

NATIONAL HEALTH INSURANCE PROPOSALS

HEARINGS
BEFORE THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
NINETY-SECOND CONGRESS
FIRST SESSION
ON THE
SUBJECT OF NATIONAL HEALTH INSURANCE
PROPOSALS

OCTOBER 19, 20, 26, 27, 28, 29; NOVEMBER 1, 2, 3, 4, 5, 8, 9, 10,
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NATIONAL HEALTH INSURANCE PROPOSALS

WEDNESDAY, NOVEMBER 17, 1971

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Al Ullman presiding.

Mr. ULLMAN. The committee will be in order.

Our first witness this morning is Dr. Victor W. Sidel.

Doctor, if you would further identify yourself and your colleague for the record we would be pleased to recognize you.

STATEMENT OF DR. VICTOR W. SIDEL, CHAIRMAN, PHYSICIANS FORUM; ACCOMPANIED BY DR. BERNARD D. CHALLENGOR, CHAIRMAN-ELECT

Dr. SIDEL. Thank you, Mr. Chairman.

My colleague is Dr. Bernard Challenor who is the chairman-elect of the Physicians Forum and who is also the assistant dean of the Columbia University College of Physicians and Surgeons.

Mr. ULLMAN. We are happy to have you here too, Doctor.

Dr. CHALLENGOR. Thank you.

Dr. SIDEL. My name is Dr. Victor Sidel. I am the chairman of Physicians Forum, on whose behalf I testify. I am also chief of the Department of Social Medicine, Montefiore Hospital and Medical Center, and professor of community health, Albert Einstein College of Medicine.

Mr. ULLMAN. Thank you, you are recognized.

Dr. SIDEL. If we may have your permission to have our testimony plus the accompanying material describing the forum's proposals put into the record I could briefly summarize it and, save time for questions.

Mr. ULLMAN. We would appreciate that.

Without objection the full statement and the supplemental materials will be in the record.

(The statement and supplementals referred to follow :)

STATEMENT OF DR. VICTOR W. SIDEL, CHAIRMAN, PHYSICIANS FORUM

My name is Victor W. Sidel, M.D.; I am the Chairman of the Physicians Forum, on whose behalf I testify. I am also Chairman of the Department of Social Medicine, Montefiore Hospital and Medical Center, and Professor of Community Health, Albert Einstein College of Medicine; I have written numerous articles on health insurance, Medicare, and related topics. I am accompanied today by Bernard D. Challenor, M.D., Chairman-elect of Physicians Forum and

also Assistant Dean of the Columbia University College of Physicians and Surgeons.

The Physicians Forum is a national organization of physicians which has for more than 30 years fought for the principle that good medical care is a fundamental right—not merely a privilege—for everyone in the United States. In carrying on this battle, the Forum has supported every major proposal for a strong and comprehensive national health insurance system: we supported the Wagner-Murray-Dingell Bill in the late 1940's; the Forand Bill in the 1950's; and we were the first physicians' organization to come out in favor of the King-Anderson Bill, which formed the basis of the Medicare portion of Public Law 89-97 passed in 1965.

Since that time, the Forum has repeatedly called for extension and improvement of national health insurance in the United States as part of a restructuring of our national health care system. It may be of interest to the Committee to be reminded that the American Medical Association does not represent the views of all American physicians; that many physicians believe that a strong national health insurance program is needed to improve health care; and that many are therefore eager to work within the framework of such a program.

It is the Forum's position that the purpose of a national health insurance program is not simply to pay the nation's medical bills but rather to reform its anachronistic, fragmented, dehumanizing, and therefore relatively ineffective medical care system. In 1971, the Forum still believes—as it has for 30 years—that what is needed is a thorough overhaul of medical care delivery in the United States rather than half-hearted and misguided attempts at patching only a few of its obvious defects. In fact, as the long-term results of certain portions of P.L. 89-97 has demonstrated, patching some of the financing defects without changing the delivery system may serve only to magnify its other defects.

For this reason, the Forum has prepared a statement of principles for a National Health System, which in restructuring medical care in the United States goes far beyond any of the legislation which your Committee is now considering. Our proposal, a copy of which is attached to this testimony for inclusion in the record—with your permission, Mr. Chairman—calls for:

Adequate distribution of facilities and personnel in kind and number so that patient care services are based on demonstrated health needs;

Creation of local and regional community-controlled health boards with responsibility for the provision of all personal and environmental health facilities and services;

Practice by personal physicians and other health workers on a salaried basis in groups which are based in neighborhood health centers;

Peer and consumer review of quality of care provided and continuing education for health workers of all types;

Obligatory service for physicians, nurses, and other health workers—who should not have to pay personally for their training—in rural and poverty areas and other areas of medical need;

Payment for all personal health care through and equitably financed national health care fund, to be a mandated trust fund so constituted as to remove it effectively from dependence on annual appropriations by Congress; and

Establishment of a National Department of Health with full Cabinet rank.

Of the current proposals which are being discussed by this Committee, those such as the AMA's Mediredit proposal (S. 987 and H.R. 4960), the HIAA's Health Care proposal (H.R. 4349), and the Catastrophic Health Insurance Plan (S. 1376) introduced by Senator Long are totally unacceptable to the Forum because these plans basically provide only financing mechanisms which in the main leave virtually untouched the problems of bureaucracy, inefficiency, added expense, and private gain in the health insurance industry. More important, these plans propose no significant changes in the current health care system.

The Nixon Administration proposal, the National Health Insurance Partnership Act (S. 1623 and H.R. 7741), is also unacceptable to the Forum for similar reasons. Additionally, this proposal perpetuates and institutionalizes a two-class system of medical care—a system which has produced the current glaring inequities in health care between the advantaged and disadvantaged patients in our country. It would further institutionalize the indignities of “means-test medicine” and would force the poor to attempt to pay large co-insurance expenditures. Also, the Act would establish new programs on top of old and proliferate the problems which we now have. The Act does make reference to Health Maintenance Organizations, but these are defined so generally and may take such a variety of forms (including the creation or continuation of groups run for profit by entrepreneurs) that the Act—in the Forum’s view—is inadequate for the support of the nonprofit, salaried, pre-paid, group-practice medicine which is needed in the United States.

