, and the like are out of control. No program of health reform can ignore the cost crisis.

Second, there is the acute and worsening shortage of all kinds of health personnel, especially the shortage of doctors. One of the best-known facts of the health crisis is that we need 50,000 more doctors than we have today. There are hundreds of counties and thousands of communities in the Nation without a doctor, and countless more have far too few to meet the needs that exist. The same dismal facts can be recited for dentists, nurses, and the allied health professions. No program of health reform can ignore the manpower crisis.

Third, there is the problem of the system, the archaic and inadequate arrangements by which we organize and deliver health care, the maldistributions, the obvious inequity of access to health care and availability of health care. Too often, the system is an obstacle course for the consumer, not a path to better health.

Too often, the system seems to accommodate every special interest group except the most important group of all—the people the system is supposed to serve. The resources we do have are inefficiently organized. If you live in the inner-city, a suburb, or a sparsely populated rural area, your chance of ready access to health care is poor indeed.

The fact that the emergency room of virtually every community hospital in the country is transformed, though ineffectively, into an outpatient clinic at night, and on weekends and holidays, makes clear that the lack of availability of health care is by no means unique to the ghettos or rural areas. No program of health reform can ignore the system crisis.

Fourth, there is the problem of the quality of care. Much of our health care is of high quality. Some of it is not as good as it should be. Too often, it is inadequate, incompetent, or worse. The point is not that we can eliminate bad medical care, though we must strive to do so. Rather, it is that the consumer of health care today has very little chance to feel confident that diagnoses are accurate, or that therapies are appropriate, or that continuity of care will exist.

There is no correlation between higher cost of health services and better quality. The profound weakness in the quality of health care can affect all Americans, regardless of their income. No program of health reform can ignore the quality crisis.

These four elements are not the only ones which, by their interactions with one another, combine to perpetuate our health care crisis. They are, however, four of the most important in terms of irrationalities, inequities, and inhumanities of the existing system. The American public will no longer tolerate the perpetuation of this crisis. The public demands reform. The question is no longer whether there should be reform, but what the reform should be.

Accordingly, the Senate Health Subcommittee today begins public hearings into the health care crisis in America. Our goal is to find the facts and to do whatever is necessary to set the system straight. We must enhance and strengthen what is excellent in our health care industry, and we must work to make excellent every aspect of the system that has a reasonable potential; but we must discard what is counter-productive to America's health, regardless of political expediency.

These hearings will be both systematic and comprehensive. They will delve into every major area relevant to the way our health care system works. Over the coming weeks here in Washington, and later across the Nation, we will be examining many areas, including:

1. The President's Program;
2. The quality of health care;
3. The cost of health care;
4. The role of the health professions;
5. The role of the consumers of health care;

6. The private health insurance industry ;
7. Health professions education ;
8. Group practice of medicine and health maintenance ;
9. Medical economies ;
10. Biomedical research ;
11. The role of private foundations in health ;
12. Dental health care ;
13. Preventive care ;
14. Mental health and retardation ;
15. Inner city health care ;
16. Health care in rural areas ;
17. Health needs of the elderly, the young, minorities, and other special groups ;
18. Comparisons with health care systems in foreign nations.

I look forward to these hearings as an opportunity to hear the views of experts and citizens in all parts of the Nation on the source of our health crisis, and how best to deal with it. To right the wrongs of generations of neglect of our health system will require a determined effort, but I am confident that we are equal to the task.

Before introducing the Secretary, Senator Pell, do you want to comment ?

Senator PELL. Thank you, Mr. Chairman.

I congratulate you for your initiative, based on your long term interest in the field of health, in making a comprehensive assessment of the health system the health subcommittee's first order of business.

I know I have long believed that a systems approach is the only way the Nation's health crisis can be dealt with in an orderly manner, and I am delighted we will be taking a wide ranging approach.

The health care crisis is a complicated problem involving detailed questions of financial management, techniques of medical care, and sometimes conflicting philosophical approaches. It is a problem that cannot be handled with ad hoc solutions or facile cliches.

Therefore, it is my hope we can proceed to rationally analyze the many facets of the health care crisis with a minimum of partisanship and of one-upsmanship as to who can do the most for different groups, and with a maximum of hard, thorough analysis by our witnesses and by the subcommittee.

I see no reason for drawing the national health care issue on partisan lines. The problem cuts across partisan lines, as I believe can be seen in the fact that some of the elements of the President's key health proposals are basically the same as I put forth in my own national health care bill introduced in the last session of Congress.

I know I have long believed that a systems approach is the only way the Nation's health crisis can be dealt with in an orderly way, and am delighted that we will be taking a wide ranging approach.

The complexity of the health crisis, moreover, requires a systems approach, not a partisan approach. In fact, I believe the stage has been already set for a systems approach to the health care problem by the passage last session of my amendment requiring the Department of Health, Education, and Welfare to make two comprehensive reports to the committee this year on a systems analysis of alternative national health care approaches.

I would hope that we do not pass any national health care legislation until those reports required by my amendment under law are analyzed.

Under the provisions of my amendment in Public Law 91-515, Secretary Richardson will be providing us, first, on March 31, a detail cost and coverage report on the national health care bills introduced last session by Senator Kennedy, Senator Javits myself, and others. This study will give us some accurate cost figures with which to grapple, as we frame our final legislative proposals.

Second, before September 30, Secretary Richardson will be providing us with a more comprehensive systems analysis of the advantages and disadvantages of alternative routes we have to a total national health care reform. This systems study should provide us with expert advice on the pros and cons of the national tax route versus the nontax route to national health care reform; it will tell us how accessible health care benefits would be to different socioeconomic groups under the different approaches to national health care reform; and it will also require the systems experts to give an objective evaluation of the pros and cons of the administration's own approach.

I believe this systems study and the fine set of hearings planned by Senator Kennedy can provide the Congress and the administration with a rational means of approaching solutions to our national health crisis. I am hopeful that these vehicles can serve as a basis for cooperative discussion and analysis by all interested in bringing our citizens the quality of health care they deserve and can have.

Thank you, Mr. Chairman.

Senator KENNEDY. Senator Dominick?

Senator DOMINICK. Thank you, Mr. Chairman.

I am delighted to be here this morning, Mr. Secretary, as the ranking member of the health subcommittee, and to have the opportunity to hear you on how to improve the health care in the United States. I might say here that I watched you on Face the Nation yesterday, and thought you did a remarkably excellent job in describing the administration's programs.

I discussed various aspects of this complex problem with you before, and came away very impressed, not only with your understanding of it, but your balanced and realistic approach to finding solutions.

It is clear to me that the improvement of our health system, in order to make good health care available to all Americans, is one of the most urgent and important challenges facing the United States today. The President, in my opinion, has put forth a proposal that will meet that challenge, and I give it my endorsement.

It is comprehensive, imaginative, and balanced, and, importantly, it can be implemented at a cost which this country can afford. It will retain and strengthen the good features of our present system, and will provide maximum opportunity for participation by the private sector.

It envisages a pluralistic rather than a monolithic system, which will preserve a wide range of choice for both deliverers and consumers of medical care.

Now, Mr. Chairman, this committee will be considering this legislation offered to implement the President's proposal, as well as that offered by others, and there are, of course, going to be differences in

the committee, and I am sure, in Congress, as to the various legislative approaches.

I think these differences are primarily going to be one with respect to methods, rather than goals. As far as I am concerned, it is important that any legislation we report should preserve a wide range of choice, to doctors, to hospitals, as well as patients, and should provide the maximum opportunity for participation by the private sector.

I look forward to participating in the deliberations of this committee, and I hope that we can reach a resolution that will not put the private medical profession out of business, as I think some of the proposals that have been made would do.

I thank you, Mr. Chairman.

Senator KENNEDY. Senator Nelson? Senator Schweiker?

Senator SCHWEIKER. Thank you, Mr. Chairman.

I just would like to welcome the Secretary before our committee today, and say, too, that we all know the health crisis is very severe. I think this severity in itself creates an opportunity for a constructive health care program.

I am glad to see that our committee has begun a dialog between the administration and the Congress, and also a dialog between the Congress and the people. I think this dialog can only accrue to the benefit of the American people as far as our health care is concerned.

Thank you, Mr. Chairman.

Senator KENNEDY. Senator Eagleton?

Senator EAGLETON. No comments. Thank you.

Senator DOMINICK. Could I have unanimous consent to put in a statement in behalf of Senator Javits?

Senator KENNEDY. It will be so included.

(The prepared statement of Senator Javits follows:)

PREPARED STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM
THE STATE OF NEW YORK

Senator JAVITS. I congratulate the chairman for initiating extensive hearings on America's health care crisis. I have long urged we begin extensive examination of the shortcomings of our health care system, evidenced by skyrocketing costs and exacerbated by inadequate health personnel and facilities. I believe the hearings will provide a framework upon which the committee can implement the President's health message, which urged us to build a national health strategy to assure that quality health care is readily and equally available to all Americans.

We are confronting a deepening and massive crisis in America's medical system and we need a new approach equal to the complexity of the multifaceted challenge confronting us. The President urged we utilize a new concept—the reorganization of the delivery of health care through the development of an organization to provide a comprehensive range of medical services for a fixed contract price, paid in advance by all subscribers—which is, I believe, vital.

This new method can have a variety of forms and names and sponsors. The President applied the term HMO's (Health Maintenance Organizations). I choose to accomplish that end and provide for the rationalization of medical care services and facilities by comprehensive health service systems and last week introduced the Local Com-

prehensive Health Service Systems Act of 1971. This measure has been referred to this committee for consideration and I ask unanimous consent, Mr. Chairman, that a copy of the bill, S. 837, together with my floor statement and analysis of the bill's provisions, be made a part of my remarks.

I believe our committee's study through this series of hearings on America's health care crisis will help arouse the conscience of the Nation to join together in a common effort to meet this crisis and develop a better and universal system of health care for every American—more readily accessible, more economical, and more equitably distributed.

At this point we will enter a statement by Senator Prouty.

**STATEMENT OF HON. WINSTON PROUTY, A U.S. SENATOR FROM
THE STATE OF VERMONT**

Senator PROUTY. Mr. Chairman, I welcome these hearings and the opportunity to explore the future of health care in our Nation. We have a health care system that has contributed so impressively to the conquest of disease, but has not been able to distribute the benefits of its research equally to those in need. The system has aroused the hopes of the people, but they became frustrated as we encountered roadblocks to the application of these discoveries. The system has proven excellent at discovery but poor at delivery.

I should note that while these hearings may open a debate on the financing mechanisms for health care, they find a common agreement on the need to redirect the supply of health care services as we consider the expansion of demand for such services. In our deliberations on medicare and medicaid in the early 1960's, consideration of the impact of increased demand was overlooked in our deliberations and all Americans have paid the price.

At the onset of these hearings, I should note that I have an open mind about the alternative health care plans before us. At this point in time I have more questions than answers.

We rank eighth in life expectancy for females—behind the Scandinavian countries and England and France.

We rank 13th in infant mortality—behind those same countries and Australia, New Zealand, and East Germany.

We rank 27th in life expectancy for males—behind those above and Japan, Poland, Czechoslovakia, Bulgaria, Greece, and the U.S.S.R.

What is worse, we are falling back rather than catching up: 20 years ago, we ranked sixth, seventh, and 10th respectively, in these three measures of our health status.

Senator KENNEDY. We are privileged to have you with us as we open these hearings, Mr. Secretary. We want to welcome you and thank you for coming at the outset of the hearings.

Mr. Richardson is a native of my home State of Massachusetts, and my acquaintance with him goes back over many years. He has had a distinguished public career at both the State and National levels, which eminently qualifies him for the position which he occupies today.

Secretary Richardson has held office in Massachusetts, both as attorney general and Lieutenant Governor, before he left elective office in his home State and served under President Eisenhower as the Assistant Secretary of Health, Education, and Welfare. And when President Nixon came to office, he called Mr. Richardson back to serve on the Federal level as Assistant Secretary of State. His tenure there was marked by considerable contributions in the field of strategic arms limitation and by his great organizational talents.

He has brought these same talents to the Department of Health, Education, and Welfare, where he has served with energy and distinction.

So it is with a feeling of high respect that we await the Secretary's testimony today. We are embarking on a truly momentous exploration of the present and future of health care in our Nation and we hope we are approaching this vitally important subject not in the spirit of political debate but in the spirit of national dialog.

This is certainly my intention, and judging from the even-handed and reasoned approach that Secretary Richardson has taken in his public discussions of health care, I believe it is his intention as well.

With that spirit in mind, the committee looks forward to your testimony, sir.

Your prepared statement will be printed in the record following your testimony.

STATEMENT OF HON. ELLIOT L. RICHARDSON, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY LEWIS H. BUTLER, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION; AND DR. ROGER O. EGEBERG, ASSISTANT SECRETARY OF HEALTH, EDUCATION, AND WELFARE FOR HEALTH AND SCIENTIFIC AFFAIRS

Secretary RICHARDSON. Thank you, Mr. Chairman, and members of the subcommittee.

I am flanked by my colleague, Dr. Roger Egeberg, Assistant Secretary of HEW for Health and Scientific Affairs, and on my left by the Assistant Secretary of HEW, Lewis H. Butler, Assistant Secretary for Planning and Evaluation. Behind me is Deputy Under Secretary Robert Patricelli.

These three gentlemen, with others, have worked very closely together with me and with members of the White House staff and representatives of other Departments, in a very broad, we hope, thorough analysis of the health problems confronting the United States.

I think it is fair to say at the very outset, Mr. Chairman, that our diagnosis of these problems is very close in all its essential elements to that with which you opened these hearings, and so we particularly welcome the opportunity to try to contribute in the spirit you described to a developing national dialog on this extremely important subject.

I appreciate particularly, Mr. Chairman, the opportunity to read what, while on its face is a rather long statement, nonetheless is a

succinct survey of these interrelated problems and what seem to the administration to be appropriate responses to them, as we could produce.

On February 18, the President sent to the Congress his proposals for "Building a National Health Strategy." Today, I should like to discuss the problems, and their causes, that led to the remedies proposed in the President's health message.

I should like to convey to you our understanding of the principal health problems and their causes, because if we misunderstand the nature of the problems, we shall likely apply the wrong solutions. And further, if we are to debate the issues meaningfully and productively, it would be well for all to start at least, by agreeing to discuss the same issues.

STATUS OF THE NATION'S HEALTH

Amid all the passions raised about health in the United States, it is all too frequently forgotten that a variety of measures indicate that the health of our people has been steadily improving. Since 1950, life expectancy has increased by 3.4 percent, the infant death rate has dropped 2.3 percent, the maternal death rate has gone down 66 percent, and the neonatal death rate has fallen by 19.5 percent.

Between 1960 and 1968, the days lost from work per person have decreased by 3.5 percent, and the days lost from school per person have decreased by 7.5 percent.

Another set of indices tells us that the national effort to purchase better health has been expanding at a rapid rate. Health care expenditures, for example, have been increasing at a faster rate than the growth in the gross national product: in 1955, total health expenditures were \$18 billion, or 4.7 percent of GNP, whereas in 1970 they amounted to \$67 billion, or 7.0 percent of GNP.

Federal health expenditures have increased at an even faster rate. The public sector increased its share of health expenditures from 25 percent in 1966 to more than 37 percent in 1970, two-thirds of which is the Federal contribution.

Yet other indices inform us that resources have been growing faster than has population, especially in recent years. There were 12.4 hospital beds per 1,000 people in our civilian population in 1963; by 1968, there were 13.5. Between 1950 and 1966, while the population of the United States was increasing by 29 percent, the number of people in health occupations increased by more than 90 percent—three times as fast.

In 1960, health workers comprised 2.9 percent of the civilian labor force; by 1966, the percentage was 3.7 and rising. Our supply of physicians increased by 34 percent in the same period.

Finally, in our review of the facts, we note a market rise in health insurance coverage for all members of our population. In 1950, 48.7 percent of employed workers were covered for hospitalization; in 1967, almost 72 percent were so covered. In 1950, only 35.5 percent of employees were covered for surgical benefits, 16.4 percent for regular medical benefits, and none for major medical expenses. In 1967, the comparable percentages were 70.5, 61.2, and 28.8.

I hardly need recount the gains that have been made in providing financial protection against illness under medicare and medicaid for

the aged and the poor. For the population as a whole, 20 years ago, only 50 percent had health insurance; today, it is 80 percent.

I conclude from these facts, and I believe you will agree, that in general our critical health problems today do not arise because the health of our people is worsening, or because expenditures on health care have been niggardly, or because we have been negligent as a Nation in developing health care resources, or because we have been unconcerned about providing financial protection against ill health.

We must look elsewhere.

THE BROAD PROBLEMS

I should like to suggest that our present concern is a function of two broad problems. The first is the inequality in health status and care, and in access to financing. The other is the pervasive problem of rising medical costs.

The statistics I have cited, while true, are gross, and pertain to the Nation as a whole. The mask differences among subpopulations in the United States, and these differences have become intolerable.

The impressive growth in the number of people covered by health insurance conceals the fact that only 29 percent of all personal health expenditures were paid by insurance in 1968.

The satisfaction with which we view the spread of medicaid to 48 of the 50 States is lessened by the knowledge that only one-third of the estimated poverty population received services under this program in 1970, and only 133,000 of an estimated 750,000 women and infants in low-income circumstances received comprehensive maternity and infant care.

The indices of general improvement in health pale in importance when we look behind them and see that the poor and nonwhites are doing far worse than whites and those with decent incomes.

Our resources, to be sure, are growing at a rapid rate. But that can offer little reassurance to the people of Mississippi, with fewer than one-half the national ratio of physicians to population, or to the people in 1,000 midwest towns where there were no physicians at all in 1965, or to the ghetto populations in Chicago and other major cities for whom the presence of a physician in their neighborhoods is a rare sight indeed.

Finally, when we look beyond our borders and compare ourselves with other nations, any sense of accomplishment over our long-run gains in health status is mitigated by the fact that other advanced nations are doing better than we are. While crossnational comparisons are imperfect and must be used with caution, we note that Sweden, which devotes about as much of its national product as we do to health, outperforms us on comparable health indices. That nation's infant death rate, for example, is about half ours.

Twelve countries have lower maternal death rates than we do; 17 have longer life expectancies for their men; and 10 have longer life expectancies for their women.

These disparities point to a gap between what we have accomplished and what remains to be accomplished, between our achievements and our expectations, between what is and our impatience for what might be.

And let us all agree that it is for the best that we have high expectations and grow impatient with the pace of change, and are incensed by the mortal injustices in the fortunes of birth. I do not doubt for one moment that, regardless of political affiliation, regardless of our positions in the Federal Government, we share today the same sense of concern over these disparities in race, age, income class, geographical location, and financial protection against illness.

The other major problem to which I referred was the pervasive inflation in medical costs. I hardly need remind this well-informed subcommittee that, since 1960, hospital costs have been rising at 15 percent a year, and physician fees have been increasing at more than twice the rate of the Consumer Price Index.

Under these circumstances, relatively minor episodes of illness become heavy burdens, and serious illness is transformed into large and lingering debts, and sometimes bankruptcy.

Just as we find the disparities in health status among our people to be intolerable, so too do we find the rising cost of health care, for individuals as well as for the Nation. We are dismayed over health care costs by our realization that other hopes and purposes are being usurped.

For the young family whose savings are wiped out by an illness, it is more than a bank account that has been depleted—it may be the end of their hopes for their first home. Likewise, for the Nation, the dollars we spend on medical care are dollars we cannot spend revitalizing our cities, reducing pollution, or improving our transportation systems. This is not to downgrade the importance of health. But it is not the only important purpose we have, and if the same amount of health can be obtained with fewer dollars, then we shall all be better off.

Causes:

So far, I have tried to share with you our conception of what is and what is not at the crux of the health care crisis. I should now like to probe a bit into the causes, not to blame or accuse anyone or any institution, but rather to understand, and thus fit the remedy to the cause.

At the outset, we should understand that the low health status of the disadvantaged in our society simply replicates their low status in other respects: their housing is poorer, their education is poorer, their job opportunities are poorer, and so on. All these factors are interdependent.

I wish, therefore, to underscore the point made by the President in his February 18 message, that the welfare reform proposals are also a health message, that the administration's expanded efforts to end hunger in America are a health message, and that whatever we do to improve the education of the disadvantaged, to create jobs through a full-employment budget, and improve the environment of our inner cities and rural areas, will also constitute a health message.

We must be very careful, especially in reviewing the health problems of the disadvantaged, not to restrict our vision to medical care alone.

There are a number of other causes that we may group together and understand in terms of rewards and penalties or, to use the jargon of economists, incentives and disincentives. It is fair to say that normal

people generally pursue rewards and eschew penalties, and much of the behavior that has produced disparities in health care as well as in rising medical prices can be understood within this context.

As an example, for some time there has been a migration to our large urban areas. It is to be expected that physicians, as well as other service personnel, dependent as they are on a reservoir of population for their livelihood, would migrate also.

Lately, physicians have left the center cities and moved to the suburbs because there were no disincentives—no loss in income or status or professional prestige—for doing so, and they sought the same amenities that others were seeking in moving to the outskirts of the “urb.”

Similarly, fewer services have become available from primary care physicians—general practitioners, pediatricians, and internists—because their numbers are declining. And they have been declining for a number of reasons: the large infusion of research dollars into the medical schools after the Korean War gave young medical students a clear signal of national priorities.

Moreover, the increase in knowledge has been leading to an increase in specialization, and some specialties have been—both from the press they received as well as the heights to which their incomes could reach—more prestigious than others. They obviously have been more prestigious than the local medical doctor, as some medical schools still contemptuously refer to the family physician, practicing in “Elsewhere, U.S.A.”

Our medical care system is geared to sickness, not to health. Under these circumstances, the incentives have been to care for the sick, and constantly to do a better job of caring, and few incentives or none to prevent illness, or to diagnose illnesses in their early stages and treat them before they become “interesting.”

Along somewhat similar lines, we have very powerful incentives in our society to smoke, drink, eat excessively, and lead sedentary lives. These have taken enormous tolls in heart disease, lung cancer, automobile accidents, and the like.

Beyond these causes is a simple one—that people are generally shortsighted, preferring to take pleasure where they may and ignore the Devil’s due waiting to be paid in the future.

And there are complex causes, such as cutting up our living space in such a fashion that it is inconvenient to do anything without a car, and leaving few places in which to play.

As an aside, I do wish medical scientists would discover how to enable us to be as obese as Winston Churchill, smoke as much as he did, drink as much as he did, and live as long as he did—and, oh yes, be as smart as he was—instead of discovering that we shall survive longer if we give up tobacco, alcohol, and fine foods. As the old joke had it, we may not live to be a hundred, but it will seem like it.

Incentives that have led to inflationary medical costs are not too difficult to discern. When medicare was introduced, it provided that physicians would be paid their customary fees. Some had been giving care free of charge or at prices below what they considered to be their value, and hardly customary. Hence, there was a rather rapid jump in the cost of physicians’ services after the birth of medicare.

Medicare and medicaid, as well as private health insurance companies, have been willing to reimburse hospitals at cost, which has become a euphemism for a blank check. There has been little incentive to hold down costs, to search for means of increasing the productivity of health manpower and facilities, or to substitute capital for labor.

Our insurance plans also reward people if they go to the hospital for services, and penalize them if they obtain the same services outside the hospital. No wonder, then, that hospitals have been excessively and inappropriately used.

In trying to understand the reasons for the lack of depth in our insurance coverage—as stated earlier, covering less than 30 percent of personal health expenditures—we cannot find a satisfactory answer either in the factors underlying the problems of the poor or in the rewards and penalties that have led the medical care sector to behave they way it does.

The disparities in this instance have been pointing to a fundamental inequality in access to a basic necessity. This inequity has been recognized for what it is, namely, a social injustice. And that is intolerable.

Remedies: All too briefly, I am afraid, I have tried to bring into the light of discussion a description of the problems we confront, and their causes. The equation for the remedies quite obviously is not found in a child's primer.

This administration's proposals, as I shall now endeavor to show, are addressed to the specific problems and their causes, and together constitute a strategy for reforming and renovating our health care system. I am firmly convinced, to recall a phrase used by Jefferson, that we have found the right-sized patch—neither too large nor too small—to cover the hole.

Our proposals largely reflect our desire to lodge new responsibilities with our people and institutions, trusting them to be responsive, having faith in our system and its ability to change. At the heart of these proposals is a basic governmental philosophy underlying the President's proposals for revenue-sharing, the consolidation of categorical grants, and the reorganization of the Federal Government.

Its roots are in the liberal philosophy of Jefferson, that calls for decentralized and pluralistic foci of power, and shaping the Federal role into a precision instrument. The health proposals are a part of this pattern.

What, then, do we propose? I could categorize our proposals in a number of different ways, but I prefer to present them to you in relation to the problems and their causes and in terms of their objectives.

Problems of Distribution: The Nation is confronted by a geographic maldistribution of health care services. The administration proposes to attack this problem in many different ways.

We shall promote the development of health education centers, which are community facilities generally affiliated with medical and dental schools for the training of physicians and other health personnel in areas deficient in the supply of these resources.

We shall thus encourage medical schools to expand their capacity for graduating physicians in these areas at a much faster pace than in the existing medical school buildings. We shall encourage them to

hold down the cost of medical education by converting community hospitals and other clinical facilities into teaching facilities.

In effect, we shall implement the recommendation of the Carnegie Commission report on "Higher Education and the Nation's Health." The fiscal year 1972 budget will contain up to \$40 million for this purpose.

Senator KENNEDY. Mr. Secretary, we just have received your testimony this morning, so I don't know whether you are going to have a chance to elaborate on how you think the \$40 million or the various loan programs are going to meet the stated objectives of your testimony. I hope you will develop that at a later time. If not, I think that is one of the most imaginative and creative aspects of the President's program. I hope that you will have a chance to elaborate later on.

As I say, I am just following your testimony as you are proceeding now.

HEALTH MAINTENANCE ORGANIZATIONS

How many are you going to develop? What number do you think you will be able to realize with the direct grants or planning grants that you have outlined in the program? How many people you think will be served by them?

We really want you to have a chance to elaborate. If it is included later in your testimony, I will wait until then. If not, I do think that you ought to perhaps go into that subject.

Secretary RICHARDSON. I think. Mr. Chairman, that if I could give this broad overview, we would then be glad to come back to the elaboration of any of the proposals, including the pace at which the various elements of the system would be developed.

At this point, I would just note that the \$40 million for the area health education centers is a first-year figure, beginning with the fiscal year beginning this coming July, and it is an important part, of course, of the capability of our system to provide care. And so this proposal, and some others that have to do with supply component are designed to go forward as rapidly as possible, leaving the financing proposals to come at a later stage, after hopefully some momentum has been developed in improving the capacity of the system.

We shall provide incentives for the development of health maintenance organizations that will emplace health care resources in areas now lacking them. I shall have more to say about health maintenance organizations later, but it is important to note here that they will serve to ameliorate distributional as well as other problems. We shall expand support for the training of Medex and similar types of physicians' assistants to enlarge the capacity of physicians to care for patients, and to lessen the burden that many family physicians carry in small towns and other scarcity areas.

We shall support the development of new neighborhood health centers or, as we prefer to call them, family health centers, which will later evolve into health maintenance organizations or health maintenance organization satellites.

We shall create a new health service corps under the authority of the Emergency Health Personnel Act of 1970. Because this will be a

direct Federal activity, and because, at best, it will operate only on the margin of the total health care industry, we look on these efforts as a necessary short-run measure to assist in overcoming blatant geographical disparities before other efforts to improve the distribution of the entire health care industry take hold.

We shall provide incentives to new medical and dental graduates to practice in areas lacking physicians and dentists, by forgiving part of all of the guaranteed loan indebtedness they incur while in school. I should be less than frank if I were to suggest that we are extremely optimistic about the likely success of this proposal. However, we are hopeful that a growing idealism among medical students, the size of their indebtedness, or their awareness of the urgent needs will in fact make this proposal work.

The Nation is also confronted by the maldistribution of certain types of services, and primary care services in particular. As pointed out earlier, the absolute and relative numbers of family physicians, pediatricians, and internists together are declining. Yet these types of physicians can handle most of the illnesses people have, they provide more services than other specialists, and the unit prices of their services are lower than those of other specialists.

Furthermore, it is to be noted that while other advanced nations who appear to do better than we on health indices, have fewer physicians in relation to population, they have a higher ratio of primary care physicians.

Our proposals, therefore, contain incentives to increase the supply of primary care physicians.

In the new area health education centers, we shall provide support for setting up residencies in the primary care specialties.

We shall offer support for medical schools to set up preceptorships or clerkships for undergraduate medical students to enable them to obtain firsthand experience in the primary care specialties and to provide a counterbalance to the incentives in medical school today to concentrate on hospital-using specialties.

Our loan forgiveness provisions will apply also to students who enter the primary care fields.

Through the development of health maintenance organizations and area health education centers in scarcity areas, we shall be helping to create an environment and a type of practice that should be appealing to primary care physicians.

We shall greatly expand the Nation's efforts to train child health associates or pediatric nurse practitioners, obstetric assistants, or nurse midwives, as well as assistants for general practitioners and dentists.

Our studies indicate, for example, that if we can produce about 3,000 child health associates a year—a quantity beyond the present capacity of our training facilities—within 5 years we should be able to provide an adequate supply of child health services for the entire population, with only a modest increase in the supply of pediatricians and not unrealistic changes in their geographic distribution.

MEDICAL COSTS

I should now like to turn to the administration's proposals to bring medical costs under control.

For the long run, our strategy calls for a determined effort to prevent illness, and thereby reduce demands on our health care resources. Among our proposals in this regard, the most important are:

To maintain the broad base of our biomedical research attack against most of the diseases and impairments that afflict mankind, and upon that base, launch major new programs to conquer cancer. As you know, we propose an additional \$100 million in fiscal year 1972 for this purpose.

We shall also increase our efforts fivefold to determine means of preventing or controlling sickle cell anemia, a disease that is found almost exclusively among our black population and occurs in one out of 500 births.

We shall help create a private Health Education Foundation, whose objective will be to make every citizen aware of the importance of maintaining good health—to avoid cigarettes, to avoid excessive use of alcohol, to eat a well-balanced, nourishing diet, to maintain physical fitness, and the like.

We shall implement the Occupational Health and Safety Act for our working population and, in particular, to improve the safety of those who handle toxic substances. I should also note that mandating employers to provide a basic insurance coverage for employees, which I shall discuss in a moment, in conjunction with the health maintenance organization option, should provide an incentive to employers to improve the healthfulness and safety of the work environment.

We have added \$62 million in fiscal year 1972 for family planning, almost doubling last year's program. As a health measure, family planning not only allows women to avoid the birth of unwanted children but also can prevent illnesses of mothers and children through, for example, the proper spacing of births.

To improve the nutrition of households in general, and of children in particular, the administration nearly tripled the outlays for food stamps between fiscal year 1970 and fiscal year 1971—from \$577 million to \$1.4 billion. The fiscal year 1972 budget calls for more than an additional \$500 million.

The child nutrition programs nearly doubled between fiscal year 1970 and fiscal year 1971—from \$299 million to \$522 million, and an additional \$39 million has been requested for fiscal year 1972.

As I pointed out earlier, other actions and proposals of this administration will have a decided preventive impact on the health of our people—including rigorous controls over environmental pollution, the welfare reform proposals, and others.

In addition to the anticipated reduction in demand for health services through the agency of prevention, we are also proposing a number of direct actions to reduce medical care costs. In effect, we are offering incentives to shift the medical care industry from its preoccupation with acute care in hospital settings.

Rather, we will offer incentives for the application of preventive measures—procedures like immunizations, to prevent an illness from occurring, or like Pap smears, to catch a disease in its early and treatable stages, or like the early ambulation of surgical patients, which leads to early recovery and rehabilitation.

We believe that this shift will occur, if there are sufficient incentives. Prepaid arrangements in health maintenance organizations, we be-

lieve, provide such an incentive. Under these arrangements, health maintenance organizations will receive a contractually-fixed amount for the care of their enrolled members.

If the health maintenance organizations health care staff pays little attention to prevention and continues with acute care in hospitals, then they will exceed the contracted amount for the care of each person. If, on the other hand, the health maintenance organization bends its concern to prevention—or, in other words, to low cost care—its costs will be within the set amount. It will profit by maintaining the health of its members.

Will this be sufficient incentive? We believe there is convincing evidence to warrant that conclusion. Moreover, when populations with similar characteristics are compared, those served by existing HMO-type organizations do better on measures of health than those who receive services under other auspices.

This leads us to conclude that the quality of care is not sacrificed when health care providers consciously try to control costs.

Group practices and foundations, similar to our conception of health maintenance organizations—and which I shall henceforth refer to as health maintenance organizations—compare favorably with other means of providing care. Data on hospital use for 1,000 persons per year as follows: in health maintenance organizations, 744 hospital days versus 955 in the others; 70 hospital admissions versus 88; 49 hospitalized surgical cases versus 69; 47 tonsillectomies versus 94.

These comparisons were standardized for age, sex, income, residence, and, excepting tonsillectomies, out-of-plan services. In comparing the annual health costs per family in health maintenance organizations with costs under two different insurance plans, we find that the premium and out-of-pocket costs totaled \$224 in the health maintenance organizations, \$252 in one insurance plan, and \$259 in the other.

We also compared the average medicare benefit payments per person in two regions in which there were both health maintenance organization (HMO) and nonhealth maintenance organization beneficiaries. In one region, the savings in medicare payments amounted to 15 percent in the health maintenance organization; in the other region, the savings were 7 percent. These data were standardized by age and residence.

Health maintenance organizations also compare favorably on measures of health. In health maintenance organizations, premature births per 100 live births for whites was 5.5 and 8.8 for nonwhites; in traditional modes, the comparable figures were 6.0 and 10.8. Infant mortality among whites per 1,000 live births was 22.7 in health maintenance organizations; outside, it was 27.3; while, for nonwhites, the figures were 33.7 and 43.8.

The annual mortality of the elderly population, 18 months or more after joining a health maintenance organization, was 7.8 percent; outside, it was 8.8 percent.

Experiments with health maintenance organizations over the years indicate that such an environment provides an inescapable context for peer review—a quality control factor for the most part absent among physicians who practice alone and whose use of hospitals is a matter of privilege.

We have no intention of leaving quality control simply to chance. Review for quality of care as well as for the utilization of resources is part and parcel of our proposals. We are, in fact, providing for several kinds of checkpoints.

We are proposing that professional standards review organizations (PSRO's) be established within the States to take a number of actions under the direction of the Secretary of HEW. They will determine, for example, whether the quality of care meets professional standards, and whether resources are being used efficiently and effectively. They will review both health insurance and HMO contracts.

Furthermore, to advise the Secretary of HEW and to assist him in contracting with professional standards review organizations (PSRO's), we propose setting up a national professional review council, comprising representatives of the health professions as well as representatives of employers, labor groups, and consumers.

This council will review the activities of the local professional standards review organizations and publish information on comparative performances, as well as undertake other activities on behalf of the Secretary.

We shall also request—and this proposal should be viewed as well in the light of the President's efforts to improve the planning capability of State and local governments—that State and local planning agencies review and comment on all forms of assistance to health maintenance organizations. Under medicare, the planning authorities will have veto authority over capital reimbursements to health maintenance organizations, with, of course, an opportunity for health maintenance organizations to appeal such decisions to the Secretary.

Before I take up our insurance proposals, I should like to point out that we are proposing to offer \$23 million in fiscal year 1972, in planning grants and contracts to initiate some 100 health maintenance organizations. For health maintenance organizations serving areas that are now underserved, we shall offer an additional \$22 million in grants, contracts, and loans for fiscal year 1972, and provide for up to 3 years of operating support.

We shall also seek authority to guarantee as much as \$300 million in loans for capital and working costs. Beyond that, however, I intend to see that my Department puts together "packages" of resources, negotiating with a single instrument and permitting advance payments to be made—with later adjustments, if necessary—to enable Health Maintenance Organizations to get as rapid a start as possible.

I am convinced that the frustrating experience of those who earnestly wish to implement national purposes but are blocked by the compartmentalization of Federal funding can be ended, and will be ended—in HEW.

Our health insurance proposals, described below, provide additional incentives to reduce costs. Both in the mandated employer-employee plan and in the family health insurance plan, benefits include outpatient as well as inpatient surgical and medical care.

Moreover, services in extended care facilities or in the home can be substituted for equivalent inpatient hospital care.

To encourage the use of outpatient services and to reduce unnecessary utilization of health care resources, we are proposing differential

coinsurance payments and deductibles on a rising scale. Outpatient coinsurance will not apply until family (of four) income exceeds \$4,000 a year; hospital deductibles will take effect only when family income exceeds \$3,500. Preventive services are not subject to deductibles.

Cost consciousness must be a fact of life not only for Health Maintenance Organizations, but for all our citizens above a minimum income level. When people pay virtually nothing for a service, they have little incentive to use the resources efficiently or to keep demand within reasonable bounds.

We do not believe that the suggested coinsurance and deductible schedule will create a barrier to the use of services for those truly in need of them. But they should be sufficient to create an awareness that resources are not free.

FINANCIAL ACCESS

In addition to improving the distribution of services and reducing the inflationary rate of price increases for medical care, our objective is to improve financial access to care—in the President's words, "to insure that no American family will be prevented from obtaining basic medical care by inability to pay."

We therefore offer a comprehensive national health insurance program that draws on the strengths of both the private and public sectors. The main elements of our proposal are:

A national health insurance standards act, which will require nearly all employers to provide basic health insurance coverage for their employees. The precedents for this proposal are to be found in the minimum wage laws, disability and retirement benefits, and occupational health and safety standards.

The minimum benefits will include outpatient and inpatient services, maternity care, well-child care, and the care of children's eyesight, as well as catastrophic cost protection amounting to at least \$50,000 per person with an automatic restoration of \$2,000 per year.

Employers and employees will share the costs, and deductibles and coinsurance will be required—the latter for up to \$5,000 in medical bills per person per year. The employers' share will begin at least at 65 percent, rising to at least 75 percent.

Employers will have to provide their employees with an option of obtaining services through traditional providers or in prepaid Health Maintenance Organizations if available. Cost control measures, utilization review, and quality standards will be required of all providers, as I noted earlier.

The second element is the family health insurance plan. This plan will provide basic health insurance protection for all low-income families with children, not covered by the employer plan. The benefits will be federally financed and uniform throughout the States, and include both outpatient and inpatient services.

The plan will remove the inequities in the medicaid program between families headed by a woman and those headed by a man; among the States with regard to varying eligibility requirements and among income groups, by scaling cost sharing so as to avoid the sudden loss of benefits.

In the family health insurance plan, as in the employer plan, options for care under HMO's will be included; and there will be similar requirements for quality standards, cost controls, and utilization and peer review.

The third element will be to continue the medicaid program for the aged, blind, and disabled.

The fourth element will be to have employers and employees pre-pay contributions for that share of the part B premium in medicare to which the aged now contribute for physician services—about one-half the costs. General revenues, which have paid for the other half, will continue to do so.

The fifth and final element calls for the establishment of private insurance pools for risk sharing among employers with small numbers of employees, the self-employed, and people outside the labor force. This proposal will enable such individuals and firms to purchase insurance at group rates.

I am aware that there are some who are uneasy about the partnership we propose with the insurance industry, an essentially unregulated industry. This has surely been an anomaly in the past. It need not and will not be.

This administration is proposing that the insurance industry be regulated. We shall see to it that citizens have better and cheaper coverage through competition among carriers. The abuses that have been reported in the past—lack of clarity on coverage and exclusions, failure to perform claims and utilization reviews, exclusions of high risk groups, and sudden cancellations of policies—will be fairly but firmly dealt with.