Of all the plans currently under consideration, the one which comes the closest to meeting the Forum’s criteria is the Health Security Act (S. 3 and H.R. 22-23) introduced by Senator Kennedy and Representative Griffiths from plans drafted by the Committee of 100 and by the AFL-CIO. However, even this proposal falls short of addressing in an effective manner many critical deficiencies in our present system:

(1) Although the Act attempts some restructuring of the health care system, its recommendations are far too limited and too slow in their approach; the Forum believes that the restructuring required is much more extensive and should be accomplished at a more rapid rate.

(2) A number of medical services are limited and many dental services are not covered by the Act; in the Forum’s view all such services should be covered.

(3) While some provision has been made for consumer participation in advisory bodies, the word “consumer” is not appropriately defined and adequate mechanisms for consumers to exercise local control over the policies of health care institutions are lacking. In addition, decision-making appears to be highly-centralized in a 5-member board appointed by the President, with little provision for appropriate decentralization of policy-making.

(4) The taxation system proposed is regressive. For example, there is a \$15,000 ceiling beyond which income will not be taxed for the support of the plan; this means that those with the lowest income will carry a disproportionate share of the burden for its support. The taxation is also in part based on the “social security” tax principle rather than on a progressive income tax. The Forum believes that taxation should be steeply progressive, with elimination of loopholes in the current income tax structure for the wealthy and with correspondingly less or no taxes to be paid by the poor. The Act also does not totally remove the financing from Congressional appropriations, making it subject to destructive fluctuations in support and to political uncertainties and pressures.

(5) Finally, while the Act appropriately seeks to discourage fee-for-service practice—which the Forum believes is an important barrier to rationalization of our health care system and reduction of costs—the Act is relatively ineffective in that it does not seek rapidly to eliminate or substantially curb such practice.

On the positive side, the Health Security Act does eliminate co-insurance and deductibles, it seeks some fundamental changes in the nation’s health care system rather than simply providing payment mechanisms, and, as a recent HEW study showed, it will add a relatively small amount to the nation’s total health care bill—an especially small amount in relation to the additional services which will be provided. Therefore the Physicians Forum supports the Health Security Act as the legislation closest to our view that is politically feasible at the present time, but urges that it be amended to provide for the correction of the deficits that we have described. With these changes the Act would be more effective; but even without them the Act will at least start us on the road toward meeting the urgent need for restructuring the American medical care system so as to provide optimal health care for our people.

A National Health System

Proposed by



THE PHYSICIANS FORUM, INC.

510 Madison Avenue, New York, N.Y. 10022 • (212) MU 8-3290

The American health care system is failing. Medical care is a commodity to be bought rather than a right for all. The poor are ignored or offered charity; care for other groups is deteriorating. Physicians concentrate in affluent neighborhoods and have largely abandoned rural and ghetto areas. Other health workers receive meager wages and scant respect. A fragmented, institution-dominated system of care is unresponsive to the community and is pervaded with racial, economic and sex discrimination. The war machine is well fed but public health, hospitals, medical education and medical research are starved relative to increasing needs. For the world's most affluent and technologically advanced nation, our health indices are a disgrace.

The American people need and deserve a society that guarantees the right of all to health.

I A HEALTHY LIFE FOR ALL

The physical and mental health of the American people is dependent on the social and economic health of the nation. We recognize that ultimately the health problems of our country can be effectively attacked only with a fundamental restructuring of our society from the present private-profit, special-interest oriented system to one which is structured primarily for the social welfare of all its people.

We therefore propose:

- The eradication of racism from all phases of American society.
- A guaranteed income, set at a level high enough to eliminate poverty.
- The abolition of hunger and malnutrition, a national disgrace in this most affluent country.
- The planned reconstruction and transformation of our decaying cities to provide better housing which is intelligently deployed in relation to educational, recreational, transportation and employment facilities.
- Opportunities for education and vocational development, available to all, with adequate opportunity for advancement commensurate with ability and achievement.

2 A HEALTHFUL ENVIRONMENT

The industrialization, mechanization and commercialization of our country have produced hazards of grave concern to our health and well-being. Among the by-products is pollution of our physical and social environments. The federal and local governments have abdicated their responsibility; corporate interest has replaced the public welfare.

We therefore propose:

- *Rigid enforcement of existing air-pollution codes and establishment of new ones where needed, with penalties of sufficient magnitude to discourage chronic offenders.*
- *Crash research programs to produce non-pollutant engines and other technological innovations to reduce pollution.*
- *Immediate promulgation and strict enforcement of the highest safety standards for the automobile industry and strict enforcement of laws aimed at the prevention of highway accidents.*
- *Establishment of plants capable of treating and converting solid wastes.*
- *Strict control of industrial wastes and hazards with the cost borne by industry.*
- *Establishment of a national consumer code with strong laws protecting the people by insuring truth in advertising, packaging and labeling of foods and drugs.*
- *Renunciation of nuclear, biological, chemical and all weapons of mass destruction; disavowal of war with its intolerable psychological and physical toll on others as well as ourselves.*

3 THE NATIONAL HEALTH CARE SYSTEM

Lack of organization and coordination of the several aspects of health care makes it impossible for people to receive adequate care. Services have been established which meet the needs of professionals, not patients. Until our health resources are appropriately structured and placed under consumer control, they will continue to fail to meet the needs of patients. The following proposals establish the foundation of a new system designed to solve the national health care crisis.

Manpower

Current methods of training health care personnel cannot begin to provide the manpower to meet the nation's immediate needs. Our country is confronted with a health manpower crisis that requires emergency measures now.

We therefore propose:

- *A massive increase in enrollment and training programs in the health professions based on the immediate expansion of existing medical, dental and nursing schools and other facilities, as well as creation of new training resources. Large scale federal financing is needed for both new and expanded facilities and training programs.*
- *Elimination of economic barriers to education and training programs through federal financial support for schools and students.*
- *Creation of new health careers, unrestricted by outmoded requirements, with special emphasis on recruitment of personnel from those sections of the population that have been excluded from the health field because of economic and racial discrimination.*

- *A large increase in the number of physicians and other health care personnel, sufficient to provide adequate services for all, including people in rural and poverty areas.*
- *The use of allied personnel to assume many of the tasks currently performed by physicians. These personnel would function as members of the health care team.*
- *Development of an adequate salary structure for all health workers so that health personnel will not be exploited by institutions or practitioners. The right to unionize should be established for all health workers.*
- *Elimination of separate state licensure requirements and establishment of national criteria for all health workers.*

Facilities and Services

The availability and distribution of health care facilities and services are inadequate in type, quantity and scope, and they do not begin to meet even the most urgent health needs of the nation. Our hospitals and medical centers are being used inappropriately; their services are provided on the basis of ability to pay or the ~~personal interests~~ and convenience of the professionals.

We therefore propose:

- *Creation of local and regional community-controlled health boards with responsibility for the provision of all personal and environmental health facilities and services. Each board should have its members selected by the actual consumers of health services in the area.*
- *Distribution of facilities in kind and number so that patient services are based on health needs. The types of facilities and services should include educational and preventive services, screening programs, neighborhood health centers, acute and chronic hospitals, organized home care, rehabilitation services, skilled nursing homes and all other services required to provide comprehensive care.*
- *Creation of regional networks of health facilities and services, including medical schools, hospitals, neighborhood health centers and other health services, in order to make the full range of services available to all people in the region regardless of where they live. These networks are to be under the direction of the regional community-controlled health boards.*
- *Encouragement of diversity and experimentation with new and different methods of providing care.*
- *Abolition of discrimination because of economic status, color, sex, religion or political affiliation in all facilities and services.*

Health Workers and Health Care

To assure effective and high quality personal health services, we propose:

- *Practice by personal physicians and other health workers in groups which are based in neighborhood health centers.*
- *Payment of physicians, as well as other health workers, by annual salaries commensurate with training, experience and ability.*
- *Peer and consumer review of the quality of care provided and ongoing educational experiences for all health workers, including full time postgraduate education without loss of salary.*
- *Creation of clear avenues of advancement-career ladders—for all health workers.*
- *Obligatory service for specified time periods by physicians, nurses and other health workers in rural, poverty and other deprived communities.*

Financing of Health Services

Our present method of payment for personal health services precludes adequate health care for the people of the United States and supports the two classes of medical care which currently exist. Prevention is not encouraged. Too few incentives for better care exist. Inefficient systems are supported and rewarded.

We therefore propose:

- *Establishment of a national health care fund to pay for all personal health care, including preventive, curative, and rehabilitative services. This is to be a mandated trust fund, so constituted as to remove it effectively from annual appropriations by Congress. It is to be financed by a progressive income tax surcharge for health.*
- *Distribution from the trust fund of all funds for personal health services to be made to the regional and local community-controlled health boards on a per capita basis.*
- *Funding through general tax funds for environmental health services, medical research, health education and construction of health facilities.*
- *Establishment of a national Department of Health with Cabinet status, which would be responsible for the administration of all health services, personal and environmental. The Department of Health is to consult regularly on basic policies with a National Health Board composed of representatives from the regional community-controlled health boards.*

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Dr. SIDEL. Thank you.

To review our testimony briefly, the Physicians Forum is an organization of physicians which has been in existence for some 30 years. One of its major points of emphasis over the 30 years has been working for significant national health insurance legislation in the United States.

The forum supported the Wagner-Murray-Dingell bill in the late forties, the Forand bill in the fifties, was the first physicians' organization to come out in favor of the King-Anderson bill, and since the passing of the Medicare Act has continued to press for new and expanded health insurance legislation.

The forum is very concerned that what may come out of these hearings is simply a bill for the financing of medical care. We believe very strongly that far more than that is needed. We need not simply reform of financing but reform of the Nation's health care system.

In our written statement we have reviewed those principles which we feel to be important in a national health care system for the United States. These include: Adequate distribution of facilities and personnel; creation of local and community controlled health boards; practice by personal physicians and other health workers on a salary basis in groups which are based in neighborhood health centers; peer and consumer review of quality of care provided; obligatory service for physicians, nurses, and other health workers in areas of manpower shortage; and payment for all personal health care through an equitably financed national health care fund.

Turning to the specific bills which your committee is considering, we feel that such bills as the AMA's medicredit proposal, the HIAA's health care proposal or the catastrophic health care plan introduced by Senator Long are totally inadequate to meet the needs.

We feel that the administration's proposal would simply perpetuate the two-class system of medical care in the United States and institutionalize "means-test medicine." We feel that "health maintenance organizations" are so vaguely defined in the administration bill as to be almost meaningless, the concept would apparently include groups run for profit by entrepreneurs, which we find unacceptable.

The bills which come closest to the forum's view, on the other hand, are the Kennedy-Griffiths proposals. We feel, however, that they fall short and have emphasized five points which we would like to see strengthened. These include the restructuring of medical care; the provisions for consumer participation, which we believe not strong enough; the limitations on medical and dental services; and the regressive tax system.

However, the Health Security Act does eliminate coinsurance and deductibles, it seeks some fundamental changes in the Nation's health care system rather than simply providing payment mechanisms, and, as a recent HEW study showed, it will add a relatively small amount to the Nation's total health care bill—an especially small amount in relation to the additional services which will be provided.