HEALTH MANPOWER

I should like to discuss one further subject. In many of our proposals, you will have noted that we are asking the health professions as well as the schools that train them to assume a significant share of the responsibilities for reforming and renovating the health care delivery system.

To no small extent, the professional schools will have to undertake reforms of their own in order to carry their share. I have already mentioned the desirability of expanding enrollments in area health education centers to improve the distribution of health services, and converting existing nonteaching facilities into teaching facilities to hold down costs.

But there is more to be done. And once again, we have structured our incentives to encourage the schools and students to move toward these other objectives.

At the same time that we are making demands of the professional schools, many of them are experiencing financial distress. The administration proposes to increase support to diminish and possibly eliminate this distress.

Our specific proposals, and their objectives, are these:

We shall increase the basic support of medical, osteopathic, and dental schools about threefold, on the average. This basic support will be in the form of a capitation grant for each student the schools graduate. The average capitation amount now is about \$600 per year,

or about \$2,400 over a 4-year period. Our proposal calls for \$6,000 for each graduate.

The emphasis is on graduates for several reasons. First, it tells the schools that we are interested in their output, not their enrollments. Second, it provides an incentive for the schools to shift to 3-year curricula; if they do, instead of spreading \$6,000 over 4 years, at \$1,500 per year, they would spread it over 3, which would mean a "bonus" of \$500 per year for each graduate.

Third, it should encourage schools to replace students lost by attrition—by, for example, integrating the professional school curriculum with the curriculum of the graduate science departments in universities. While attrition has dropped to about 8 percent in medical schools, and schools are replacing some of those who have dropped out, the remaining vacancies constitute the output of seven or eight large schools.

Finally, if the schools reduce the length of their curriculum by 1 year, the students will be a year closer to earning their professional incomes—in effect, reducing their educational costs.

In addition to the basic capitation grants, special project grants will be awarded to achieve such specific objectives as: Expanding enrollments, revamping the curriculum, training physicians and allied health personnel to work as a team, and participating in the development of a health maintenance organization.

In line with the administration's efforts to improve the management of grants, we are recommending that five construction grant programs for health training facilities be consolidated into a single authority, and that resources in the form of guaranteed loans and other financial incentives be added.

Our construction authorities in general will be used to modernize existing plants, to convert nonteaching facilities into teaching facilities, and to assist the schools in expanding their enrollments. We anticipate that this consolidated authority will generate approximately \$340 million in construction above current levels.

For student support, we are particularly interested in improving the mix of minority students—now vastly underrepresented in health professional schools—and other students from low-income backgrounds, as well as insuring that finances will not be an obstacle to any student who wants a professional education.

To achieve these objectives, we are proposing to increase scholarship aid for medical and dental students from \$15 million to \$29 million—to an average of \$3,000 a year per student. To help alleviate the concern of low-income students who may have to borrow funds and who are afraid to carry the burden of a loan, we are proposing to forgive their indebtedness if they are unable to complete their professional education.

For all other medical and dental students, we are proposing that the students be allowed to borrow up to \$5,000 per year in guaranteed loans.

In closing, I cannot possibly overemphasize the importance of considering each of our proposals as an interlocking part of a comprehensive strategy. It would make little sense, it seems to me, to say "Go ahead and increase the supply of primary care physicians," but then

deny the means to provide an environment in which such physicians would be pleased to work.

It would make equally poor sense to say, "Let's go ahead and improve financial access to the health care industry," but then deny the means of improving the organization of that industry and of increasing its efficiency.

What we are proposing is not simply a compilation of bits of this and pieces of that. Rather, we propose an integrated strategy, at once coherent and comprehensive. It builds on present strengths. It seeks reform and renovation. It reposes trust and confidences in our people and our institutions.

That concludes my statement. Mr. Chairman and members of the committee. I would be glad to respond to your questions, to the extent that I can, and I hope that I may call upon my colleagues here for answers to questions that I can't answer.

Senator KENNEDY. Thank you very much, Mr. Secretary. It is a very extensive and comprehensive comment, which I know will provide a good deal of food for thought for all of us who are interested in this subject.

What I would like to do is open the hearing to some questions. I know there are many questions by different members of the subcommittee, so we will try to take just a few minutes at a time, and keep moving through various members of the subcommittee on both sides of the aisle.

You have many different features in your program, and one of the things those of us who are supporting different approaches towards meeting the health care crisis are interested in is what is going to be the impact of this program on Mr. Joe Q. Citizen?

Take, for example, someone who works on an assembly line out in Peoria and say he is operating under your program; as I understand it, he will have to pay 35 percent initially and later 25 percent of the insurance program.

I imagine that the individual cost comes to approximately a hundred dollars a year, based on general actuarial figures that it costs us about \$300 per person for health over the period of a year. So he will be paying, as I understand, about one-third of that \$300 cost. It will be about a hundred dollars that he will be paying?

Now, say his wife gets sick and she goes down to the hospital and has her appendix out. And she goes in there for a few days, say \$10,000 a year, will start off by paying \$100 as a deductible. And he will also pay the first 2 days in the hospital, which can cost anywhere from \$60 to perhaps \$100 a day.

So he is paying, now, under your program, approximately a hundred dollars under his contribution to the employer's program, then his wife gets sick; over the period of the year, he has the \$100 deductible right away, plus 2 days in the hospital, whatever that figure is. Let us say, at a minimum, it is an additional hundred dollars.

So with his wife getting sick and his own contributions, he is up to approximately \$300, as a very minimum figure. Then his son breaks his ankle or breaks his leg, and goes into the hospital. He is going to have to pay the first \$100 deductible again. Maybe his son will not have to stay in the hospital, but if he does stay in the hospital, that worker is going to have to pay for 2 more days in the hospital.

And then maybe thirdly, his wife is going to have a baby, and goes down to the hospital for the third time, or say it is another family accident, but they go for the third time. He is going to have that \$100 deductible and he is going to pay for the first 2 days in the hospital again.

So we start off with the worker who is paying approximately a hundred dollars or so for his contribution. Three family accidents require him to pay those opening deductibles and hospital expenses; if this sort of circumstances happens to him, it will cost \$600 to \$700, or more.

And as I understand further, that any additional kinds of expenses that he will incur, beyond, say, those few days, he is going to be required to pay 25 percent of those costs, up to \$5,000. And then he falls eligible to your provision where his expenses from \$5,000 up to \$50,000 are free.

Do I understand that if that set of circumstances occurred to that worker on the assembly line out in Peoria, and he is not covered by other kind of insurance from collective bargaining, this would be a reasonable interpretation of the kinds of expenses that that worker would be required to pay under these suggested programs?

Secretary RICHARDSON. That is a summary, Mr. Chairman, of the illustrative maximum contributions that an individual worker might be required to make if he received his care in the traditional manner.

To put it the other way around, an employer must have health insurance coverage for his workers and their families—that is at least that adequate. It might be more so. The problem, of course, is the problem of how much of the worker's own income and of income that might come to him if it were not siphoned off into prepayment health care costs, is a desirable balance to strike.

I think it is clear that if a larger share of the kinds of cost that you have summarized were to be prepaid, then the total payments by the family would be less than what you described. This occurs because an HMO balances the risk of Joe's family illness with that of others, all of whom have prepaid. So what we are really trying to do, in effect, is to strike a reasonable balance between the portion of health care costs that is paid for ahead of time through some form of employer-employee contribution, whether mandated as under our Standards Act or through taxes.

In any event, the dollars are going to be paid, and we think that it would represent major gains in coverage for millions of workers and their families to require coverage at least as adequate as this, even though one could very well imagine a more expensive program that would cover more of the costs.

Senator KENNEDY. If these circumstances occur—and they are not extraordinary in any given family, given the administration's kind of proposals, that worker would still be required to pay for these costs. When that worker comes and asks us what the cost will be to him, we would have to respond with the kind of example that I gave and with the deductibles and the kinds of payments that he would have to make.

Secretary RICHARDSON. This is true, but primarily if the family elects to have its care provided in the traditional manner. The health main-

tenance strategy I have outlined would provide the family with protection against a large number of coinsurance and deductible payments for only slightly higher premium payments by the employer or employee. Furthermore let me underscore the very substantial contribution to his relative sense of financial security, in comparison with his present situation, that is inherent in the \$50,000 coverage per person for catastrophic costs, with a maximum of \$5,000 in total bills over the year for any member of the family, which would be subject to coinsurance.

The most he would pay in that case would be \$1,250, or a quarter, after the quarter of the \$5,000, and in the case of very severe prolonged illness or injury, where the bills run over \$5,000 to \$10,000 or \$15,000 or \$20,000, the insurance program would pay the whole bill.

Every family, therefore, of an employed worker, would to this extent be relieved of the fear that catastrophic illness might wipe out savings and take the house and so on.

Senator KENNEDY. I wouldn't question the last observation you made—certainly in comparison to what exists at the present time. But I suppose I am looking at other approaches that would have suggested that the total payment that that worker would have, given the employee's tax, would reach the \$100 with no additional expenditures if his wife or his child or he went to the hospital.

He would lay out that \$100 a year, and you can't get away from the fact, and I think it is a terribly important fact, that still he would not have any of those additional deductibles which are under another program.

So I think we are not really trying to compare your program that we have here today versus what is in existence; for I think, as you stated so well and articulately in your comment, we have a crisis and the real question is the point of departure and the way we are going to reach our goal.

Furthermore, even under the passage of your program, in terms of, for example, working people, you also realize that there are a number of unions who have a more comprehensive measure than the one that is being suggested by the administration. So actually, they are not going to really benefit at all, are they? I am thinking of Teamsters, UAW, Machinists, Steel Workers, Rubber Workers, a number of others.

Secretary RICHARDSON. Well, even most of these would be benefited by the catastrophic coverage provisions, which are better than almost any collective bargaining program, by and large.

I would emphasize, too, that the health maintenance organization is important to this proposal; in them the deductible provisions you enumerated would not apply, because the family would have paid for the costs of comprehensive care in a total amount. They would have to pay slightly more, in premium costs, but once they had done this, the premium payment for membership in the HMO would take care of all the costs of the family's health care up to that point.

Senator KENNEDY. Of course, what we are talking about is this worker in Peoria. He wouldn't even be covered under your program during that first 90-day period, would he?

Secretary RICHARDSON. He would not be covered until he had been employed 90 days.

Senator KENNEDY. Until at least 90 days, so this fellow who goes to work and has any of these kinds of problems, is just out the window. To the extent that the present program—

Secretary RICHARDSON. No, he would be likely covered in that case by the family health insurance plan. We consider these as interfacing, and he continues 90 days of coverage under the family health insurance program, after he is laid off any job. So if he is reemployed within that 90 days, his coverage under the two programs in effect dovetails.

Senator KENNEDY. Nonetheless, the worker under this program, in order to show that perhaps either he or his family have visited the hospital three different times, is going to be required to keep all the various applications and all those forms, do all the paperwork. He is going to have to indicate, if he is going to, when his expenses get up to a certain figure, up to the \$5,000 figure, and be able to show when he comes back for the fourth time that actually he has been there three other times.

Secretary RICHARDSON. The record would be kept for him by the insurance carrier, as it is now, under group plans or by the health maintenance organization should he elect that option. I might add that the HMO, because it relies on prepayment and centralized record keeping, reduces the administrative costs and losses due to failure to collect coinsurance.

Senator KENNEDY. But I mean it is significant now that even under existing kinds of a feature, that 30 percent of the deductibles never get recovered by the people that are taking advantage of various health insurance programs at the present time.

And you are imposing not only a system that I think is going to be costly to working people but you are imposing on them, and I am very much concerned about this, a whole different administrative bureaucracy.

Secretary RICHARDSON. I don't see, Mr. Chairman, that it imposes a different bureaucracy. To the extent that employer-employee group plans apply now, there might be some modification in the requirements of coverage, but there would be no different kind of machinery necessary than applies now.

Senator KENNEDY. I suppose there would be those who would suggest that you would just be compounding the existing administrative bureaucracy.

Secretary RICHARDSON. Well, you have some bureaucracy under any program, and the question is whether on balance, the bureaucracy is likely to be held down in costs through a competitive system that allows carriers to compete for the business in any given employer-employee group, or whether it is likely to be compounded by a Post Office Department-like operation, for example, administered by Government.

Senator KENNEDY. Like Social Security?

Secretary RICHARDSON. I don't think there is any guarantee that a Social Security type operation for the entire population will involve less paper work and bureaucratic red tape than a privately run structure subject to competition and regulatory control.

Senator KENNEDY. Or Medicare. Those are national programs. And I think people that function within them are really quite con-

tent about it. They are not content that the kind of benefits that they have are sufficient or adequate, but when these words are talked about, nationalizing or national program, I think those people that believe Social Security is a national program or Medicare a national program, are extremely happy and content under those. I don't see why an additional insurance program that provides basic equality of health as a matter of right should provide any additional threat.

Secretary RICHARDSON. Well, the situation really is that in the case of Medicare, for example, we are covering only a segment of the population, and it is thus not a fully national program.

The essential question when you come to the question of financing health care, is whether the net gains to be achieved by a single nationalized system outweigh its losses.

To put it the other way around, why create the structure unless it is really necessary? And what is the case for the conclusion that it is really necessary? This, I suppose, is the central issue.

Now the questions on packages of benefits and coverage and insurance and deductibles and so on don't help to answer this, because you could propose perfectly well under a national health insurance standards plan that it not have these coinsurance deductibles and futures.

You could add benefits not proposed to be required, at least in the early years, under our proposal. And so, the issue is not an issue of comprehensiveness of coverage. It is an issue of whether on balance and in the long run people are likely to be covered more economically and more efficiently under a system that preserves opportunity for choice and bargaining among carriers than under a system that substitutes a Government plan.

Senator KENNEDY. Take, for the purpose of example, somebody who comes back, say, from Vietnam. He is unemployed. He would not be covered, unless he had some other kind of private insurance, would he?

Secretary RICHARDSON. An individual? Unmarried?

Senator KENNEDY. Unmarried.

Secretary RICHARDSON. He wouldn't be covered.

Senator KENNEDY. Well, even if he was married.

Secretary RICHARDSON. Without children?

Senator KENNEDY. And without children. So he comes back, he is not covered. And now he gets married, he is still not covered, no matter if he is—say he is unemployed, say he gains some kind of employment, making not more than \$3,000. He is married now. He doesn't have any children. But he is not covered.

Secretary RICHARDSON. If he is employed, he would be covered. If he were not employed, he would be covered under the family health insurance plan, which is designed to be coextensive in coverage basically with the family assistance plan of welfare reform.

Senator KENNEDY. All right. Well, say he is married, he has children, and he falls under the family assistance program. Does he have deductibles to pay as well?

Secretary RICHARDSON. Assuming he has two children, not if his income is less than \$3,500.

Senator KENNEDY. I believe he does have the family assistance program, doesn't he?

Secretary RICHARDSON. The family health insurance——

Senator KENNEDY. Well, if his income is between \$3,500 and \$5,000, he has to pay the deductibles, does he not?

Secretary RICHARDSON. Yes. But it is a very small amount.

Senator KENNEDY. And as his income now moves up from \$3,000 to \$5,000, he would have to pay a premium charge on a graduated schedule, would he not?

Secretary RICHARDSON. Yes. This is a very small amount, too.

Senator KENNEDY. But it changes. I mean——

Secretary RICHARDSON. It goes up. So that by the time his income crosses the \$5,000 threshold, he would at that point be paying approximately the premium amount that he would be paying under the employee plan, or a hundred dollars a year.

But it starts out much less than that, and it only reaches a hundred dollars at the \$5,000-income level.

Senator KENNEDY. Now if he were part-time, of course, he wouldn't be covered, would he? A part-time employee?

Secretary RICHARDSON. No, not under the mandated plan. He could still be covered under the family health insurance plan.

Senator KENNEDY. I would like to ask some of the other members.

Senator Pell?

Senator Eagleton?

Senator EAGLETON. Mr. Secretary, I have one basic question.

It appears to me that in any system that is either proposed or ultimately adopted, the key to its ultimate success in significant measure will rest on the medical manpower supply. That is, absent an adequate supply of medical manpower throughout the full spectrum of the medical industry, any system adopted is foredoomed to failure unless the manpower is present.

So if I am correct in that premise, I would like to then ask a question or two on the medical manpower supply situation. I address myself first to your prepared remarks. It says, "We shall encourage them to hold down the cost of medical education by converting community hospitals and other clinical facilities into teaching facilities."

Could you expand on that statement for me, insofar as what concept you intend to pursue to use community hospitals, for instance, here in the District of Columbia, to use D.C. General, or other community hospitals in the large metropolitan centers of the country, to expand them into teaching facilities. What would be the interrelationship of said facilities with already existing teaching institutions in those cities, again getting back to the District of Columbia and taking as an example Georgetown and George Washington University?

Secretary RICHARDSON. Could I divide my answer into two parts, Senator? I can ask Dr. Egeberg to supplement my answer to the second part of it.

Let me say first that our long-term approach to the manpower problem is to reduce the demand on our medical schools by encouraging physicians to practice in organized settings, particularly health maintenance organizations. In addition, we are proposing in the near term to rely on all organized settings as foci for medical education as a way of increasing the output of trained professionals and of exposing young professionals to the delivery of care in a variety of settings.

Now, the passage you are referring to in my prepared statement is addressed specifically to area health centers and these are conceived of, in the first instance, as centers for the education of internes and residents and for the continuing education of doctors in the area, to be located in areas too sparsely populated to support a medical school or the teaching center of a medical school.

They would ordinarily, therefore, be satellite institutions attached to or affiliated with a medical school teaching center some distance away. The reason for the use of converted community hospitals is, in a relatively sparsely populated area to have them become the nucleus for the area health education center, which would then, as I say, become the point for continuing education as well as education of new doctors.

Beyond that, we visualize a greater use of community hospitals by new and expanding medical schools, as distinguished from the construction from the ground up of brandnew medical teaching complexes. And it is this part of the answer I would like Dr. Egeberg to expand on, because he has given a lot of thought to the question of how most efficiently to expand medical education.

Dr. EGEBERG. Thank you, sir.

Senator EAGLETON, the medical schools have treasured in the past their teaching hospitals, where medicine in an ideal form can be taught. And in so doing, they have probably ignored the excellent teaching that could be accomplished in many, many community hospitals, particularly if the medical schools showed an interest in keeping up the level of care in such community hospitals.

There are a number of advantages to this matter, and one is that as students finish medical school and get ready for practice, very few of them, probably only about 7 or 8 percent, are going to be able to practice medicine in the kind of a teaching hospital from which they came. The rest will be teaching or working in independent community hospitals or, hopefully, in HMOS of a high level.

So what you do, if you use community hospitals for teaching, is two things: You begin to teach students who are going into practice much of what they are going to meet when they go into practice, and the circumstances under which they are going to meet it, at the same time that you help to raise the level of practice in that hospital by its association with medical schools.

Senator EAGLETON. Well, more specifically, what is the carrot in your proposal that would induce an already existing medical school to broaden the scope of its activities and hence enhance its output of doctors and nurses and other medical personnel by the more in-depth relationship with the existing community hospital in that area?

For illustrative purposes, how would you induce, monetarily, Georgetown and George Washington Universities here in the District to assume a greater burden of interest with D.C. General or, from my home city of St. Louis, how would you induce Washington University Medical School and St. Louis University Medical School to take on a greater burden of interest so far as the St. Louis City Hospital is concerned, to the mutual benefit of both, and producing more doctors and paramedics into the mainstream of medicine?

Dr. EGEBERG. Well, in the first place, I think you have got to assume that at least some of our medical schools are pretty much ideally motivated and are trying to help us increase the number of physicians. They are also getting interested in the community, and trying to help raise the level of care in the community.

If, aside from the general capitation that the Secretary has discussed, one has an extra capitation for increasing the number of students graduating, one would have the No. 1 incentive to teaching in community hospitals. It would allow for teaching a larger number of students.

And as one looks at the project grants that will be available to schools, some of those probably will be directed toward schools that want to enter into work particularly with community hospitals.

Senator EAGLETON. All right, that takes me then to page 29.

Secretary RICHARDSON. May I add a word, Senator? Just on numbers here. And this will help also to supply an answer that Senator Kennedy expressed an interest in earlier.

With reference to area health education centers, where we propose to provide \$40 million as noted in your prepared statement, for fiscal 1972, we think that this is about enough to encourage the creation of 40 new centers in fiscal 1972, that with a similar amount of money in 1973, we could develop 40 more, and with a somewhat increased amount in appropriations, 46 more in fiscal 1974, which would bring the total to 126, which is the number recommended by the Carnegie Commission.

That total amount available for project grants to medical schools, as proposed in the budget, is \$118 million, and it would be that \$118 million that could be drawn on for the expansion of medical schools or for projects having to do with utilization of community hospitals, to which Dr. Egeberg referred.

Senator EAGLETON. Well, then, maybe that answers my question on page 29, where in the last sentence of the first full paragraph, it states:

We anticipate that this consolidated authority will generate approximately \$340 million in construction above current levels.

I take it, then, that \$340 million is a figure that is geared over a series of years, or is that a 1-year period?

Secretary RICHARDSON. No, that is the fiscal 1972 aggregate for construction. That is, of course, a different purpose for the availability of funds than the other two.

The \$40 million for area health education centers is really to enable them to get under way, and the total amount available to schools, \$90-some million for capitation grants, and \$118 million for special projects, would not be for construction. This amount of \$340 million is for construction, and needs to be seen against the very large backlog of applications, of which we have now about \$126 million in grant funds.

Senator EAGLETON. Of the \$340 million in construction, how much of that is in the form of grants and how much would be in the form of loans?

Secretary RICHARDSON. That is all visualized as in the form of subsidized guaranteed loans—loans with an interest rate of 3 percent, the balance of the interest being paid with appropriated funds.

Senator EAGLETON. The whole 340 is in loans?

Secretary RICHARDSON. There is in the budget \$90 million for grants for medical school construction.

Senator EAGLETON. \$90 million is in the present budget for medical school construction grants.

Secretary RICHARDSON. But I take it that the reference here to a new consolidated program is to funding through loans only, on a guaranteed subsidized basis, which is proposed to be a new approach to be instituted for the continuation of grants hereafter, but there is a \$90 million appropriation request for grants in the interval.

Senator EAGLETON. You said \$90 million is in the proposed budget for constructive grants. You have pending already, I think you said, requests or applications for about \$126 million in construction funds?

Secretary RICHARDSON. No, I said in the fiscal 1971 budget, that is, the current year, there are appropriations for medical education facilities construction of \$126 million. The comparable figure for 1972 is \$90 million; for the future, we propose a consolidated program of subsidized loans, in place of grant programs.

Senator KENNEDY. Would the Senator yield?

Secretary RICHARDSON. The pending backlog of applications is much more than \$126 million.

Senator KENNEDY. As I understand, just to carry the point further, you have over \$300 million in requests by medical schools that have actually been approved, have you not?

Secretary RICHARDSON. I believe so.

Senator KENNEDY. And of that \$300 million, how much do you expect to approve this year? That is, the \$90-odd million. Is that correct?

Secretary RICHARDSON. No, since we are in fiscal year 1971 now, we are approving applications currently drawing on the \$126 million appropriation for fiscal 1971.

We don't have a 1972 budget yet, and the 1972 budget seeks the \$90 million, as a counterpart of the current 126; and we hope that in the meantime we can shift more new facilities construction into guaranteed subsidized loans, instead of grants.

Senator KENNEDY. As I understood the direction of the Senator's question, it was actually the construction grants that are decreasing.

Secretary RICHARDSON. Yes. And we could not in any case—

Senator KENNEDY. I suppose, at least I thought the thrust of his question was that in spite of these other steps that are taking place, you can't get around the fact that actually your construction grants to medical schools under the administration budget will be decreasing.

Secretary RICHARDSON. That is right, and that is because we think—you see, we haven't had enough money in grants in any recent year to come anywhere near funding the backlog of applications. And we think that with the substantial increase in funds for current operations of medical schools, which we are proposing, the threefold increase, roughly, per student, and the project grants, that it is reasonable concurrently to propose the funding of capital outlay on a guaranteed loan basis, instead of grants, and we would hope that we could move the funding of future construction in that direction.

I should add one more thing, though, or reemphasize the point that Dr. Egeberg was making earlier with respect to community hospitals. We could substantially reduce the demand for grants and for capital outlays by medical schools if we could encourage them in more cases to rely upon the existing facilities of the universities to which they

belong for basic science instruction rather than building whole new laboratories, and if we could encourage them to make greater use of community hospitals for clinical teaching purposes rather than constructing brand-new medical centers.

And a lot of the existing backlog of requests is for the construction facilities in the traditional mold of the teaching hospital, medical center, laboratory complex. And I think we feel that the health manpower needs of the Nation could be met, and much less expensively, through greater reliance on existing capital resources.

Senator KENNEDY. Does that reflect the medical schools' opinions as well?

Secretary RICHARDSON. I will ask Dr. Egeberg to comment on that, if I may.

Dr. EGEBERG. Medical schools are also hungry, and I don't think they will stop being that for a long time, but I would like to say that a number of them are seeking new ways and cheaper ways of educating medical students.

The University of Washington School of Medicine has a project in which they are reaching out and expect to continue to reach out, as you probably know, into about three other States other than Washington, in which they will use the university at Seattle with the help of universities of those other States, and the better community hospitals, to double or triple the number of students that they are going to be able to graduate.

And as I said in the reply to Senator Eagleton, this will help raise the level of care in that community as well as make available a much cheaper way of educating.

Now I could go on. Ward Darley, who is connected with Wiche, an interstate higher education commission, has been encouraging the three States of Montana, Idaho, and Wyoming, their better hospitals, their universities, and their medical societies, to create a consortium for the teaching of students in medicine.

Now he used to be the executive director of the Association of American Medical Colleges, so he is a man with a great deal of experience. He feels that if we will try different systems of teaching doctors, possibly letting them change their emphasis, change their specialization requirements after they have had a year or two in school, that we can do the job much more cheaply, and that we would do it probably more quickly, if for a while at least we don't emphasize the standard teaching hospital of a university medical school.

Now Indiana and Illinois are doing similar things, and we are seeing this happen in a number of States.

Senator KENNEDY. Senator?

Senator EAGLETON. Well, not to belabor the point, but I find it difficult to comprehend how with the enormous backlog of applications already approved for construction grants, that we would cut back from the already meager \$126 million to the \$90 million.

Most deans of medical schools that I have talked to, and I have talked to several, both in my home State and elsewhere, point out to me that the loan program is somewhat of an empty shell or promise—that is, it is very difficult to go to a bank and borrow money on a new

physics lab, or a new biochemistry lab, or anatomy lab, and if the bank forecloses on a laboratory it doesn't have much of a resale value.

Secretary RICHARDSON. These, Senator, are guaranteed loans, and as I learned long ago, when working with a group of savings banks in Massachusetts, that we are investing in FHA insured loans; it took them a little while, but they realized after a while that they were doing this by Government paper, and this federally guaranteed loan doesn't create any problems for the bank in terms of foreclosure on laboratory or the cadavers, for that matter. That is a concern of the Federal Government.

Senator EAGLETON. Well, Mr. Secretary, many of our universities, aside from the very affluent group at the top, are on the borderline of bankruptcy at the present time, and to say, "Well, go out and borrow more money on the Government-guaranteed loan basis at 3 percent," is to require them to assume a burden that pushes them even closer into fiscal disaster.

Secretary RICHARDSON. It would, if we were not concurrently providing them with substantially increased Federal funds for operating purposes.

Senator EAGLETON. All right. One final question.

It is my recollection that the Carnegie Commission report recommends the establishment of, I think, 12 new medical schools during the decade of the 1970's.

What comment do you have on that recommendation of the Carnegie report?

Secretary RICHARDSON. We think this is as good a general projection as can be made, and we have been gearing our funding requests and so on to that general target. We have adopted, as I said earlier, their projection of need for area health educational centers as satellites of these new schools that are existing schools.

Senator EAGLETON. Thank you, Mr. Chairman.

Senator KENNEDY. Senator Prouty.

Senator PROUTY. Thank you, Mr. Chairman.

Mr. Secretary, what is the estimated shortage of doctors at the present time?

Secretary RICHARDSON. 50,000 is the generally cited figure, and the expansion of medical education that we are aiming for in conjunction with efforts to improve distribution and utilization, would overcome this shortage between now and the end of the decade.

I think it should be made clear, however, that this is an estimate, at best. It does not rest on a very solid basis. On the other hand, for us to fail to act on it could well create a deepening crisis as the decade goes on.

It should be emphasized, however, that all of the measures that we have touched on that contribute in one way or another to more efficient use of resources, prevention as a means of reducing pressure on these resources, that would bring about greater reliance on allied health manpower, for paraprofessionals, and so on, would cumulatively tend to reduce the aggregate number of additional doctors needed.

Senator PROUTY. What about nurses?

Secretary RICHARDSON. We think that we are going to need a lot more nurses, anyway, and, of course, to the extent that we can train more nurses, they themselves reduce pressures on the need for doctors.

Dr. EGBERG. We estimate that we probably need about 200,000 more active practicing nurses than we have now.

There are those who feel that we might get many of those if we could encourage people to come back to nursing after they have begun to raise their families, because, of course, that is where many of them go.

But while efforts have been made in this direction, they will have to be strengthened, and we are going to push to increase the number of graduate nurses at the three levels, the baccalaureate level, the associate degree level, and probably to some degree at the diploma level.

In the meantime, today we are having a meeting over in our headquarters, searching the relationships between nursing and the other paraprofessionals, the allied health professionals, the physicians, the dentists, and so forth.

There are many different ways of solving this question, and this is a very fluid time.

Senator KENNEDY. If the Senator will yield, could I ask about the Nursing Act which expires this year. That will be a matter of great importance for this subcommittee, and, as you point out, there is a lot of thinking being done on it. We would certainly hope that you could have your recommendations at the earliest possible time, so we could give them full consideration.

Dr. EGBERG. Thank you, sir.

Senator KENNEDY. Go ahead.

Senator PROUTY. It is true, is it not, that for any national program to function at maximum efficiency we must have an adequate supply of doctors and nurses as well as facilities?

I think we all recognize that our health manpower shortage is perhaps the most serious problem right now.

Mr. Secretary, the President's national health strategy and alternative proposals place a major emphasis on group practices or health maintenance organizations.

I am aware that such practices or organizations have succeeded in urban settings but I am curious about the applicability of health maintenance organizations in isolated rural areas. Is there any experience in this regard that might aid our studies?

Secretary RICHARDSON. There has been some experience in California. The San Joaquin Foundation is a health maintenance organization that serves migrant farm workers in a rural area, as part of its membership. The foundation provides transportation and mobile clinic services, paid for by Medical. There are other examples in Colorado and Montana of individual practice HMO's like San Joaquin providing or planning to provide care of rural populations. By stressing underserved areas in our HMO proposals, we think HMO's will develop other innovative ways of providing rural care.

Going back to your earlier point about the supply of doctors, it is quite clear, given the record today, that some health organizations make more efficient use of doctors than the fee-for-service system does. They can provide quality health care to a larger number of people with

a smaller proportion of physicians, and so what you would have, presumably, would be a hospital that provided the acute care needed by the members of health maintenance organizations for a large surrounding area.

It would presumably have outpatient diagnostic and ambulatory care facilities, or family health centers, in communities in the outlying regions, and would provide a doctor for these.

In communities too small even to support that doctor, they could have a well-trained physician's assistant.

There are opportunities in such areas, also, for the effective use of closed circuit television for diagnostic purposes, and we would like to support and encourage means for the more efficient and speedy transportation of patients from remote communities to a central point for emergency treatment.

Senator PROUTY. Where is the supply of managers to operate HMO's?

Secretary RICHARDSON. Since HMO's in most respects are a business, requiring skills of financial management, accounting, marketing, planning, and investment analysis, there will be a large demand for individuals with these management skills. Most successful HMO's have relied on individuals with training in both health and business administration.

It is our hope that developing HMO's will draw upon the capital and management resources of the private sector. Many young professionals are anxious and able to enter more exciting fields, especially in the human services area. In addition, we anticipate that hospital administrators will make able HMO managers. Finally, let me add that because HMO's require the involvement of individuals from a variety of disciplines—law, business, actuarial, social sciences, and consumer affairs—I expect to see a new breed of managers evolve as HMO's are established.

Senator PROUTY. Well, do you think we need a new career category for health care management?

Secretary RICHARDSON. Why don't I ask Dr. Egeberg.

Dr. EGEBERG. These come from many areas, from existing clinics, industrial corporations, insurance corporations, and schools of management. In addition, schools of public health are aiming in this direction, in creating managers from physicians and from nonphysicians, both.

Every large city or county that has a hospital system is constantly training people in its hospital system, and most teaching hospitals are continually training managers.

So we have three or four or perhaps five or six different group sources for the people who are going to have to run them.

Senator PROUTY. Mr. Secretary, does experience with prepaid group practice indicate that enrollees in such programs are apt to be from a similar social and economic background, or has a cross section of the population been attracted to such plans?

Secretary RICHARDSON. To the best of my knowledge, Senator Prouty, they have attempted to enroll a general cross section of the population. However, few prepaid groups have been able to achieve this goal due to inadequacies in coverage for some groups and to the

lack of incentives to serve some geographical areas. In fact, existing prepaid groups tend to serve younger and more wealthy members.

We would not want, however, to leave to chance that they enroll beneficiaries of medicare or the family health insurance plan, and so we are seeking appropriations that would enable us to subsidize any additional costs of starting up with the enrollment of low-income people. And we propose for this purpose to enter into contracts between the Federal Government and the new HMO to provide that kind of service.

I might emphasize here, too, another point that was not covered in my prepared statement, that is really very important, and that is that pursuant to these contracts we would undertake to override limitations of State law which restrict the provision of medical care through prepaid group practice plans, and we would also override limitations of State law preventing the use of allied health personnel in exercising and delegating responsibilities from a doctor working in a health maintenance organization, so that these three things taken together, subsidy of enrollment of low-income people, and provision for creation of Health Maintenance Organizations, without regard to State legal restrictions and use of allied health personnel, should all help to contribute to bringing them into being.

Senator PROUTY. The health security program proposed by the chairman of this subcommittee and others would establish national standards for participating individual and institutional providers which would be more exacting than medicare standards.

In your estimation, how difficult administratively would national standards be to enforce? And I might follow that up with another question: Could the imposition of overly rigid standards perhaps have a detrimental effect on health care?

Secretary RICHARDSON. I think that the great problem is in the effort to rely exclusively on or to push too hard to bring about the use of a particular form of prepayment for organization of service and means of enforcing standards.

The proposal that is contained in Senator Kennedy's bill would have the effect of failing to enlist enough doctors voluntarily, and yet, on the other side, have gone so far in the direction of creating a totally new structure as to lead to potential confusion and inadequacy.

And so this again is a reason why we believe, as a matter of judgment, and on balance, that we ought to proceed by building on existing resources and existing systems, to encourage the creation of Health Maintenance Organizations at a pace that does permit them to enroll doctors and other allied health personnel as their staffs.

Senator PROUTY. During his questioning, the chairman gave an example of an employee whose family was confronted with a series of serious health problems. Would it be correct to assume that through collective bargaining most employer-employee insurance packages will be steadily expanded in their coverage and benefits beyond the mandated minimums?

Secretary RICHARDSON. Yes, and, indeed, if the Congress were to enact the administration's proposal establishing mandated minimums, I think we could look forward to a period a few years down the road when we could agree that the combination of benefits provided for could be expanded.

We have considered, for example, the inclusion of dental benefits for children, psychiatric care, which are not mandated in the present proposal, nor is certain coverage for prescription drugs, but I think we could agree that these would be good things to include, further down the road, and they are, of course, all subjects, as you point out, for inclusion in collective-bargaining agreements, now, and at any point after the enactment of the program.

Senator PROUTY. I thank you, Mr. Chairman.

Senator KENNEDY. Senator Pell.

Senator PELL. Thank you, Mr. Chairman.

It seems particularly appropriate that at this hearing on health, the Secretary himself is recovering from flu, or as been, and I congratulate him on his own stamina.

I was struck with the Secretary's remark about Winston Churchill. I know how much many of us envied him.

I am also struck with the remark of my own predecessor, Theodore Green, when he was 90, and he was asked, "Theodore, how does it feel to be 90?" And he said, "Preferable to the alternative."

It is a good thought to consider, too.

I have a couple of general questions, and then a specific few.

One question that your statistics brought out, and I was wondering what the answer was, was that men always have a much shorter life than women, statistically.

Secretary RICHARDSON. Well, I suppose the answer is a combination of one, general wear and tear, and two, that men are weaker.

Senator PELL. I quite agree with you.

Secretary RICHARDSON. Constitutionally, they are not as tough as women.

Senator PELL. I think it is a matter of interest, particularly to men, that the statistics show that in the average home, generally, there is about a 5-year differential between men and women. I don't know if there is a medical reason.

Senator PROUTY. If the Senator will yield, if women's lib has its way, perhaps those statistics will not hold up in the future.

Dr. EGEBERG. There is a slight difference in the glands, too, that I think play a part.

Senator PELL. Now, the approach that the administration has, and an approach that I find a pretty good one, and all of us have different approaches, is to bring into application the old Chinese maxim of paying the doctor to keep you well. It is cheaper that way.

I guess we can never go as far as I have always heard the Chinese once did, of getting the doctor to pay you when you are sick, but this approach is a good one.

I am wondering in connection with the number of doctors, that we are talking about restricting the curriculum, if it is not in danger, if you shorten it by a year.

I remember at the time of the Spanish Civil War, the Spaniards were turning out doctors in a 2-year period. We could probably do it in a 3-year period, but do you think that we really should give thought to reducing the time this way?

Secretary RICHARDSON. The Carnegie Commission examined this question very carefully, and concluded that it could be done, and should

be done, and indeed, we have adopted from their recommendations the proposal to provide an aggregate capitation amount for 3 years that would be the same as the amount available for 4 years.

We have talked also to the deans of the medical schools, and to representatives of the medical profession, and there seems to be quite substantial consensus that the 4 years can be condensed.

I think it should be emphasized, on the other hand, that we would want to see this accomplished in tandem with the improvement of opportunities for continuing education, and to see the established pattern of doctors returning for periods of supplementary education. The area health education centers would contribute to this.

As far as our own experience is concerned, World War II, of course, showed that we could condense the period of medical education by running it more nearly year round.

Senator PELL. It is my memory that the subcommittee some years back, when we tried to increase the finances for students in medical schools, the doctors were very like plumbers. They wanted to keep the supply down.

Do you think that would be a correct statement today, in any way, or not?

Secretary RICHARDSON. No, I don't think so.

Senator PELL. I am glad to hear that.

Secretary RICHARDSON. We have found substantial agreement, not only on the part of medical school deans, but the American Medical Association, with the target of 50,000 additional doctors.

There was a considerable period when spokesmen for organized medicine were not prepared to agree that there was such a thing as a doctor shortage, but that period is now behind us, and we are working on essentially the same set of estimated requirements.

Senator PELL. How do you intend to have your bill drafted? I know you have excellent lawyers in HEW. Which committee are you going to try and direct it to? Judiciary, Finance, Commerce, or this one?

Secretary RICHARDSON. Well, we visualize three bills, which, incidentally, should be available for submission to the Congress, I hope, tomorrow, or no later than the middle of the week.

One would be focused on the development of Health Maintenance Organizations, and that, on its face, would appear—I don't want to second-guess the Parliamentarians, but we have supposed that bill would be referred to the Senate Committee on Labor and Public Welfare.