Therefore, the Physicians Forum supports the Health Security Act as the legislation closest to our view that is politically feasible at the present time, but urges that it be amended to provide for the correction of the deficits that we have described. With these changes, the act would be more effective; but even without them, the act will at least start us on the road toward meeting the urgent need for restruc-

turing the American medical care system so as to provide optimal health care for our people.

Mr. ULLMAN. Does that conclude your testimony?

Dr. SIDEL. Yes; it does.

Mr. ULLMAN. We would be happy to hear from you, Doctor.

**STATEMENT OF DR. BERNARD D. CHALLENGOR, CHAIRMAN-ELECT,
PHYSICIANS FORUM**

Dr. CHALLENGOR. I would just add to the testimony already given that the Kennedy-Griffiths proposals, although not mandating an all-inclusive health system, could well serve as a significant step forward toward achieving an equitable and effective national health care program.

We view with special favor the provision of equal access and equal benefit entitlement for all residents in the country.

Also, we recognize the potential in the proposal for creating a central administrative health agency, with the potential again of linking and coordinating many existing Federal programs, in addition to setting national standards for the providers of health services.

I would say that it is the Physicians Forum's view that this bill can well provide—particularly with the recommendations the forum has made—incentives for and encouragement of major improvements in the organization and delivery of health care.

Mr. ULLMAN. Thank you very much. We remember the testimony that your organization gave during our consideration of medicare, and it was very helpful.

Are there questions?

Mr. PETTIS. Mr. Chairman.

Mr. ULLMAN. Mr. Pettis.

Mr. PETTIS. Thank you, Mr. Chairman.

I have just quickly looked through the testimony, and there may be something in this testimony on the subject, but in case there is not, I ask this question. If there is, maybe you would reiterate your answer. We have had a great deal of testimony to the effect that one of our major problems in this country is maldistribution of physicians and possibly an undersupply of physicians and paramedical personnel.

Have you any advice to give this committee on how we would solve that problem? I think most of your testimony bears in another direction.

Dr. SIDEL. My view is that we are only going to be able to solve this problem by creating a national health system for the United States. Experiments limited to patching of the financial structure have not in the past served to redistribute our physician resources and is not likely to do so in the future.

By a national health system we mean a program in which there are institutions such as neighborhood health centers, rural centers, hospital referral systems, and others set up so as to meet the needs of each area in an organized and structured fashion rather than in a haphazard fashion. Such institutions could attract and hold personnel.

Mr. PETTIS. What are you going to do in these areas where you don't have personnel? In many of the rural areas of this country, what you

talk about is impossible unless you by some mechanism put people or facilities into those areas. How would you do that?

Dr. SIDEL. In a number of ways. First, by selectively recruiting into medical school, students who live in those areas. They might have a better chance—not 100 percent, to be sure—but a better chance of returning to practice in areas with which they are familiar and in which they are comfortable.

Second, by selectively recruiting students of low socioeconomic status. At present, 20 percent of American medical students are drawn from the top 2 percent of the families in the United States by income, and only 9 percent are drawn from the bottom 25 percent.

If we totally changed our pattern of admitting students to medical schools and other schools of health professions, we might find many more doctors and other types of health personnel who are willing to work in these areas.

Third, there must be a structure in which the personnel can work. For example, the National Health Service Corps is apparently finding it possible to recruit physicians to work in underdoctored areas. They can do this because they have a structured situation in which physicians can be assigned to a given area and work in appropriate facilities with the support of the communities in which they work.

Finally, such personnel must be appropriately rewarded, both by salary and by relief from other obligations, such as service in the National Health Service Corp. substituting for military service.

I think there are great possibilities for recruiting personnel to work in these areas. It is just that we have never tried them.

Mr. PERRIS. Do you think this would work in ghettos as well as the sparsely settled parts of our country?

Dr. SIDEL. We hope so. We are currently applying to the National Health Service Corps to have the South Bronx designated as an area of critical health manpower shortage and to have U.S. Public Health Service personnel assigned. We have gathered the data, which demonstrate the incredible shortage of health manpower in that area. We hope the National Service Corps will recognize the South Bronx as an area of shortage and will assign U.S. Public Health Service personnel—doctors, dentists, nurses, and others—into the area.

Mr. PERRIS. All of this failing, would you go so far as to advocate some kind of a draft system to provide personnel in these areas?

Dr. SIDEL. I think we can stop one step short of that by providing—as we have not provided before—the incentives and structure that will bring physicians into these areas.

The Physicians Forum has recommended that there be no tuition for students of the health professions and that students, indeed, be paid a stipend during their period of training. In return for the free education and stipend there should be a period—say 3 years—in which the graduate will be expected to work in an assigned area. After that experience, many may choose to stay.

I don't know whether you would call that a "draft." In our view it certainly seems worth trying.

Mr. PERRIS. If those students go to the area for 3 years the chances are very good, at least looking at the history of medical practice in the United States, that they will stay only that period and then move on to areas where they can get residencies or improve their training situ-

ation. Unless you have some mechanism beyond that then I think you have really scuttled your program because you have then left these areas to the kind of a practitioner that is not the best practitioner in terms of experience and all the rest since he is always going to be a young fellow just out of medical school or somebody similarly prepared. Is this not true?

Dr. CHALLENGOR. I would just underline what we view as the very crying need to recruit more widely and provide adequate financing for physicians from the inner-city areas; they are underrepresented now in the Nation's medical schools. In answer to your specific question, I don't know if we have adequate experience to really say that if they were better represented if they would not practice on a longer range basis in the community from which they came.

Mr. PETTIS. You believe that if we took in more of the young people from the lower socioeconomic levels that they would have more of a tendency to stay in those areas than today's graduates?

Dr. CHALLENGOR. I think this certainly is a step that we must take. In addition, however, the matter of stipends that Dr. Sidel has mentioned has not, to our knowledge, been tried—certainly not on a widespread basis. This could well be an additional incentive, in addition to programs such as the National Health Service Corps.

Dr. SIDEL. There is no guarantee that every person recruited from the lower socioeconomic groups of society is going to remain in such areas to practice. Many will almost certainly move out, but it is in our view somewhat more likely that a student who has been raised in a rural area would be more comfortable practicing in such an area and that those who were raised in areas of poverty might be more likely to be willing to work in and to help others living in these areas. It would be worth trying because, as you have pointed out, we have not yet found any other solution to the problem.

With regard to your question whether personnel will stay in the area, we believe they must be provided with a structure to permit them to stay there, with a form of medical care system which is comfortable for them, with referral back-up facilities and with appropriate salary arrangements.

Again, there is no guarantee that such techniques will work. But there is every evidence that the current system isn't working.

Mr. ULLMAN. Are there further questions?

If not, Dr. Sidel and Dr. Challenor we appreciate your appearance here very much.

Dr. SIDEL. Thank you.

Mr. ULLMAN. Our next witness is Dr. Walter J. Morrison.

Dr. MORRISON, if you would further identify yourself for the record, we would be very happy to recognize you.

STATEMENT OF WALTER J. MORRISON, PH. D., CHAIRMAN, PHYSICAL HEALTH COMMITTEE, ARKANSAS COMPREHENSIVE HEALTH PLANNING

SUMMARY

It is becoming increasingly difficult, if not impossible, for any single source to assume the responsibility for the provision of cost containing health services. The electronic data processing system developed to maintain records which will satisfy a variety of administrative needs also provides the potential for identify-

ing unique preventive health services which particular individuals need but have not received. Therefore, health insurance programs should be designed in a manner which enables not only the provision of cost containing preventive health care services but also such medical histories as might be needed by beneficiaries and medical practitioners under a variety of conditions.

Any health insurance program should provide for a balanced utilization review rather than one with a limited objective of cost containment. Short-run cost containment objectives could be detrimental to long-run cost containment objectives. Additionally, this need is sufficient to warrant a clear statement of congressional concern for balanced utilization review efforts.

In order to reduce program costs and/or improve program cost-benefit ratios, health insurance programs should include the provision of outpatient prescription medication.

DR. MORRISON. I am Dr. Walter J. Morrison, chairman, Department of Pharmacy Administration, University of Arkansas School of Pharmacy; vice chairman, Section of Teachers of Pharmacy Administration, American Association of Colleges of Pharmacy Conference of Teachers; delegate, National Pharmacy Insurance Council; member, board of directors, Arkansas Health Systems Foundation, Arkansas Family Planning Council, and Arkansas Pharmaceutical Association.

I appear this morning on behalf of the Office of Arkansas Comprehensive Health Planning which I serve as a member of Governor Bumper's advisory council and its executive committee as well as chairman of its physical health committee.

MR. ULLMAN. Dr. Morrison, I am sure that the chairman regrets that he is not in town this morning to greet you here.

DR. MORRISON. We know that Chairman Mills has a very demanding schedule and can certainly understand his inability to be here today. We appreciate this opportunity to appear before this committee in its investigations on national health insurance.

HEALTH INSURANCE PROGRAMS SHOULD ENABLE THE PROVISION OF COST CONTAINING PREVENTIVE HEALTH CARE SERVICES

It is becoming increasingly difficult, if not impossible, for any single source to assume the responsibility for providing comprehensive, adequate, or even minimal preventive health care services. A mobile society with rather desultory health care demands (for example, the selection of multiple health care providers), ignorance, faulty memories, and the burdens of medical practitioners are examples of items which are partially responsible for this situation.

Generally, there is a fragmentation and discontinuity of care which practically precludes records which would enable practitioners to assume the responsibility of providing individualized preventive health care; and for reasons which include those previously mentioned, consumers cannot be expected to assume this responsibility. We need not and should not accept this deplorable situation because any public and/or private health insurance program could include a component which would enable and perhaps insist on the provision and receipt of individualized preventive health care.

Even though public and private health insurance programs should provide for freedom of choice among health care providers, those records required for individualized preventive health care could and should be maintained by that local administrative agency, fiscal inter-

mediary, or carrier serving as the single source for the payment for services provided beneficiaries.

The electronic data processing system developed to maintain records which will enable the payment of claims, utilization review, and the satisfaction of other administrative needs also provides the potential for identifying unique preventive health care services which particular individuals need but have not received.

One approach to the accomplishment of a general objective of providing for individualized preventive health care which would enable the delivery of essential health services and encourage the use of those preventive and health maintenance services that reduce the probability of serious illness, the necessity of inpatient procedures and prolonged hospitalization is:

1. Define preventive health care via the preparation of preventive health care service profiles. The profiles should be based upon the medically recognized needs of beneficiaries as indicated by age, sex, race, personal and family medical histories.

At the time these profiles are prepared, priorities based upon known or estimated cost-benefit ratios should be established. Available resources might preclude the provision of each of the recommended services, and priorities would facilitate adjustments based upon existing, but fluctuating, resources. Once the various profiles have been developed, a single, branching, comprehensive profile can be prepared.

2. After the preparation of the comprehensive profile, it can be incorporated into the electronic data processing system developed for the particular health insurance program. Forms for notification of needs and claims, including deductibles, can be prepared. These forms could enable a check mark response to indicate those preventive health services provided.

The resulting records can be compared periodically, perhaps on the birthdays of the respective beneficiaries, to the comprehensive profile. New needs, if any, can be indicated and the respective beneficiaries and/or providers can be notified of these existing needs.