The health manpower legislation, the second bill, which does anticipate the expiration of the allied health training legislation, would also be likely to be referred to this committee.

The financing proposals we see as interrelated. The family health insurance plan is, to a large extent, conceived of as a substitute for medicaid, and therefore would amend the Social Security Act, and would presumably be directed to the Senate Finance.

And the Standards Act, since it is complementary to the Family Health Insurance Plan, would probably go to Finance, also.

Senator PELL. I know my own thought as being that we should set up some sort of select committee that might be able to have members from each of these committees that would grapple with all the bills.

I intend to introduce such a proposal. I have no idea how it would fare.

Secretary RICHARDSON. Could I add, Senator Pell, that these three bills that we just mentioned as hoping we would be able to submit this week would be joined by a fourth bill, further down the road, maybe in 3 months, and that is the bill that would provide for Federal regulation of the insurance industry, which I stressed earlier, and for the utilization under regulations established by the Secretary of HEW of PSRO's as means of controlling costs and maintaining quality.

Senator PELL. Now, I imagine you are familiar with the bill I introduced in the last Congress, and in this Congress. It has been referred to this subcommittee, although it is not on the agenda for today. It deals in this general area.

The thrust of my bill is to restructure the health finance and health delivery mechanism in the private sector in order to make these services available to all, regardless of their incomes. My bill does not attempt to refinance, through Uncle Sam, health services in general.

Would I not be correct in saying that the approach of the administration's bill and my bill is the same in this regard?

Secretary RICHARDSON. Yes, it would be.

Senator PELL. Thank you.

Senator RICHARDSON. We profited from your example and your draftsmanship in the development of our proposal.

Senator PELL. I appreciate that.

In my bill, I attempted to slow health cost inflation by providing mechanisms to balance the demand for health services to the supply of these same services and use employees under the minimum wage concept to finance the demand and to use health maintenance organizations for the Federal charter to provide the supply of services relating to supply and demand, using the free market concept.

Would I be correct in saying that the administration supports this basic approach?

Secretary RICHARDSON. Yes.

Senator PELL. Thank you, sir.

In my bill I put health maintenance organizations on a quasi-corporate form called community health organizations—which is an arbitrary name I gave them. They could just as well be HMOs—in order to attract private moneys.

I believe the grant and the guarantees and loans and the authority to operate in any State provided in my bill are really the same as the administration's provisions to support HMO's, health maintenance organizations.

Would that not be correct?

Secretary RICHARDSON. Yes, although we have not proposed that they be chartered in any specific way, but in general, the authority and purpose and scope of operation would be the same under both proposals.

Senator PELL. Thank you.

In my bill, S. 703, employers have to provide for a minimum level of health benefits to their employees and their families, along the lines of the minimum wage.

To furnish these benefits, employers have three options. One, they may buy insurance premiums for their employees; or, second, they may contract directly with no insurance middlemen but with a health maintenance organization toward the services; or, three, they may furnish the services directly themselves, like Kaiser does.

Does the administration's bill provide these three separate options?

Secretary RICHARDSON. All three of these options can be accommodated by our proposals. However, we would qualify your third option to require employers who plan to provide services to employees directly, to offer dual choice coverage. This preserves some choice on the part of the employee, an important principle.

Senator PELL. Part of the idea that I have was that there would be free competition here, and that the employer could either provide the services himself, or he could go out and find what you call an HMO, or find an organization that would give the services. He does not have to worry about the insurance companies.

One of the concerns, I know, of the chairman of the subcommittee is the perhaps overemphasis on insurance companies, and this would be a way of avoiding that.

In my own bill, I allow for the combination of area health education centers and HMO's, where they are needed.

Do you support the formation of area health education centers in combination with the HMO's, in other words, relating or matching the education centers with the HMO's?

Secretary RICHARDSON. Yes, very much so, and in fact we hope to encourage medical schools to develop HMO's around their teaching centers, and as well around area health education centers.

Senator PELL. Thank you.

Under my systems study amendment of last year, which was enacted into law, as you know, you are required to study all the bills, such as my own and the others that have come along, and to make two reports.

In this regard, I have got two questions. One, did the initial study of my own bill by HEW have any effect on the President's recommendations, and on your own drafting?

Secretary RICHARDSON. Yes. We reviewed it very carefully in conjunction both with the development of the basic approach that we are advocating as well as in the drafting of our legislation itself.

We were substantially assisted in both respects.

Senator PELL. I don't want to seem petty, but pride of authorship is strong in any of us as individuals. Plagiarism is the greatest compliment there is, and I would hope that partisanship would not play a role here, and that if the bill was really two-thirds that of a Member of the Senate, that the authorship could remain.

I gathered, though, that that is not the case.

Senator MONDALE. May I ask unanimous consent for that?

Secretary RICHARDSON. The committee, of course, is free to decide whatever bill number it chooses to report out. I only say that we hope that it will report out a bill along the lines both of your bill and the one which will be submitted as the administration bill.

Senator PELL. Well, if you will forgive this personal comment, I would like to move on.

Would it be possible to complete the cost study before March 31, do you think, so we could have it in our hands very soon?

Secretary RICHARDSON. We will do our utmost. We have run into very considerable difficulties with respect to cost data.

There is involved the effort to determine, for example, what employers have what scope of coverage now. There is surprisingly little available accumulated information on this, apparently because there has not existed any national regulation of health insurance.

But we will do our utmost, at least, to meet, if not to beat that date,

Senator PELL. And even more important, I think, will be the result of the systems study, which is due by September 30, and this will really give us a sense of the cost and the benefits, and who will be affected, and for us to make an intelligent judgment up here, we will need that study, too.

Do you see any possibility of rolling up the date there?

Secretary RICHARDSON. I really don't have a good enough feel for it, Senator, but I will be glad to look into that and get back to you on it.

Senator PELL. I think you can really help all of us, as we assess the relative merits of the different approaches.

Now, finally, and in an important parochial way, in the President's message, he indicated strong support for building neighborhood health centers as the basis of the HMO's, the health maintenance organizations.

In Rhode Island, we have plans to convert the entire State into a series of HMO's, make it really a model health State. We actually have nine of these neighborhood health centers, and have a group health association getting started.

I wonder if thought would be given, whether you would be willing under existing Federal authority for health demonstration funds to be put into a State like mine, very shortly, in order to demonstrate the merits of the President's approach.

In other words, will there be any possibility of you, in the Department, searching around for ideal model health care States?

A city State like our own, we think, would fit the bill just beautifully, or other parts of the country.

I wonder if thought was being given to that.

Secretary RICHARDSON. We have given thought, Senator Pell, to the desirability of identifying opportunities for this kind of demonstration, bringing together the health maintenance organization, a form of prepayment, the utilization of outpatient ambulatory diagnostic facilities, such as neighborhood health centers, and the affiliation of these with a central general or community hospital.

And we have, in fact, identified about \$6 million in the current 1971 budget that could be made available. I don't mean for one single demonstration, but could be used for the purpose of that kind of demonstration, and we would be very glad to examine the opportunity for the funding or partial funding of such a demonstration in Rhode Island, and, of course, we would invite competing applications from other States.

Senator PELL. I noted the reference, actually, in the 1972 budget, too.

We do think that we have the neighborhood health center setup, really without peer in the country, and we hope you would consider this.

Thank you.

Senator KENNEDY. Senator Dominick.

Senator DOMINICK. Thank you, Mr. Chairman.

Mr. Secretary, I was glad that you started out your statement by pointing out the fact that the health care has materially improved in the country.

From many articles which you read, you would believe that we were falling into a total catastrophe insofar as physicians are concerned, and medical care, and the rest of it, and it does look as though your statistics indicate, at least, that we are doing better than we have, than we were, I would say, in the 1950's and middle 1960's.

I was particularly interested in the fact that you said that the supply of physicians had increased by 34 percent between 1950 and 1966, while the population was increasing by only 29 percent.

Now, my question is not whether or not we need more physicians. I think it is obvious that everybody agrees that we do. My question would be, in your statistics regarding our supply of physicians, I presume that only those with medical degrees are included. In other words, paramedical personnel are not included?

Secretary RICHARDSON. Not including them in what, Senator?

Senator DOMINICK. In your statistics reflecting the national physician to population ratio.

Secretary RICHARDSON. They are not in the physician population we show, no. That refers to medical doctors of all types, as you have said.

Senator DOMINICK. Now, in your statement you refer to the expansion of the Nation's efforts to train child health associates or pediatric nurse practitioners.

Now, I, as the Secretary well knows, have been very interested in Dr. Silver of the University of Colorado Medical Center's effort in this field, and he has done very well in producing pediatric nurse practitioners, in fact, doctors' assistants who will be out and help and do a lot of work that a doctor ordinarily would do.

Is it my understanding that you would be trying to increase the supply not only in that field but in other fields in terms of primary medical assistants?

Secretary RICHARDSON. Yes, that is correct.

Senator DOMINICK. Now, how are we going to expand the Nation's efforts in such training?

Secretary RICHARDSON. Well, in the first place, we do have now under way two programs that are designed to get more physicians' assistants into the system. One is the so-called MEDIHC program. It is Medical Experience Directed Into Health Careers, and it reaches toward the some 30,000 medical corpsmen discharged from the military services every year.

As it is now, about a third of them do go into some sort of health career. We would like to reach another third of them. So far, about 6,000 in the current year have been going through some form of supplementary training at point of discharge, and before entering civilian medical services. And this offers an opportunity for substantial expansion of that number.

We also support a program called the MEDEX program. That is designed to get allied health personnel specifically into rural areas.

And we would contemplate under our various proposals outlined to you that a medical school, for example, could receive project grant money for the training and education of doctors to work with the allied health personnel, a kind of combined training program.

And then there is the legislation that deals with the allied health professions themselves.

Moreover, and very importantly, under contracts with health maintenance organizations, we could expand the use of subprofessional and paraprofessional people by providing under the terms of our contract with the MHO that a doctor could delegate any function that he was licensed to perform to such a person, notwithstanding the limitations of State law.

Finally, one other piece of this is the development in the Department for discussion with the States, and hopefully their enactment, model State legislation on the licensing and use of allied personnel.

Senator DOMINICK. Mr. Secretary, switching now to HMO's, I discussed with you previously the situation that we have in Denver where the medical societies in the Denver area have formed a foundation which is along the line, I think, that Senator Pell was talking about, for prepaid health care, similar to an HMO.

The difficulty is that under present law the foundation cannot qualify to provide care to Federal employees because it does not have "successful experience." It is different from a clinic, in that the patient can go to any private physician that he cares to choose, once he has prepaid into this foundation.

Now, today I will introduce a bill which would remove that requirement of "successful experience," and I would ask whether this type of foundation, you feel, would fit in with the group practices and foundations referred to in your prepared statement.

Secretary RICHARDSON. Yes, it would.

We would need to look at the specifics of the terms under which it was organized, but the essential component of the kinds of organization, whether foundation or health maintenance organization, more broadly, that we are seeking to encourage is the prepayment for comprehensive services that are provided by the group of health people who are associated in it; and if it does that, in other words, if it does provide comprehensive care on a prepayment basis, then it would be the very kind of thing that we are seeking to encourage to come into existence.

Senator DOMINICK. Well, I appreciate that, because I think this is something which is going to be very fruitful, not only in helping to provide overall care for people, but also in generating private funds to support this type of operation.

I notice that you talked at some length to the chairman's questions on the poor guy in Peoria. I have great sympathy for that hypothetical case, but at 11:30 p.m. on Saturday night, I received a call from a small businessman in Colorado, wanting to know what in the world I thought I was doing by trying to impose upon him, who was making a gross of about \$20,000 a year in his business, and who had one employee, the necessity of providing comprehensive health care for that employee. I might add that this small businessman also said that

he had a wife and five children, so that he had a considerable number of expenses.

Do you have any idea whatsoever of the effect on small business, in terms of cost, that this particular requirement would have?

Secretary RICHARDSON. Well, it would cost any small business which does not have any group plan for its employees now, about \$200 per year per employee.

And this is one reason why we propose a deferred effective date, to July 1, 1973, so that there would be some opportunity to get used to the idea. That is one reason.

The other is, as I mentioned earlier, so that we can focus on the supply side in the interval. And it is also one reason that we have proposed that the employee bear a relatively larger share of the cost in the first 2½ years than later.

He would bear 35 percent, and the employer 65 percent, until January 1, 1976; and after that the employer would pick up three-quarters, and the employee one-quarter.

We also had this in view when we arrived at a total benefit package, which at the costs anticipated for the fiscal year in which the program was to come into effect, would be worth around \$300. Otherwise, we could have, you know, added more benefits.

Senator DOMINICK. Did you give consideration in the process of presenting this package to the possible exemption of small business, depending upon the number of employees or their gross total dollar volume?

Secretary RICHARDSON. Yes. We did consider this. In the case of the Fair Labor Standards Act, there is a provision that an employer extend to all employees, one or more, but they must have a gross of at least \$250,000.

We thought of that, but since it was our basic objective to provide coverage for all families, either under the Family Health Insurance Plan, under additional programs, so far as we could constitutionally reach, we concluded that it was not too burdensome to require employers to meet this \$200 per employee cost.

On the other hand, we did not wish to discourage job opportunities in small firms, and this is one reason why we struck the balance, as I said a moment ago, where we did.

Senator DOMINICK. I can understand your reasoning: But I might say that the small businessman that called me at 11:30 on Saturday did not agree with you, and he felt that the \$200 additional might easily be the last straw on his back in terms of additional expenses that were necessarily created, particularly with the five children he already had, as I said. I don't know whether he is having any more or not. As a population planner, I would hope not; but I don't know what is going to happen, and I don't think he does, either.

In conclusion on my questions here, one of the series of talks that I have had with practitioners recently, and I have had quite a few talks with them over the last few years, is the increasing cost and the non-availability of malpractice insurance.

Now, to what extent is the administration looking into this? I know that, for example, I believe it was in Arizona, there was only one company that would issue any, because of the size of the verdicts the juries were giving; and in Hawaii, as I understand, they all closed down for

awhile, and we were able finally to get one to reintroduce some type of malpractice insurance.

What type of study is being made of this really serious problem, which has the inevitable effect of passing on increased medical costs to the patient, and to the Government, in this case?

Secretary RICHARDSON. This is, as you rightly say, Senator, a very serious problem. The President's health message does deal with it. It has a subsection headed, "A Special Problem: Malpractice Suits and Malpractice Insurance," and the concluding paragraph of that portion of his message says:

Now, I am therefore directing, as a first step in dealing with this danger, that the Secretary of Health, Education, and Welfare promptly appoint and convene a Commission on Medical Malpractice to undertake an intensive program of research and analysis in this area. The Commission members should represent the health professions and health institutions, the legal profession, the insurance industry, and the general public. Its report, which should include specific recommendations for dealing with the problem, should be submitted by March 1, 1972.

We did give quite a lot of thought in the course of the development of the various recommendations that have been the subject of today's hearing to possibly more immediate action, but we simply could not develop a solution that seemed sound enough and workable enough, in the time we had: and this is why, therefore, the President has directed the Department to create a commission to develop these recommendations.

Senator DOMINICK. I am certainly delighted to hear this, and I look forward to the results of this study, because there is no doubt in my mind, from the great and varied number of physicians that I have talked to, as well as the schools and some of the hospitals, that this is one of the major problems in the increasing cost of medical care.

Secretary RICHARDSON. May I ask Dr. Egeberg to add just a word?

Dr. EGEBERG. Yes; we have been sensitive to this for the past year or two, and I can hardly give a talk without people asking me that question.

In health services and mental health administration, we have a section which has been gathering a good, solid base of information, which will be available to this Commission when it starts; and this has been going on, on the part of a number of people there, in considerable depth, over the past 2 years.

Senator DOMINICK. Mr. Secretary, in your statement before the committee, you referred to the fact that you were particularly interested in improving the mix of minority students, now vastly underrepresented in health professional schools, something which I would certainly agree with.

My question, however, is not as to whether or not we should not increase our efforts there. My question is, How do we do that, and still insure that we don't lower standards?

As you know, there have been many universities which in an effort to do this have lowered their standards, and have found themselves in really quite serious problems—not only in connection with the students that they have recruited, but also with the reaction that has occurred, as to the number of those who have been kept out of those universities, even though people with lower standards have been admitted.

Now, what do we do about that, in this particular instance?

Secretary RICHARDSON. Well, I think we start, Senator Dominick, with the fact that there are something like twice as many qualified applicants for medical schools today as are being admitted, or as there are places for, and many of these qualified applicants are representatives of minorities.

Beyond that, there is the problem that has been emphasized in meetings that we have had with the National Medical Association, which, as you know, is a largely black medical organization, in which they have stressed the reluctance of qualified students, college students, from disadvantaged backgrounds, to borrow substantially for a future career, and up to now there have been relatively inadequate resources available for scholarships in medical schools.

We have tried to take some action to overcome this administratively, under our existing authority, and have channeled the largest portion of work-study projects into the primarily black medical colleges, but under their proposal we would provide increased scholarship funds, and increased money in an amount of \$300,000 a year.

The total increase in scholarship funds would just about double the amount available, from \$15 to \$29 million. And this, coupled with the provision for forgiveness of any borrowed amounts beyond that for a student who does not complete his medical degree program, should, we think, help to overcome the reluctance to go to medical school on the part of black students who are qualified, and who now enter some other career instead.

Senator DOMINICK. Do you have any idea of what percent of the disadvantaged medical students who graduate, the ones that actually graduate, do go into the areas of maldistribution whether it be in the inner cities or in the rural areas?

Secretary RICHARDSON. I don't have an answer to that, offhand. However, we do know that a larger proportion have gone into primary care practices than have white students. Dr. Egeberg?

Dr. EGEBERG. I think when they become physicians, they do want to hit as good a neighborhood as they can, but there is an increasing number, and of this, I am very much aware, that do want to get their medical education so that they can help solve the community problem.

Senator DOMINICK. Now, one last question, Mr. Chairman.

In the rural areas of this country—and I might add for the benefit of the chairman that as far as I know, eastern Montana is bigger in terms of geography than much of New England—there is great difficulty for a person who is sick or injured to be able to be taken to a clinic or a hospital where he can get treatment.

There have been provisions suggested in the past, for helicopter service, for assistance ambulance services, and things of this kind.

Will there be any provision in the legislation which will be sent up, because it is not touched on here in your statement as far as I know, for this kind of service to take care of the rural areas?

Secretary RICHARDSON. Not in specific terms, although this is a form of service for which funds may be available on a project or demonstration basis, or as part of the costs of starting the health maintenance organization. I should point out that some areas of the country are trying to arrange with the National Guard to provide emergency helicopter services.

Senator DOMINICK. That is all, Mr. Chairman.

Thank you, Mr. Secretary.

Senator KENNEDY. Senator Mondale.

Senator MONDALE. Thank you, Mr. Chairman.

I just have one general question. I think your position on this Nation's health needs moves us a long way toward solution. As I read your testimony, you are saying, first, that there is a profound crisis in health care in this country, and, second, that the National Government has a responsibility to help shape an answer which is adequate in terms of social and economic needs, in terms of geographical requirements, and in terms of any proper definition of health needs in this country.

And I think that this commitment makes the problem manageable and brings this country to a more hopeful posture than we have ever enjoyed before.

But in the course of reaching that objective, I notice that we are now reinstituting categorical grants—eight new ones—in this program, setting up a new program which will affect labor-management relations, and a host of others.

I applaud you because we must meet the problem of the national health.

But how is this particular need different from, say, education, where we seem to be going in the other direction? Or manpower training and employment, where we seem to be going in the other direction? Or national housing programs and urban renewal, where we seem to be going in the other direction? Or, for that matter, legal services?

Since you are the Secretary whose responsibility covers many of these other fields, do you see a distinction between this Nation's educational crisis or manpower or public service employment crisis and the Federal responsibility therefor, on the one hand, and the problem in health and the Federal responsibility on the other hand?

What is the philosophy and resulting direction of the Department and the administration?

Secretary RICHARDSON. Well, basically, Senator Mondale, we seek, I think, most fundamentally, to try to define what the problems in each of these areas are, and then to design, to the best of our ability, specific solutions to these problems.

I referred, of course, in my prepared remarks to the effort to design a patch big enough to cover the hole, whatever it is. And we think that our approach is consistent, area by area, just to take, within HEW, education and health.

Now, you referred to the policy of reliance on categorical programs touched on in the course of this testimony. I would emphasize, however, that there is another side to it.

In the case of health education, of construction, for example, we have proposed a consolidation of grant programs into one.

In the case of the funding of various forms of community health centers, and I use that term to embrace the kind of neighborhood health centers providing ambulatory care and outpatient diagnostic cases that Senator Pell referred to in Rhode Island, I would include community mental health centers, I would include pre-natal and child care clinics, and I would include clinics that emphasize early diagnosis and treatment of heart attacks, for example, under the regional med-

ical programs. In the case of these several forms of categorical funding, I emphasized toward the end of my testimony the proposition that we have to do a better job to enable a community or an area seeking to strengthen the network of its services to obtain funding on a basis that does not require six or eight or 10 different applications, and that would permit, if possible, prepayment for services to be provided through this network.

And that I consider to be an effort very much consistent with what we were proposing in the way of consolidation of grants and special revenue sharing in education.

There is one other area for potential consolidation not covered here, but which I propose to make an urgent priority in the Department, and that is a better integrated approach to the comprehensive planning of health care services.

I do say in the course of the testimony that we do not propose to permit Federal funds to be used to amortize capital outlays for health facilities construction which is inconsistent with the regional plan development by the agencies set up under section 314(e) of the Public Health Act, and yet we still have fragmentation between that legislation and the regional medical program, if we do go forward as proposed here, and with the funding of area health education centers, that could create some further confusion.

I think we need to have these things brought into a clearer focus.

To put it most simply, we think that when it is important to move forward into a new area quickly in order to meet a defined national need, a categorical grant program is a useful and often necessary device.

On the other hand, because there has been such a proliferation of grant programs in the past, we ought to try to clear away the underbrush and simplify the total structure by consolidating established programs in the areas where there is no longer such a clear and urgent need.

Senator MONDALE. Well, I am impressed by the nature of the commitment you have made today both for its understanding of the health crisis, and for its attempt to deal with that crisis. As I said earlier, I think it now brings us to the point where we can discuss remedies, with an agreed national objective.

But in all deference to your response, I don't see anywhere near the same commitment or acceptance of the national responsibility in education or manpower, or housing, or saving our cities, or rural development, or in providing jobs.

This is not the place to debate those issues. But I think they are all, equally, matters of profound national concern. If we could have the same commitment in these other areas, I think we could truly undertake a national strategy to deal with the entire scope of human problems, and not just separate categories, although I do agree that they relate in some ways.

In a sense we are nationalizing health, through the strategy proposed today. However, at the same time the administration is localizing education and manpower, and the rest.

Secretary RICHARDSON. Well, Senator, let me say first of all that I appreciate very much your very generous references to the scope and

significance of these proposals. And perhaps it does not serve a great deal of purpose to debate the point at hand.

Today, I would simply say that we think, in the administration, that we are seeking to approach these problems in ways that identify their dimensions, their interrelationships, and their individual aspects.

It was being said, until we submitted this program, that we were neglecting the field of health, and it took us a significant amount of time to be able to come forward with a set of proposals that are as balanced and as integrated and as mutually reinforcing as we hope these are.

In the case of education, we are trying to achieve both a greater degree of order and simplicity among programs, without abandoning the national objectives that are reflected in our present concerns for the education of the handicapped or of the disadvantaged, for example.

In place of the existing categorical grant programs we will propose substitutions that seek to encourage real planning by States and communities to deal with these problems, as distinguished from the mere compliance with a statutory requirement for the submission of a so-called plan that usually, under past examples, amounts to not much more than a collection of boilerplate.

And we hope that we will be able to stimulate the establishment of objectives toward which State and local education systems work, helping us to provide them with more effective technical assistance than we have done heretofore.

We have discussed before your subcommittee the desirability of objectives that demonstrate what can be done, for example, to provide better education in poor areas, and so on. And these we recognize as appropriate national functions.

I would hope that by the time our approach to all of these inter-related programs has been fully laid out, that it will be both adequate and consistent.

Senator MONDALE. Mr. Chairman, I would like to place in the record some statistics which show that despite some advances, in comparison with the health measures of other countries, we have actually been slipping backward for some years now.

(The information requested had not been supplied at the time this hearing went to press.)

Senator MONDALE. I would also ask the staff to summarize another statistical indicator which was first used in a document called *Toward a Social Report*. It measures not just the years that a person manages to survive, but the number of years he manages to survive as a healthy person.

I think that is a very important indicator of the effectiveness of our health care.

Senator KENNEDY. That will be so ordered.

(The information subsequently supplied follows:)

LIFE EXPECTANCY

In "Toward a Social Report", the expectancy of a healthy life was discussed on pages 2-4:

"Since the mid-fifties, there have been some gains in health, some losses, and some areas where we are holding our own or where progress has been uncertain. . . .

"We can get an impression of what this mixed picture of gains and losses means on balance with the aid of a social indicator calculated for this Report. This is the "expectancy of healthy (italics) life" (or, more precisely, life expectancy free of bed-disability and institutional confinement). It takes into account any changes in the length of healthy life that are due to reductions in bed-disability or institutional confinement and also those that are due to increases in life expectancy. It reveals that the number of years of healthy life that Americans can look forward to has changed little since the late fifties, when the data on which this index is based first became available.

"As table 2 shows, the unchanged life expectancy over the decade and the static expectation of disability days have resulted in a nearly constant expectation of healthy life. The figure in 1957-58 was 67.2 years, but this was a year of an influenza epidemic, so no upward trend can be clearly established, and if one exists at all it is very slight. The figures on expectation of healthy life remaining at age 65, shown in table 2, also indicate only limited improvement.

"Males and females show slightly different patterns. Since 1958, females gained a full year of total life expectancy at birth or 1.3

years free of bed-disability, while males improved their situation by only 0.4 years of life expectancy or 0.6 years free of bed-disability. Expectations at age 65 show even greater sex discrepancies, with males having made no advances at all while females gained about a half year in both total and disability-free years.

*Expectation of Healthy Life at Birth, United States, Fiscal Years 1958-66
(in years)*

Fiscal year	Expectation of life †	Expected bed-disability and institutionalization during life †	Expectation of healthy life
1958	69.5	2.3	67.2
1959	69.6	1.8	67.8
1960	69.9	2.0	67.9
1961	69.9	1.9	68.0
1962	70.2	2.1	68.1
1963	70.0	2.1	67.9
1964	69.9	2.0	67.9
1965	70.2	2.0	68.2
1966	70.2	2.0	68.2

Expectation of Healthy Life at Age 65 (in years)

Fiscal year	Expectation of life †	Expected bed-disability and institutionalization †	Expectation of healthy life
1958	14.2	1.1	13.1
1959	14.3	1.0	13.3
1960	14.5	1.1	13.4
1961	14.4	1.1	13.3
1962	14.6	1.1	13.5
1963	14.4	1.1	13.3
1964	14.3	1.1	13.2
1965	14.6	1.1	13.5
1966	14.6	1.1	13.5

† Disability and institutionalization figures are given in terms of the fiscal year. Expectation of life figures are for the calendar year during which the fiscal year began.

SOURCE: Estimated from published and unpublished data obtained from the Censuses of 1950 and 1960, and from the Health Interview Survey and Vital Statistics Division of the National Center for Health Statistics.

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Senator KENNEDY. Senator Schweiker.

Senator SCHWEIKER. Thank you very much, Mr. Chairman.

Mr. Secretary, I would like to congratulate you on a very comprehensive and far-reaching statement. I feel you have well defined the problem and also indicated a broad sense of responsibility in making your statement.

I do have some questions on some specifics.

In your prepared statement, for example, you refer to a catastrophic illness program with a cost projection amounting to at least \$50,000 per person, with an automatic restoration of \$2,000 per year.

I wonder if you would just briefly explain mechanically how this would work.

Secretary RICHARDSON. Let me ask Assistant Secretary Butler, who is the man primarily responsible within the Department for the development of the financing proposals, to respond to that question.

Mr. BUTLER. Senator, this goes substantially beyond what has been available for almost all workers in the past.

The thrust is this: that, as the Secretary indicated before, once the expenditures totaling for a person reach \$5,000, then all of his expenses for any illness from \$5,000 up to \$50,000 would be covered. This maximum includes almost anyone in the country, so that the great danger of financial loss from the serious illness of a single family member would be eliminated for almost all Americans.

For example, in studying the adequacy of the \$50,000 limit, we have learned that in a full 20 years of the Federal employee insurance program, whose high option has that limit, only 16 people have ever exceeded it, and they have been cared for under other forms of relief.

Senator SCHWEIKER. Only 16 people nationally?

Mr. BUTLER. Sixteen people, and that is out of all Federal employees, nationally. For the population as a whole, only about one person out of 20,000, or a total of 10,000 people out of 200 million in the United States would ever go through that \$50,000 ceiling, so that it essentially covers more than 99.9 percent of the people in the country.

Senator SCHWEIKER. What about the restoration feature? How does that work?

Mr. BUTLER. The restoration feature works this way: Once a person has used up the \$50,000, then the policy begins to reinstate itself, at a rate of \$2,000 per year, so that for that individual the benefits will build back up over a period of years. If, say, a person had an illness in his early working career, recovered from a very serious accident, for example, was off work for a year, and came back, then his policy would build back up, and after 25 years, he would be back up to \$50,000 protection.

I think it is important to keep in mind that this applies to individuals, not to the family, if some unfortunate family, let us say, had an auto accident in which a mother and child were very seriously hurt, and had a long, long period of illness and reconstructive surgery, and all the rest of it, the family as a whole would be eligible for up to \$100,000 in benefits.

Senator SCHWEIKER. Mr. Secretary, on page 25 you refer to the aged rather briefly, and I wonder if you could elaborate whether you have any further ideas or refinements in the way that we are handling our aged problems, as far as health care is concerned.

Secretary RICHARDSON. Our only new proposal, Senator Schweiker, that directly would affect the aged is to combine parts A and B of medicare.

As you know, medicare now covers hospitalization under part A, and physicians' services under part B. People eligible for medicare elect whether or not to be covered by part B; 95 percent of them do so to date, although that still leaves about a million eligible people not covered.

Under this proposal, parts A and B would be combined into a single health insurance package, covering both hospitalization and in-hospital medical services and surgery, long term care, plus out-patient medical care.

And instead of continuing to collect a monthly premium under part B, which is currently \$5.30 for each eligible beneficiary, and becomes \$5.60 on July 1, per month, that whole amount would be paid instead out of the contributions into the medicare system, just like part A.

We would continue to pay into the system the present amount of general revenue which pays for the half of the part B cost not covered by individual premiums. The result would be to add benefits for the aged, under medicare, worth at the current rate about an aggregate of \$1,400,000,000.

This would be offset by some increase in coinsurance deductibles, and would leave a net increased benefit of about a billion dollars for medicare beneficiaries, which is equivalent to about a five percent benefit increase.

The rest of the aged, or cost of care for the aged not covered by this consolidation of parts A and B in medicare would continue to be covered as part of Medicaid.

Senator KENNEDY. Could I ask, would the Senator yield on that point?

Senator SCHWEIKER. Surely.

Senator KENNEDY. So as a final result, what you have really done is you have picked up what would be about \$400 million worth of payments under section B of the medicaid program, but you are going to be requiring in terms of increased deductibles, other coinsurance, about a billion four.

Secretary RICHARDSON. No. The other way around, Senator. The combined total of part B payments by beneficiaries is running at the rate of a billion four a year, so we are picking up the billion four.

There is a net offset of about \$400 million for deductibles and coinsurance proposed in the budget, leaving a net benefit to medicare beneficiaries of a billion dollars.

In other words, we are paying costs they are now paying, totaling a billion four. We are offering this by about \$400 million in increased coinsurance.

Senator SCHWEIKER. Mr. Secretary, on page 28 you indicate that you are going to come forth with a per capita program that is based on graduates rather than enrollment with the thought being that we are going to, hopefully, encourage the medical schools to decrease their curriculum from 4 to 3 years. I think this is a very commendable effort.

I just wonder, from a practical standpoint, whether you have had any indication at all whether the medical schools might be receptive to this, and what chance you have of success.

I feel this is a good idea.

Secretary RICHARDSON. Yes, there is a considerable amount of interest in it, and some medical schools are already reshaping the curriculum to do this.

We have had a number of meetings with the Association of American Medical Colleges, and while they would like to have a higher capitation payment than this, at the same time we are proposing to combine with the capitation payment an additional amount or amounts of der the project grant authority, and so we think in combination the proposal is both likely to meet significant response on the part of schools proposing to shorten their curriculum and also to provide a very adequate total amount of benefit.

Would you like to add to this, Dr. Egeberg?

Dr. EGEBERG. Just very briefly.

Most medical schools have certain students that go through in 3 years, and an increasing number of medical schools are offering an opportunity for all of their students to go through in 3 years, making the fourth year the equivalent of an internship.

I can best give you an example of the school of which I used to be dean, where we were searching for better curriculum for 3 years, involving 100 members of the faculty and 20 students, in a series of meetings over that period of time, and ended up with a curriculum that they thought was better, and suddenly found—or perhaps not suddenly—that it was also 1 year shorter. There was no intent to do anything but improve the curriculum.

Now, we have a number of schools that are aiming at a 6-year curriculum, from high school, the idea being that if they can specify what courses should be taken, they can make much more efficient use of those 3 years that are now spent in undergraduate work.

Senator SCHWEIKER. You say aim at a 6-year curriculum, but the 3 we are talking about is really 7 years, so you are saying 1 year less than what you are talking about here.

Dr. EGEBERG. One year less than the 7, yes.

We have found that there is so much variety in the request by medical schools, and such a niggardly recognition of some of the work done in undergraduate schools, that if we could bring these two together, we could probably cut a year.

We could undoubtedly cut a year out of the undergraduate school, as well as a year out of the medical school.

Senator SCHWEIKER. So we are talking, instead of 8 years, possibly getting it down to 6 years.

Dr. EGEBERG. Yes, sir.

Senator SCHWEIKER. One other question.

In your prepared statement you mention a scholarship aid program, average of \$3,000 per year per student. Are we talking loans, or out-right grants, in that particular program?

Secretary RICHARDSON. No, in that context we are talking about out-right grants.

On the next page we refer to the opportunity to borrow up to \$5,000 a year in guaranteed loans.

Senator SCHWEIKER. Well, I am not quite clear if we are talking outright grants. In the next sentence you say, "To alleviate the concern of low-income students who are afraid to carry the burden of a loan, we are proposing to forgive their indebtedness."

Are you then referring ahead to the next loan feature, or are you talking about the grant feature, when you are talking about forgiveness of indebtedness? If it is a grant, it would not be indebtedness, would it?

Secretary RICHARDSON. Yes, there may still be an indebtedness above the scholarships. The scholarships are proposed in the amount of \$3,000 to be made available for each of the first 2 years of medical school. The student might need to borrow beyond that, in those years.

In any event, if the student has successfully completed the first 2 years of medical school with a minimum of borrowing—the years in which the vast majority of students drop out—his opportunity then to complete medical school and to pay off borrowings is very substantial, but just to overcome any remaining reluctance to borrow at this time, we would provide this feature of forgiveness, if he does not complete school.

It would also be proposed, as I said elsewhere, forgiveness for service in a scarcity area, and in primary care.

This means, then, that the graduate of medical school who enters into internal medicine or general practice or pediatrics in a scarcity area could have his whole borrowings forgiven, if he served there.

Senator SCHWEIKER. If somebody drops out of medical school on a loan basis, I gather there is no forgiveness at all, at the present time. Is that the case?

Secretary RICHARDSON. Yes.

Senator SCHWEIKER. Thank you very much, Mr. Chairman.

Senator KENNEDY. Mr. Secretary, I just have a few areas that I would like to just explore with you, if we could.

Just in listening to the course of some of the questions that were raised here, by Senator Dominick, for example, on that small business official who maybe employed one or two employees, with the additional kinds of burden that he will be exposed to, I suppose there is great pressure on that employer to perhaps make that full-time employee into a part-time employee who would not be covered.

Or I suppose that there would be pressure on that employer to suggest, perhaps, that the employee opt out of the program—which I suppose is not something that would be a great surprise if there are only one or two employees working in a small firm.

So I think the point that was raised by Senator Dominick in terms of small business was well taken, and I think the openings that are included in the program will lead to these problems.

I think this, once again, is probably a small point, but I think it is of some significance, and I was just interested as to what your reaction might be.

Secretary RICHARDSON. My reaction, Senator, is that there is a problem inherent in proposing to require all employers to provide basic insurance coverage for their employees, and it is a problem that we

have sought to meet in the ways I identified in responding to Senator Dominick.

The other side of the coin is, however, that if we were to exempt such employers, we would be missing families who most need health insurance coverage.

Now, there is no way, really, of avoiding the problem of cost, whether it is done as is proposed in your legislation, which provides in effect for employers to contribute four and a half percent of the payroll to the cost of the program, matching this total with an additional amount from general revenue—this, too, is a cost, and it does tend to fall proportionally heavily on smaller employers.

On balance, though, I think you would say that it is important to consider the benefits provided by coverage, including the benefits to employers generally, and to industry generally, and to consider also, at the appropriate time, the interrelations between payroll contributions for other competing purposes, including medicare, and including social security benefits, and potentially, to take into account also at an appropriate time what adjustments ought appropriately to be made within the minimum wage.

Senator KENNEDY. Well, I can understand you feel it is important that these individuals would be covered, but I think once again it raises the question of whether this is the best means to attempt to reach them or through a more progressive kind of general tax system, which would be national in scope.

I want to skip around just a bit, and then come back to quality and cost at the end; but on the questions of the incentives that are being given to medical schools trying to attract minority students, I can see the advantage of attempting to provide flexibility to medical schools when they are reaching out to try and train some of the minority qualified personnel.

Would you give some thought to what could be done about providing incentives to medical schools that are trying to reach and train qualified minority personnel, without sacrificing standards, but recognizing that an additional year might be worthwhile, and of value?

Secretary RICHARDSON. We would be very glad to consider that, Senator Kennedy.

Let me just say in this connection, because it might help, too, to expand the record a little bit, and to rephrase some of the route we covered in coming forward with the manpower proposals that are summarized here, that we weighed two competing alternatives at the outset.

One would have provided for the negotiation, medical school by medical school, of a kind of contractual approach to the Federal funding of various kinds of activities undertaken by the school, having identifiable national interests. This would have been on an individually tailored basis.

It would have avoided counting graduates, or students, and provided a flat amount per student, or per graduate, but it would have required, on the other hand, considerably more precision in the accounting capabilities of medical schools than they now possess. It would have required a sharp distinction between funds allocable to research, to patient care, to teaching, and so on.

And while eventually this might be an appropriate way for designing the Federal role, we did not think that it would serve very well in the short run.

So what we came down with is a division of the available Federal funds into two principal parts. One is for capitation, as described in the statement, and the other is for special projects which was also referred to generally.

Now, we visualize the special project money as available for various things, several of which have been touched on, including training of doctors and allied personnel together, the development of doctors equipped to serve as part of a medical team within a health maintenance organization, and so on, and one of the things, certainly, that we would look on very sympathetically for the use of this special project money could very well be to develop a program aimed at the special needs of minority students.

Senator KENNEDY. We talked earlier in your testimony about the development of the HMO's; and I would like to review that with you, because in going through your testimony and listening to your responses to questions this morning, obviously you place a heavy stress on HMOs being one of the imaginative and really creative proposals, which I think it is, in terms of helping to meet the health crisis.

Now could we go over it? As I understand in your prepared statement, you talk about \$23 million for 100 HMO's. Could you tell us how you reached the figures of being able to say that with \$230,000 you can create the HMO?

As I understand, there is a very strong body of expert opinion which thinks that it would cost at least \$500,000.

I would be interested in how you arrived there.

Secretary RICHARDSON. We think that most new HMO's can do all of the necessary planning for about \$250,000. This average figure does not reflect the likely range of HMO planning costs, which will vary from \$50,000 for a medical foundation—\$500,000 for a large public general hospital.

The total amount of \$23 million for planning grants and contracts was arrived at as a matter of projecting numbers of new HMO's that we could hopefully encourage to come into existence within the coming fiscal year. In addition, we made annual estimates of HMO development through 1976.

May I ask Assistant Secretary Butler, who is more familiar with the figures than I am, to expand on that?

Mr. BUTLER. Senator, as you can understand, these are averages. As the Secretary has indicated, the mature organizations now will not need substantial planning money from the Federal Government, so that requirements will vary widely from place to place. The figure of 100 HMO's in fiscal year 1972 refers to the number of organizations receiving planning money and does not refer to the number of HMO's actually operating. The projections that we are working with indicate that the numbers of new HMO units actually operating (or receiving aid) could reach a total of 125 in fiscal year 1972, 375 in fiscal year 1973 and 1,500-1,700 by fiscal year 1976. Of course, these are our estimates which were made for program planning purposes only. The actual number depends upon physician, consumer, and investor interest, a factor which the Government could control directly.

I think it might be a more significant figure to say that if the growth is as we expect it to be, based on the kind of interest that has been expressed to date, then about 80 to 90 percent of the population, of which 10 or 20 percent would probably be largely in rural areas, by 1976 would have the alternative of enrolling in health maintenance organizations or of continuing in the present system of care.

The dollars involved in those growth years, of course, will depend upon the planning and operating needs of the organizations.

If the growth largely takes account of existing hospital units, with their sophisticated training and capabilities, the Federal cost would be less. If many new people are going to come into the arena, we will need about \$500,000 on the average worth of planning money to get started, and costs will be more.

But as I say, we would expect, within present budgetary projections, to be able to reach up to 80 to 90 percent of the population with this operation.

Obviously, the number enrolled will be much lower than that, but they will have the choice, which is what our objective is.

Senator KENNEDY. Well, how many do you figure will be covered by each HMO?

Mr. BUTLER. Well, that can vary, Senator, as it does now. The minimum number will probably be around 15,000, maybe 10 to 15 thousand, to spread the risks, on up to the existing kind of organizations that we are familiar with now, in which the enrollment would exceed 100,000. For example, Kaiser has 2 million members, HIP has 800,000 and Group Health Cooperative of Puget Sound has more than 100,000.

Senator KENNEDY. Would it exceed 100,000?

Mr. BUTLER. Or in some existing organizations.

Senator KENNEDY. What do you see as an average? There are some, obviously, with 10 or 15 thousand.

Mr. BUTLER. For our planning we assumed the Federal Government should base its support to HMO's on the basis of 30,000 member units. After that point HMO's could break even or begin to seek additional support for a second unit of 30,000.

Senator KENNEDY. Well, under your figures, the optimum figures by 1976 would cover 45 million people.

Mr. BUTLER. Yes, very roughly. Our projections, based on 30,000 may turn out to be incorrect; some will want to enlarge their units.

Secretary RICHARDSON. I think 30,000 is too low for an average figure, because you start out with, say, 10 after the first year.

I would have thought more, as the minimum viable economic base on which to operate. So maybe 30,000 might be immediate in the sense that there were an equal number of HMO's, with perhaps larger, or smaller, than that. But the average would, I think, come out considerably higher.

Senator KENNEDY. To start down this road, you are allocating \$23 million. Is that right?

Secretary RICHARDSON. Yes; \$23 million for planning grants and contracts.

Senator KENNEDY. Is that new money?

Secretary RICHARDSON. Yes. There is also \$22 million in grants and contracts, the first-year amount, for a 3-year contract to start HMO's

for people in low-income communities. We would also provide up to \$300 million in guaranteed loan for working capital and ambulatory care costs. We think that based on what we have been able to find out so far that this would probably be enough.

To put it the other way round, Mr. Chairman, we conceive an HMO to be, in principle, a self-financing organization which can draw on large amounts of private capital. The question then is what are the specific needs for Federal funding that would help to get them started. It is not apparent that very large amounts of Federal money are going to be needed for this purpose, particularly if—and I want to underscore this again—we can avoid the compartmentalization of Federal funds I talked about, if we can, in fact, package them.

Take, for instance, a low-income neighborhood, where we want to encourage rational distribution of facilities and manpower to provide good quality care to low-income people.

We already have authority for the funding of maternal and child health agencies, under title V of the Security Act.

We would be providing prepayment of any medical care costs under the proposed family health insurance plan, or whatever its equivalent may be. We would have some residual medicaid coverage, medicare, community mental health services, alcoholism clinics, and so on.

Now, if you could—if as an applicant for support for the creation of a rational system and distribution of services, you knew that you could get Federal funds in advance for an estimated number of people eligible for services under these various Federal titles, and add all this up, as an assured sort of income for the coming year, and supplement that by the amount you charged to people who paid the full cost of their premiums for membership in the HMO, you could get this kind of thing started much more easily than had been possible up to now, and indeed, Dr. Cronkhite in Boston is following somewhat this approach, even against the limitations of present categorical compartmentalization of funds.

So to put it as succinctly as possible, we think that if we bring the right kind of encouragement and help in getting this done, and provide more easily the potential sources of funding for the payment of care that are already authorized under existing law, then it should not take massive amounts of new Federal money to get these things started.

Senator KENNEDY. Do you think you could give us, for the record, what material you have describing the costs of these HMO's, and tell us how you reached the figures of the number of people that will be able to be covered by it?

Secretary RICHARDSON. Yes.

Senator KENNEDY. I think, obviously, at a later time we are going to review it in greater detail, but I think it would be useful if you could submit for the record whatever material you have in reaching the costs of these HMO's the numbers that you really expect will be developed based on the kinds of commitments you have made, the numbers of people that actually would be served, whatever information you could give us.

Secretary RICHARDSON. We would be glad to do that, Mr. Chairman. (The information subsequently supplied follows:)

HEW DEVELOPMENT PROGRAM FOR HMOs (FY 72-76)

The table below shows HEW estimates of potential Health Maintenance Organization development. Although actual rate of growth of HMOs depends upon the degree of interest shown by physician groups, consumers and investors, these estimates reflect a balanced program which would permit approximately 50 million more Americans to join HMOs by the end of the decade.

HMO "units" were used in order to estimate the likely planning, development and initial operating expenses for 30,000 new members (a unit). Clearly, all new HMOs will not have 30,000 members. Some may expand to over 100,000 in which case we assume that one HMO (e.g., Kaiser) really has multiple "units" and might require the same multiple of planning, development and operating support. Others may expand beyond 30,000 without using Federal support, thus understating the potential enrollment. As a result, new HMO "units" are not necessarily "new HMOs".

<u>HMO DEVELOPMENT PROGRAM (Units) 1/</u>						
	<u>FY 72</u>	<u>FY 73</u>	<u>FY 74</u>	<u>FY 75</u>	<u>FY 76</u>	<u>FY 72-76</u>
HMOs receiving planning funds	92	236	272	200	200	1000
HMOs receiving Fed'l operating support	122	230	314	392	442	1500
HMOs without Fed'l operating support 1/	<u>6</u>	<u>17</u>	<u>59</u>	<u>68</u>	<u>50</u>	<u>200</u>
Total	128	247	373	460	492	1700
Cumulative	128	375	748	1208	1700	
Enrollment (millions) 2/						
Potential	3.78	11.25	22.46	36.30	51.00	
Actual	1.26	5.03	12.52	23.37	36.66	
Budget Authority (\$millions) 3/	49	131	186	205	241	

1/ Assumes 25% of those receiving planning funds in previous year operate HMOs without Federal support.

2/ Assumes 30,000 members per unit as potential enrollment and a three year build-up to 30,000 as actual enrollment; since all units may not be operating by the end of the year, this may overstate actual enrollment.

3/ Includes Medical School support from Manpower Bill.

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1. Planning. HEW will provide \$23 million in planning grants and contracts to any HMO for up to a two year period. Each award will average \$250,000 per unit and will vary between \$50,000 for a foundation plan and \$500,000 for larger group practice plans. The table below shows estimates of planning costs for 30,000 member units based upon the experience of recently formed HMOs.

<u>Type of HMO</u>	<u>Planning Costs (\$000)</u>	<u>% of Total Appli- cations (est.)</u>	<u>Average Cost (\$000)</u>
Group practice (general) .	\$100-300	60%	
Group practice (under- served)	300-500	30)	\$250
Individual practice (general)	50-150	10)	

2. Operating support. There are three major programs for operating support for HMOs contained in the HMO Assistance Act and the Manpower Bill.

a. Underserved areas. HEW will provide \$22 million initial operating grants, contracts or loans to public or private HMOs which plan to serve predominantly underserved areas. Each unit would receive grants or contracts for an average of \$500,000 per year for three years. Public HMOs would receive loans averaging \$4 million per unit to cover initial operating losses and ambulatory facilities construction. The table below shows estimates for average initial operating costs for HMOs in underserved areas. These costs are experienced in the 2-4 year initial start-up period.

	<u>Initial Operating Costs (\$ millions)</u>
Ambulatory facilities	\$1.5
Initial operating deficits (3 yrs.)	2.5
Total	4.0

Private HMOs could receive up to \$1.5 million total in grants and contracts and could rely on guaranteed loans or non-Federally-supported financing for the other \$2.5 million. Since public HMOs are unable to borrow capital, they could receive an average loan of \$4 million, or some combination of grants and loans.

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b. General population. New private HMOs serving a cross-section of the population could receive guarantees for working capital loans in the first three years of operation and for ambulatory facilities and equipment. The total authorization would be approximately \$300 million. The table below shows estimates of average initial costs based upon the experience of existing HMOs.

	<u>Initial Operating Costs</u> <u>(\$ millions)</u>
Ambulatory facilities	\$1.5
Initial operating deficits (3 years)	<u>2.0</u>
Total	\$3.5

These costs will vary from HMO to HMO. However, we assume an average guarantee authority of \$3.5 million per new 30,000 member unit.

c. Medical schools. Medical schools generally incur higher operating costs (up to 25%) for delivering health care due partially to the added expense of training. Under authority contained in the Manpower Bill, HEW will provide continuing operating support to medical schools which become HMOs or to those which affiliate with HMOs. These grants and contracts would be sized roughly upon the number of Federal beneficiaries (Medicare/Medicaid/FHIP) enrolled in the HMO and the additional costs of training in the HMO. In this way, we provide operating support in proportion to the additional costs, but retain the incentive for the HMO to enroll new members. For planning purposes, we assume each medical school gets approximately \$75 extra per Medicare/Medicaid/FHIP beneficiary for up to 25,000 such beneficiaries.

3. Enrollment. Potential enrollment is based upon the number of new 30,000 member units receiving operating assistance. As indicated above, HMOs will vary in break-even size depending upon whether they own their own beds or not, whether they lease or buy equipment and other factors. Some HMOs will grow without Federal support once the break-even point is reached. The 30,000 figure is merely a convenient reference for break-even size and does not necessarily reflect average anticipated enrollment per HMO. Actual enrollment is based upon a growth rate of 10,000 per year in the first three years for new HMO units.

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4. Budget Authority. The Table below contains detailed budget estimates to support the HMO development program. This reflects the funds which would be needed if HMO development activity occurs at the rate shown above.

	<u>Program Budget (Units/\$ millions)</u>					
	<u>FY 72</u>	<u>FY 73</u>	<u>FY 74</u>	<u>FY 75</u>	<u>FY 76</u>	<u>FY 72-76</u>
Planning..	92/\$23	236/\$59	272/\$68	200/\$50	200/\$50	1000/\$250
Operating Grants/ Con-						
tracts..	36/\$18	70/\$35	100/\$50	94/\$47	90/\$45	160/\$195
Loans ..	1/\$04	6/\$24	9/\$36	12/\$48	12/\$48	40/\$160
Special Medical School <u>1/</u> Grants/ Con-						
tracts..	<u>10/\$04</u>	<u>25/\$13</u>	<u>50/\$32</u>	<u>75/\$60</u>	<u>100/\$98</u>	<u>100/\$207</u>
Total Budget Authority (\$M) ..	49	131	186	205	241	812
Operating non-bud- get) Guaran- tees ..	(75/\$263)	(175/\$613)	(250/\$875)	(325/\$1140)	(375/\$1310)	(1200/\$4200)

1/ Not included in HMO Assistance Act

Senator KENNEDY. Now, over the course of the morning we have seen that we have basically four different health programs that the administration has recommended.

You have the family program for low-income families, you have the workers' program, you have a continuation of the medicaid program, and then you have your special risks program.

Why should we not just have one approach for everyone?

Secretary RICHARDSON. I am not sure, before I answer the question, a special risk program, I don't—oh, the pool.

Senator KENNEDY. The pool program.

Secretary RICHARDSON. That really is a subheading of the mandated insurance coverage.

Well, I think, Mr. Chairman, the answer to the question basically depends upon the route that we have taken in developing these recommendations.

A lot depends, really, as a premise, or point of departure, on whether or not you start out believing that the existing system is a good system, subject to serious flaws, or whether it is a system that is so shot and riddled with deficiencies that we need to start over again.

We feel that the system is basically a good one, subject to serious flaws, and we are trying to correct these through carefully designed responses to those problems.

Now, there is still room, eventually, and in the light of available Federal funds and so on, to take additional steps, building on these.

I would hope, for example, that we could eventually extend the family health insurance plan to cover couples without children, and single adults. I would hope that we could eventually extend it to substitute completely for the adult category of medicaid.

There are problems in the short run in doing this, from the standpoint of the administration. They involve shared costs, as opposed to a wholly federally financed initiative, and they must be considered in the light of other things we are doing that also absorb present State expenditures, such as the save harmless clause under the family assistance plan, general Federal revenue sharing, and so on.

This proposal as it is will relieve additional State costs under medicaid, but, trying to do all these things together—welfare reform, general revenue sharing, as well as a rational substitute for medicaid—has led us to combine these things in this way.

Senator KENNEDY. Well, tell me what is in your program that you believe will actually bring a halt to the rising costs in our health system at the present time, other than those which you have outlined preventive care.

You have in your briefing sheets the example of California, where they have four times as many tonsillectomies as other parts of the country. This is just one example. I am sure there are scores of others.

And what is inherent in your program that is going to give assurance to the American people that we are not going to have these kinds of abuses in the future? Because obviously, every time you have the abuse, you have increased costs, increased inefficiencies.

And I fail to see suggested in your recommendation the kind of quality control or cost control which I am sure you must agree is

absolutely necessary in terms of bringing this health crisis under control.

Secretary RICHARDSON. Well, I think I certainly would not want, by apparent acquiescence, to leave the impression that prevention is not a critical element in cost control. We believe that it is, and, of course, this does account for the emphasis we place on Health Maintenance Organizations, which have strong incentives to control utilization of health resources, leading to reduced costs.

I also want to reemphasize at this point that portion of my testimony which points out that we are proposing that Professional Standards Review Organizations be established within States to do a number of things that bear directly on standards of quality and cost.

These PSRO's, which, as I point out here, would be representative of labor groups and consumers as well as of the health professions, and would be directly charged by the Secretary with both utilization review and review of quality. They would be charged with recommending appropriate action to disqualify providers of care that were abusing appropriate standards of utilization of services, for example, or overcharging for services.

They would not have the responsibility of fixing charges as such, but they would provide the standards by which to judge the relative efficiency or economy of a given provider. And beyond this, we would be utilizing under the family health insurance plan, as under medicare, such proposals for holding down costs as we have already initiated administratively in medicare, whereby, for example, we will only pay a physician for medical services at the 75th percentile of charges in the area. In other words, we will not pay more than that percentage of the charges made by other doctors in the community.

Senator KENNEDY. But the PSRO's under your recommendation will be principally advisory. They have no power of control. And there are—

Secretary RICHARDSON. It is advisory, but when coupled with the proposed regulation of national health insurance, and coupled with the opportunity both through medicare and under medicare, and medicaid, and the family health insurance plan, to refuse to pay excessive charges, it becomes a fairly significant legislative device.

I would also, in addition to these things, want to emphasize, too, that we are very deliberately proposing to incorporate elements of cost consciousness in each of these insurance approaches.

Now, this is, on its face, a debatable measure.

Your earlier question bringing up the costs that a family could incur, in highly unfortunate circumstances, in 1 year, reflects one of the greatest contributors to the spiraling inflation in health care costs, I mean the practice of providing first-dollar insurance coverage. We think that if we can shove the system in a somewhat different direction, by requiring some contribution to the cost of coverage and of care, then this is likely to reduce excessive demands on the system, and thus help to hold down costs.

I would just say, Senator, the only thing we don't propose is price-fixing itself. That is, the actual establishment through Federal standards and through Federal action of fees for services and hospital care.

Everything else that I have heard of suggested, that seems to make any sense, is incorporated here. We shrink from the direct fixing of fees and charges, for the same reason that we would like to see competition and relative freedom maintained in the economy. We have refrained from doing so, for example, in construction.

Senator KENNEDY. You are not going to compare the construction industry to medical responsibilities? I mean, someone comes up, wants a house built, and one group can do it at a cost, and if he does not like it, he can shop around.

Someone comes on in, then, because he is sick, he is going to take what that doctor recommends or suggests to him.

And I think a part of the problem has been that we have been looking out after the interests of the consumer, and in this case the consumer has been the doctor rather than the person who has been sick.

Secretary RICHARDSON. We would have the opportunity, as I say, relying on the professional standards review organizations, to decline to pay excessive charges, and this we would do.

And the PSRO would have the function of establishing standards of quality and cost, and value, and so on.

But I think we think this goes as far as it is reasonable to go. That is what it comes down to. We are afraid that if we go farther than this, we will be creating an enormously complex and expensive regulatory system, in the first place, and that we may have achieved the result of drying up sources of health care.

We don't have a system, and cannot have one, really, which potentially rests on a doctor draft.

Senator KENNEDY. You see, I have difficulty following the cost-consciousness argument.

We have cost consciousness now, under existing insurance programs, and it doesn't seem to help to keep costs down.

You have a variety of deductibles and other costs which the individual has to pay, and I don't see how that has reflected itself in lower medical costs for the people in this country.

And so I fail to understand why maintaining that concept in the administration's approach, which will mean that time and time again that family of that worker or that businessman is going to have to lay out those deductibles, really helps to bring the cost under control, and provide better quality.

Secretary RICHARDSON. The cost consequence, of course, of failing to preserve some element of deductible and coinsurance is to require higher initial costs. It is just a different way of spreading the cost.

There have been considerable, and undoubtedly, Mr. Chairman, you will want to go into this further, there have been studies of cost consciousness as a factor affecting use. Conversely, in systems where drugs, for example, have been made available on a no-cost basis, there has tended to be a greater use of drugs than might be medically desirable.

Senator KENNEDY. Does that include surgery, too?

Secretary RICHARDSON. No. But I would say we are glad to work with you, Mr. Chairman, and with your colleagues, on this committee and other committees, in the development of effective means, as effective as possible, of holding down costs.

I am not aware, for example, of any proposal in any pending bill, including your own, which seems more likely to be capable of solving this problem than we have proposed here.

And as you go further in the direction of establishing cost controls, you do encounter the problem inherent in trying to make what is fundamentally a system resting on a large element of freedom of decision on the part of the health care provider work at all.

Senator KENNEDY. I have just one more question, but Senator Pell wants to question.

Senator PELL. Just one late reaction.

That is, your law, Mr. Secretary, or the bill, your health benefit provision for employees, is expected to be drafted in such a way that it will go to the Finance Committee.

I am struck here by the fact that the minimum wage bill comes to this committee. The minimum health benefits bill being drafted comes to this committee. And I would hope that you would give a thought to having that particular bill drafted in such a way that it could come here, where we really are concerned with this question of minimum health benefits.

Senator KENNEDY. Or at least have joint responsibility, so that even if it did not come here, at least we would have an opportunity to work on this matter.

Senator PELL. I would agree.

Secretary RICHARDSON. We would be glad to work with you and your colleagues in every way that will be agreeable to you.

Senator KENNEDY. If I may, Mr. Secretary—the hour is late, you have been extremely kind and generous with your time, and responsive—I think one of the classical differences, obviously, in the approach of the administration and those of us who have offered a national health insurance program is based on the fact that the insurance industry has really failed the American people in providing the kind of high-quality care which I think is essential for our times.

You cannot get around the fact that today only one-third of the health expenses are actually paid by the insurance companies. There is illustration after illustration of people who feel that they have some kind of coverage, and yet when the bills come on in, they find out they have deductibles, coinsurance, and other expenses which limit their coverage.

And you cannot get around the fact that in terms of the administration costs for various commercial carriers, only 50 cents out of all the premiums that are paid in for benefits are actually paid out, in terms of family policies.

And that in terms of even the Blue Cross, as I understand, it is approximately 7 percent, and medicare it is 5 percent, and the best kind of estimates that have been made in terms of a national health insurance approach bring it down to anywhere from 2 to 3 percent.

Given this track record, do you believe that we ought to really compound the difficulty or excessive costs that we have seen over the period of recent years, and work through the insurance mechanism to meet the problem of quality health care for the people?

Secretary RICHARDSON. I would say, Mr. Chairman, we are dealing with insurance mechanism one way or another. Wherever we are talking about—

Senator KENNEDY. Well, the insurance mechanism—the insurance companies, corporations, as a means, versus insurance mechanism.

Secretary RICHARDSON. Their record is a record which has to be understood as having evolved in the absence of a requirement for the provision of health insurance coverage for employees.

And so one could say, I suppose, that it is remarkable that, considering that the United States has never mandated any particular level of prepayment coverage for medical services, health needs, that it has gone as far as it has.

The question is really whether, on balance, we would be in a stronger position to build on this, and the answer to that question depends largely upon the premium we attach to the preservation of competition, preservation of opportunities for choice among various competing approaches, or alternative approaches, to benefit packages and so on.

Let me just say, finally, on that business about 50 cents on the dollar, the only data I know about in this connection undertakes to identify the total amount retained by private health insurance organizations, both profitmaking and nonprofitmaking, for the combination of operating expenses in addition to reserves and profits, and for the last full year we have, 1969, the percentage retained by private health insurance organizations for all three of these purposes was 10.8 percent.

Senator KENNEDY. Well, we could—the best estimate that we have had was made by Mr. Rashi Fein, who is a distinguished medical economist, who said 50 percent of the commercial carriers' premiums are used for administration and administrative expenses, and that 20 percent of the group policies are used for administration.

If you have other figures that reach different conclusions, I would hope that you make those available.

It seems to me that when you review the facts, there will be additional deductibles that will be necessary for individuals to pay, and that what you are really going to see is competition from these companies to provide additional supplementary insurance programs to reach these various deductibles. You will not only have the program or the approach of the Administration, but you are going to have additional kinds of insurance by private companies and industry. This is just going to compound the difficulty in reaching the kind of quality health care which I know that you are interested in.

Don't you believe that these companies are going to be moving into these areas of deductibles, coinsurance?

Secretary RICHARDSON. Certainly. They have done that under medicare, or the coinsurance deductibles. They are already provided under medicare law.

We hope to be able to exercise a little ingenuity to develop possible disincentives to do this, which, of course, would follow from the belief that cost consciousness is important. But I recognize the point.

Could I ask to insert here, Mr. Chairman, a tabulation from the Social Security Administration Bulletin for February 1971, which covers retentions by private health insurance organizations, which contains the figures I gave you?

It may be that Dr. Rashi Fein was referring to the percentage that was retained under individual policies by private insurance companies. This cost is approximately 50 percent, and presumably reflects the relatively high costs of selling and collecting on such policies.

But their comparable figure for group policies, for private insurance companies, is 5.9 percent.

Senator KENNEDY. Is that administrative overhead, or what, that you have there?

Secretary RICHARDSON. No, the word "retention" is a generic term embracing operating expenses. In other words, administrative overhead, plus additions to reserve, plus profits. And for all private insurance organizations, in the aggregate, their combined percentage for 1969 was 10.8 percent.

For private insurance companies, group policies, it was 5.9 percent.

For private insurance companies, individual policies, it was 49.2 percent.

It may be that he was referring to that last figure, but obviously, that is not a pertinent figure under a legislative proposal that would require employers to have the group policy.

Senator KENNEDY. Well, I would like to pursue that, and put that in. I appreciate that.

(The material requested had not been supplied at the time this hearing went to press.)

Senator KENNEDY. I want to thank you very much, Mr. Secretary, and I think in your comments earlier today you have attempted to recognize the crisis, the health crisis, in our country.

I would hope that even with your comments and statements on page 3, when you talk about the fact that the critical health problems today do not arise because the health of our people is worsening, you know as well as I, and as has been pointed out by the nutritional subcommittee here in the Senate, that the problems of adequate nutrition and hunger still operate as a very severe health hazard to hundreds and thousands and millions of Americans and that the inadequacy of sufficient and adequate health care for many of our senior citizens is continuing to bring a deterioration of health to many of our people. Then, expenditures on health care have been niggardly, and this has been one of the real contributing factors in the health crisis today.

And then you say we have been negligent as a Nation in developing health care resources, or we have been unconcerned about providing financial protection against ill health.

There are those that believe that insurance coverage has been most inadequate.

I think the approach which has been taken by your Department, by the administration, and by the President in identifying this crisis and providing for health and assistance to medical schools in the development of these HMO's can provide, if adequately financed and followed through with, is an important contribution in meeting the crisis.

I still find that there are some very deep, implicit and explicit problems in the approach, in terms of cost control, in terms of quality control, in terms of the utilization of the private insurer, in terms of meeting the health crisis in the country.

And I think we are going to find hundreds and millions of Joe Q. Citizens who will be still required to pay the deductibles under your program that really put an extraordinary continuing hardship on many individuals in this country. I don't think that they ought to be required to pay these deductibles—at least in the way and means that have been suggested.

But we will explore these matters further with you, and I want to commend you and your associates this morning for your help, your assistance, and your responsiveness to these questions, and your willingness to give us the information that we desire to try and help meet the health crisis in this country today.

Secretary RICHARDSON. Thank you very much, Mr. Chairman.

For my associates and myself, let me thank you and the members of the subcommittee for giving us this opportunity to testify to these problems, and to our approaches toward solving them.

Thank you very much.

(The prepared statement of Secretary Richardson follows:)

Testimony of
Elliot L. Richardson
Secretary, Department of Health, Education and Welfare

Before the
U.S. Senate, Labor and Public Welfare Committee
Health Subcommittee

Monday, February 22, 1971

9:30 a.m.

Room 318, O.S.O.B.

Mr. Chairman and Members of the Subcommittee:

On February 18, the President sent to the Congress his proposals for "Building a National Health Strategy." Today, I should like to discuss the problems, and their causes, that led to the remedies proposed in the President's health message.

I should like to convey to you our understanding of the principal health problems and their causes because, if we misunderstand the nature of the problems, we shall likely apply the wrong solutions. And further, if we are to debate the issues meaningfully and productively, it would be well for all to start, at least, by agreeing to discuss the same issues.

Status of the Nation's Health

Amid all the passions raised about health in the United States, it is all too frequently forgotten that a variety of measures indicate that the health of our people has been steadily improving. Since 1950, life expectancy has increased by 3.4 percent, the infant death rate has dropped 2.3 percent, the maternal death rate has gone down 66 percent, and the neonatal death rate has fallen by 19.5 percent. Between 1960

and 1968, the days lost from work per person have decreased by 3.5 percent, and the days lost from school per person have decreased by 7.5 percent.

Another set of indices tells us that the national effort to purchase better health has been expanding at a rapid rate. Health care expenditures, for example, have been increasing at a faster rate than the growth in the Gross National Product: in 1955, total health expenditures were \$18 billion, or 4.7 percent of GNP, whereas in 1970 they amounted to \$67 billion, or 7.0 percent of GNP. Federal health expenditures have increased at an even faster rate. The public sector increased its share of health expenditures from 25 percent in 1966 to more than 37 percent in 1970, two-thirds of which is the Federal contribution.

Yet other indices inform us that resources have been growing faster than has population, especially in recent years. There were 12.4 hospital beds per 1,000 people in our civilian population in 1963; by 1968, there were 13.5. Between 1950 and 1966, while the population of the United States was increasing by 29 percent, the number of people in health occupations increased by more than 90 percent--three times as fast. In 1960, health workers comprised 2.9 percent of the civilian labor force; by 1966, the percentage was 3.7 and rising. Our supply of physicians increased by 34 percent in the same period.

Finally, in our review of the facts, we note a marked rise in health insurance coverage for all members of our population. In 1950, 48.7 percent of employed workers were covered for hospitalization; in 1967, almost 72 percent were so covered. In 1950, only 35.5 percent of employees were covered for surgical benefits, 16.4 percent for regular medical benefits, and none for major medical expenses. In 1967, the comparable percentages were 70.5, 61.2 and 28.8. I hardly need recount the gains that have been made in providing financial protection against illness under Medicare and Medicaid for the aged and the poor. For the population as a whole, 20 years ago, only 50 percent had health insurance; today, it is 80 percent.

I conclude from these facts--and I believe you will agree--that in general our critical health problems today do not arise because the health of our people is worsening, or because expenditures on health care have been niggardly, or because we have been negligent as a Nation in developing health care resources, or because we have been unconcerned about providing financial protection against ill-health.

We must look elsewhere.

The Broad Problems

I should like to suggest that our present concern is a function of two broad problems. The first is the inequality

in health status and care, and in access to financing. The other is the pervasive problem of rising medical costs.

The statistics I have cited, while true, are gross, and pertain to the Nation as a whole. They mask differences among sub-populations in the United States, and these differences have become intolerable.

The impressive growth in the number of people covered by health insurance conceals the fact that only 29 percent of all personal health expenditures were paid by insurance in 1968.

The satisfaction with which we view the spread of Medicaid to 48 of the 50 States is lessened by the knowledge that only one-third of the estimated poverty population received services under this program in 1970, and only 133,000 of an estimated 750,000 women and infants in low-income circumstances received comprehensive maternity and infant care.

The indices of general improvement in health pale in importance when we look behind them and see that the poor and non-whites are doing far worse than whites and those with decent incomes.

Our resources, to be sure, are growing at a rapid rate. But that can offer little reassurance to the people of Mississippi, with fewer than one-half the national ratio of physicians to population, or to the people in 1,000 midwest

towns where there were no physicians at all in 1965, or to our ghetto populations in Chicago and other major cities for whom the presence of a physician in their neighborhoods is a rare sight indeed.

Finally, when we look beyond our borders and compare ourselves with other nations, any sense of accomplishment over our long-run gains in health status is mitigated by the fact that other advanced nations are doing better than we are. While cross-national comparisons are imperfect and must be used with caution, we note that Sweden, which devotes about as much of its national product as we do to health, out-performs us on comparable health indices. That nation's infant death rate, for example, is about half ours. Twelve countries have lower maternal death rates than we do; 17 have longer life expectancies for their men; and 10 have longer life expectancies for their women.

These disparities point to a gap between what we have accomplished and what remains to be accomplished, between our achievements and our expectations, between what is and our impatience for what might be. And let us all agree that it is for the best that we have high expectations and grow impatient with the pace of change, and are incensed by the mortal injustices in the fortunes of birth. I do not doubt for one moment that, regardless of political affiliation, regardless of our positions

in the Federal Government, we share today the same sense of concern over these disparities in race, age, income class, geographical location, and financial protection against illness.

The other major problem to which I referred was the pervasive inflation in medical costs. I hardly need remind this well-informed subcommittee that, since 1960, hospital costs have been rising at 15 percent a year, and physician fees have been increasing at more than twice the rate of the Consumer Price Index. Under these circumstances, relatively minor episodes of illness become heavy burdens, and serious illness is transformed into large and lingering debts, and sometimes bankruptcy.

Just as we find the disparities in health status among our people to be intolerable, so too do we find the rising cost of health care--for individuals as well as for the Nation. We are dismayed over health care costs by our realization that other hopes and purposes are being usurped. For the young family whose savings are wiped out by an illness, it is more than a bank account that has been depleted--it may be the end of their hopes for their first home. Likewise, for the Nation, the dollars we spend on medical care are dollars we cannot spend revitalizing our cities, reducing pollution, or improving our transportation systems. This is not to downgrade the importance of health. But it is not the only

important purpose we have, and if the same amount of health can be obtained with fewer dollars, then we shall all be better off.

Causes

So far, I have tried to share with you our conception of what is, and what is not, at the crux of the health care crisis. I should now like to probe a bit into the causes, not to blame or accuse anyone or any institution, but rather to understand--and thus fit the remedy to the cause.

At the outset, we should understand that the low health status of the disadvantaged in our society simply replicates their low status in other respects: their housing is poorer, their education is poorer, their job opportunities are poorer, and so on. All these factors are inter-dependent. I wish, therefore, to underscore the point made by the President in his February 18 message--that the welfare reform proposals are also a health message, that the Administration's expanded efforts to end hunger in America are a health message, and that whatever we do to improve the education of the disadvantaged, to create jobs through a full-employment budget, and improve the environment of our inner cities and rural areas, will also constitute a health message. We must be very careful, especially in reviewing the health problems of the disadvantaged, not to restrict our vision to medical care alone.

There are a number of other causes that we may group together and understand in terms of rewards and penalties or, to use the jargon of economists, incentives and disincentives. It is fair to say that normal people generally pursue rewards and eschew penalties, and much of the behavior that has produced disparities in health care as well as in rising medical prices can be understood within this context.

As an example, for some time there has been a migration to our large urban areas. It is to be expected that physicians, as well as other service personnel, dependent as they are on a reservoir of population for their livelihood, would migrate also. Lately, physicians have left the center cities and moved to the suburbs because there were no disincentives--no loss in income or status or professional prestige--for doing so, and they sought the same amenities that others were seeking in moving to the outskirts of the "urb." Similarly, fewer services have become available from primary care physicians--general practitioners, pediatricians, and internists--because their numbers are declining. And they have been declining for a number of reasons: the large infusion of research dollars into the medical schools after the Korean War gave young medical students a clear signal of national priorities. Moreover, the increase in knowledge has been leading to an increase in specialization, and some specialties have been--both from the

press they received as well as the heights to which their incomes could reach--more prestigious than others. They obviously have been more prestigious than the Local Medical Doctor, as some medical schools still contemptuously refer to the family physician, practicing in "Elsewhere, U.S.A."

Our medical care system is geared to sickness, not to health. Under these circumstances, the incentives have been to care for the sick--and constantly to do a better job of caring--and few incentives or none to prevent illness, or to diagnose illnesses in their early stages and treat them before they become "interesting."

Along somewhat similar lines, we have very powerful incentives in our society, to smoke, drink, eat excessively, and lead sedentary lives. These have taken enormous tolls in heart disease, lung cancer, automobile accidents, and the like. Beyond these causes is a simple one--that people are generally short-sighted, preferring to take pleasure where they may and ignore the Devil's due waiting to be paid in the future. And there are complex causes--such as cutting up our living space in such a fashion that it is inconvenient to do anything without a car, and leaving few places in which to play.

(As an aside, I do wish medical scientists would discover how to enable us to be as obese as Winston Churchill, smoke as much as he did, drink as much as he did, and live

as long as he did--and, oh yes, be as smart as he was-- instead of discovering that we shall survive longer if we give up tobacco, alcohol, and fine foods. As the old joke had it, we may not live to be a hundred, but it will seem like it.)

The incentives that have led to inflationary medical costs are not too difficult to discern. When Medicare was introduced, it provided that physicians would be paid their "customary" fees. Some had been giving care free of charge or at prices below what they considered to be their value-- and hardly "customary." Hence, there was a rather rapid jump in the cost of physicians' services after the birth of Medicare. Medicare and Medicaid, as well as private health insurance companies, have been willing to reimburse hospitals "at cost," which has become a euphemism for a blank check. There has been little incentive to hold down costs, to search for means of increasing the productivity of health manpower and facilities, or to substitute capital for labor.

Our insurance plans also reward people if they go to the hospital for services, and penalize them if they obtain the same services outside the hospital. No wonder, then, that hospitals have been excessively and inappropriately used.

In trying to understand the reasons for the lack of depth in our insurance coverage--as stated earlier, covering

less than 30 percent of personal health expenditures--we cannot find a satisfactory answer either in the factors underlying the problems of the poor or in the rewards and penalties that have led the medical care sector to behave the way it does.

The disparities in this instance have been pointing to a fundamental inequality in access to a basic necessity. This inequity has been recognized for what it is, namely, a social injustice. And that is intolerable.

Remedies

All too briefly, I am afraid, I have tried to bring into the light of discussion a description of the problems we confront, and their causes. The equation for the remedies quite obviously is not found in a child's primer.

This Administration's proposals, as I shall now endeavor to show, are addressed to the specific problems and their causes, and together constitute a strategy for reforming and renovating our health care system. I am firmly convinced, to recall a phrase used by Jefferson, that we have found the right-sized patch--neither too large nor too small--to cover the hole.

Our proposals largely reflect our desire to lodge new responsibilities with our people and institutions, trusting

them to be responsive, having faith in our system and its ability to change. At the heart of these proposals is a basic governmental philosophy underlying the President's proposals for revenue-sharing, the consolidation of categorical grants, and the reorganization of the Federal Government. Its roots are in the liberal philosophy of Jefferson, that calls for decentralized and pluralistic foci of power, and shaping the Federal role into a precision instrument. The health proposals are a part of this pattern.

What, then, do we propose? I could categorize our proposals in a number of different ways, but I prefer to present them to you in relation to the problems and their causes and in terms of their objectives.

Problems of Distribution

The Nation is confronted by a geographic maldistribution of health care services. The Administration proposes to attack this problem in many different ways.

-- We shall promote the development of health education centers, which are community facilities generally affiliated with medical and dental schools for the training of physicians and other health personnel in areas deficient in the supply of these resources. We shall thus encourage medical schools to expand their capacity for graduating physicians in these areas at a much faster pace than in the existing medical school

buildings. We shall encourage them to hold down the cost of medical education by converting community hospitals and other clinical facilities into teaching facilities. In effect, we shall implement the recommendation of the Carnegie Commission Report on "Higher Education and the Nation's Health." The FY 1972 budget will contain up to \$40 million for this purpose.

-- We shall provide incentives for the development of Health Maintenance Organizations that will emplace health care resources in areas now lacking them. I shall have more to say about HMOs later, but it is important to note here that they will serve to ameliorate distributional as well as other problems.

-- We shall expand support for the training of MEDEX and similar types of physicians' assistants to enlarge the capacity of physicians to care for patients, and to lessen the burden that many family physicians carry in small towns and other scarcity areas.

-- We shall support the development of new Neighborhood Health Centers or, as we prefer to call them, Family Health Centers, which will later evolve into Health Maintenance Organizations or HMO satellites.

-- We shall create a new Health Service Corps under the authority of the Emergency Health Personnel Act of 1970.

Because this will be a direct Federal activity, and because, at best, it will operate only on the margin of the total health care industry, we look on these efforts as a necessary short-run measure to assist in overcoming blatant geographical disparities before other efforts to improve the distribution of the entire health care industry take hold.

-- We shall provide incentives to new medical and dental graduates to practice in areas lacking physicians and dentists, by forgiving part or all of the guaranteed loan indebtedness they incur while in school. I should be less than frank if I were to suggest that we are extremely optimistic about the likely success of this proposal. However, we are hopeful that a growing idealism among medical students, the size of their indebtedness, or their awareness of the urgent needs will in fact make this proposal work.