3. Use the comprehensive profile in health education efforts.

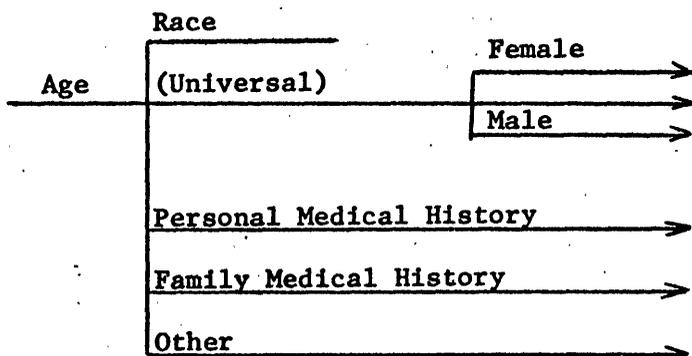
Many, if not most, of the services to satisfy the preceding needs could be deferred until a condition stimulated beneficiaries to seek the services of medical practitioners. But, for efficiency and economy, this information needs to be available to physicians (1) in a practical form which will enable rapid review and decision, and (2) at a time when he can use it, specifically when the patient is in his office or is confined.

It should be noted that such records would enable the preparation of two basic types of medical histories, one suitable for beneficiaries and another for medical practitioners. The former should include such basic information as hypersensitivities, blood type, the date services were received, the nature of the services provided, the name and address of practitioners providing such services and such other information as the need for same indicates. A more definitive history should be made available to practitioners from whom services are sought.

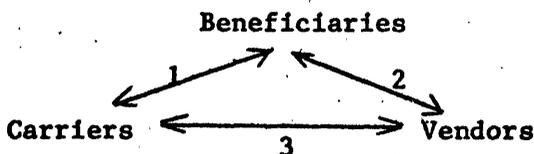
Another classification of medical histories could be based upon confidentiality considerations. A history should be available to cover emergency events. This history would contain noncontroversial information which is essential to optimum care in emergency situations.

Examples of such information would include severe hypersensitivities, immunizations and blood type. A definitive history containing items which could be regarded as very confidential should be available to those physicians whose services have been sought for personal care.

Although vicarious experience indicates that examples of programs employing procedures such as the preceding exist, we are not prepared to present the particulars of a practical preventive health care program which would meet the needs of beneficiaries, practitioners and the sponsors of such insurance programs as might be developed. However, a short schema for a proposed program might resemble the following:



1. PROFILE



2. RELATIONSHIPS

Under profile, age serves as the universal factor from which other factors, as indicated, branch. The profile enables selective screening as well as indicating other preventive health care procedures.

Under relationships, the triangle indicates: (1) Customary contact and communication between carriers and beneficiaries regarding program information and health services received, as well as notification of indicated preventive health care needs.

(2) Customary contact and communication between physicians and patients, who would be prepared to (a) provide answers to the routine questions in new relationships, (b) update records in established relationships, and (c) indicate those preventive health care services which might, in the discretion of the physician, be indicated.

(3) Customary contact and communication between carriers and providers as well as the availability of more definitive information when the need for same is indicated by providers.

**HEALTH INSURANCE PROGRAMS SHOULD INCLUDE A BALANCED UTILIZATION
REVIEW**

Any health care system should provide for utilization review, which includes any organized activity which analyzes the records reflecting the health care provided patients. The general objective of utilization review would be to insure the provision of appropriate services (1) of the best quality, (2) in the optimum quantity, (3) at the most effective time, and (4) at a reasonable cost for the condition being treated. Obviously, the degree to which this general objective could be accomplished would be limited by existing knowledge and resources.

This subject is being brought to your attention because of an experience during a conference on "Computer-Based Information System in the Practice of Pharmacy," which was sponsored by and held at the University of North Carolina School of Pharmacy on July 19-20, 1971.

During a workshop session addressed by Mr. Joseph A. Higgins and Mr. Riley J. Jeansonne, both of whom either are or have been associated with the Social Security Administration, I received a distinct impression that future Federal utilization review efforts would tend to be limited to cost containment because this was the only area in which congressional concern had been expressed.

I would like to think that I misunderstood these gentlemen or that they have misunderstood congressional concerns and intent. But, if not, I implore you to investigate utilization review as a component in any insurance program.

I am confident that such an investigation would lead to a recognition that (1) the general objective of utilization review efforts, as previously mentioned, cannot be accomplished if shortrun-cost containment is the sole objective of such efforts; (2) shortrun-cost containment efforts can be detrimental to longrun-cost containment objectives; and (3) the need for balanced utilization review programs warrants a clear statement of congressional concern regarding same.

For example, underutilization might lead to shortrun-cost containment but longrun and undefined increases in program costs. Underutilization can result in unnecessary and inexcusable longrun losses in both dollars and lives.

**HEALTH INSURANCE PROGRAMS SHOULD INCLUDE THE PROVISION OF OUT-
PATIENT PRESCRIPTION MEDICATION**

The failure to include the provision of out-patient prescription medication (1) in our title XVIII program, and (2) as a component of the minimal service requirements in our title XIX program perhaps represent examples of a concern which is limited to cost containment.

Does it make sense to pay a physician for an office visit if medication is not available to alleviate or eliminate the diagnosed disorder?

When the average annual medication needs of beneficiaries will cost less than the daily hospital cost, does it make sense to hospitalize patients in order to provide desperately needed medication or, at a later date, attempt to rectify a condition which could have been prevented by prescription medication?

Restrictions on the alternative services available to a physician limit his ability to provide for his patients' needs in a least cost manner. We don't believe we can afford these restrictions; therefore, we believe any health insurance program should include the provision of out-patient prescription medication. This belief also is shared by the National Pharmacy Insurance Council, the faculty of the University of Arkansas School of Pharmacy, and the Arkansas Pharmaceutical Association.

On behalf of the Office of Comprehensive Health Planning and Governor Bumper's advisory council, we appreciate the consideration provided by this distinguished committee.