The Nation is also confronted by the maldistribution of certain types of services, and primary care services in particular. As pointed out earlier, the absolute and relative numbers of family physicians, pediatricians, and internists together are declining. Yet these types of physicians can handle most of the illnesses people have, they provide more services than other specialists, and the unit prices of their services are lower than those of other specialists. Furthermore,

it is to be noted that while other advanced nations, who appear to do better than we on health indices, have fewer physicians in relation to population, they have a higher ratio of primary care physicians.

Our proposals, therefore, contain incentives to increase the supply of primary care physicians.

-- In the new area health education centers, we shall provide support for setting up residencies in the primary care specialties.

-- We shall offer support for medical schools to set up preceptorships or clerkships for undergraduate medical students, to enable them to obtain firsthand experience in the primary care specialties, and to provide a counterbalance to the incentives in medical school today to concentrate on hospital-using specialties.

-- Our loan forgiveness provisions will apply also to students who enter the primary care fields.

-- Through the development of HMOs and area health education centers in scarcity areas, we shall be helping to create an environment and a type of practice that should be appealing to primary care physicians.

-- We shall greatly expand the Nation's efforts to train child health associates or pediatric nurse practitioners, obstetric assistants or nurse midwives, as well as assistants for general practitioners and dentists. Our studies indicate, for example, that if we can produce about 3,000 child health associates a year--a quantity beyond the present capacity of our training facilities--within five years we should be able to provide an adequate supply of child health services for the entire population, with only a modest increase in the supply of pediatricians and not unrealistic changes in their geographic distribution.

Medical Costs

I should now like to turn to the Administration's proposals to bring medical costs under control.

For the long-run, our strategy calls for a determined effort to prevent illness, and thereby reduce demands on our health care resources. Among our proposals in this regard, the most important are:

-- To maintain the broad base of our biomedical research attack against most of the diseases and impairments that afflict mankind, and upon that base, launch major new programs to conquer cancer. As you know, we propose an additional \$100 million in FY 1972 for this purpose. We shall also

increase our efforts fivefold to determine means of preventing or controlling sickle cell anemia, a disease that is found almost exclusively among our black population, and occurs in one out of 500 births.

-- We shall help create a private Health Education Foundation, whose objective will be to make every citizen aware of the importance of maintaining good health--to avoid cigarettes, to avoid excessive use of alcohol, to eat a well-balanced, nourishing diet, to maintain physical fitness, and the like.

-- We shall implement the Occupational Health and Safety Act for our working population and, in particular, to improve the safety of those who handle toxic substances. I should also note that mandating employers to provide a basic insurance coverage for employees, which I shall discuss in a moment, in conjunction with the HMO option, should provide an incentive to employers to improve the healthfulness and safety of the work environment.

-- We have added \$69 million in FY 1972 for family planning doubling last year's program. As a health measure, family planning not only allows women to avoid the birth of unwanted children but also can prevent illnesses of mothers and children through, for example, the proper spacing of births.

-- To improve the nutrition of households in general, and of children in particular, the Administration nearly tripled the outlays for food stamps between FY 1970 and FY 1971--from \$577 million to \$1.4 billion. The FY 1972 budget calls for more than an additional \$500 million. The child nutrition programs nearly doubled between FY 1970 and FY 1971--from \$299 million to \$522 million, and an additional \$39 million has been requested for FY 1972.

As I pointed out earlier, other actions and proposals of this Administration will have a decided preventive impact on the health of our people--including rigorous controls over environmental pollution, the welfare reform proposals, and others.

In addition to the anticipated reduction in demand for health services through the agency of prevention, we are also proposing a number of direct actions to reduce medical care costs. In effect, we are offering incentives to shift the medical care industry from its preoccupation with acute care in hospital settings. Rather, we will offer incentives for the application of preventive measures--procedures like immunizations, to prevent an illness from occurring, or like "Pap smears," to catch a disease in its early and treatable stages, or like the early ambulation of surgical patients, which leads to early recovery and rehabilitation.

We believe that this shift will occur, if there are sufficient incentives. Prepaid arrangements in Health Maintenance Organizations, we believe, provide such an incentive. Under these arrangements, HMOs will receive a contractually-fixed amount for the care of their enrolled members. If the HMO's health care staff pays little attention to prevention and continues with acute care in hospitals, then they will exceed the contracted amount for the care of each person. If, on the other hand, the HMO bends its concern to prevention--or, in other words, to low cost care--its costs will be within the set amount. It will profit by maintaining the health of its members. Will this be sufficient incentive? We believe that there is convincing evidence to warrant that conclusion. Moreover, when populations with similar characteristics are compared, those served by existing HMO-type organizations do better on measures of health than those who receive services under other auspices. This leads us to conclude that the quality of care is not sacrificed when health care providers consciously try to control costs.

Group practices and foundations, similar to our conception of HMOs--and, which I shall henceforth refer to as HMOs--compare favorably with other means of providing care. Data on hospital use for 1,000 persons per year were as follows: in HMOs, 744 hospital days versus 955 in the others;

70 hospital admissions, versus 88; 49 hospitalized surgical cases, versus 69; 47 tonsillectomies, versus 94. These comparisons were standardized for age, sex, income, residence, and, excepting tonsillectomies, out-of-plan services. In comparing the annual health costs per family in HMOs with costs under two different insurance plans, we find that the premium and out-of-pocket costs totalled \$224 in the HMO, \$252 in one insurance plan, and \$259 in the other. We also compared the average Medicare benefit payments per person in two regions in which there were both HMO and non-HMO beneficiaries. In one region, the savings in Medicare payments amounted to 15 percent in the HMO; in the other region, the savings were 7 percent. These data were standardized by age and residence.

HMOs also compare favorably on measures of health. In HMOs, premature births per 100 live births for whites was 5.5 and 8.8 for non-whites; in traditional modes, the comparable figures were 6.0 and 10.8. Infant mortality among whites per 1,000 live births was 22.7 in HMOs; outside, it was 27.3; while, for non-whites, the figures were 33.7 and 43.8. The annual mortality of the elderly population, 18 months or more after joining an HMO, was 7.8 percent; outside, it was 8.8 percent.

Experiments with HMOs over the years indicates that such an environment provides an inescapable context for peer review--a quality control factor for the most part absent among physicians who practice alone and whose use of hospitals is a matter of privilege. We have no intention of leaving quality control simply to chance. Review for quality of care as well as for the utilization of resources is part and parcel of our proposals. We are, in fact, providing for several kinds of checkpoints.

We are proposing that Professional Standards Review Organizations (PSROs) be established within the States to take a number of actions under the direction of the Secretary of HEW. They will determine, for example, whether the quality of care meets professional standards, and whether resources are being used efficiently and effectively. They will review both health insurance and HMO contracts. Furthermore, to advise the Secretary of HEW and to assist him in contracting with PSROs, we propose setting up a National Professional Review Council, comprising representatives of the health professions as well as representatives of employers, labor groups, and consumers. This Council will review the activities of the local PSROs and publish information on comparative performances, as well as undertake other activities on behalf of the Secretary.

We shall also request--and this proposal should be viewed as well in the light of the President's efforts to improve the planning capability of State and local governments--that State and local planning agencies review and comment on all forms of assistance to HMOs. Under Medicare, the planning authorities will have veto authority over capital reimbursements to HMOs, with, of course, an opportunity for HMOs to appeal such decisions to the Secretary.

Before I take up our insurance proposals, I should like to point out that we are proposing to offer \$23 million in FY 1972 in planning grants and contracts to initiate some 100 HMOs. For HMOs serving areas that are now underserved, we shall offer an additional \$22 million in grants, contracts, and loans for FY 1972, and provide for up to 3 years of operating support. We shall also seek authority to guarantee as much as \$300 million in loans for capital and working costs. Beyond that, however, I intend to see that my Department puts together "packages" of resources, negotiating with a single instrument and permitting advance payments to be made--with later adjustments, if necessary--to enable HMOs to get as rapid a start as possible. I am convinced that the frustrating experience of those who earnestly wish to implement national purposes but are blocked by the compartmentalization of Federal funding can be ended, and will be ended--in HEW.

Our health insurance proposals, described below, provide additional incentives to reduce costs. Both in the mandated employer-employee plan and in the Family Health Insurance Plan, benefits include outpatient as well as inpatient surgical and medical care. Moreover, services in extended care facilities or in the home can be substituted for equivalent inpatient hospital care.

To encourage the use of outpatient services and to reduce unnecessary utilization of health care resources, we are proposing differential coinsurance payments and deductibles on a rising scale. Outpatient coinsurance will not apply until family (of four) income exceeds \$4,000 a year; hospital deductibles will take effect only when family income exceeds \$3,500. Preventive services are not subject to deductibles. Cost consciousness must be a fact of life not only for HMOs, but for all our citizens above a minimum income level. When people pay virtually nothing for a service, they have little incentive to use the resources efficiently, or to keep demand within reasonable bounds. We do not believe that the suggested coinsurance and deductible schedule will create a barrier to the use of services for those truly in need of them. But they should be sufficient to create an awareness that resources are not free.

Financial Access

In addition to improving the distribution of services and reducing the inflationary rate of price increases for medical care, our objective is to improve financial access to care--in the President's words, "to ensure that no American family will be prevented from obtaining basic medical care by inability to pay." We therefore offer a comprehensive national health insurance program that draws on the strengths of both the private and public sectors. The main elements of our proposal are:

-- A National Health Insurance Standards Act, which will require nearly all employers to provide basic health insurance coverage for their employees. The precedents for this proposal are to be found in the minimum wage laws, disability and retirement benefits, and occupational health and safety standards. The minimum benefits will include outpatient and inpatient services, maternity care, well-child care, and the care of children's eyesight, as well as catastrophic cost protection amounting to at least \$50,000 per person with an automatic restoration of \$2,000 per year. Employers and employees will share the costs, and deductibles and coinsurance will be required--the latter for up to \$5,000 in medical bills per person per year. The employers' share will begin at least at 65 percent, rising to at least 75 percent. Employers will

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have to provide their employees with an option of obtaining services through traditional providers or in prepaid HMOs if available. Cost control measures, utilization review, and quality standards will be required of all providers, as I noted earlier.

-- The second element is the Family Health Insurance Plan. This plan will provide basic health insurance protection for all low-income families with children, not covered by the employer plan. The benefits will be Federally financed and uniform throughout the States, and include both outpatient and inpatient services. The Plan will remove the inequities in the Medicaid program between families headed by a woman and those headed by a man; among the States with regard to varying eligibility requirements; and among income groups, by scaling cost-sharing so as to avoid the sudden loss of benefits. In FHIP, as in the employer plan, options for care under HMOs will be included, and there will be similar requirements for quality standards, cost controls, and utilization and peer review.

-- The third element will be to continue the Medicaid program for the aged, blind, and disabled.

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-- The fourth element will be to have employers and employees prepay contributions for that share of the Part B premium in Medicare to which the aged now contribute for physician services--about one-half the costs. General revenues, which have paid for the other half, will continue to do so.

-- The fifth and final element calls for the establishment of private insurance pools for risk-sharing among employers with small numbers of employees, the self-employed, and people outside the labor force. This proposal will enable such individuals and firms to purchase insurance at group rates.

I am aware that there are some who are uneasy about the partnership we propose with the insurance industry, an essentially unregulated industry. This has surely been an anomaly in the past. It need not and will not be. This Administration is proposing that the insurance industry be regulated. We shall see to it that citizens have better and cheaper coverage through competition among carriers. The abuses that have been reported in the past--lack of clarity on coverage and exclusions, failure to perform claims and utilization reviews, exclusions of high risk groups, and sudden cancellations of policies--will be fairly but firmly dealt with.

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Health Manpower

I should like to discuss one further subject. In many of our proposals, you will have noted that we are asking the health professions as well as the schools that train them to assume a significant share of the responsibilities for reforming and renovating the health care delivery system. To no small extent, the professional schools will have to undertake reforms of their own in order to carry their share. I have already mentioned the desirability of expanding enrollments in area health education centers to improve the distribution of health services, and converting existing non-teaching facilities into teaching facilities to hold down costs. But there is more to be done. And once again, we have structured our incentives to encourage the schools and students to move toward these other objectives.

At the same time that we are making demands of the professional schools, many of them are experiencing financial distress. The Administration proposes to increase support to diminish and possibly eliminate this distress.

Our specific proposals, and their objectives, are these:

-- We shall increase the basic support of medical, osteopathic, and dental schools about threefold, on the average. This basic support will be in the form of a

capitation grant for each student the schools graduate. The average capitation amount now is about \$600 per year, or about \$2400 over a four-year period. Our proposal calls for \$6,000 for each graduate. The emphasis is on graduates for several reasons. First, it tells the schools that we are interested in their output, not their enrollments. Second, it provides an incentive for the schools to shift to three-year curricula; if they do, instead of spreading \$6,000 over four years, at \$1,500 a year, they would spread it over three, which would mean a "bonus" of \$500 per year for each graduate. Third, it should encourage schools to replace students lost by attrition--by, for example, integrating the professional school curriculum with the curriculum of the graduate science departments in universities. While attrition has dropped to about 8 percent in medical schools, and schools are replacing some of those who have dropped out, the remaining vacancies constitute the output of seven or eight large schools. Finally, if the schools reduce the length of their curriculum by one year, the students will be a year closer to earning their professional incomes--in effect, reducing their educational costs.

-- In addition to the basic capitation grants, special project grants will be awarded to achieve such specific objectives as: expanding enrollments, revamping the curriculum,

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training physicians and allied health personnel to work as a team, and participating in the development of an HMO.

-- In line with the Administration's efforts to improve the management of grants, we are recommending that five construction grant programs for health training facilities be consolidated into a single authority, and that resources in the form of guaranteed loans and other financial incentives be added. Our construction authorities in general will be used to modernize existing plants, to convert non-teaching facilities into teaching facilities, and to assist the schools in expanding their enrollments. We anticipate that this consolidated authority will generate approximately \$340 million in construction above current levels.

-- For student support, we are particularly interested in improving the mix of minority students--now vastly under-represented in health professional schools--and other students from low-income backgrounds, as well as ensuring that finances will not be an obstacle to any student who wants a professional education. To achieve these objectives, we are proposing to increase scholarship aid for medical and dental students from \$15 million to \$29 million--to an average of \$3,000 a year per student. To help alleviate the concern of low-income students who may have to borrow funds and who are afraid to carry the burden of a loan, we are proposing to forgive their indebtedness

if they are unable to complete their professional education. For all other medical and dental students, we are proposing that the students be allowed to borrow up to \$5,000 per year in guaranteed loans.

* * * *

In closing, I cannot possibly overemphasize the importance of considering each of our proposals as an interlocking part of a comprehensive strategy. It would make little sense, it seems to me, to say "go ahead and increase the supply of primary care physicians," but then deny the means to provide an environment in which such physicians would be pleased to work. It would make equally poor sense to say, "let's go ahead and improve financial access to the health care industry," but then deny the means of improving the organization of that industry and of increasing its efficiency.

What we are proposing is not simply a compilation of bits of this and pieces of that. Rather we propose an integrated strategy, at once coherent and comprehensive. It builds on present strengths. It seeks reform and renovation. It reposes trust and confidence in our people and our institutions.

Senator KENNEDY. The subcommittee will recess until 9 o'clock tomorrow morning.

(Whereupon, at 1:32 p.m., the subcommittee recessed, to reconvene at 9 a.m., Tuesday, February 23, 1971.)

HEALTH CARE CRISIS IN AMERICA, 1971

TUESDAY, FEBRUARY 23, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 9:12 a.m., pursuant to recess, in room 2228, New Senate Office Building, Senator Edward M. Kennedy (chairman) presiding.

Present: Senators Kennedy, Pell, Mondale, Eagleton, and Javits.

Committee staff members present: LeRoy G. Goldman, professional staff member to the subcommittee; and Jay B. Cutler, minority counsel to the subcommittee.

Senator KENNEDY. The subcommittee will come to order.

Today is the second day of the subcommittee's hearings into the Nation's health care crisis. Yesterday we heard Secretary Richardson of the Department of HEW describe the major portion of the President's recent health message. We were impressed with the emphasis in that message in respect to health maintenance, increased support for medical education, implementation of the Emergency Health Personnel Act, and special incentives for attracting disadvantaged students into the health professions.

However, there remain considerable questions with regard to the means by which we can reasonably hope to overcome the major crisis which plagues our health care industry.

For example, it is not at all clear how the President's proposals will really control the runaway costs of health care. Equally unclear is the extent to which the American people can hope to be afforded the kind of accessibility to, and quality of, health care that realistically should be theirs by right.

Also, there is serious question with regard to the substantial number of Americans who would not be covered at all by the proposed programs.

In addition, there is the basic issue with regard to the mechanisms employed in the President's program which depend heavily upon the private insurance industry with its high overhead and administrative costs as well as a quite limited range of covered services.

If we are to have a chance to bring reform to the health care system, we must be willing to fairly evaluate the advantages and the disadvantages of the present system. Clearly, we should not be in favor of perpetuating the status quo simply because it exists, or because to recommend change will disrupt the comfort index of those who have grown accustomed to "business as usual."

Today, therefore, we will hear from the Health Security Action Council of the Committee for National Health Insurance, and from an eminent health economist. And we are hopeful that their views will help to clarify the nature of this growing crisis and help to clarify the means by which we can rectify it.

I want to extend a very warm welcome to Mr. Leonard Woodcock, president of the UAW, who has appeared before this subcommittee last fall on the same subject. He has been extremely active in the development of the programs which have been introduced and which I am a sponsor of in the Senate. He has brought a great concern and interest, and I think an understanding of the problems that the working people face in this country in terms of health and their needs; and being one who has been discussing this at the bargaining table for so many years, he brings really an extraordinary background of concern to this subcommittee and to this subject.

So, we want to express to you, President Woodcock, a warm welcome.

Dr. Falk is a distinguished professor at Yale University, emeritus. He has had an extremely distinguished career in health matters. We welcome also Mel Glasser, whom we had an opportunity to work with on this legislation and other legislation, and Max Fine, who has been a source of great information to this subcommittee.

We have a distinguished group of individuals here who can help us immensely in our consideration of this subject, and we want to extend a warm welcome and ask you to proceed in your own manner.

STATEMENT OF LEONARD WOODCOCK, PRESIDENT, INTERNATIONAL UNION, UNITED AUTO WORKERS, ACCOMPANIED BY MELVIN GLASSER, DIRECTOR, SOCIAL SECURITY DEPARTMENT, UAW; DR. I. S. FALK, PROFESSOR EMERITUS OF PUBLIC HEALTH, YALE UNIVERSITY SCHOOL OF MEDICINE AND MAX FINE, SECRETARY, HEALTH SECURITY ACTION COUNCIL

Mr. Woodcock. Thank you, Mr. Chairman.

I am, as you indicated, Leonard Woodcock, president of the International Union United Automobile, Aerospace and Agriculture Implement Workers of America (UAW) and chairman of the Health Security Action Council.

With me today are three associates who are actively supporting the proposal for a National Health Security program: Dr. I. S. Falk, professor emeritus of Public Health, Yale University School of Medicine; Mr. Melvin A. Glasser, director, Social Security Department, UAW; and Mr. Max W. Fine, secretary, Health Security Action Council.

I wish to express our appreciation to this subcommittee for holding these hearings on the health care crisis in the United States. Few issues demand more urgent action than the issue of good health for all Americans.

Many are saying that this Congress is expected to enact legislation to deal with the crisis situation in medical care. I hope this will prove to be correct. We all know that the issues and problems in health care are complex. Nevertheless, there is a single and simple overriding alternative before us. Either we are going to go through another pro-

longed agony of patching and fixing and tinkering with a system that does not produce the health care that the American people need and deserve, or we are going at long last to face the fact that what we need and can have is a unified, rational, well-financed and carefully planned health care system.

If the Congress chooses the former course of action, we have to ask on whose behalf are we doing all that patching and fixing? Is it patching and fixing on behalf of the American people? I think not. I think it is patching and fixing on behalf of some groups of providers of health care services and of the health insurance industry, patching and fixing designed to preserve or even to increase the role of major elements that have failed us again and again. It would not be on behalf—or in the best service—of the American people.

I do not speak from either partisanship or the joy of attack when I say that what annoys me and many others most is that the beneficiaries of the patching and fixing job would be principally those who have stood in the way of the progress in our health care system that we have needed desperately—to do that, and then to call it a partnership that builds on the strengths of the presently existing medical care system is a cruel hoax.

Mr. Chairman, my associates and I have accepted your invitation to appear today before your subcommittee primarily to tell you about the Health Security program embodied in Senate bill 3, introduced by you and 24 other Senators on January 25, 1971.

However, since the President sent a health message to the Congress on February 18, 1971, and Department of HEW, Secretary Richardson and associates testified before you yesterday on the President's program, I am obligated to indicate some comparisons and contrasts and to express some opinions on the issues specifically presented to you by these two proposals which, to be sure, have some elements in common but which pose a clear choice of the signpost the Congress should follow.

At the outset, let's be clear about the problems. We have a crisis, and there is now a wide consensus about the five major causes of this crisis. We will not achieve good health care for all Americans unless we deal meaningful with the major causes of the health care crisis and with all of them.

These are:

1. Runaway health care costs. For 15 years now health costs have been increasing at twice the rate of increase in the general cost of living. We now spend over \$70 billion a year for health care purposes—7 percent of our entire gross national product. And, under the present system there is no end in sight for these steeply rising costs.

2. National shortages of health manpower, particularly of physicians, continue. And there is no adequate remedy in our present resources and practices.

3. The system for the availability and delivery of medical care is grossly inadequate; it has long been failing the American people. And it will continue to fail unless strong and directed national measures are taken.

4. Quality of medical care ranges from superb to horrid and we lack necessary and sufficient controls for the assurance of that high quality of care which the American people have a right to expect.

5. Our system of medical care functions more and better for those who provide health care services, and for those who insure its costs than for those who use services. It should be restructured to serve both equally and adequately.

Citing these five causes of crisis is not enough for the diagnosis as a basis for therapy and rehabilitation. We must also recognize that each of these five is interrelated with all the others.

Consequently, a sound and adequate program must deal with all of them, simultaneously. And the dimensions and severity of the crisis, and the outlook that it will continue and worsen, dictate that we should deal with them now.

Two years ago, under the chairmanship of my predecessor, Walter P. Reuther, the Committee for National Health Insurance began to develop a program of national health security which would deal with all major causes of the crisis. A knowledgeable and expert technical committee, supported by specialists in the various areas of comprehensive health services, succeeded in developing a most thorough and complete program.

It is a plan for an evolutionary movement in the health system. It is a plan for an improved system for the efficient delivery and financing of high-quality, continuous, comprehensive health services for all in our Nation. It is a plan for assured financial security for American families against the unpredictable costs of serious illness which can be crushing to almost any family and which can come unpredictably to almost any family.

Most importantly, it is a single plan, it is not a piecemeal approach, it is not a hodgepodge of badly fitting mosaic pieces poorly related to the needs of the American people. It is not fragments of ideas developed to accommodate special interests rather than the general public interest. And it is a plan whose operation can be readily understood and utilized by the American people.

THE HEALTH SECURITY BILL

The health security program incorporated in Senate bill 3 would deal simultaneously with selected aspects of the problems associated with manpower shortages, and with the basic problems of spiraling costs, unacceptable variations and uncertainties in quality of care, and the root cause of all of these: lack of effective organization for the delivery of services.

This combined and comprehensive approach favors a rationalized system of national health insurance. Surely a country with the world's most advanced management skills and administrative capacities can expect these to be applied to health care. The health security bill envisages that the funds we as a nation can afford to provide will finance the essential costs of good medical care for the years ahead.

At the same time, these funds will be building up our capacity for making the availability and delivery of medical care adequate, efficient, and reliable on an evolutionary course of development in the years ahead.

The bill would provide the framework for a living program, adaptable to emerging technology and delivery mechanisms. It does not propose nationalized or socialized medicine. It does not propose

that the Federal Government take over the Nation's resources for providing medical care—the hospitals, or the physicians, dentists, nurses, and the personnel; nor would it arbitrarily compel the health professionals in our country to reorganize and coordinate their fragmented services into more efficient and less costly health care system.

It leaves the furnishing of medical care in the private sector, with wide choices and elections for patterns of practice carefully preserved.

The bill proposes, rather the thoroughly American approach of utilizing national economic resources to provide the financial and professional incentives and supports to improve the health care delivery system, with built-in quality and cost controls.

It would provide viable and acceptable alternative payment methods to the fee-for-service system without excluding this traditional practice.

Thus, if the health security program is described as “nationalization” or “monolithic”—as some are doing, it should be clear that these horrendous words fairly apply to the basic, supportive financing. But they do not apply to the continuing private provision of medical care which preserves diversities, alternatives, voluntary actions of many kinds.

Senator KENNEDY. The words “national programs” don't frighten you, then, Mr. Woodcock. I have heard that suggested by administration spokesmen that what we are talking about is a national program.

I think it was used, really, to frighten people. I am sure you are aware, as your employees must be, of the value of social security and medicare. These are national programs and provide enormous value and benefits to millions of people in this country, and I look at this program in that spirit.

I gather from your comment you do as well.

Mr. Woodcock. Yes, and I want to reemphasize that the nationalization, or the charge of being monolithic, goes to the financing mechanism, not to the conveying of the health care, which is left entirely to an evolutionary development.

So, we say through this partnership of national governmental financing and private provision of the services supported by that system of financing the health security bill provides a sound foundation upon which this Nation could build a modern medical care system.

Its cornerstone is the recognition in official national policy that access to the best available health care is a fundamental right in a progressive society.

Further, the program contains practical provisions to translate this promised right into reality.

The benefits of the health security program would be available to all persons resident in the country. Eligibility would not require either an individual contribution history or any means test.

With four modest limitations, the benefits are intended to embrace the entire range of personal health services—including care for the prevention and early detection of disease, the treatment of illness and physical rehabilitation. There are no restrictions on needed services, no cutoff points, no coinsurance, no deductibles, and no waiting period.

The principal limitations are:

Dental care, which is restricted to children through age 15 at the outset, with the covered age group increasing thereafter until

persons through age 25 are covered; and with those who once become eligible remaining eligible thereafter.

Skilled nursing home care, which is limited to 120 days per benefit period. The limit does not apply, however, if the nursing home is owned or managed by a hospital, and payment for care is made through the hospital's budget.

Psychiatric hospitalization, which is limited to 45 consecutive days of active treatment during a benefit period; and psychiatric consultations, which are limited to 20 visits during a benefit period.

Prescribed medicines, which are not covered unless they are provided through a hospital or organized patient care program, or are required for the treatment of chronic or long term illness.

In other respects, the program provides full coverage for physicians' services, hospital services, and coverage for optometry services, podiatry services, devices and appliances, and certain other services under specified conditions.

Senator KENNEDY. Could I ask you at this point, Mr. Woodcock, what percent of personal expenses would be covered under this program? What do you estimate and do your economists estimate in terms of the legislation that we have before us?

Mr. WOODCOCK. If we take as an index of 100 what is presently spent for health care, this would go to approximately 70 percent of that total.

Senator KENNEDY. Seventy percent. In terms of its coverage, what percent of personal expenses would be covered by the administration program?

Mr. WOODCOCK. We haven't a figure in that regard. It is substantially less than that, and we have later in this statement an illustration of what would be a typical situation in a family.

Senator JAVITS. Mr. Woodcock, if the Chair would allow me, would you undertake to provide a complete comparison, and your reasons for it? I do think we have a number of comparable approaches. I have great respect for yours. I joined Senator Kennedy in the bill.

But I think the administration's program is not to be sloughed off. It is a very impressive and important program. So, I think the direct comparison can only help us all, and do the cause good.

Obviously his cause is a good one. We agree that we have to have a universal national health plan. So, if you will help us that way with the Chair's permission, I will be grateful.

Mr. WOODCOCK. We will be happy to undertake that as soon as possible after the administration's bills are available to us.

Senator KENNEDY. I think Mr. Fine is going to have an opportunity to talk about this later, but I think it would be valuable if you would give us the benefit of it.

Mr. WOODCOCK. Yes.

The health security program recognizes the necessity of moving rapidly, and concurrently with the proposed insurance mechanism, to increase and improve the Nation's resources for the delivery of health services.

A special feature of this bill would provide a resources development fund. A fixed percentage of overall program funds will be earmarked and used to strengthen the Nation's resources of health personnel and facilities and its system for delivery of care.

This resources development fund would supplement rather than supplant present governmental programs. It would give incentive and innovative support to comprehensive group practice and other organizational means to achieve the efficient use of personnel in short supply and for the productive delivery of services.

It would provide supplemental funds for education and training programs for new personnel—especially for those disadvantaged by poverty or membership in minority groups. It would also provide financial support for the location of needed health personnel in both urban and rural shortage areas.

All services covered under the health security program will be financed on a budgeted basis. Advance budgeting will restrain the steeply rising costs and provide a method of allocating available funds among categories of covered services. Through this process, the bill can support a range of basic and auxiliary services and modify the undue emphasis on high-cost services and facilities.

By a system of regional allocation of funds, annual budgetary review and approval of institutional service expenditures, and financial reviews and controls on service costs, the bill provides the means of effecting important health cost controls.

The financial provisions for the health security program carry out the declared intentions to provide adequate and assured financing. It is assumed that the fiscal resources would be geared to where we are with respect to expenditures for medical care in the United States at the time the program becomes operational.

The system would then operate on an annual budget basis, providing nationally an amount of money equal to what is being spent for the categories of covered services.

In successive years, the budget amounts would be adjustable with regard for growth of population, changes in price levels, and other factors. The funds would be allotted geographically and by categories of services. Thus, budget provision and control would replace and put an end to open-end escalating costs.

Because of avoidance of waste, reduction of inefficiencies and many other factors our fiscal experts estimate that in the first year of operation the health security program would cost no more to provide comprehensive health services to 210 million Americans than would be expended in that year for fragmented and partial services for far fewer people.

Furthermore, we believe this relationship of cost factors would continue in ensuing years.

The needed funds for the program would be derived in part from general revenues and in part from earmarked taxes on employers (3.5 percent of payrolls) and on individuals (1.0 percent of wages and salary income and on unearned income), and 2.5 percent on self-employment income. The precise allocation of the costs among these various sources is endlessly arguable. However, the use of the several sources is, we believe, completely sound.

Since the earmarked income for the program would go into a permanently-appropriated trust fund—as in the social security insurance programs—the functional operations would have secure and stable financing.

The financial and administrative arrangements of the entire program are designed to move the medical care system toward organized programs of health services, utilizing teams of professional, technical, and supporting personnel. Earmarked funds would be available to support the most rapid practicable development toward this goal. State statutes which restrict or impede the development of group practice programs are superseded by provision of the health security program.

A key principle of the health security program is guaranteeing new options in the delivery of health services. We believe the doctor and the patient should both be free to choose an organized health services plan as an alternative to solo service.

In either case, there should be freedom of choice to select a doctor or accept a patient.

The program includes significant provisions to safeguard quality of care. It would establish national standards for participating individual and institutional providers. Independent practitioners would be eligible to participate upon meeting licensure and continuing-education requirements. Provision is made for professional review and competent peer judgments to assure a level of service delivery compatible with good medical standards.

Consumers will be assured a meaningful role at every administrative level. A national health security advisory council, with a majority of consumer members, would work closely with the proposed health security board in establishing policy and operating procedures. Consumer organizations will be given technical and financial assistance to establish their own comprehensive health care programs.

For the first time, consumer organizations will be on an equal footing with even the most powerful of insurance groups.

Health security builds upon the real strengths of American medicine today and establishes practical measures to eliminate the weaknesses. The bill provides a transition to new patterns of organizing, financing, and delivering health services wholly within the context of our American value system.

Health security will increase the opportunities available to doctors, hospitals, and other providers to extend the range and effectiveness of their services. The program provides a framework in which health professionals can improve conditions of practice, quality of education, and professional opportunities. Physicians will have improved support from other members of the health team, enabling them to reduce their heavy work schedules and enjoy additional leisure time.

Medical careers at all levels will attain a security and stability within the system, and the program will serve as an attraction for increased recruitment into the various health careers. This will be especially true when adequacy of resources for good practice and easy communication within the system are added to the guarantee of decent income.

When considering a program of the magnitude of health security, especially remembering the experience of such federally financed programs as medicare, medicaid and CHAMPUS, it is easy to conjure up the specter of hospitals and physicians inundated by unremitting paperwork.

Providers struggle today with the conflicting eligibility and reporting requirements of more than 1,800 private health insurance carriers and a score of State and Federal programs. Many physicians spend much of their valuable time each day filling out insurance forms, and a significant amount of money for billing and financial recordkeeping. The burden on hospitals is even worse. The cost of this inefficiency is now somehow passed on to the consumer in higher health care and health insurance costs.

Rather than increasing this mountain of paperwork, the health security program would reduce it. Under health security there will be one administering agency and one set of forms—highly simplified. Both patients and physicians will welcome the change. Hospital billing would be vastly simplified or largely replaced by patterns of annual budgeting and auditing.

The program would further simplify today's complex web of payment arrangements for many fragmented public programs for personal health services by incorporating into the health security program all of medicare, and almost all of medicaid, and a number of other public medical programs.

The equally fictitious prospect of an enormous uncontrolled increase of administrators at the central office of a national health program can be disposed of as well. Health security places most administrative responsibility at the regional and local levels. It will establish national standards and assure national financing, but the important decisions affecting allocation of resources and delivery of care will be made in the field. State governments will be actively involved in survey and utilization review programs.

Mr. Chairman, we strongly endorse the health security program and Senate bill 3. And we recommend its sympathetic study by your subcommittee.

I turn now, Mr. Chairman, to President Nixon's program, especially as elaborated by Department of HEW Secretary Richardson.

In his health message, the President said that he does not mean to allow each part of the health care system to go its independent way, with no sense of common purpose. But his program is itself, fragmented and far from being a comprehensive approach.

He stated that it would be wrong to ignore any weaknesses in our present system, and equally wrong to sacrifice its strengths. But his "insurance partnership" recommendations would support major weaknesses, not strengths.

We welcome President Nixon's enlistment in the efforts to resolve our Nation's massive health care crisis. Until now, this administration has had little to look backward to with pride in the health field. Unfortunately, we believe the President's new program discloses little to look forward to with hope. His is mostly a plan for the "fifties" not for the "seventies" or "eighties," despite the fact that this program includes some elements which we can warmly endorse.

Permit me to list these proposed supports for established or new programs.

- (1) To promote the development of health education centers;
- (2) To expand support for the training of MEDEX and similar types of physicians' assistants;

(3) To create a new health service corps under the Emergency Health Personnel Act of 1970;

(4) To provide new—and we hope augmented—support for medical schools and other professional education and training institutions, and for students and trainees;

(5) Continuing support for biomedical research;

(6) Inauguration of special programs to attack and conquer cancer and sickle cell anemia;

(7) To help create a private health education foundation;

(8) To implement the Occupational Health and Safety Act; and

(9) To provide more generous financial support for the family planning and food stamp programs.

Further, I take special pleasure in complimenting the administration in placing great emphasis on the need to support the development of HMO's—health maintenance organizations. This term embraces neighborhood health centers and family health centers, and—what we and many others have for years known as group practice prepayment plans (GPPP's) and professional foundations (PF's).

We are however, deeply disturbed that the praiseworthy objectives for HMO's are not likely to be achieved because of inadequate financing proposals and an unrealistic timetable of organization in the framework of a National Health Insurance Standards-type of program.

Indeed your bill, Mr. Chairman, gives even more emphasis to systems improvement, comprehensive and continuing care, quality and cost controls through incentives and supports for comprehensive health service organizations and professional foundations. However, we need not quarrel about a name or priorities in its design and development.

At this point, Mr. Chairman, I regret that I must cease to be friendly to the President's proposals.

He has proposed financial access to medical care for most of the population through a National Health Insurance Standards Act. From the limited information available about it at this time, it proposes a backward and intolerable imprisonment of medical care financing in the operations of the insurance industry.

We have developed an illustrative case of a worker with an annual wage of \$7,000, with a wife and two children, to show the impact of the Administration's plan on the worker.

Assume: \$60 per month family premium. This is an estimate, of course, but we think a realistic one or \$720 annually. Worker pays 35 percent or \$252.

Assume: Three hospitalizations in 1 year:

(a) worker illness 5 days pays physician fees \$200;

(b) child accident 5 days pays physician fees \$200; and

(c) maternity delivery 5 days pays physician fees \$250.

This family pays:

\$252 (35 percent of premium);

\$300 (three deductibles of \$100 each);

\$480 (2 days each—6 days—deductible hospital care at \$80 per day);

\$240 (25 percent of costs of \$960 charge for 12 additional hospital days);

\$162.50 (25 percent of costs of \$650 physicians' fees) ;

\$100 (drugs, incidentals for out of hospital care connected with illnesses) ;

\$50 (25 percent of \$200 physiotherapy treatments for child).

This, then, comes to a total of \$1,584.50.

This represents approximately 23 percent of this worker's income in 1 year. It does not include payments for other health services not connected with the three hospitalizations.

I believe this is a graphic illustration that the "patch" proposed by the administration continues to leave unreasonable large gaps for the worker to fill.

Senator JAVITS. Mr. Woodcock, would you allow an interruption?

Mr. WOODCOCK. Yes.

Senator JAVITS. Under your plan, wouldn't the worker have to have paid a social security tax?

Mr. WOODCOCK. Yes, sir.

Senator JAVITS. How much would that social security tax be?

Mr. WOODCOCK. It would be 1 percent, which under this illustration it would be \$70.

Senator JAVITS. In other words, you could give all the benefits free to the worker and he would still pay only 1 percent? Remember, you have to match these benefits against the package you are giving him for his 1 percent.

Mr. WOODCOCK. We admit in the statement, Senator, that the percentage division of the costs is an arguable matter, but the principle of three-part financing is, we think, quite justifiable.

Senator JAVITS. Thank you.

Mr. WOODCOCK. Mr. Nixon has proposed a family health insurance plan (FHIP) which would preserve a separate limited insurance plan for low-income families with children which would be less generous than medicaid in many States and would result in reduction in eligibility and in benefits to many families through its income ceilings, deductibles, and co-insurance.

C. He has proposed preserving a separate and limited medicaid program for the poor and near-poor aged, blind, and disabled.

D. He has proposed improving medicare by combining part A (hospitalization) and part B (medical, et cetera) and relieving the aged of premiums for part B; but he has also proposed reducing the benefits—which have been less than adequate since the program's enactment; in effect, he is proposing savings for the elderly who are well and increased costs for those who are ill.

E. He has proposed separate private insurance pools for those not embraced by his national insurance program; and

F. He has overtly included in the pattern something identified as a "partnership with the insurance industry"—with no specific assurances at this time that this would be a partnership in the public interest rather than for private exploitation.

It is interesting that only a day after the President's health message, the annual report published by HEW on private health insurance reached our offices. The report presents current available data on the performance of the health insurance carriers on whom the administration is placing primary dependence for the operation of its pro-

gram. The report confirms the failure of private insurance not only to provide health security for the American people but also to operate very effectively. And the performance of the commercial carriers in some respects is worse now than even 20 years ago.

In the data year of 1969, the commercial insurance companies received \$7.6 billion in premium payments for both group and individual health policies, and returned only \$6.3 billion in benefits—a takeout of 16.7 percent for administrative costs and profits.

For the 41,469,000 Americans who were forced to purchase individual or family hospital or other health insurance policies in the year 1969, the insurance companies retained 49.2 percent of their total premium income for operating expenses, additions to their reserves or profits. In other words, only \$957 million of the \$1.9 billion paid by these more than 41 million individuals to health insurance companies—only very slightly more than half—was returned to them in the form of benefits.

The administrative records of Blue Cross and Blue Shield are considerably better, but few national organizations approach the low administrative costs incurred by the social security program.

The private health insurance industry which organized labor helped create, has failed to deliver the health care or protection that legitimately has been expected of it. Moreover, there is nothing in its history or its structure that suggests private insurance can or will do appreciably better in the future.

It provides sickness insurance, not health insurance.

It fails to control costs or assure quality.

It provides practically no preventive health services and has minimized cost-saving ambulatory care.

It has failed completely to make available health services to the poor and the medically indigent.

It frequently directs care away from appropriate, but uninsured, methods of relatively low cost care; to high priced, but insured, institutional methods—raising the overall cost of care and health insurance.

Despite some 30 years of private insurance company effort, 30 million Americans have no coverage whatsoever. What coverage there is, is so limited that today, private health insurance covers just over a third of consumer health expenditures.

Mr. Chairman, we have looked—but in vain—for the specifications we had a right to expect for cost controls to contain catastrophic and continuing escalations of costs; for protections and assurances of quality of care; for estimates of expected costs of the principal insurance program; for estimates of the impacts of those costs on employers—large and small, with high and low labor staffing; for estimates of impacts on families of various compositions, in various economic circumstances, in diverse employment situations.

We have tried to infer what we have not found in the available record. We can only report that the combination of what has been formally reported and what we can infer leads to the conclusion that the President's insurance program would be an invitation to disaster.

There is a basic reason for the unacceptability of major features of the President's program, especially those dealing with the financ-

ing of personal health care services. Instead of dealing realistically with the needs of the crisis situation, he has come up with what Secretary Richardson described as "the right-sized patch."

In conclusion, Mr. Chairman, while President Nixon's health proposals are imprecise in essential aspects, it is nevertheless clear that his strategy for dealing with the health crisis—which he himself decried 19 months ago—is to promote a health insurance industry that is no longer able to meet the Nation's needs.

We find his program an attempt to patch up the present system rather than to deal resolutely and adequately with the crisis problems and needs.

The health security program presented in Senate bill 3, which we favor, offers the means of making comprehensive personal health services available to all Americans and the means to effect major improvements in the organization and methods of delivering care.

We hope your subcommittee will study this program and that from your consideration will emerge further clarifications and improvements so that the needs of the American people can best be served.

We urge the subcommittee, the committee and the Congress to give high priority to the health security program for legislative study and action lest the medical care crisis swell to the proportions of a massive disaster.

Senator KENNEDY. Mr. Woodcock, I want to commend you for the comments that you have made before us this morning, for analyzing the legislation which has been introduced and also for providing a very interesting and informative analysis of the administration's program.

I think it has been fair and balanced, and I think it is extremely helpful.

In your testimony, I feel you help us focus on one of the very essential differences between the administration's approach to solving the health crisis, and that which others of us have felt would be the best means of handling the situation in terms of whether we ought to build upon the existing health insurance programs or provide a new and different and more balanced system. The record of the various insurance companies, both in terms of the resources that they paid out in private health policies, which show that they paid out slightly more than half of all the premiums that they took in and that even in group practices they retained 16.7 percent for administration costs and profits, certainly contrasts with the social security system in terms of administration. This is really a dramatic indictment, I think, of the approach the administration has taken in this matter.

But beyond the questions of administration, I would be interested in how you view the private insurance companies' records in holding costs down or in providing quality service.

I think we are equally interested, probably more so, in what their record has been in terms of maintaining cost control or providing quality care under the existing programs.

Mr. Woodcock. It has been our experience in dealing with the commercial insurance carriers, for example, that they not only make no effort to control costs, but they make it a point to say that is really not their function.

If a particular bill is way out of line with the common standard, they may raise a question about it, but they make no effort to control what would otherwise be the common standard.

Unfortunately, Blue Cross-Blue Shield take essentially the same position. They make only very limited attempts to control costs, and unfortunately make equally little attempt to control quality.

Senator KENNEDY. This is something which obviously is of concern, because we heard a great deal of commentary yesterday on the concern for maintaining cost consciousness through individual payments, coinsurance and deductibles. It was said that these mechanisms would help create a cost consciousness in terms of the individual.

We always have difficulty, and I think there isn't a person in the country who isn't cost conscious in terms of health care at the present time.

The corresponding question that we have to ask ourselves is, What is involved in the administration's program that is going to help maintain or reduce costs? I think your experience in terms of the insurance companies is interesting.

Do you have any comment that you would like to make in terms of quality control? Do you think that the administration's program is liable to provide a greater sense of quality control in health care?

Mr. Woodcock. On the record to date, Mr. Chairman, I see no evidence in the administration's proposal of any mechanism that is designed to meet this essential problem of quality control. Really, quality and cost tend to go together. We think we can get better quality with cost control than a situation where little attention is paid to costs tends to go along with, sometimes, little attention being paid to quality.

We think these are two cardinal considerations that the Congress has to meet and tackle.

Senator KENNEDY. The administration talks about the PSRO, the advisory group which is going to include representatives of the medical world as well as labor and consumers. You direct your attention to the significance of the role of the consumer on page 12 of your testimony.

Do you feel the kind of advisory council that is suggested here, with a majority of consumer members whose work would be proposed to the Health Security Board in establishing policy and operating procedures, is a preferable way of proceeding rather than the PSROs that the administration has suggested would be the instrument for providing that quality control?

Mr. Woodcock. We believe it is, Mr. Chairman. I can go to my own State of Michigan, where the UAW is the major customer of Blue Cross and Blue Shield. We have just doubled our representation on the Blue Shield board—from one to two people out of 35. And we have no influence whatsoever on the conduct of the doctors Blue Shield program, and unfortunately, we have as little influence on the conduct of the hospital program, which is Blue Cross; and there has to be found an outlet for meaningful consideration of the consumer's point of view.

Senator KENNEDY. What is suggested by this is the PSROs might become a sort of an additional extension or arm of the medical pro-

fession. It is almost like putting the fox in the chicken coop, so to speak. At least it would appear that way at first reading, and based upon your experience in Michigan where you probably have had as great an influence as perhaps any other group on any of these Blue Cross-Blue Shield areas, it has been rather modest indeed.

Mr. Woodcock. "Modest" is an overly generous word, Mr. Chairman.

Senator KENNEDY. So you have some serious reservations about just appointing a PSRO group like that suggested by the administration, because I think that at least in philosophy and concept it is perhaps too close to the kind of advisory commissions that have been established under Blue Cross and Blue Shield.

Mr. Woodcock. That is correct, sir. If the basic check is the market mechanism, again going back to the State of Michigan, if the UAW would go to the employers and say we want to move our coverage to the commercials, the Blue Cross-Blue Shield program would collapse.

So, we are in an excellent position to have influence, yet we have little influence in fact.

Senator KENNEDY. You have in Detroit, Mich., a community health association which has been developed by the UAW, and which is an example of an HMO. I was wondering if you would give us the benefit of your experience in the light of the administration's HMO proposal, perhaps review with us what it costs to start an HMO, how many can serve, and so forth. What information can you give us?

Mr. Woodcock. I am told—I wasn't here yesterday—that this can be done with an initial expenditure of \$250,000. We have been operating CHA for 8 years. I would hope that some way we could get back the \$5½ million that we have so far as a union put into this project to make it viable.

It takes an inordinately large sum to get such a thing going, and there has to be the capacity to absorb losses until the program becomes accepted by a wide group of consumers.

Senator KENNEDY. This is one proposal here that has cost how much?

Mr. Woodcock. We, as a union, have put into it, even today, over \$5½ million.

Senator KENNEDY. We heard yesterday that they would cost \$230,000. They expect to have 1,600 of them by 1976, serving 90 percent of the population, which seems to be an extraordinary expansive interpretation of what really could be done, particularly since you have had sort of a functioning and working in operational experience.

I was wondering what your experience has been.

What obstacles do you face in setting these programs up? How many people do you think they can effectively serve? What sort of problems are being faced?

Mr. Woodcock. We now have after 8 years of operation of the group program in Detroit 70,000 individuals. There was a slow period over the first 2 and 3 years in which the program inevitably was in a loss position.

This is not unique to Detroit. We have had a similar experience with the Cleveland Health Foundation in Cleveland, which the Kaiser Foundation Health Plan has now taken over. That has been operating for 4 or more years. Kaiser has now taken it over to manage it, and is even yet losing money.

Even in St. Catherines, Ontario, where we have some other advantages, situations as far as the provincial program is concerned, there is a considerable input of money which runs into \$2 million or \$3 million that was made there by the local UAW.

Senator KENNEDY. Did you say 7,000 or 70,000?

Mr. WOODSTOCK. 70,000 now, after 8 years.

Senator KENNEDY. 70,000?

Mr. WOODSTOCK. 70,000.

Senator KENNEDY. You represent in terms of a union 1,700,000 and including the families, 7 million people. What would the administration do for your union?

Mr. WOODSTOCK. Within that number, we have all variations of insurance coverage. In terms of the major automobile companies, the parts companies, the agricultural implement companies, the aerospace companies, we have very good insurance coverage; and the administration program would be much inferior to what we currently have.

Senator KENNEDY. In light of your program and those of a number of other unions, this wouldn't be of any significant help at all in providing additional coverage?

Mr. WOODSTOCK. No, it would not.

Senator KENNEDY. I mean directly. In terms of the various different administration health programs, their worker program, their Federal Health Insurance program, their continuation of medicaid, or their special grouping programs, the different types of programs which they have suggested. I don't see how these programs would really affect the people or families that you represent.

Mr. WOODSTOCK. I would like to make two points, Mr. Chairman. In terms of benefit levels, for the overwhelming number of our people, there would be no advantage whatsoever—to the contrary.

Now, we do have some marginal employer situations where we have inadequate insurance programs, but the fact that we have an inadequate insurance program grows out of the marginal economic condition of that employer, and just to put on him a cost that he now cannot bear through the normal process of collective bargaining would raise the question whether or not that enterprise could continue.

The other thing is, we fear, and I think we have good reason to fear, that there would be a sharp escalation of costs and therefore inflation, and so it would have the effect upon our superior programs, where it is already going up at the rate of 10 percent a year, increasing that escalating cost.

One of the major problems we had in the General Motors strike was the insistence, until the end of that strike, that General Motors wanted future insurance increases to be paid by the workers.

We met that demand, because on the cost of living escalator program, where the arithmetic entitled us to a 0.3 relationship, we accepted 0.4 in return for acceding to their demand. So it would have a detrimental effect in that regard.

Senator KENNEDY. There would be a corresponding increase in costs without any significant strengthening of quality control; and actually this may very well jeopardize the achieved benefits that your unions won, and other unions have won, under collective bargaining.

Mr. WOODSTOCK. We have grave concern about that, yes, sir.

Senator KENNEDY. Just before leaving these HMO program developments, I know they developed this program up at New Haven, and I was wondering if Dr. Falk might tell us a little bit about that.

Dr. FALK. Mr. Chairman, we have several programs in New Haven. We have one operational program that is in the nature of a HMO in the New Haven area. It is a group practice plan, but not a prepaid program, and it was developed primarily for service to the poor and near poor in the major poverty area of the city. It is funded principally by grants from the U.S. Children's Bureau and is supported by the resources of the Yale-New Haven Medical Center. It has been in considerable difficulty because of the very complex problems involved in developing the program, and in funding its costs, in developing clientele which it can serve, and because it has to go through the annual agonies of the appropriations process in Washington which doesn't let them know how much money they are going to have much more than 6 months in advance.

We also have a program we are developing as a community undertaking which is more nearly of the kind of the health maintenance organization that the President's program has proposed. It is quite specifically the kind that is contemplated in the bill which you and Senator Javits and others have sponsored, a group practice prepayment plan.

We have been 10 years in the process of designing and planning this program, because we had to overcome so many of the difficulties that are inherent in action in this field, such as, to begin with, obstructive State legislation, which makes it impossible for a consumer group to even sponsor and undertake such a program in many States in the country—not in all.

The problems are many, even after the legal problems are overcome. There are the difficulties of developing the planning work and financing it, of developing the appropriate kinds of facilities for a well organized group practice to operate, and funding and financing of the construction and equipment in such facilities.

Then there are the problems of preparing the community to understand wherein it may be in their interest to get their services through a well-organized group practice plan rather than in the customary ways of getting their services through solo practitioners.

And there are problems of making and effecting the arrangements, whereby the funds used for purchasing insurance can become available, on the election by the individuals concerned, to have that money used to be paid over for services provided by a well-organized group practice prepayment plan. This involves dual-choice clauses in the collective bargaining agreements. These can be achieved, ordinarily, only at the time that collective bargaining is open.

Then there are the problems of getting the funding and recruiting the appropriate staff and being able to do this with the necessary responsible assurances to professional and technical staff before you know that you will have an enrolled population and funds coming in from them to sustain the program on a viable and durable basis.

These problems are not peculiar to our undertaking in New Haven, I assure you. They are inherent in the undertakings. This is the reason this is a slow, complex, difficult, and expensive development.

I have a hunch that the figures that were cited in the President's message to the Congress and in Secretary Richardson's testimony may lend themselves to some misinterpretation. He had a figure, I think, of \$23 million proposed for the first year's support of the planning activity in this field, and expecting that this would enable the planning of about 100 of these HMO's, or about \$230,000 for each of them; and then a similar amount of money in the succeeding year and the third year. At the end of the third year, they might have 300 of them through the planning stage, effected with something like \$69 million.

I suspect that somebody slipped a cog here.

Senator KENNEDY. Slipped a what?

Dr. FALK. Slipped a cog in their arithmetic; \$230,000 per plan is about the amount of money that the DHEW has been giving as grant support for the development of a plan of this kind in the few in the country that have had these grants.

But that by no means covers the planning costs that the group has to undertake. They have to find a great deal more money, the applicant's share as it is called, for this planning process.

Perhaps we have not been as skillful as we might have been in New Haven. It has taken us 10 years to get the plan so that it is ready to become operational this summer. We would not expect that another group, however much they profited by our experience and the experiences of groups in Detroit and Cleveland and Denver and many other places, would be able to do this job in a year, I am sorry to have to say, to do it in a year is rather unthinkable.

Much more would have to be made available in fiscal resources and in technical aid of many kinds, in help from the Federal Government in overcoming obstructive State legislation, and in giving many other kinds of support, both money and technical aid and other kinds of assistances—and time.

In the course of a few years it is quite sure, I think, that well-organized comprehensive plans can be developed, as they should be. But this cannot be done quite as fast as the Secretary in his testimony yesterday suggested. I wish he were right. I can't believe he is.

This kind of a program must go forward. But it needs much stronger, more comprehensive, more extensive supports, such as are proposed in Senate bill No. 3. With adequate support of these various kinds, the program can go forward; but we must not expect that we can hurdle all the neglect and obstruction of the past, and in a year or two or three achieve a sufficient number of these programs so that they can be available to more than a small fraction of the population that needs their services.

With time, and continued assured support—and it has to be assured—such a program could get underway. Within 4 or 5 or 6 years, perhaps in a decade, we could really have well-organized comprehensive services of good quality available to considerable portions of the population, particularly in the urban areas.

Senator KENNEDY. I gather, then, from your practical experience in New Haven, and from your knowledge of other development of HMO programs, and from what Mr. Woodcock has suggested, that the goal the administration has established in the terms of the

numbers of HMO's is ambitious and creditable, but in terms of the resources they are talking about are completely unrealistic.

Dr. FALK. I think so, Senator. We can do nothing less than give the warmest support to the goal, the objective, and the general pattern. But realism requires us to recognize in advance, lest we have disappointments later, that the supports for such a program must be more generous, more comprehensive, and more assured than dependence upon uncertain annual appropriations.

Senator KENNEDY. I would like you to submit whatever information you could to the subcommittee in terms of the costs of the development of your program up in New Haven, and I would hope that perhaps Mr. Woodcock could as well. It doesn't have to be exhaustive, but I think what we are trying to do is to evaluate the realism of the suggested recommendations, and the resources which are committed to it. I think whatever you give us in terms of your experience would be enormously valuable and helpful.

(The information referred to follows:)

Costs for the development of the Community
Health Center Plan in New Haven, Conn.

1 As requested, the following tabulation has been prepared to
2 summarize the financing involved in the development of the Community
3 Health Care Center Plan (CHCCP) in New Haven, Connecticut. The Plan is
4 being developed by a non-profit community corporation in affiliation
5 with the Yale-New Haven Medical Center. Its objectives are: (a) to
6 make comprehensive family health care available -- through prepaid
7 group practice -- to a voluntarily enrolled population of 30,000 - 40,000
8 persons, constituted as nearly as practical like a cross-section of the
9 area population, including the poor and near-poor "welfare" eligibles;
10 (b) to utilize the medical care specialty and inpatient resources of
11 the Yale-New Haven Medical Center; (c) in conjunction with the Medical
12 Center, to utilize the prepaid group practice as a resource for the
13 training of next generation practitioners and supporting staff in a
14 group-practice setting; and (d) to engage in research and evaluation
15 studies.

16 The Plan design and development is now nearly completed; the Health
17 Center facility is under construction; a substantial part of the area's
18 labor force has been prepared for enrollment in the Plan through
19 community-wide and special educational activities, the achievement of
20 "dual choice" clauses in collectively-bargained employment agreements,
21 etc.; clinical staff recruitment is in progress; and the Plan is scheduled
22 to become clinically functional in the Summer of 1971.

23 The expenditures incurred and expected to be incurred in Plan
24 designing and development and for underwriting the initial operational
25 stages are as follows, exclusive of (a) the costs to be incurred in

- 1 health manpower training, (b) the costs of long-range research and
- 2 evaluation activities, and (c) prepayment income and contractual
- 3 reimbursements for services to enrollees.

Actual and estimated expenditures

A. Planning, design, and development

1. Initial program planning and design studies (3 years)

a. PHS contract support	\$ 239,000
b. Locally contributed funds and services (circa)	50,000
Sub-total	<u>\$ 289,000</u>

2. Program development and initial operations support

a. HSMHA (314e) support grant (3 years)	\$ 900,000
b. HSMHA (NCHSR&D) support for research and evaluation studies program (3 years)	100,000 ^{a/}
c. HSMHA (314e) support for initial dental care development (circa)	80,000
d. Private gifts (circa)	100,000
e. Borrowing for working funds (circa)	100,000
Sub-total	<u>\$1,280,000</u>

Total for planning, etc. \$1,569,000

B. Capital investments for Health Center facility (loan funds) (circa)	<u>\$3,100,000</u>
C. Total design, development and capital investment (circa)	\$4,669,000

^{a/} Amount estimated as bearing directly on initial aspects of program development, exclusive of expenditures for longer-range research and evaluation studies.

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Senator KENNEDY. If I could, Dr. Falk, I would ask you what your impression is of the role of the insurance industry in responding to the health crisis; in other words how do you evaluate the reliance upon the insurance system?

Dr. FALK. Mr. Chairman, I think that it is very difficult to give a very simple, easy answer to a question that involves so much.

By and large, the history of the performances of the insurance carriers, the nonprofit groups or the commercial companies, whether they are stock companies or mutual companies, has been one of massive success in selling insurance and making the public aware, not that there is a need for insurance—people know that only too well—but that there are ways of dealing on a group-payment basis with the uncertain and variable and potentially burdensome medical costs.

They have done a massive selling job over the past 20 or 30 years, one of the most extraordinarily successful selling jobs in the history of the world.

If you think in terms of the amount of sickness insurance in 1930 or 1935, when they was very little, and today when nearly everybody in the United States who has reason to have insurance against medical costs has some insurance, you recognize that this is the massive success of the insurance companies and the Blue Plans. And they have helped millions of people to meet some of the costs of medical care.

However, there has been an equally massive failure because of the incapacity of those insurance systems to make available reliably adequate and effective insurance for the general population which needs medical care insurance.

After 30 years or more of effort, and almost incredibly large resources, the insurance carriers have succeeded in covering approximately one-third of the private costs of personal health services, leaving two-thirds still to be paid out-of-pocket by the insured.

No developed country in the world has had the patience to put up for nearly two generations with such an inadequacy in performance in a field of very great concern to the public welfare.

In this respect, the insurance carriers have demonstrated conclusively that unless Government comes to their rescue with subsidies, and with other special supports and opportunities which may be provided by public law, they cannot do the job with respect to health insurance that is needed for the people of this country.

I am not giving that only as an opinion or only as a prognostication; on the contrary that is an easily supportable interpretation of the plain facts of the past and is a recognized position of the principal insurance carriers.

I find by and large that, except for the possible role of serving as a useful administrative agent within a system which is supported by public financing, there is as yet no clear or demonstrated necessity for their preservation. I make that statement though I know that some of the insurance carriers would sincerely and earnestly like an opportunity to demonstrate that they can play an even more useful role in the future than in the past by helping to develop better and more efficient patterns for the delivery of medical care.

I think it would be an act of folly and a very dangerous commitment to place the reliance of the Nation, through an act of Congress for dealing with major medical care needs of the country, in the lap of the insurance industry without the most stringent kinds of controls and responsibilities that should go along with such an assignment. Such controls should extend to costs, utilizations, quality, public participation, public accounting, and so forth.

The demonstrated weaknesses and failures of private health insurance result not from lack of skill or enterprise but from reasons inherent in the nature of the insurance carriers and their operations. The nonprofit Blues are limited by their relations with the providers of care and the consequences for controls and noncontrols. The insurance companies have inherent limitations from the nature of their patterns and activities, because they are principally conduits for the flow of money mainly with no direct relation with providers, and with no real opportunity for control of services, of utilization, of quality of care, or of expenditures. For such reasons, which I emphasize have been inherent in the nature of their operations and performances, the present private insurance carriers cannot be expected to do the job that the Nation needs to have done. The risk-taking and the financing can be done better, more assuredly and more effectively, by the Federal Government, as it has been doing for our national social insurance.

Senator KENNEDY. Doctor, if we keep going down the road of insurance companies, do we have any prospect of improving the quality of care for the American people?

Dr. FALK. Mr. Chairman, I think we would have to say that unless the Congress were prepared to associate, with such a commitment, mechanisms for improved performances by the providers, and also for the control of many of the activities of the insurance carriers, needed quality control is not likely to be achieved. If we did institute the necessary measures, these would probably involve a negation of the presumed independence of the carriers, and which I think might justifiably be unacceptable to them. Further, I would add, unless we are prepared to institute quality and cost control mechanisms, that would have to be stringent and extensive and expensive, I think this is not the direction the country should go.

Senator KENNEDY. The administration has proposed regulation of the insurance companies. Do you think that this type of regulation could devise the kind of quality and cost control that is necessary?

Dr. FALK. I know nothing about the content of that proposed regulation other than the statement which I think the Secretary made that a program of this kind is contemplated and would be presented, I think he said, some months hence.

If a proposal for regulation of the insurance industry met the kinds of qualifications I have indicated I think are necessary, I would expect—regulation of the industry might serve some useful purposes, more particularly in other fields of insurance than in the field of health insurance. Beyond that, I have no basis for judgment what might be expected of it.

Senator KENNEDY. I yield to Senator Javits, and then to Senator Eagleton.

Senator JAVITS. Thank you, Mr. Chairman.

Gentlemen, I find myself in an interesting position. I think it is my duty and a duty to the public to get as exact a comparison as humanly possible between the two proposals. At the same time, I have for a long time favored essentially this approach, so that I hope that I will not be considered unfriendly to something I myself favor in the effort to really get a comparison.

I hope you will bear with me in that regard.

I think the administration is entitled to have the plans laid side by side, and life being what it is, I have little doubt that for two reasons, one, to get a national health program at long last, and two, because that is the way life goes, when we follow it through, there will be some, perhaps a good deal of what they propose in the final product.

So, we might just as well make it the best we can.

The thing that interests me the most is this: As I see it, and I am tremendously impressed with Dr. Falk's testimony and that of Mr. Woodcock and his colleagues, but as I see it, and correct me if I am wrong, we have to do the same thing if we take the plan that Senator Kennedy has put in, which is essentially a plan you are all testifying to, and the administration's plan, in developing a better, more rational, more economical delivery of health services, for there are no health maintenance organizations now nearly adequate for the task.

Isn't it a fact, Mr. Woodcock, that if we legislated S. 3, we still have to set up exactly the same network of health maintenance organizations to provide care, since we only have the existing system now to utilize?

Therefore, if that is true, and confirm if I am right or wrong, why do you maintain that under your plan we have a better chance to do it quicker—let's even leave out "cheaper"—than under the administration's plan?

Mr. Woodcock. We don't promise anything more quickly, because we think the promise of speed is somewhat unrealistic, as Dr. Falk has indicated, and the essence of S. 3 is to start with what is.

We don't propose to wipe out overnight what is, on the contrary, we propose through the use of incentives, budgetary and financial incentives, to move the system in an evolutionary way to a more capable and more efficient method of delivering health care.

The essential difference between the two programs, and we will be happy to try to prepare a side-by-side analysis, the essential difference is that one is a health program and the other is an insurance program.

Of course, we propose more benefits, and we propose obviously more financing to go, without question, hand in hand. And a key part of the Senate bill 3 is the resources development fund which will begin to tackle the question of professional supply and the question of health facilities.

The New York Times, on Sunday, had a really tragic story about the number of qualified young men and women who are being turned away from our medical schools. Under our proposal, the resources development funds come from an earmarked portion of the trust fund and thus would be freed from the vagaries of annual appropriations so that they could guarantee a systematic and sensible, long-term budgeting for this very purpose.

It takes years to develop a medical school. The medical schools today that are tied to State universities are subject to what they can get year by year, essentially, out of a State legislature. This makes it very difficult to plan in any sensible way. The administration program really does not meet this problem.

Senator JAVITS. But the administration claims it does, does it not, Mr. Woodcock? Doesn't the administration claim its measure does everything, if not more—I think they claim even more—they claim that they do everything you want to do on rationalizing health care, “beefing-up” medical schools, and we need make no apology on that point. The Senate was the first to pass, at my own request and with Senator Kennedy's help and others, a \$100 million financed disaster relief provision for medical and dental schools. We didn't get all of it, but we got some assistance.

Isn't it a fact that the administration claims that it is doing at least what you are doing in that very field, and aren't we under the necessity, therefore, as we take this piece by piece, to put you to your proof? You say you do more. How? Where?

Mr. WOODCOCK. I certainly wasted the morning if I haven't tried to put that point in the record.

We do not just brush aside and say the administration's proposal is entirely bad. There are nine specific points where we hail what is proposed as measures for substantial progress, but the cardinal thing is that the administration would rely on the existing insurance industry and utilize it for the solution of major health care and cost problems.

I think the statistics that we have show that over 41 million Americans who pay for individual insurance policies, for every dollar they put in only get approximately 50 cents back in benefits. And these are the people who, I think the Secretary indicated, fall between the cracks—there must be an awful lot of cracks to have 41 million fall through. That is not counting the 30 million who are without insurance.

Senator JAVITS. I must say that I think Dr. Falk thinks his figures are crushing. I don't. It is a fact that the insurance companies—and I certainly draw no brief for them—made, I think, a colossal error in not undertaking what they could have undertaken when President Jack Kennedy was in the Senate and we had a bill ready to go if they had just picked it up.

They didn't. So as I said, I have no brief for them.

But it is a fact, as the doctor said, that one-third of the private costs are covered by the present system. You testified 70 percent of the present costs would be covered by your system.

Well, that is, you know, not one-third to 100, it is one-third to 70, and therefore, I don't think the resultant figure is quite as crushing a refutation as it might be. And I would like to point out, too, that in our country, we are willing to pay some premium or profit for services, and I am worried Mr. Woodcock, and I hope you will be able to prove this irrevocably, about the fact that in all this time costs have been going up fantastically under social security financing for medicare. They haven't had any real control over costs, and their own costs and it is acknowledged that their permissiveness has really caused

this tremendously spiraling cost of medical care which has far outstripped the index of the cost of living.

So, I hope very much you could give us either now, or in due course—this isn't cross-examination—any comment that you would care to from that complexion.

Mr. WOODCOCK. I would like Dr. Falk to comment on what you said. But the thing that bothers us about the administration proposal is precisely what you say. Medicare has substantially contributed to what was already an inflationary situation, and made it that much worse, not simply for those under medicare, but for all recipients of health care.

Our worry is that what is proposed is more of the same.

Senator JAVITS. But Mr. Woodcock, the medicare system is exactly the system you now wish to extend, and I do it in my own bill, by the way, universally. Therefore isn't some contradiction there.

Mr. WOODCOCK. No, because there are no elements in medicare which go toward changing this system of purveying health care and of instituting reasonable public control of the costs, which are key ingredients in the Kennedy bill.

Dr. FALK. May I address myself, Mr. Chairman, to three points Senator Javits raised, and properly so. First, with respect to the last, the costs of medicare and medicaid. Mr. Woodcock has indicated that it is because of two basic weaknesses and failings in those programs that our health security program undertakes to make certain changes. One is to provide the means and the resources for improving the system, something which has not been built into medicare or medicaid. Second, to get rid of the signed, blank check guarantees of payment of costs which we have in medicare and medicaid, and which we think must have an end put to them. We have to move to a budgeting system.

Under medicare, for example, each of 7,000 hospitals, roughly in the United States, was given assurances that it would be reimbursed substantially in full for whatever costs it incurred in caring for persons covered for services under medicare, whatever the level of those costs. Similarly, 200,000 or more physicians were given guarantees of payments for services at rates and volumes largely determined by them.

There was almost no authority, except for routine audits and reasonable controls to avoid unconscionable extravagances and unlawful performances, given to the Secretary and his staff.

Under medicaid, we have had substantially the same situation with only such controls as the States have been able to impose, because of their fiscal matching participation in the State programs.

We believe that, as far as we can tell, there is nearly nothing in the President's present proposal that would begin to strike at the need for the system's improvement, except the HMO's, to which I will return in a moment, and nothing yet has been presented—perhaps there is something yet to come—but nothing is yet before this committee or the country to indicate provision or any intention in the President's program for even promising cost controls.

We have been given nothing yet to indicate that anything more than two factors, in their words, cost consciousness on the part of

the consumer, and the play of forces in the marketplace, to control the costs.

Senator JAVITS. About the play of forces, Doctor, let's sharpen it—you mean competition?

Dr. FALK. Competition, demand, and supply.

Senator JAVITS. Between companies?

Dr. FALK. Between companies, insurance representatives, sources for service, and the demand for service by the consumers, all of which we embrace within the dynamics of the marketplace.

Senator JAVITS. And the HMO?

Dr. FALK. I am not referring to the HMO.

Senator JAVITS. But they would also be a yardstick.

Dr. FALK. In a fashion.

Let me return to that. My first comment was on the point of medicare and medicaid. The second comment I would like to speak on is your reference to support of medical education.

We warmly support the proposals made by the President's program, with uncertainties as to whether the specific amounts of the funds or the details of the funding process are altogether adequate. But the goal, the objectives, the intent, as Mr. Woodcock indicated in his testimony, we endorse that, and we support it, and we hope the provisions will be fully adequate.

So, on this front we have no major quarrel on the basis of what information is available to us at this time about the President's program.

Now, with respect to the HMO, I think that all of us here at this table, Senator Javits, would like to leave no ambiguity whatever about our position. We think that the President's message and the Secretary's testimony with respect to the HMO was the highest compliment that could be paid to the provisions in S. 3, because the administration's provisions, so far as they have been spelled out, are as nearly identical with what we proposed as they could be in the limited material that has been presented by the administration.

When we see the bill and the details, we may not have any quarrel on the details, but the concept of HMO and the intention for the goals of the HMO, and the intention to provide needed fiscal and other support, on that we have nothing to say except that we welcome this endorsement of the position which we have been advocating. So that we have no quarrel there.

Whether their proposed resources will be adequate, or as adequate as what has been proposed in Senate bill No. 3, remains yet to be seen.

So I wanted to be sure to clear up any ambiguity that might persist.

At what pace this could go, what precise supports are needed remains to be seen in the President's message.

We have one difference, I think, in the method of providing this support. Under Senate bill 3, the support for the development of HMO's, though we call them by other names, the supports for their development and for other improvements in system and in organization, would come from clearly and explicitly earmarked portions of the resources available in the trust fund.

I would infer from what has been presented thus far that the President's proposed program intends to finance the support needs from

annual appropriations coming through the Congress via the annual appropriations process.

I think in the respect the proposal in S. 3 is better—much better—than the proposal which appeared in the Secretary's testimony yesterday.

Senator JAVITS. Doctor, thank you very much—and in order to have the record clear, Mr. Woodcock, may we assume that the testimony given by Dr. Falk is the testimony you are presenting?

Mr. WOODCOCK. I will freely admit, Senator, without Dr. Falk I would be nothing in this area. [Laughter.]

Senator JAVITS. That still doesn't answer my question.

Mr. WOODCOCK. The answer is "Yes."

Senator JAVITS. Thank you.

Isn't it a fact that under the S. 3 plan, we have—I say "we" because I am a cosponsor—have already considerable dependence on general revenue? We don't intend to finance the entire plan. As I understand it, about 50 percent of the costs would be from general revenue, again an annual appropriation. So, doesn't that narrow the differences even further?

Dr. FALK. In a formal sense, of course it does. Whether the 50 percent figure is precisely the right figure is a separable question. That there should be sharing in the financing of the program from the several sources that have been proposed in S. 3, I think is sound.

Now, the fact that the sharing through funds that would come from the general revenues of the Treasury or would have to be appropriated by the Congress annually is a procedure that would have to be followed, and is similar to the annual appropriations under the President's program.

But under S. 3, the amount required from general revenues through the appropriations procedure is on a formula specified in the legislation. If the legislation were enacted as it is presented in S. 3, then it would only be a pro forma but an essential activity of Congress to appropriate that money, such as Congress meets its obligations in appropriating the funds needed under other kinds of trust fund activities, say for the civil service programs, or in meeting the obligations annually under open end appropriations required by Federal-State combined programs.

So that there is a relevancy to what you say, Senator Javits, but I think the nature of the relevancy is somewhat different.

Senator JAVITS. Now, the last question I have is this: as you narrow these differences, do I gather that it is your opinion, Dr. Falk, and Mr. Woodcock has made it very useful to us by adopting your testimony, that you don't think the annual competitive benefit we would get in competition among providers of health services, including the present providers, the insurance companies, is worth what you believe we would have to pay for it, compared to an essentially governmental system which is provided in S. 3, and where the element of competition, such as the Government-created yardsticks and so forth, would not be as great?

Do you think we are called on to pay too much in the way of costs for the competition which would be introduced by the administration's plan?

Dr. FALK. Yes, I do, Senator. I think we would pay vastly too much. A very large proportion of the national product, the national income, or the spendable income of families and organized groups, would go down the drain in supporting competitive activities of those who want, each, to get a larger share of a pie which, in general, would be of a given size. There would be too little or no great value to those who have to support the cost, considered as against the much better ways there may be to do the job, as through, say, a parallel with the national social insurance program.

On some of this, I think, if I may suggest, Mr. Glasser can add with respect to some of the characteristics of the available insurance programs which bear on this.

Senator JAVITS. If I may interject another question just to help to get us the most illuminating answer. You still think we would do better, notwithstanding the notorious and traditional wastefulness of Government spending per se?

We always have to compare the two, because we are not living in a dream world. The Government is not going to be all that efficient, either; but, nonetheless, the point made, the basic point made, is that we are still better off and get more for our dollar in health care on essentially a Government-controlled program than a program piped through the private sector?

Mr. GLASSER. May I make three responses, sir?

Senator JAVITS. Please do.

Mr. GLASSER. There is competition provided for in S. 3. It is competition among delivery systems as to which can provide the most effective services at the lowest prices. We think that is the right kind of competition rather than competition among insurance companies.

(2) The record of the insurance companies under the Federal health employees' system where there is in fact such competition is not an illuminating one—well, I suppose it is an illuminating one in terms of the evidence that they have done nothing to control the escalation of costs, and we see nothing in the administration's proposals which would in fact make for any differences.

(3) To me, Senator, we have the most graphic demonstration of the differences in the two proposals in No. 3. The administration's proposal repeatedly goes to coinsurance, deductibles, and other kinds of deterrents to the use of care. At the same time, the administration's proposals repeatedly address themselves to preventive health services.

We, for example, in the labor unions, have been educated by the physicians of this country to believe that early diagnosis and treatment constitute what they call secondary prevention, and that, if you don't get early diagnosis and treatment, the patient is frequently in very difficult condition.

When we have hundred-dollar corridors, and the cost of 2 days' hospitalization, and 25-percent copayments, the administration's plan is saying, "We are providing a proposal which is an insurance proposal to make economic use of dollars."

S. 3, sir, we believe, is providing a proposal to give health protection, and we think this is the essential difference in philosophy and approach.

Senator JAVITS. Do I gather, then, that you feel we shouldn't give any attention to some discipline and use, and that the balance of the public interest requires the discipline and use, which even the British had to put in, by some payment, is something we should not incorporate in this legislation?

Mr. GLASSER. Our experience, and I speak from experience, sir, with contracts covering some 5 million—as Senator Kennedy indicated—some 5 million Americans, our experience has been that it was counterproductive to introduce hesitations, coinsurance, and corridors, if we were interested in protecting the health of our members.

Furthermore, our experience has indicated that over a modest period of time, this levels off.

We do not in fact expect excessive use of services. We have no indication from our health maintenance organization already in operation, including the one that we are closely associated with in Detroit, that the removal of coinsurance and deductibles in fact escalates costs.

On the contrary, we believe firmly that if the administration believes in preventive health care, as we do, when a patient feels that he has a problem, he ought to be able to feel he can quickly get medical consultation and not have to consult the budget to determine whether he can afford to get that treatment.

So that we repeat, sir, the issue is, are we interested in providing health care, or are we interested in providing insurance at a modest cost?

Senator JAVITS. Mr. Chairman, I think that the testimony has been extremely illuminating, and I would deduce that we really have—I think I have got the two critical points of difference. One point of difference is the trading off of competition among suppliers, and what is considered to be the greater efficiency of basic government direction of the health delivery system; and, second, this question of whether deductibles and various permutations exercise any constructive discipline over the utilization of services.

Thank you.

Senator KENNEDY. Senator Eagleton?

Senator EAGLETON. Thank you, Mr. Chairman.

Mr. Woodcock, in recent years in this country it has been the practice to declare all sorts of domestic wars, wars on poverty, on ignorance, on poor housing, and now perhaps a war on sickness.

We seemingly declare these wars rather glibly, but then we sometimes don't fight them too well.

It seems to me an indispensable part of the health care program would be adequate financing, and adequate personnel properly situated in order to deliver on the promises made.

Part of the disenchantment of our time is that we have this enormous gap between promises and performance.

With that as a prelude, may I direct your attention to the resources development fund concept as contained in your program.

As I read the digest sheet supplied us all, it states that an essential feature of the program is the resources development fund which will come into operation 2 years before benefits begin.

Is it implicit, then, in that concept that even if S. 3 were to be the law today by some miraculous legislative mechanism, passed by Con-

gress and signed by the President, and become operative today, you recognize that we couldn't begin to deliver the manpower and personnel under our present situation?

Mr. WOODCOCK. Senator, we could begin to do medically as well as we are now doing, and for many Americans, including many of the people that I have the privilege to represent. They have adequate protection now, they would get no less adequate protection under S. 3.