Mr. ULLMAN. Dr. Morrison, without objection the drawings and supplemental material will be included in the record.

(The material referred to follows:)

AN ORGANIZED APPROACH TOWARD THE PROVISION OF PREVENTIVE HEALTH CARE SERVICES TO TITLE XIX BENEFICIARIES¹

Although it would appear that any health care system should include the provision of preventive care, it is becoming increasingly difficult, if not impossible, for any source to assume the responsibility for providing "comprehensive" or even "minimum" preventive health care services. A mobile society with rather desultory health care demands (e.g., the selection of multiple providers), faulty memories, ignorance, and the burdens of practitioners are partially responsible for this situation. Generally, there is a fragmentation and discontinuity of care which practically precludes records which would enable individualized preventive health care. The Arkansas Medicaid Program offers the potential for overcoming this particular problem for its beneficiaries.

The Arkansas Medicaid Program does provide for freedom of choice among vendors of health care; but, an administrative agency, Medical Services Division, Arkansas Social and Rehabilitation Services Department serves as a single source for payment for services provided. Therefore, the electronic data processing system developed to maintain records which will enable the payment of claims, utilization review, and the satisfaction of other administrative needs also provides the potential for identifying unique preventive health care services which particular individuals need but have not received. One approach to the accomplishment of this general objective is as follows:

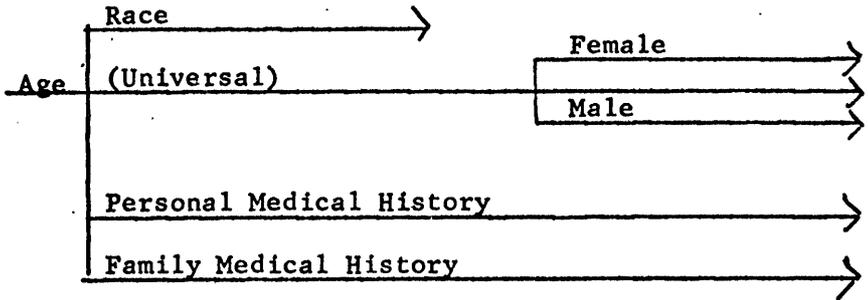
1. Define "minimum" preventive health care services via the preparation of "minimum" preventive health care service profiles. The profiles should be based upon the medically recognized needs of beneficiaries as indicated by age, sex, etc.

At the time these profiles are prepared, priorities based upon known or estimated cost-benefit ratios should be established. Available resources might preclude the provisions of each of the recommended services, and priorities would facilitate adjustments based upon existing, but fluctuating, resources. Once the profiles have been developed a single, branching, collective profile can be prepared.

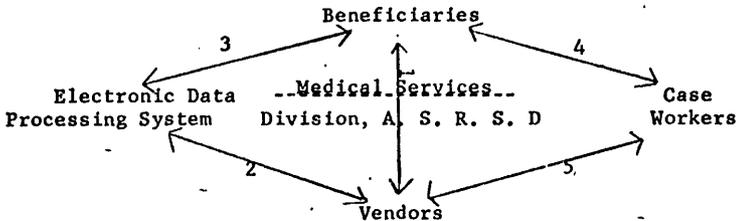
2. After the preparation of the single profile, it can be incorporated into the electronic data processing system developed for the Arkansas Medicaid Program. Forms for notification of needs and claims can be prepared which enable a check-mark response to indicate those preventive health services provided. The resulting health records periodically can be compared to the preventive health care profile. New needs can be indicated and the beneficiaries, case workers, and/or providers notified of the existing needs.

At this time, the particulars of a practical program and the resulting relationships which would meet the needs of beneficiaries, medical practitioners, and the administrative agency have not been developed. However, a short schema for the proposed program might resemble the following:

¹ Walter J. Morrison, Ph. D., Chairman, Physical Health Committee, Office of Arkansas Comprehensive Health Planning, University Tower Building, Little Rock, Arkansas.



1. PROGRAM



1. Customary contact between patient and physician.
2. Information regarding the medical history of the patient.
3. & 4. Program information and assistance in securing services.
5. Assistance as needed in developing the program at the local level.

2. RELATIONSHIP

Mr. ULLMAN. Are there questions?

You have been exceedingly helpful.

This committee is quite concerned about the proper procedure for preventive care. You have given us some guidelines that I think will be helpful to us.

Dr. MORRISON. Mr. Chairman, would you entertain some extemporaneous remarks in regard to the question Mr. Pettis asked of the previous speaker?

Mr. ULLMAN. We would be happy to.

Dr. MORRISON. It was in regard to the availability of manpower in rural areas.

We recently had a conference on physician's assistants in Arkansas and one of our speakers was Dr. Edward Alexander of Newport News, Va.

One of the programs that he has been in the process of developing includes the provision of a health care team for rural communities.

In addition to providing a team, the program would provide backup services in the form of information and, more importantly, relief for extended vacations as well as for continuing education purposes.

Mr. PETTIS. Mr. Chairman.

Mr. ULLMAN. Mr. Pettis.

Mr. PERRIS. What you say has worked in some areas if you can get people to consider these rural areas as "a mission field" because this is exactly what they do in other parts of the world where there is a great need.

They give the doctors and nurses and other paramedical people a furlough every so often so that they can come home and recharge their batteries.

We haven't devised any plan yet that will work in this country for those rural areas or ghetto areas that will keep people in the area.

Dr. MORRISON. Although I don't know exactly how far along he is with the development of his program, Dr. Alexander did indicate that he expected it to be functioning next year. You might want to note his progress.

Mr. ULLMAN. Thank you again, Dr. Morrison.

Dr. MORRISON. Thank you, sir.

Mr. ULLMAN. Our next witness is Mr. Cyril F. Brickfield.

If you would further identify yourself and your colleagues for the record we would be happy to recognize you.