But we could then begin to move toward getting better care for the 41 million who now have to buy individual policies, the 30 million, mostly in our core cities and our rural areas, who are entirely out of the system, but it won't happen in terms of competence to deliver overnight, because we have a growing gap in the supply and demand situation as far as health professionals are concerned.

Senator EAGLETON. So if S. 3 were to be the law today, with respect to the 41 million covered by the various kinds of programs—and I am not talking about the Auto Workers and Machinists and the Teamsters, et cetera, who have good health care programs, but I am talking about the 40 million in the middle of the group, and the lower 30 million—if S. 3 were to become law today, we would be holding out in some respects the promise of better health care, but we couldn't begin to deliver on that promise today, especially with respect to those 30 million at the lower end.

Mr. WOODCOCK. Those people would have the same immediate entitlement as every other U.S. resident but I have to be honest and admit that given the present situation there would be a congestion in terms of delivery.

Senator EAGLETON. All right.

Pursuing that to the next step, is your lead-time period of 2 years, called in your memo the "tooling-up" period, is that a reasonable period of time in terms of manpower and manpower distribution for a total coverage system? Could we begin to have available not only the capital facilities that would be necessary, but the additional manpower that would be also necessary in such a brief 2-year period?

Mr. WOODCOCK. If I could, Senator, I would like to ask Dr. Falk to comment.

Dr. FALK. The answer is unequivocally no, Senator Eagleton, because in the first 2-year period we would merely begin to tool up. The provision of appropriations of \$200 million the first year and \$400 million the second year is for the purpose of saying, "We can afford no waste of time in this field."

While the administrative system, the procedural practices, the contracting arrangements, et cetera, have to be effected, and providers of services have to be prepared for participation, let us also use the 2 years to make a beginning for a job that will take at least the next 10 years to go toward developing HMO's, and other organizational improvements.

So the two tooling-up years call for appropriations.

Then, the earmarked funds from the trust fund, 2 percent the first year and escalating up to 5 percent in the successive years, would take over and provide more ample resources for the continuation of the system developments.

But as Mr. Woodcock indicated, this is an evolutionary process. No one can envision reliably how we go about overcoming the neglect and

the gaps that have been permitted to develop over the past 20 or 30 years.

It will take at least a decade, shall we say, to make an effective accomplishment so that the program resources, service resources, can begin to approach adequacy. In that period, the 70-percent cost coverage figure to which Senator Javits called attention, which is the coverage at the beginning of the program when there are benefit gaps because S. 3 does not undertake or promise what surely cannot be delivered, the benefits program can proceed to expand in that decade after the 2-year tooling-up period.

Senator EAGLETON. That is very important testimony, Doctor, and I think we should underscore it. I take it from your testimony that it would take at least 10 years to begin to meaningfully fulfill the promises implicit in the national health insurance program. We would have directors of manpower, et cetera. So we don't deceive people, where I think we have on so many occasions heretofore, where we make great promises and hold out expectations and then there is the cleavage between the hope and the fulfillment. I think in merchandising any program we don't want to oversell it as an instant, utopian cure overnight.

Dr. FALK. I agree completely. It would be a gross disservice to let the impression get abroad that on the effective date after enactment of S. 3 we reach utopia.

On the contrary, we must institute an educational process, a very sober, serious one, that on the effective day the situation would be not only as good as it otherwise would be without the intervention of the program, but with such improvements as could have been effected in the tooling-up period, and with such improvements as providers of public and private agencies would have undertaken knowing that the program and its fiscal supports and assurances were coming.

So that a good deal could be done, more than could be measured by the number of dollars that could be made available in that 2-year period if Congress had made the commitment that the program will be available to become effective at the end of, say, 2 years.

A great deal can be done. In that respect, when the program becomes operational, the situation, not for everything but for many people, can be much better than it is today, or than it would otherwise be 2 years after enactment. The educational process must be very effective. It must make very strenuous efforts to explain that the program has a goal for the availability of adequate care, but that that is not the promise to be fulfilled on the effective date.

Mr. WOODCOCK. If I may, Senator, there is one intangible, but nevertheless a bright hope, that might move the problem along faster, and that is the rising idealism of the medical students today. If they can see before them the prospect of a rational system, there will be responses from them in imaginative and innovative ways that I think will surprise all of us.

Senator EAGLETON. Let me ask this question, Mr. Woodcock, or Dr. Falk, and I guess this is the chicken and the egg problem. It is alleged by some that until such time as we have the requisite manpower available and properly deployed that it is folly, in the opinion of some, to commence a new scheme, an overall new program that cannot be delivered upon at the time the program is begun, and that

the massive health effort of our time in the year 1971 and henceforth, should be a massive beefing-up of health manpower, the health manpower field throughout the full gamut, nurses, paramedics, doctors, dentists, and the like, and that once we do have an adequate manpower pool available, then trigger the new program.

That is, have the people ready to go before the program goes on the books.

How do you answer that?

Mr. WOODCOCK. I defer to my mentor.

Dr. FALK. What you state, Senator Eagleton, as the hen and the egg problem, if I were to single out any argument as to why we are in this crisis, that is it. There has been an argument for 20 or 30 years that we must first develop manpower and facilities, and have demonstration and pilot projects, and then when we know most or all of the answers, that would be the time to face the financing problem. This has been a catastrophic folly. It has meant we have had a long series of categorical programs to support education and training and facilities construction, and the development of various other categories of personnel, and various experiments and demonstrations, many of which have been very wisely designed and skillfully administered principally by the Federal Government.

The Federal Government has put billions of dollars into these categorical efforts, and the end effect is that we have been sending a boy on a man's errand. There should be no doubt now, I think, because of the decisions taken explicitly and implicitly about 20 years ago, and persisted in, a decision that we must first resolve the problems of resources for health services and medical care and then face the financing, that it has been totally wrong policy.

The indications from history, and, by the way, many other countries in the world faced this hen and the egg problem before us, and they made their mistakes, and then resolved them by deciding "You have to have a hen and an egg simultaneously, even if the egg didn't come from that hen." We have to go ahead with both aspects of a single integrated problem. The crisis situation demands today that we put an end to the disputations and discussions on this subject and get on with the job. By improving the fiscal resources for health services and medical care we provide the leverage and the assurances for the system's improvement and for the development of resources. The fiscal improvements and the fiscal supports give the guarantees that as we develop the personnel and facilities and organizational provisions, the money will be there to make effective use of the augmented resources for health care.

Senator EAGLETON. I am certain now why Mr. Woodcock relies so heavily on you.

Were you a member of the faculty at the Yale Medical School?

Dr. FALK. Yes, until my formal retirement, when I became busier than ever as a lecturer.

Senator EAGLETON. Then you know something about funding.

Are you aware in the President's budget submitted to Congress recently for the Federal grant program for expanded facilities to medical schools, that it is recommended by the President that the budget from last year be cut? It was already meager last year, with some

applications last year unfunded, and that we cut this program this year to \$90 million, with, presumably, an increased number of applications for grants.

Now, based on your knowledge of medical schools, how costly they are, and the financing of them, do you see any way that we can expand the supply of doctors without greatly expanding the grant-in-aid program—by “grant” I mean grant rather than ethereal loans to already bankrupt schools. Can you envision any other way to expand the productive capacity of medical schools other than to increase medical participation in grant programs?

Dr. FALK. Senator, I must say I am not an expert in this field of financing, and I have to qualify my answer somewhat.

I know from the anguished cries, not only from our medical school in New Haven, but from medical schools across the country, that they are greatly disappointed by the proposal which appears to mean a cutback in the amount of money that would be available for direct grants.

They are also expressing anguished cries against the proposal that funds should become available for construction of needed facilities through guaranteed loan processes, which the administration has recommended.

I am sympathetic with their agonized cries, because I know that they will have very great difficulties in many of the medical schools to be able to obtain construction funds under those terms, and I know the plight of quite a number of the medical schools with respect to the need for the enlarged direct grants to support their general operating expenses.

I am fearful that a cutback, whether it were to come sharply and suddenly or on a gradual de-escalation process, would be a very serious matter for many of the medical schools in this country.

There is need for much further study by the administration and the representatives of the medical schools on how to deal adequately and equitably with the needs of the medical schools, especially in light of the greater expectations society is indicating on what is expected from medical schools in the way of production of needed personnel.

This is complicated by many important and technically intricate questions, whether or not the medical schools' needs are assured with respect to education and training in light of what they are enabled to spend in biomedical research activities. These are not separable questions, because they are interlocked in the activities and the budgets of the medical schools. Then there are the questions of whether or not the medical schools need to go through considerable revision of curriculum toward 3 years of undergraduate medicine as against 4, and how many of them can do it well and how rapidly. And the questions of what kinds of doctors are they training, for what purposes; is it for academic purposes, for research, for practice and performance with respect to patient care. These are the questions about the controls that need to be exercised, or the guidelines that need to be developed, as to whether they are training not only the right numbers of doctors for patient care but also the right kinds of doctors.

All of these are matters that are involved in the question of how much grant support should the medical schools expect to receive at

least for the near future, whatever the program may be for the longer program future, from the Federal Government.

Senator EAGLETON. Thank you, Doctor.

Mr. Chairman, I have completed my questioning. I would like to suggest, if at all possible, that the staff assemble some information for the committee which I think would have value to the hearings that you are conducting.

It is my belief, based on such contacts as I have had with medical school deans, et cetera, that a substantial percentage of the 109 medical schools in this country are on the verge of bankruptcy, that since medical manpower is the indispensable key to any program, be it S. 3, the administration's program, or the Hale-Mondale program, or whatever, that it would be a horrendous tragedy if we found a year from now that the 109 medical schools a year from now had dwindled to 99 and so forth.

It is my further belief that the offer of low interest rate government-guaranteed loans to an almost virtually bankrupt academic institution is an empty offer. That is, the right to go further in debt is not much of a right. Many medical schools, including George Washington University here in the District, are already eating into non earmarked funds—endowments. St. Louis University in St. Louis, Mo., is in the same position with respect to its medical school. Even one of the Cadillac schools, as it were, of medicine, Johns Hopkins, is experiencing significant financial difficulty.

I think it has a bearing on what this committee and other committees of Congress do with respect to health care. We should have as much information as we can for this record that points out the plight of medical schools in this country, and the fact that unless they get substantial direct grants, that many of them will go under.

Mr. Woodcock. May I comment on that, Mr. Chairman?

In Michigan, we have three medical schools, one in Ann Arbor and one at Wayne State University and a very embryonic school at Michigan State University. I have been on the board of Wayne State for 11 years. It is now 6 years since the legislature directed Wayne to increase the medical school class from 100 to 200. Six years later, they have been able to creep up to 115.

It is an agonizing problem for the board. If we were to submit to the legislature the full operational needs of the medical school to reach the proper level of 200, it would take the total possible money—more than the total possible money—available for the whole university. To sort between these priorities is most difficult, and there is only one place in which we can get the needed sustenance, and that is from the Federal Government.

Senator KENNEDY. I think the comment is well taken. We expect to have the representatives of the medical schools testifying next week, and I think the kind of points Senator Eagleton has put out today and yesterday are extremely basic to the whole health crisis in our country. I am hopeful that next week we can at least add some input from the medical schools themselves as to how they view the crisis.

I think you will substantiate what Senator Eagleton has commented on here today.

I want to thank you very much, gentlemen, for your appearances here, your comments and your extremely comprehensive testimony and useful responses to our questions. You have added a great deal to our understanding, President Woodcock, I want to thank you and your panel for appearing before this subcommittee. I am hopeful that we will be able to maintain contact with you over the period of these next several months, because I know that you have been able to accrue a great deal of information in all these areas, and we value this information and experience.

I want to thank you, all of you.

Mr. Woodcock. Thank you very much.

Senator KENNEDY. Our next witness this morning is Mr. Rashi Fein.

Dr. Fein, who is professor of medical economics at Harvard Medical School, is one of the most distinguished medical economists and medical philosophers in the Nation. He is the author of a number of brilliant volumes on various aspects of health care in America. In fact, his most recent book, written with Prof. Gerald Weber, of Berkeley, "Financing of Medical Education," is being published this week by McGraw-Hill for the Carnegie Commission on Higher Education.

I am delighted to welcome you to the Health Subcommittee, Professor Fein, and I look forward to your testimony.

STATEMENT OF DR. RASHI FEIN, PROFESSOR OF MEDICAL ECONOMICS, HARVARD MEDICAL SCHOOL, CENTER FOR COMMUNITY HEALTH AND MEDICAL CARE, HARVARD UNIVERSITY

Dr. FEIN. Thank you, Senator.

I would like to request that my statement be filed for the record, because I would like to excerpt it in order to leave as much time as possible for questions and answers.

Senator KENNEDY. Your statement will be included in its entirety at the conclusion of your testimony.

Dr. FEIN. I do not propose to dwell on the statistics with which you are all familiar. Though the data change from month to month, and from hearing to hearing, their broad outline is clear and well known. In essence, the story that they tell us is that national health expenditures are rising sharply. From fiscal 1960 to fiscal 1970, total health expenditures rose from \$26 billion to \$67 billion. As a percentage of gross national product, they increased from 5.3 percent to 7.0 percent.

Unclear, of course, is where we are headed and what will happen to health expenditures in the years ahead.

We can derive little comfort from the projections of the future that have been published by the Office of Research and Statistics of the Social Security Administration. The Office's low estimate for 1975 is that national health expenditures will total \$111 billion, or 7.9 percent of the GNP. It's high estimate projection is for outlays of \$120 billion (8.6 percent of GNP). For 1980, the low estimate is \$156 billion, which is 8.0 percent of GNP, and the high estimate is \$189 billion, representing 9.8 percent of the gross national product. That is, almost one out of every \$10 in the American economy.

None of us, of course, should consider these projections as predictions of the future. They are based on assumptions that the Office has

carefully stated. Thus, to the extent that the private and the public sector take actions to alter the assumptions, the projections of the future will change. Nonetheless, these projections are valuable. They are the best statement we have of what the future may look like if we do not take action. And let me stress the latter words, "if we do not take action."

I should like, later in my statement, to return to this matter and to raise the possibility that the assumptions on which the HEW projections are made can, in fact, be altered if this committee and the Congress of the United States choose to do so.

Senator KENNEDY. Professor Fein, these estimates and figures are Government figures, are they not?

Dr. FEIN. Yes, they were published by the Department of Health, Education, and Welfare within the past year.

The dollars going into the health sector, valuable dollars, are an important issue. There are many ways to characterize the decade of the 1960's, a decade that began with high hopes and great dreams and ended with a measure of disillusionment and despair. Perhaps it is fair to call it the decade in which this Nation had its rendezvous with reality. We became aware of many problems which had been with us in the past, but which we had, to a significant extent, ignored or overlooked. We learned much about ourselves, about poverty, race, urban neglect. It is no longer acceptable to take these problems for granted, to "live with them." But solving problems requires resources—not rhetoric. Our resources, like that of every other nation, are limited. This is the reason that the financial crisis in the health sector is so very important.

There are many things to be done in the United States, and if we are not getting full value for every dollar spent in a given sector of our economy, it means that we are wasting resources. Wasted dollars in the health sector, spiraling costs, gross inefficiencies, prevent people from receiving the medical care they need. They also prevent our being able to apply the wasted dollars and wasted resources to other social problems the Nation faces. Those, for example, who are concerned about education and housing, find themselves short of funds in part because needed dollars are being diverted into wasted dollars in the health sector. They should be calling for a rationalization of the health care sector.

Dollars are important, but they are not the only problem that the health sector faces. This Nation spends a higher percentage of a higher per capita gross national product on health than do other nations, yet, there is no evidence that the average American is healthier as a result of this allocation of resources.

In general, we spend more dollars per person on health care, we have more doctors per person to deliver health services, we have more hospital beds per person, we have more research and personnel and facilities. What are we getting for these expenditures? The answer, at best, is unclear.

The problem, however, is not alone where we stand in comparison with other nations. Rural Americans, inner-city dwellers, persons who are medically indigent. Americans of almost any income who are concerned about medical care services and financing, are troubled not

because they have heard that things are better in other countries, but because they know that things can be better here. They have been told that medical care is a right. Yet, today, many Americans find that the care is unavailable, and that if available they may be priced out of the market.

Their frustration arises because they believed what they were told: that we had adopted a national policy that health care should not be rationed through the normal market mechanism in relation to income. But they discover that there is a gap between rhetoric and reality.

The problem, I believe, in part, is one of financing. The fear of high expenditures, the decisions involved in seeking care as a function of income, the inadequacies of many voluntary health insurance policies, the fact that medicare pays less than one-half of total medical costs of the elderly, the cutbacks in medicaid eligibility requirements and services offered, the new cost-sharing approach; all of these are part of the financial crisis. In part, however, the difficulty stems from the lack of availability of care, from its highly fragmented nature, from the difficulties that people have in entering the medical care system, from their frustration with the medical care marketplace and its organization. The problem, then, is not one of dollars alone. Financial protection would help, but it is not enough. The problem is also not one of the delivery system alone. A more responsive and responsible delivery system would help, but it is not enough. In the former case, even with the dollar protection, some people would be unable to obtain care; in the latter case, even with a better distribution system, some people would be unable to pay for care. Those are the twin problems as seen by the consumer. From the perspective of government, there is yet a third problem. Government dollars are pouring into the health industry to purchase services for those who are eligible for coverage. Government has a responsibility to the taxpayers and to other social programs to make certain that the dollars are spent wisely, that they do not reward inefficient producers, that they do not purchase expensive services when less expensive ones are sufficient, that the quality of care achieved is the highest consistent with that expenditure.

There are those who believe that the problem of efficiency and economy in the production of health services can be attacked through existing Federal funding mechanisms. They argue that these programs already provide the Federal Government with substantial leverage. Our public discourse is replete with references to new experiments, arrangements, regulations, amendments, all designed to develop and encourage new methods of reimbursement that will provide incentives to physicians, hospitals, and nursing homes to become more efficient.

Part of our difficulty in translating words into action is related to the problem of leverage. Though the programs which we would hope to use to improve the organization and delivery of care loom large in the Federal budget, they account for a small proportion of total health care expenditures. Furthermore, they are directed toward a solution of problems for special groups, often involving the most vulnerable in our society, the poor and the aged. Often the experiments are on the periphery of the medical care system. Often they lose their experimental flavor as they become service programs for people who have no

other services available. Such experiments remain isolated from the mainstream of medicine. It may well be that if the Federal Government tried to use medicare, medicaid, and OEO programs as the lever to bring change, that the lever would break—that the most vulnerable would suffer as producers exhibited a lack of interest in offering services in new organizational structures.

The issue, therefore, is not really whether the Federal Government and State governments are doing as much as they can to effect change. The more basic question relates to the amount of impact that Federal dollars can have, given the fact that only 23 percent of total personal health care expenditures in fiscal 1970 were Federal dollars. Nor should we be misled even by this figure. Federal expenditures for health care are unequally distributed among the various sectors. In fiscal 1970, over half of all Federal expenditures went for hospital care. Of the \$14.5 billion of Federal expenditures for health services and supplies, only approximately \$2.7 billion went for professional services, accounting for about 15 percent of total, expenditures for professional services. Eighty-five percent of the leverage lies elsewhere. Eighty percent lies in the private sector. Federal leverage exerted through existing programs may result in a cutback in services for the beneficiaries of those programs rather than in a restructuring of the health care system.

Piecemeal approaches to the problem of maldistribution are also insufficient. One can argue whether federally funded health centers established to provide health care resources to poor rural and urban areas are the longrun solution to the maldistribution problem. It is clear, however, that in the immediate future such centers are fulfilling a vital need. Yet, in fiscal 1972, partnership for health centers, maternal and child health centers, and OEO centers will be serving only 2 million people. Does this represent leverage on the mainstream of medicine?

Nor are Federal efforts in the financing of health care likely to solve the financial health problems of the population. Let me repeat the words in the special analysis for the budget for fiscal year 1972, "Legislation will be proposed that will extend cost-sharing arrangements with medicare beneficiaries." Cost-sharing arrangements is a euphemism. It means that medicare beneficiaries will be required to assume greater financial obligations. This will also be the case for medicaid recipients.

All of us understand the need for tight restraint on growth of budgets. I submit, however, that the attempt to control budgets by transferring obligations from the public sector on to the aged and the poor is hardly consistent with the goals and objectives of the legislation when it was enacted.

The difficulty with piecemeal legislation and piecemeal change is not that the individual pieces may not do some good for those people who receive the benefits. The difficulty is not that new proposed programs may not be better than the existing patchwork quilt. The difficulty, rather, is that less than a comprehensive approach is likely to entail more escalation costs, more frustration, more administrative chaos. The difficulty is that less than a comprehensive approach is not likely to alter the health care delivery system. The difficulty is that

less than a comprehensive approach may benefit some, may hurt others, but will further escalate the total costs beyond all reason.

Let me quote the assumptions made by the Department of Health, Education, and Welfare in projecting total health expenditures for 1975 and 1980. We do this since it is these assumptions that must be altered if the projections are not to become the reality. In my view, the critical ones are:

1. The current public medical care programs will continue with no major change in scope and type of benefits or in persons served.

2. Financing of health care services through public and private sources will remain at approximately the same relative proportions as in 1968.

3. No major changes in the organization and delivery of health care services will take place by 1980.

4. Medical care outside the hospital will continue to be provided primarily by solo practitioners.

Those are the assumptions which have to be changed, and I do not believe that a piecemeal approach is likely to invalidate these assumptions. But there is an alternative to piecemeal actions. I believe that alternative lies in a comprehensive national health insurance program. That is what is required. It is under such a program that the costs of medical care can be equitably shared. It is under such a program that front-end money and development funds can be supplied so that innovation can spread from one section of the country to another.

In speaking of national health insurance, let me make several points.

The first point that must be made is that we should not be frightened away from a program of national health insurance because the budgeted figures loom large. A national health insurance program, comprehensive in scope, covering the population, will involve a substantial increase in the Federal budget. But, and I cannot make this point too strongly, it does not represent new dollars; indeed, if drawn correctly, total health expenditures would be less than they will be without NHI. The increase in the Federal budget financed through an equitable tax mechanism is counterbalanced by a decrease in private expenditures for health care. The increase in the Federal budget does not represent an increase in the percent of GNP going for health services; it represents a substitution of public dollars for private dollars. We will be spending the moneys—HEW has said that. The question is how. This is a critical point. Our focus should be on total costs and on an equitable manner of sharing those costs.

Programs that masquerade as solutions cannot achieve that purpose if they are constructed in a way which leaves the major proportion of expenditures in the private sector. The purpose to be served requires a transfer to a more equitable financing pattern and that is not achieved by private regressive financing mechanisms.

We will be told, by opponents of National Health Insurance that the Federal expenditures under NHI will be many tens of billions of dollars. I would ask of those who cite such figures as the basis of their opposition, why they prefer that these tens of billions of dollars remain as private expenditures distributed in an inequitable fashion. That is the relevant question. It must be remembered that we are speaking about the public financing of services which are now financed in the

private sector, that we are speaking of a transfer of funds, not of new dollars. It is not—I repeat—it is not new money.

If I might paraphrase what Secretary Richardson said yesterday, there is no such thing as a free lunch. We are going to pay for the care. The point is how: inequitably, as at present, or equitably?

Furthermore, the costs of illness are not alone the budget dollars. The costs of illness involve pain, discomfort, disability. They involve a loss in production, a withdrawal from the labor force, a cost to all society. These indirect costs loom large. Some of them could be prevented by earlier diagnosis and by better treatment. It is not likely, however, that the individual who confronts, a financial barrier will be able to receive that early diagnosis, that better treatment. All of society will, therefore, pay; will, therefore, lose—just as it would have lost had the financing of education been left in the private sector, had sons and daughters of poor parents been left illiterate.

A second basic consideration is that National Health Insurance must be structured in a manner that would be responsible and that would exercise restraints on rising expenditures, that would stimulate changes in the organization of the delivery system. The basic consideration, therefore, is whether the National Health Insurance program is merely a financial mechanism or is one which is designed to develop options and to help in the restructuring of the system.

I believe that §. 3, built to create a national system of health security, would accomplish these and other purposes, and it is not at all clear to me that the various programs offered by the administration would exercise cost restraint.

For too long a time the Department of Health, Education, and Welfare has been a mailing address receiving checks from the Treasury and readdressing the envelopes to State and city governments and to providers. It has a responsibility to make certain that the dollars are used efficiently. It must be given the authority to provide incentives, and it must have the resources to be imaginative in the development of incentive mechanisms. I do not underestimate the difficulty of this task. But one thing is clear: however difficult it may be to make more than a mailing address of HEW, it is surely easier to do that than to make more than a mailing address of our existing health insurance carriers. Yet the administration's financing proposals, it seems to me, do just that. Thus, in examining any proposed solution to our health crisis one should ask: If it is enacted, how will things look differently a decade hence, what is there in the financing proposed itself that would stimulate and lead to change? Financing and the system itself are, after all, inexorably linked. The program's financing mechanisms must be drawn to stimulate the development of options and incentives, if the legislation is to accomplish that which is required. A traditional financing approach will maintain the traditional delivery system organization—and we need change.

A third basic consideration involves equity, equity both in health expenditures and in the collection of tax revenues. A national health insurance program should be financed in a manner which is equitable as possible to relation to income. It must also be concerned with the distribution of total personal health expenditures. That total should be distributed as equitably as possible. Thus, the coverage must be

comprehensive. Reliance on private financing mechanisms, on co-insurance, on deductibles, on cut-offs on services, on non income-related premiums is inconsistent with the achievement of equity. A \$300 deductible has a very different impact on a family that is at a \$6,000 income level and on a family at \$16,000 or \$26,000. And I ask what philosophy leads one to say that that is fair?

The temptation to extend coinsurance and deductibles comes, in part, from the fact that it permits the Government budget to look smaller. But making the Government budget smaller, while making the private expenditures greater, does not save total costs. The temptation also arises because it is assumed that such "cost-sharing", for example, reduces hospitalization utilization. But this ignores the key role of the physician in determining utilization. The task is to develop incentives that help the physician in reaching responsible decisions, that remove economic incentives for him to hospitalize the patient. This is a different issue than making it expensive for the consumer—including the consumer who needs to be in the hospital—to purchase hospital care.

Equity and financing, provision of incentives, development of new organizations; these are among the basic considerations. These are the axes on which suggested solutions to the health crisis should be assessed.

We will be told that it will be too expensive. Medical care is costly. The question is who shall bear the cost. A public program would be more equitable and less expensive than a collection of private programs trying—and failing—to do the job.

We will be told that we are not ready for the program, that we need to develop system change and additional resources before we embark on this endeavor. System change, however, cannot be brought about under existing financial arrangements, under existing or piecemeal programs.

We will be told that we should not allocate this much to health, that the country has other social priorities that are even more pressing. But how will other social programs find the resources if we fail to act? If we do not act now, health expenditures may approach \$200 billion by 1980. To permit this to happen is to be irresponsible.

We will be told that national health insurance is not necessary—that the crisis can be solved by a national health insurance partnership involving a national health insurance standards act, a family health insurance plan, the retention of the current medicaid program, and changes in medicare—all these in conjunction with the development of health maintenance organizations, changes in medical education, the development of a national health service corps, and so on. We will, in effect, be told that a comprehensive health policy can be built without a comprehensive financing mechanism. I do not believe that this is the case.

There is much to commend in the President's health message. It describes in dramatic fashion the crisis we face. It recognizes the need to move on a number of fronts. No longer can it be argued that necessary action could or should be delayed till the latter half of the decade. Furthermore, the message offers a number of specific proposals that, I believe, should be supported by all concerned Americans. The emphasis on HMO's, on meeting needs in scarcity areas,

on new kinds of support for medical education, on merging parts A. & B. of Medicare—these are among the proposals whose general thrust has considerable merit. In some areas at this time we lack sufficient detail and in some the President has proposed insufficient funding, but more details can be developed and more funds can be appropriated. There is more to be done, but there is much that can be built upon.

Regrettably, however, the efficiency of the administration's proposals on the supply side is greater than those offered on the financing side of the ledger. On the financing side we retain—indeed, expand—the categories and programs—and in what manner and to what purpose? Surely it is not the administration's purpose to create an administrative nightmare—but the proposals I believe would do so. Surely it is not its purpose to maintain inequities—but the proposals would do so. Surely it is not its purpose to make it disadvantageous for the employer to hire full-time workers and heads of households—But I believe the proposals would do so. Surely it is not its purpose to leave millions of persons outside the various categories eligible for some coverage—but the proposals would do so. Surely it is not its purpose to place undue burdens on small or marginal employers of low-income persons—but the proposals would do so.

What we should be told, what we should recognize, is that pluralism in the delivery system—the creation of options that do not exist today—is required. But we should also recognize that pluralism in providing a financial base means confusion and inequity. What we should recognize is the need for a national program not unlike the social security system. What we should recognize is the need to create universal coverage, not omitting some—and the most vulnerable—Americans. What we should recognize is that there are alternatives to the administration's proposals on financing—alternatives based on progressive taxes, not on regressive mechanisms.

What we should recognize is the importance of linking an adequate, efficient, equitable financing mechanism with the delivery system in order to bring change.

Senator KENNEDY. Thank you very much, Professor Fein. It is an excellent statement and commentary, and highlights the principal differences in the approach taken by the administration and S. 3.

I would like to ask you to elaborate a bit on how you view the question of the equity between the approach of the administration and that included in S. 3, particularly for working people.

I think we reviewed both from the example that was given earlier today by Mr. Woodcock in a series of expenses incurred if it were necessary for a working family to go to the hospital on two or three different occasions. So I gather what we are doing with the deductibles, the coinsurance, and the concept of cost consciousness, is really talking about an extremely regressive system, as compared to the universal national system included in S. 3, which would be a more progressive system.

I would be interested if you could develop your views a bit on it. You made an excellent comment in the statement, but I think it is one of the principal contrasts. We have been listening this morning to the fundamental differences in terms of the approaches being pursued, and I think it would be useful if you could elaborate on that.

Dr. FEIN. I would like to, Senator. I believe—perhaps because I am professionally an economist, but I think for other reasons as well—that this is one of the most critical issues.

The need for medical care hits some people and not others in any given year. Today one pays for that medical care if one can, out of one's income. That is not the way we pay for education, it is not the way we pay for retirement benefits, it is not the way we pay for disability insurance through the social security system, and it is not the way we pay for survivors' benefits through the social security system.

And it is not accidental that we have adopted other methods of payment to share the burdens that will befall some and not others.

Under the administration's proposals, we would shift to insurance, but the cost of that insurance would not be borne as a function of income.

Let me be clear. My income is above the average income in the United States. It is, I believe, quite proper—through a progressive mechanism, through social insurance—quite proper for me to share some of that income with others who need medical care. That cannot be done under the system that has been proposed through the voluntary health insurance sector. Poor people will have to pay the same dollar amounts for their premiums as I. That means they will have to pay a much higher percentage of their income for that insurance. If you are at \$5,000, you will be paying a lot of money for the insurance, and your employer will be paying a lot of money for the insurance. This will amount to a significant percentage of your income, much higher than for upper income groups. It will amount to a significant percentage of payroll, much higher than if the cost were equitably shared.

What I am saying is that the administration has not proposed a mechanism that takes account of where workers are on the income scale. For example, workers start out earning less than they do later, but they pay the same amount even when they are just beginning to earn income.

Of course, I also feel that the program has deficiencies because it omits many people. This, too, is a matter of equity.

If you are a worker and a full-time worker, and your employer has offered you the policy under such conditions that you take it, you will have coverage, but there are many Americans, perhaps as many as 30 million, who would not be covered through these various proposals.

I would suppose that there are many Americans who are so poor, that though the policy will be afforded to them—they will have to contribute to it—though the policy is offered to them, they may find that the need for food, clothing, and shelter will be so important to them that they will not purchase the policy, and we will be back to the charity ward medical situation.

Senator KENNEDY. Just to illustrate this point, I suppose what you are talking about is perhaps the employee that is making above \$5,000, has a large family and is working for a small firm. Rather than paying what would be his share of the 35 or 20 percent premium, he would have sufficient requirements for food and for housing to save this maybe \$200 a year to take care of those needs.

Dr. FEIN. That is correct.

Senator KENNEDY. And this is an additional example.

Dr. FEIN. That is correct.

We may say tomorrow, "Gee, this is a very good buy, you ought to take advantage of it," but it may not be in the individual's power to take advantage of it if at that moment in time, he places higher priority on food and shelter. And who are we to say he is wrong?

So he will take his chance, and we will develop the charity hospitals and charity medicine again.

I think the administration's proposals fail on equity grounds: some people are left out, the low-income worker who will be paying a very high percentage of his income for the insurance, if it provides comprehensive coverage, and if it doesn't provide it, will be paying a very high percentage of this income on coinsurance, deductibles, first 2 days of hospital, the whole paraphernalia—all of these, and other problems as well, indicate the weakness of the approach.

Senator KENNEDY. Let's just illustrate this again. In other words, one of the regressive aspects of the administration's approach is that whether you take the \$5,000 worker or the \$20,000 worker, both are going to have the same amounts of deductibles, are they not?

If you have the same family, for example, that had to have three hospital visits a year, and with the various hospital deductibles and the various expenses, there really isn't a difference, is there, in what that worker would actually be paying out in total cash amounts whether he made \$5,000 or \$20,000? I suppose that the point that you said so well this morning is that this is the feature of the regressive aspect of the whole program.

Dr. FEIN. That is correct. Let's be frank about it—a \$100 deductible in any given year, as is proposed, is not going to make me an awful lot more cost-conscious than I already am.

Conversely, however, that \$100 deductible for a person at \$5,000 is going to keep him from getting medical care that he may need. I don't consider that very equitable.

I don't think there is any way of licking that problem, because if you impose a figure high enough to affect some, it will be disastrous for others. The figure is not related to the income of the individual, and that is the critical element. The financing is not dependent on its income, and that is the critical element. There is no sharing on the part of the population in the costs of medical care, and that, I believe, is the critical element in the issue.

Senator KENNEDY. Why can't there be a sliding scale in terms of income, and terms of deductibles?

Dr. FEIN. I think for elegance one could develop it. I think if we started to develop that kind of system, Senator, I would be constrained to say that the proposals were not proposed to be of benefit to the health insurance industry, but to the paper manufacturers of the United States.

Senator KENNEDY. It would be an administrative nightmare in effect.

Dr. FEIN. Yes. It would also get us back—unless we do it through the tax mechanism—it would get us back to the means test, something

which we have been trying, not always fully successfully, to get away from.

Senator KENNEDY. Could you comment on the cost control features suggested by the administration and the utilization of the insurance industry in terms of striving to reach some kind of cost control? What comments can you make on that?

Dr. FEIN. The cost consciousness which we consumers are supposed to have under the proposals comes out of cost sharing. That is, we are supposed to pay part of the premium costs, deductibles, and coinsurance.

As I have indicated, I believe a total sharing of total cost is the key. I don't think we ought to hit at the sick. I don't think we have any data that demonstrates that deductibles and coinsurance lead to lower utilization. I think that is a very critical element.

If the administration wants to peg its program for cost control on "cost sharing," let it produce the data. I might add, if it could produce the data, I would still be quite concerned, because I am concerned about not only averages, but how deductibles and coinsurance affect different people, and for some those deductibles would be important.

I believe it was Franklin Delano Roosevelt who, quoting Mark Twain, once said, "It is small comfort to the drowning man to be told that the average depth of the Mississippi is only 3 inches."

It is small comfort to those who are told that on the average 30 percent of the costs of medical care are covered if they fall in a different category.

The interesting thing on cost control is that we already have HMO's or models of prepaid group practice, which effectively control costs even though there are no deductibles and coinsurance.

How do they manage? They manage because the behavior of the physician was changed, because it is in his interests to control costs. The physician is the key. The question then becomes, Is the voluntarily health insurance industry likely to provide reasons for the physician to change his behavior?

I don't see it. I don't see that this has been their function in the past. I don't think they are equipped to do it. I do think they are equipped to do some things. They have computers, and they can process pieces of paper, and that is an important function in any government program or any private program. There is, however, no reason to think that they would do the job of cost control well. There is every reason to think that they might do it poorly.

Cost control involves other matters as well. It involves administrative costs. I think that under the proposals that have been submitted we would have higher administrative costs: keeping track of whether the person is covered by a family health insurance program, how his contribution changes as his income increases, at which point he switches to another program, moving across the country finding a new carrier to cover him, or changing employment and having to find a new carrier. These are costs. They may not be considered costs of medical care, but they certainly are costs of administering the program.

It is hard for me to see very much cost control in the proposals that have been offered, with the exception of HMO's and I think those were discussed at an earlier point.

I would like to add one point on HMO's. I think the administration is to be commended for the proposals about health maintenance organization. I think it relies, however, on the good will of physicians for the growth in HMO's.

I would prefer to place my reliance not only on good will, which I am sure exists, but also on incentives that make it advantageous for the physician to join an HMO.

I think that S. 3 in fact provides such incentives. So I would expect that even though the administration is proposing HMO's S. 3 would move us much more rapidly to a situation where major parts of the population could avail themselves of that form of medical care.

Senator KENNEDY. Would you comment on the contrast of the financing through the insurance companies versus the social security system? You touched on it in some of the earlier questions, but I would like to get more on that.

Dr. FEIN. I think there are a number of differences, some of which deal with financing and some of which deal with basic philosophy.

Let me start with the most basic point. I don't believe that the interests of commercial health insurers are necessarily consistent with the consumers' interests. I do believe that the interests of commercial health insurance—I do in part exclude Blue Cross—is in making money. I do not think that that is the interest of the Social Security Administration. I think the interests of the Social Security Administration are in protecting people, and I think there is a big difference in protecting people and making money.

Now, what does that mean in real life? It does not mean that insurance agents aren't nice guys, that they aren't kind, and that they aren't humane; they are nice guys, and they are kind, and they are humane, and so are physicians. Some of my best friends are physicians. [Laughter.]

But they are caught up in system that gives them rewards based on incentives which are not the incentives that ought to exist. So we have a processing of claims that makes things difficult for the individual. The Social Security Administration lends a hand, and says, "You are eligible for benefits." I rather doubt that the commercial health insurance sector is going to go out of its way to remind people that they ought to collect on some claim. That is not their bag.

What we have, then, in the first instance is a basic difference in the role, the function, of the institution.

In the second instance, we are going to have, according to the proposals, competition in the insurance industry. Now, this will not be competition on controlling costs. because any insurer may have subscribers that avail themselves of all kinds of facilities, all kinds of delivery systems. He may not have very much relationship with any single provider. The competition will be competition in selling the product, and commercial health insurance carriers will substitute on TV for cigarette commercials.

Well, that may be an advance and welcome to TV, but it is going to raise the cost of selling the product to us.

And for what purpose? If the products offered were different—but, no, they won't be different. We were told that there is going to be Federal regulation that would make the product the same. The policy ought to look pretty much the same at the basic minimum.

Why have a lot of extra costs by a carrier who is not interested in accomplishing the purpose that the President spoke about when he delivered his health message? The President's outline of the purpose to be served was excellent. I doubt, however, that the commercial voluntary health insurance industry can deliver on achieving those purposes.

Senator KENNEDY. You are saying that the importance of the health system in our country is too important to be left to private industry, no matter how public-spirited it might be.

Dr. FEIN. I agree with that statement. If I said it, I meant to say it.

Senator KENNEDY. Let me ask this, Professor: We talked this morning about the burden of demonstrating that the approach that has been taken by S. 3 is superior to the administration's program in terms of providing quality health care.

I think in response to your earlier answers in terms of equity, cost, and quality and contrast between the private insurance companies and the social security measure, you have given us extremely important worthwhile and commendable examples where the approach that has been incorporated in S. 3 is actually more significant and weightier in achieving quality health care.

Is there anything further you would want to add?

Dr. FEIN. I carry in my pocket, Senator, a clipping from the New York Times, December 28, 1970. I find that I have occasion to use it when I am asked questions in this field. Let me read it. I think it will provide a framework for my response. The headline is "800,000 Coupons To Get Kidney Machine for Boy."

"Richmond, Calif., December 27, (UPI) : Churches, schools, Scouts, neighbors and social organizations collected 800,000 food coupons in 2 months to give 12-year-old Buddy Geise a kidney machine for a holiday gift.

The drive was started with the target date of Christmas Day. Mrs. Eban Geise said it had gone "over the top" with coupons still pouring in. She said 100,000 coupons arrived from three sources over the weekend.

The coupons will be turned into General Mills, Inc., in exchange for a kidney machine for Buddy's home use. The boy now must make three trips a week to a San Francisco hospital for treatments that cost \$200 each." And it being the Christmas season, below the story was the line that all of us who read the Times are aware of, "Remember the neediest."

I think that tells what S. 3 is about. I don't want Buddy Geise to have to worry about whether his father happens to fall within a category covered by the President's program. I think it is much more important that all Americans be covered, that it be universal, and that Buddy Geise, 12 years old, doesn't have to have that concern.

Now that story can be read two ways. I think one can say, "What a marvelous population we have that when Buddy Geise needed the coupons, we all contributed." But I read it the other way: "What a sad commentary on a society that when Buddy Geise needed a kidney machine, and we know how to produce it, and it is sitting somewhere,

that somebody had to raise coupons for him and he had to wonder whether he would make it or not."

I think that S. 3 addresses the Buddy Geises and says, "It doesn't make any difference whether your father is working, or not working, whether you hit the deductible, or whether you hit the \$50,000 limit." I think the clipping describes a problem that all of us ought to be ashamed exists.

Senator KENNEDY. If all this is true, and I would agree with you that you have made an extremely strong case that it is. Why did the administration rely on the insurance industry to meet the health care crisis in the country?

Dr. FEIN. I have speculated on that.

Senator KENNEDY. What is your speculation?

Dr. FEIN. I don't know. I don't know. I really don't know.

Senator KENNEDY. Senator Pell.

Senator PELL. Thank you, Mr. Chairman.

Mr. Fein, as I understand it a reason you believe the bill of Senator Kennedy's is the best bill is because, one, it provides the broad range care that is needed, and second, it doesn't give enough insurance. Is that correct?

Dr. FEIN. It provides the broad coverage that is needed. It is financed in an equitable manner which relies on mechanism that we have traditionally relied on in the United States for social programs, namely, ability to pay, and it is designed, also, to change the delivery system in order to make it more responsive.

Senator PELL. Have you had a chance to look at the bill I put in, which does not depend on the private insurance industry as does the administration's bill, and did not go as far as I would like to go, but also would be maybe less expensive, and put a greater emphasis on preventive care and also a greater emphasis on distribution?

Have you had a chance to look at it?

Dr. FEIN. I have had a chance to look at it.

Senator PELL. What were your reactions?

Dr. FEIN. Perhaps my reactions were indicated by the fact that I indicated I prefer S. 3.

One of the things that troubles me, Senator, in the bill is the following, indeed, you used the words just now. You do in the bill not go as far as you would like to go, but it is less expensive.

I submit that it isn't less expensive. It means somebody else will be paying for it, the "somebody else" being essentially sick people. Broader coverage is not financed with new dollars.

Now, maybe this is the reason the administration offered its proposals. More comprehensive proposals would involve new budget expenditures—I did notice that the Urban Coalition was prepared to put in a new figure in its budget the other day.

New expenditures in the budget (even if receipts would be increased via social insurance funding) may be frightening to some. I submit, however, an increase in the budget removing at the same time the private cost for medical care is a shift in funds, not new funds.

Senator PELL. But isn't one of your objections to the administration proposal that it unnecessarily gives a windfall to the insurance industry?

Dr. FEIN. Yes, that is one.

Senator PELL. That would not apply with my bill, is that correct?

Dr. FEIN. That is correct.

Senator PELL. Another question with respect to S. 3, which would go within the mechanism of the Social Security Administration to handle, which does it at a reasonable price indeed. I remember being quite struck at one point as the chairman of the Railroad Retirement Subcommittee, I was wondering if your examination, whether you thought there might be merit to having the idea of having the railroad retirement complex, which does it at half the cost of the Social Security Administration, enlarge and take on this bill.

Dr. FEIN. This is not a subject that I claim any expertise in.

Senator PELL. It is about 50 percent of the overhead cost.

Dr. FEIN. I think there are some things that one ought to be aware of, and perhaps they explain some of the differences.

In the case of the Social Security Administration, you are dealing with a much larger population, many of whom are not aware of what their benefits might be under the program, and it is the responsibility of the Social Security Administration to seek those people out. I doubt that the Railroad Retirement Board faces quite the same problem.

Senator PELL. I am not sure the Social Security Administration has been effective in this, either.

Dr. FEIN. In my experience it has been, but I am sure they would like to improve their record, even if it was 99.9 percent effective. Furthermore, and on the issue of administrative costs: we have built in, of course, the coinsurance and deductibles in our medicare program. These have to be increasing the costs. There has to be recordkeeping which otherwise would not exist.

I have speculated with others who say how much American society has advanced because we have computers. They say to me, "We couldn't have medicare without computers." I respond, "We couldn't have the deductibles and coinsurance without computers. We might have had a better program."

Senator PELL. Thank you.

Senator KENNEDY. Senator Mondale.

Senator MONDALE. There seems to be general agreement that the key to reforming the health care system is the development of health maintenance organizations, which provide prepaid preventive care.

The administration estimates that by 1976, under their proposals 1,600 health maintenance organizations can be developed serving 90 percent of the population. Is that realistic?

Dr. FEIN. I don't think they said, Senator, serving 90 percent of the population, but available to 90 percent of the population. I think there is a critical distinction here. In fact, I am convinced that 1,600 could not serve 90 percent of the population. The question then becomes, Do I think we could have 1,600 health maintenance organizations?

I think that is a matter of funding, it is a matter of incentives, it is a question that depends in part on the expansion in medical education and in the expansion on the physician supply.

Senator MONDALE. The administration proposal, as I understood it, is that \$23 million would be provided in technical grants and incentives. Does that amount provide the incentive and mandate that you

think will achieve the objective of 1,600 health maintenance organizations?

Dr. FEIN. That will not begin to put us on the road to 1,600 health maintenance organizations, or indeed to what the administration would like to achieve in the first year. Twenty three million dollars is not much money in this field at all.

Senator MONDALE. If we are serious about trying to have a major new strategy which will achieve a national health maintenance organization system, what kinds of incentives, what kinds of funding levels would be required?

Dr. FEIN. I would be glad to submit for the record a detailed response to that. I think it is an important question. I wouldn't want to give an offhand comment.

Senator MONDALE. I am afraid we may have endorsed the best strategy for cost reduction and preventive health care, but then attached a modest, token technical assistance program that will offer little or nothing toward doing the job.

Dr. FEIN. I agree with you, I don't remember the figures Dr. Falk talked about in New Haven. I am not fully cognizant of the date involved in the Harvard program. But I do know that the first year of operation is a very tough year. You have to have the equipment, you have to have the physicians, and you don't yet have the subscribers, so you are losing money at the beginning. You are losing lots of money if you are prepared to offer good medical care. That requires substantial financial support.

Later on you are going to be in great shape, but the first 2 years you can go under simply on a cash flow problem. You have to pay the nurses, the doctors, and the bills, and you don't have the income.

Senator MONDALE. Would you submit for the record the sorts of incentives and funding levels you think would be required for an adequate national strategy?

Dr. FEIN. I would be glad to.

(The information subsequently supplied follows:)

INCENTIVES AND FUNDING FOR NATIONAL HEALTH MAINTENANCE ORGANIZATION

The Senator's question concerning the kind of incentives and funding levels required for an adequate national strategy to develop a national HMO system is difficult to answer in the absence of information concerning changes in general financing patterns for health care. As I have indicated elsewhere, the health care system is complex and includes many interrelated parts. One can hardly fail to recognize that change in one part will have impact in other areas. Thus, it should be clear that the costs involved in attaining a national HMO system will depend not only on what is done to stimulate HMO's directly but, also, on what is done in the field of medical education, in the training of additional and new types of health workers, in the financing of medical care, in the construction and utilization of hospitals, and so forth. Of vital importance, also, is the method by which physicians will be compensated under a national health insurance program.

Furthermore, the incentives and monies necessary to develop an HMO program depend upon one's definition of a Health Maintenance Organization. A precise definition is unfortunately lacking. Costs would clearly differ depending upon whether one sees an HMO as a service unit, as a plan with a number of service units, or as a fiscal device

through which monies are channeled. Costs would differ markedly, particularly start-up costs, depending upon the assumptions one makes about insurer behavior, of one, for example, assumes a continuation of voluntary and commercial insurance coverage and the absence of a more comprehensive national health insurance program.

Though views will differ on the optimal size of a service unit, in many parts of the nation one would expect that a service unit would serve perhaps 25,000 to 30,000 consumers. If such a service unit were free standing (that is, not part of a plan with additional service units), it might require, perhaps, \$500,000 in grant or loan funds before it was self-sufficient. If such sums were made available through loan funds, future premiums would have to carry a much heavier burden than would otherwise be the case, perhaps putting the service unit at a significant competitive disadvantage.

The sums required could be cut, perhaps in half, if the service unit were one of a number of such units associated with a plan. In that case the plan would have to have funds sufficient for planning purposes, start-up expenditures, and for the avoidance of the difficulties that would otherwise be encountered in cash flows in the first year or two. The amount a plan might need would depend, to some extent, on the number of service units associated with the plan. It would not be unreasonable to expect that a plan, encompassing a significant number of service units, would require several million dollars in grant and/or loan funds. It should be clear that in the absence of federal legislation that would enable persons with third-party coverage (Medicare, Medicaid, voluntary

and commercial health insurance) to more readily select a service unit prepayment arrangement, even larger sums would be required in order to enable the service unit to survive the heavy drain on resources and funds during the period when it is "open for business" but has relatively few subscribers, during the period when expenses are high because it must pay physicians, nurses, etc., and when receipts are low because consumers find it difficult to opt for this system under existing third-party arrangements.

Senator MONDALE. The President has pointed to the rapidly rising costs of health care. Do you see in his proposals any basis for expecting that the costs can be restrained?

Dr. FEIN. In a word, "No." I don't see that these proposals add up to a comprehensive strategy to restrain costs.

Senator MONDALE. In what way, if any, is S. 3 superior in cutting costs?

Dr. FEIN. I think it is superior on a number of levels. One, I think that the movement toward Health Maintenance Organizations would be much more significant because physicians under S. 3 are rewarded; that is, incentives are supplied to them, if, for example, they can cut the most costly part of the medical care system; namely, unnecessary hospitalization.

I think there is a second and very important feature in S. 3, and that is that in S. 3 you decide how much ought to be spent, how much will be spent, for health care in the United States. It is not open-ended. It is not a blank check. It is not raising premiums because the provider is charging more.

Rather, it is a responsible way, as we do in other fields, of saying, "This is what ought to be allocated for America's health. It ought to rise annually as the population grows, as providers want and deserve more economic rewards, as the costs of doing business or running a hospital increase."

But there is some agreement at the beginning about what it will or should cost. This goes from the Federal to the regional level, and down to the community.

This is responsible budgeting. We don't have that in the health field today. We don't have it in the voluntary health insurance sector today.

Ultimately the combination of Health Maintenance Organizations, of a better delivery system, of more efficiency in the delivery system, of prospective budgeting in hospital budgeting, which the administration favors as well, the combination of that with the recognition that we don't have an open-ended system, I think, would restrain costs admirably.

They will still rise. They will still rise over time, because we will discover new ways of treating people, and new disease to conquer, and that is good. We will choose to allocate more to this field, and that is fine.

But right now, and I know of your interest in education, Senator Mondale, I should think that you—interested in education—would be immensely distressed about the health sector which is eating up so many billions of dollars in an open-ended fashion that fewer dollars are left for other fields than are needed in these fields.

Senator MONDALE. The administration proposes to cancel the \$5.30 monthly premium on medicare, Part B, a proposal which I had earlier made in legislation form. But it then urges higher deductibles and reduced hospital benefits under Medicare. Does this make sense to you?

Dr. FEIN. No; it doesn't. The aged as a group under the two administration proposals would come out ahead, as a group.

As I understand the Secretary's testimony, the aged would gain \$1.4 billion by eliminating the \$5.30—\$5.60 per month on July 1—

charge for Part B, and \$0.4 billion will be taken back through the deductibles and coinsurance.

But the issue is not only the aged as a group. We passed Medicare to provide insurance, and what we are saying to some aged, to all aged is, "Think about it, some of you will be better off, and some will be worse, and you have no way of knowing in advance whether you will be better off or worse, except one thing we can tell you. If you aren't sick, you will be better off."

Now, that is a very curious approach, as I see it. To be perfectly fair, it isn't even if you are sick you will be worse off. Rather, it is if you are very sick, you would be worse off.

It is a very curious kind of language we develop when we call this cost sharing.

Furthermore, I am told that the deductibles and the coinsurance features are going to be "dynamic," that is, we will have what is called a dynamic deductible.

A dynamic deductible would be a deductible that rises as the cost of living rises. Now, note what that says.

Here is a group of people, the aged, whose income is fixed.

We have not yet tied the social security benefits to the Consumer Price Index, so their income is fixed.

Food goes up, rent goes up, clothing goes up, other expenses go up, and the deductible, to be symmetrical, will also go up.

It is a never-never land. I am sorry—it is that kind of thing that makes it difficult for me to respond to Senator Kennedy's question, "Why do you think that these various proposals were made?"

I don't know because I don't understand them.

Senator MONDALE. A year or two ago one of the Aging Subcommittees heard testimony about the medical problems of senior citizens. The doctor concluded that one major difficulty is the reluctance of senior citizens to avail themselves of health care services. If the symptoms seem serious, the elderly hesitate going to a doctor because they are afraid of bad news. In light of this reluctance, it seems to me, we ought to encourage senior citizens to have their health care needs met, and above all reduce financial exposure to the greatest extent possible.

I judge from your testimony that you think these deductibles might be an additional discouragement to citizens who will have to pay them.

Dr. FEIN. It cannot help but serve as a discouragement to some, particularly the poorest, of our elder population.

Senator MONDALE. In S. 3, we limit the payroll tax to 3 percent of \$15,000. Some have objected to the ceiling. You have stressed the advantages of a financing scheme based on progressive taxes.

Do you think it is necessary to limit payroll taxes to the first \$15,000?

Dr. FEIN. In terms of economics, I think my answer would be "No," it is not necessary. In terms of political reality, you are a better judge than I. In any case, I would hope that as with the social security base, that this base would rise over time consistent with the increases in the economy and general levels of increased earnings.

Senator MONDALE. Thank you, Mr. Chairman.

Senator KENNEDY. Just finally, if we go to the insurance companies as a means of funding and financing, what happens to consumer prices in the health field?

Dr. FEIN. There is no question but that under the President's proposals somebody is going to have to pay. That is what Secretary Richardson said, and he was quite correct.

To the extent that the cost to the employer is shoved back on to the low-income worker, the low income worker is operating under a delusion when he thinks he is only paying a third. He is going to pay it all out of his lower wages, or wages which will not increase over time. Alternatively, to the extent that the worker is able to bargain with the employer and the employer pays the premium, you and I will pay the cost, because it will be passed on in the form of higher prices. One could almost characterize some of the proposals as inflationary, but that is not the kind of word one likes to use too lightly.

Senator KENNEDY. Could you comment on the value of financing the system close to the Social Security system? You made reference earlier to it, but for the record I would be interested in your responses that Social Security financing has generally been more interested in people, so to speak, than financing through the insurance company mechanism.

I would be interested if you could make any comments on why people like it and why it has been so successful.

Dr. FEIN. Well, I am a fan of the system, and I think others are. I am a fan for a number of reasons. I remember the first time an insurance agent came to me to sell me some additional coverage. He said something very interesting. He developed a whole plan for me, and it was a plan which built to a substantial sum of money in case of death, and when I didn't say "This is beyond reason," he noted that the reason that he was in my house, that he could be there to sell me this supplementary coverage, was because Social Security provided the base. That is, he said to me, "If I had had to come in here without Social Security and a Survivors' Benefits to try and convince you to buy as much insurance as you need, you would have thrown me out. You couldn't afford it. It is because Social Security provides the base, provides the base on survivors' benefits, provides the base on retirement benefits, that on that base people can build private pensions and so on." They are able to build because they have the foundation.

I think people understand that, and over time, many more will understand it, because many more have entered into the system.

We must now have in many of our universities in the country children who are there because of the survivors' benefits. I think the public knows that. It is automatic. It is deducted. It is handled by an agency that has not been touched by scandal. It is an agency that has, I don't know how many hundreds or thousands of offices in local communities. This is the one agency, I think, that people can relate to.

I had occasion to make any number of phone calls to Social Security when my father retired, on a complex question. I always got a quick response and a very helpful and meaningful response.

When I expressed some astonishment at this to friends, they said, "But that is always true with SSA."

So I happen to be a fan, and I do start with that bias, but it is a bias that comes out of some experience with the system. It is a bias that comes out of the fact that I believe its research and statistics division is superb. It has done tremendous things in the interest of

understanding the system, and all of this contributes to an efficient mechanism.

Senator KENNEDY. And is competent to run the financing mechanism suggested in S. 3?

Mr. FEIN. There is no question. They went from how many zero insured people the day before medicare went into effect, to almost 20 million the next day.

It was overnight. I don't know that there is any other Government or private organization that could have undertaken that task as quickly as the Social Security Administration did it.

Senator KENNEDY. Let me just finally clear up one area of questioning. In earlier responses you talked about the importance and the significance of HMOs in terms of cost control, and you also referred to the advantages that have been built into S. 3 in terms of the development of this type of institution. Then you mentioned in response to some questions how insurance companies as a financing mechanism eschew any kind of significant cost control.

You have these parallel approaches within the administration's program. Would you agree that they are in conflict with each other? What do you see as their relationship over a period of time?

How is it going to function on work? How do you respond to this suggestion?

Dr. FEIN. Cost controls that HMO's can provide are many, but even under the administration's program the majority of the U.S. population would not avail themselves of care through HMO. They would have commercial insurance carriers writing policies and going, as they now do, to providers who will not face cost restraints.

There is some evidence on the inability of commercial insurers to contain costs. Many parts of the commercial health insurance sector have been losing money on their health insurance policies. As a totality, they have been losing money. I think the figure was something on the order of \$400 million in 1969.

I don't know any incentive in the American system on which we place greater reliance than the profit motive. That is to say, if these companies are losing money, that ought to be a tremendous incentive for them to do something about cost control. Even with that incentive, they have not succeeded. We will provide them less incentive, and I see no reason for this to succeed then.

Senator MONDALE. Why wouldn't a private carrier in this field seek to encourage cost reductions in order to become a profitmaking business?

Dr. FEIN. I think the problem is how does he do it. That he would like to do it, I am sure, but how does he do it in relation to the individual provider of services, in relation to the traditions in the hospital industry, in relation to the traditions of overutilization of some services and underutilization of others?

He has no handle on the field. It is not a matter of ill will, it is a matter of something bigger. He is part of a system.

As I said before, they are nice guys.

Senator KENNEDY. I want to thank you very much, Professor Fein, for your extremely helpful and valuable statements. I want to thank you for your appearance before the subcommittee.

(The prepared statement of Dr. Fein follows:)

Statement of
Professor Rashi Fein
Center for Community Health
and Medical Care
Harvard University

-Before the
Subcommittee on Health
U.S. Senate Labor and Public
Welfare Committee

February 23, 1971

My name is Rashi Fein. I am Professor of the Economics of Medicine at Harvard School of Medicine and a member of the faculty of the John Fitzgerald Kennedy School of Government. Recognizing that some confusion may be engendered because I am on the faculty of a medical school, it is perhaps useful to note that I am an economist-- not a physician.

I am pleased to have been asked to testify on the matters before you. I should like to offer some comments on the health crisis facing this nation and to discuss some possible solutions.

I do not propose to dwell on the statistics with which you are all familiar. Though the data change from month to month and from hearing to hearing, their broad outline is clear and well known. In essence, the story that they tell us is that national health expenditures are rising sharply. From fiscal 1960 to fiscal 1970, total health expenditures rose from \$26 billion to \$67 billion. As a percentage of Gross National Product (G.N.P.), they increased from 5.3 to 7.0 percent.

In part, these increases are accounted for by population growth. In part, they are accounted for by an increase in services for Americans. In large measure, however, the increases represent inflationary factors. While inflation has, particularly in the last few years, increased the prices of virtually all goods and services, the medical care sector has been among the hardest hit. There, regrettably, is little evidence that we have turned the corner on inflation in this sector. In the 12 month period ending December, 1970, the medical care consumer price index

rose by 7.4 percent, physicians' fees by 8.1 percent, and hospital daily service charges by 13.5 percent. The December and January rise in medical care, 0.7 and 0.6 percent, make it clear that the inflation problem continues. Unclear, of course, is where we are headed and what will happen to health expenditures in the years ahead.

We can derive little comfort from the projections of the future that have been published by the Office of Research and Statistics of the Social Security Administration. The Office's low estimate for 1975 is that national health expenditures will total \$111 billion (7.9 percent of G.N.P.). Its high estimate projection is for outlays of \$120 billion (8.6 percent of G.N.P.). For 1980 the low estimate is \$156 billion (8.0 percent of G.N.P.) and the high estimate is \$189 billion, representing 9.8 percent of G.N.P.; that is, almost one out of every \$10 in the American economy.

None of us, of course, should consider these projections as predictions of the future. They are based on assumptions that the Office has carefully stated. Thus, to the extent that the private and the public sector take actions to alter the assumptions, the projections of the future will change. Nonetheless, these projections are valuable. They are the best statement we have of what the future may look like if we do not take action. Let me stress the latter words, "if we do not take action." It should be clear that there are no inexorable laws of nature that suggest that the figures that I have cited must arise. In this, as in other sectors, we are to a significant extent masters of our fate. It is true that the future can only be altered to an extent that takes account of where we are today and how we got

here. The slate cannot be wiped clean. Yet, even so, there are wide limits to our actions and, therefore, wide limits to the level of health expenditures in 1975 and 1980. I should like, later in my statement, to return to this matter and to raise the possibility that the assumptions on which the HEW projections are made can, in fact, be altered if this Committee and the Congress of the United States choose to do so.

The dollars going into the health sector, valuable dollars, are an important issue. There are many ways to characterize the decade of the 1960's, a decade that began with high hopes and great dreams and ended with a measure of disillusionment and despair. Perhaps it is fair to call it the decade in which this nation had its rendezvous with reality. We became aware of many problems which had been with us in the past but which we had, to a significant extent, ignored or overlooked. We learned much about ourselves, about poverty, race, urban neglect. It is no longer acceptable to take these problems for granted, to "live with them." But solving problems requires resources--not rhetoric. Our resources, like that of every other nation, are limited. This is the reason that the financial crisis in the health sector is so very important. There are many things to be done in the United States, and if we are not getting full value for every dollar spent in a given sector of our economy, it means that we are wasting resources. Wasted dollars in the health sector, spiraling costs, gross inefficiencies prevent people from receiving the medical care they need. They also prevent our being able to apply the wasted dollars and wasted resources to other social problems the nation faces. Those, for example, who are concerned about education and housing, find themselves short of

funds in part because needed dollars are being diverted into wasted dollars in the health sector. They should be calling for a rationalization of the health care sector.

Inefficiency in the American economy, wherever it exists, means waste. It should be particularly unacceptable in a sector which represents a \$70 billion expenditure and 7 percent of Gross National Product.

Dollars are important, but they are not the only problem that the health sector faces. This nation spends a higher percentage of a higher per capita Gross National Product on health than do other nations; yet, there is no evidence that the average American is healthier as a result of this allocation of resources.

In general, we spend more dollars per person on health care, we have more doctors per person to deliver health services, we have more hospital beds per person, we have more research and personnel and facilities. What are we getting for these expenditures? The answer, at best, is unclear.

The problem, however, is not alone where we stand in comparison with other nations. Rural Americans, inner-city dwellers, persons who are medically indigent, Americans of almost any income who are concerned about medical care services and financing, are troubled not because they know that things can be better in other countries, but because they know that things can be better here. They have been told that medical care is right. Yet, today, many Americans find that the care is unavailable, and that if available they may be priced out of the market. The problem they see does not relate to how things are in other countries, perhaps not even to how things are for other Americans.

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Their frustration arises because they believed what they were told: that we had adopted a national policy that health care should not be rationed through the normal market mechanism in relation to income. But they discover that there is a gap between rhetoric and reality.

The problem, I believe, in part is one of financing. The fear of high expenditures, the decisions involved in seeking care as a function of income, the inadequacies of many voluntary health insurance policies, the fact the Medicare pays less than one-half of total medical costs of the elderly, the cutbacks in Medicaid eligibility requirements and services offered, the new "cost sharing" approach; all of these are part of the financial crisis. In part, however, the difficulty stems from the lack of availability of care, from its highly fragmented nature, from the difficulties that people have in entering the medical care system, from their frustration with the medical care marketplace and its organization. The problem, then, is not one of dollars alone. Financial protection would help, but it is not enough. The problem is not one of the delivery system alone. A more responsive delivery system would help, but it is not enough. In the former case, even with the dollar protection, some people would be unable to obtain care; in the latter case, even with a better distribution system, some people would be unable to pay for care. Those are the twin problems as seen by the consumer. From the perspective of government, there is yet a third problem. Government dollars are pouring into the health industry to purchase services for those who are eligible for coverage. Government has a responsibility to the taxpayers

and to other social programs to make certain that the dollars are spent wisely, that they do not reward inefficient producers, that they do not purchase expensive services when less expensive ones are sufficient, that the quality of care achieved is the highest consistent with that expenditure..

The health crisis, thus, has many dimensions. It must be attacked on many fronts. How are we to make medical services available to a greater proportion of the population? How are we to make it possible for them to buy these services? How, if public dollars are involved, are we to stimulate efficiency and economy in the production of these services, and how are we to do all this before expenditures get completely out of hand? Though the problems are interrelated, they can be discussed separately.

There are those who believe that the problem of efficiency and economy in the production of health services can be attacked through existing federal funding mechanisms. They argue that these programs already provide the federal government with substantial leverage. Our public discourse is replete with reference to new experiments, arrangements, regulations, amendments, all designed to develop and encourage "new methods of reimbursement" that will provide incentives to physicians, hospitals, and nursing homes to become more efficient.

But the fact of the matter is that, in spite of the words, the changes are few. In February 1967, in a report to the President, Secretary Gardner recommended the encouragement of group practice in order to use medical resources more efficiently. This January, four years later, the Council of Economic Advisors, in its report to the President says, "If more doctors were to practice in groups, where they

could take advantage of timesaving equipment and allied health personnel, their productivity could be increased." There are numerous other examples of recognition of the need for change, of calls for change. In this area we have not been averse to the use of "jawboning." But, I do not believe that in the health field it has proven particularly effective.

Part of our difficulty in translating words into action is related to the problem of leverage. Though the programs which we would hope to use to improve the organization and delivery of care loom large in the federal budget, they account for a small proportion of total health care expenditures. Furthermore, they are directed towards a solution of problems for special groups, often involving the most vulnerable in our society: The poor and the aged. Often the experiments are on the periphery of the medical care system. Often they lose their experimental flavor as they become service programs for people who have no other services available. Such experiments remain isolated from the mainstream of medicine. It may well be that if the federal government tried to use Medicare, Medicaid, and OEO programs as the lever to bring change, that the lever would break--that the most vulnerable would suffer as producers exhibited a lack of interest in offering services in new organizational structures.

The issue, therefore, is not really whether the federal government and state governments are doing as much as they can to effect change. The more basic question relates to the amount of impact that federal dollars can have, given the fact that only 23 percent of total personal health care expenditures in fiscal 1970 were federal dollars. Nor should we be misled even by this figure. Federal expenditures for

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health care are unequally distributed among the various sectors. In fiscal 1970, over half of all federal expenditures went for hospital care. Of the \$14.5 billion of federal expenditures for health services and supplies, only approximately \$2.7 billion went for professional services, accounting for about 15 percent of total expenditures for professional services. Eighty-five percent of the leverage lies elsewhere. Eighty percent lies in the private sector. Federal leverage exerted through existing programs may result in a cutback in services for the beneficiaries of those programs rather than in a restructuring of the health care system.

Piecemeal approaches to the problem of maldistribution are also insufficient. One can argue whether federally funded health centers established to provide health care resources to poor, rural and urban areas are the long-run solution to the maldistribution problem. It is clear, however, that in the immediate future such centers are fulfilling a vital need. Yet, in fiscal 1972, partnership for health centers, maternal and child health centers, and OEO centers will be serving only 2 million people. Does this represent leverage on the mainstream of medicine?

Nor are federal efforts in the financing of health care likely to solve the financial health problems of the population. Let me repeat the words in the special analysis for the budget for fiscal year 1972, "Legislation will be proposed that will extend cost-sharing arrangements with Medicare beneficiaries." Cost-sharing arrangements is a euphemism. It means that Medicare beneficiaries will be required to assume greater financial obligations. This will also be the case for

Medicaid recipients. I cannot help but digress for a moment to note that I am using the terminology that is always applied: Medicare beneficiaries and Medicaid recipients. There is a world of difference in philosophy between the words beneficiaries and recipients and, perhaps, the problem of financing is in no small measure encompassed in the contrast between these words.

All of us understand the need for tight restraint on growth of budgets. I submit, however, that the attempt to control budgets by transferring obligations from the public sector on to the aged and the poor is hardly consistent with the goals and objectives of the legislation when it was enacted. It misses a number of points. One: it is inequitable and represents a major withdrawal from commitments once made. Two: it is hardly likely that it would increase the federal leverage which is required if change is to come about. Three: it misses the point of decision making in the health sector for it presumes that it is the consumer who is making the decisions, when, in fact, most observers would agree that it is the physician who in large measure determines health care expenditures and utilization.

The difficulty with piecemeal legislation and piecemeal change is not that the individual pieces may not do some good for those people who receive the benefits. The difficulty is not that new proposed programs may not be better than the existing patchwork quilt. The difficulty, rather, is that less than a comprehensive approach is likely to entail more escalating costs, more frustration, more administrative chaos. The difficulty is that less than a comprehensive approach is not likely to alter the health care delivery system. The

difficulty is that less than a comprehensive approach may benefit some, may hurt others, but will further escalate the total costs beyond all reason.

Let us examine the assumptions made by the Department of Health, Education, and Welfare in projecting total health expenditures for 1975 and 1980. We do this since it is these assumptions that must be altered if the projections are not to become the reality. In my view, the critical ones are:

1: "The current public medical care programs will continue with no major change in scope and type of benefits or in persons served."

2: "Financing of health care services through public and private sources will remain at approximately the same relative proportions as in 1968."

3: "No major changes in the organization and delivery of health care services will take place by 1980."

4: "Medical care outside the hospital will continue to be provided primarily by solo practitioners."

I do not believe that a piecemeal approach is likely to invalidate these assumptions. But there is an alternative to piecemeal actions. I believe that alternative lies in a comprehensive national health insurance program. That is what is required. It is under such a program that the costs of medical care can be equitably shared. It is under such a program that front-end money and development funds can be supplied so that innovation can spread from one section of the country to another. It is under such a program that sufficient options can be created for consumers and producers so that maximum leverage can be

exerted through incentives.

The success of a national health insurance program will, of course, depend on what it encompasses, on how it is written, on the regulations that are drafted. As with any other program, the details matter. Let me, therefore, focus on a few basic considerations, considerations that should enter into the debate on the provision of health security for all Americans.

The first point that must be made is that we should not be frightened away from a program of national health insurance because the budgeted figures loom large. A national health insurance program, comprehensive in scope, covering the population, will involve a substantial increase in the federal budget. But, and I cannot make this point too strongly, it does not represent new dollar (indeed, if drawn correctly, total health expenditures would be less than they will be without NHI). The increase in the federal budget financed through an equitable tax mechanism is counterbalanced by a decrease in private expenditures for health care. The increase in the federal budget does not represent an increase in the percent of GNP going for health services; it represents a substitution of public dollars for private dollars. We will be spending the monies--HEW has said that. The question is how. This is a critical point. Our focus should be on total costs and on an equitable manner of sharing those costs.

Programs that masquerade as solutions cannot achieve that purpose if they are constructed in a way which leaves the major proportion of expenditures in the private sector. The purpose to be served requires a transfer to a more equitable financing pattern and that is not

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achieved by private regressive financing mechanisms.

We will be told, by opponents of National Health Insurance, that the federal expenditures under NHI will be many tens of billions of dollars. I would ask of those who cite such figures as the basis of their opposition, why they prefer that these tens of billions of dollars remain as private expenditures distributed in an inequitable fashion. That is the relevant question. It must be remembered that we are speaking about the public financing of services which are now financed in the private sector, that we are speaking of a transfer of funds, not of new dollars.

Furthermore, the costs of illness are not alone the budgeted dollars. The costs of illness involve pain, discomfort, disability. They involve a loss in production, a withdrawal from the labor force, a cost to all society. These indirect costs loom large. Some of them could be prevented by earlier diagnosis and by better treatment. It is not likely, however, that the individual who confronts a financial barrier will be able to receive that early diagnosis, that better treatment. All of society will, therefore, pay; will, therefore, lose--just as it would have lost had the financing of education been left in the private sector, had sons and daughters of poor parents been left illiterate.

A second basis consideration is that National Health Insurance must be structured in a manner that would be responsible and that would exercise restraints on rising expenditures, that would stimulate changes in the organization of the delivery system. The basic consideration, therefore, is whether the National Health Insurance program is merely a financing mechanism or is one which is designed to develop options and

to help in the restructuring of the health care delivery system. There is no question that S.3, Senator Kennedy's Bill to create a national system of health security, would accomplish these, and other, purposes. Let me be clear. Even a program whose major or sole thrust were on the financing side would be beneficial for many Americans. But it would fail to solve problems that cry for solution. It would fall short of meeting the responsibility to the taxpayer to spend dollars wisely. It would fall short to the extent that it did not develop mechanisms to stimulate efficiency. It would fall short if it behaved solely as a conduit, collecting dollars from the public and passing them on to providers. For too long a time the Department of Health, Education, and Welfare has been a mailing address receiving checks from the Treasury and readdressing the envelopes to state and city governments and to providers. It has a responsibility to make certain that the dollars are used efficiently. It must be given the authority to provide incentives, and it must have the resources to be imaginative in the development of incentive mechanisms. I do not underestimate the difficulty of this task. But one thing is clear: however difficult it may be to make more than a mailing address of HEW, it is surely easier than to make more than a mailing address of our existing health insurance carriers. Yet the administration's financing proposals, it seems to me, do just that.

Thus, in examining any proposed solution to our health crisis one should ask: if it is enacted, how will things look differently a decade hence, what is there in the financing proposal itself that would stimulate and lead to change? Financing and the system itself are, after all, inexorably linked. The program's financing mechanisms must be drawn to stimulate

the development of options and incentives, if the legislation is to accomplish that which is required. A traditional financing approach will maintain the traditional delivery system organization--and we need change.

A third basic consideration involves equity, equity both in health expenditures and in the collection of tax revenues. A national health insurance program should be financed in a manner which is as equitable as possible in relation to income. It must also be concerned with the distribution of total personal health expenditures. That total should be distributed as equitably as possible. Thus, the coverage must be comprehensive. Reliance on private financing mechanisms, on co-insurance, on deductibles, on cut-offs on services, on non income-related premiums is inconsistent with the achievement of equity. A \$300 deductible has a very different impact on a family that is at a \$6,000 income level and on a family at \$16,000 or \$26,000. What philosophy leads one to say that that is fair?

The temptation to extend co-insurance and deductible comes, in part, from the fact that it permits the government budget to look smaller. But making the government budget smaller, while making the private expenditures greater, does not save total costs. The temptation also arises because it is assumed that such "cost-sharing," for example, reduces hospitalization utilization. But this ignores the key role of the physician in determining utilization. The task is to develop incentives that help the physician in reaching responsible decision, that remove economic incentives for him to hospitalize the patient. This is a different issue than making it expensive for the consumer--including the consumer who needs to be in the hospital-- to purchase hospital care.

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Equity and financing, provision of incentives, development of new organizations; these are among the basic considerations. These are the axes on which suggested solutions to the health crisis should be assessed.

We will be told that it will be too expensive. Medical care is costly. The question is who shall bear the cost. A public program would be more equitable and less expensive than a collection of private programs trying (and failing) to do the job.

We will be told that we are not ready for the program, that we need to develop system change and additional resources before we embark on this endeavor. System change, however, cannot be brought about under existing financial arrangements, under existing or piecemeal programs.

We will be told that we should not allocate this much to health, that the country has other social priorities that are even more pressing. But how will other social programs find the resources if we fail to act. If we do not act now, health expenditures will approach \$200 billion by 1980. To permit this to happen is to be irresponsible.

We will be told that national health insurance is not necessary--that the crisis can be solved by a National Health Insurance Partnership involving a National Health Insurance Standards Act, a Family Health Insurance Plan, the retention of the current Medicaid Program, and changes in Medicare --all these in conjunction with the development of a National Health Service Corps, and so on. We will, in effect, be told that a comprehensive health policy can be built without a comprehensive financing mechanism. I do not believe that this is the case.

There is much to commend in the President's Health Message. It describes in dramatic fashion the crisis we face. It recognizes the need

to move on a number of fronts. No longer can it be argued that necessary action could or should be delayed till the latter half of the decade. Furthermore, the message offers a number of specific proposals that, I believe, should be supported by all concerned Americans. The emphasis on HMO's, on meeting needs in scarcity areas, on new kinds of support for medical education, on merging parts A & B of Medicare--these are among the proposals whose general thrust has considerable merit. In some areas we lack sufficient detail and in some the President has proposed insufficient funding, but more details can be developed and more funds can be appropriated. There is more to be done, but there is much that can be built upon.

Regrettably, however, the efficacy of the Administration's proposals on the supply side is greater than those offered on the financing side of the ledger. On the financing side we retain (indeed, expand) the categories and programs--and in what manner and to what purpose? Surely it is not our purpose to create an administrative nightmare--but the proposals would do so. Surely it is not our purpose to maintain inequities--but the proposals would do so. Surely it is not our purpose to make it disadvantageous for the employer to hire full-time workers and heads of households--but the proposals would do so. Surely it is not our purpose to leave millions of persons outside the various categories eligible for some coverage--but the proposals would do so. Surely it is not our purpose to place undue burdens on small or marginal employers or low-income persons--but the proposals would do so.

What we should be told, what we should recognize, is that pluralism in the delivery system--the creation of options that do not exist today--

is necessary. But we should also recognize that pluralism in providing a financial base means confusion and inequity. What we should recognize is the need for a national program not unlike the social security system. What we should recognize is the need to create universal coverage, not omitting some--and the most vulnerable--Americans. What we should recognize is that there are alternatives to the Administration's proposals on financing--alternatives based on progressive taxes, not on regressive mechanisms.

What we should recognize is the importance of linking an adequate, efficient, equitable financing mechanism with the delivery system in order to bring change.

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Senator KENNEDY. The subcommittee will stand in recess until Thursday morning at 9:30.

(Whereupon, at 12:30 p.m. the committee was recessed, to reconvene at 9:30 a.m., Thursday, February 25, 1971.)