**STATEMENT OF CYRIL F. BRICKFIELD, LEGISLATIVE COUNSEL,
AMERICAN ASSOCIATION OF RETIRED PERSONS AND NATIONAL
RETIRED TEACHERS ASSOCIATION; ACCOMPANIED BY ROBERT F.
SYKES, LEGISLATIVE REPRESENTATIVE; AND PROF. ELI COHEN,
UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE**

SUMMARY

Conclusions and Recommendations:

1. The health care needs of the elderly in America have not been met by Medicare and/or Medicaid. Their out-of-pocket expenditures for health care are twice those of the non-elderly population, while their median income is half that of the non-elderly population.

2. The Associations agree that the medical care system requires major reform.

3. The Associations support utilization of the health insurance organization (HMO) device for furnishing comprehensive care on a prepaid basis.

4. The Associations support the basic mechanism outlined in H.R. 7741 (Representative John W. Byrnes), providing a choice for the individual of either direct contract with an HMO or contract through an insurance underwriter.

5. The Associations oppose the benefit structure laid out in H.R. 7741 on the basis that it excludes the elderly, and because of the inclusion of deductibles, co-insurance, and cut-off periods.

6. The Associations propose a benefit structure which closely parallels the benefits structure of the Health Security Act proposal embodied in H.R. 10521 introduced by Representative Martha W. Griffiths.

7. Recognizing that the costs implicit in this benefit structure might require a reordering of National priorities in order to implement it, the Associations recommend that if the total population cannot be covered *ab initio*, the program benefits should be extended to all persons aged 62 and over with implementation for the remainder of the population at some subsequent date.

8. The Associations recommend a contributory insurance program for persons in the labor force. For others, they recommend the option of selecting an HMO or insurance underwriter of their choice; for the elderly, payment of premiums should be made directly by the Social Security Administration, to the third-party payer or the HMO as is appropriate.

9. The Associations firmly support the development of the HMO and the steps necessary to be taken through planning grants, loan guarantees, and changes in insurance regulation to bring about full development of the HMO:

Mr. BRICKFIELD. Thank you, Mr. Chairman.

My name is Cyril Brickfield. I am legislative counsel for the National Retired Teachers Association and the American Association of Retired Persons.

These two organizations have a membership of 3,300,000 and most of our members are 65 years of age and older. We are principally interested in the health care needs of the elderly insofar as these hearings are concerned.

I am accompanied, Mr. Ullman, by Prof. Eli Cohen of the University of Pennsylvania Medical School and by my associate, Mr. Robert Sykes.

I have two documents here, Mr. Chairman. One is a position paper which was developed for us at the University of Pennsylvania which I would request be made part of the record of these hearings.

Mr. ULLMAN. Without objection it will be a part of the record.
(The position paper referred to follows:)

POSITION PAPER ON NATIONAL HEALTH INSURANCE

NATIONAL RETIRED TEACHERS ASSOCIATION AND AMERICAN ASSOCIATION OF RETIRED PERSONS

FOREWORD AND SUMMARY

Congress and the Nation are preparing to act on a matter of overriding concern to the American people: A National Health Plan which would provide comprehensive health care for all of our Nation's citizens. Our Associations, representing that segment of the population most urgently in need of an adequate health maintenance system, are gratified that health care is now being given top consideration. We wish to make certain, however, that any final plan adequately meets the health care needs of the older segment of our population and not just the younger and middle age groups.

Our Associations, with the aid of health economists from the University of Pennsylvania, have prepared the following position paper presenting our views in detail. To facilitate its reading, there is set forth below a summary of our position. It is based, primarily, on an evaluation of two major bills pending in the U.S. Congress.

The two bills are (1) President Nixon's "Partnership for Health" and (2) Senator Kennedy's "Health Security Act." We have evaluated each bill or plan from the standpoint of the needs of older Americans, principally in the area of health care benefits and the delivery systems through which these benefits are received. Both guarantee the availability of comprehensive, quality health care. However, major differences exist between these two bills.

In the vital area of health care benefits, we prefer Senator Kennedy's plan, as it provides the broadest benefits for all Americans, including older persons. It would provide comprehensive health care, including prevention and disease-detection services, care and treatment of illness, long-term care, and medical rehabilitation for all, regardless of age or ability to pay. We support this approach, viewing quality health care as the right of every American. However, we realize that immediate implementation of the Kennedy plan in full would be so costly that it could only be achieved through a sweeping reordering of national priorities, which we fear unlikely.

The Nixon plan, in this same area of health care benefits, is totally lacking in provision for—in fact, discriminates against—those individuals 65 and over. Its benefits for the elderly are based on a modified Medicare/Medicaid system requiring older persons to pay 60% or more of their medical costs while the younger workers would pay only 25% of their health care premiums. In other words, those with the greatest needs and the most limited means, would be the least favored under this proposal.

The Associations take the position that it is economically feasible to implement the Kennedy benefit and financial provisions for the elderly segment of the population, the group most urgently in need of such coverage. For the younger population the Nixon plan would achieve significant progress at a cost that would be more acceptable at this time.

In the area of the delivery of health services, we prefer President Nixon's proposal, encouraging as it does the development of Health Maintenance Organizations (HMO's)—professional groups organized to provide comprehensive medical care. While both plans provide for HMO's the President's proposal, giving the individual a freedom of choice in selecting his HMO, encourages competition, so essential to high standards of health care. It also provides inducements to improve equally essential social services.

To sum up, we enthusiastically endorse the adoption of a comprehensive National Health Plan which combines the health care benefits for the elderly set forth in the Kennedy bill and the delivery of services system as recommended in the Nixon proposal.

INTRODUCTION

For almost a quarter of a century, the debate on a National health plan has ebbed and flowed, waxed and waned, surfacing from time to time in legislative debates, political campaigns, and in a variety of legislative enactments including Kerr-Mills, Title 18 (Medicare), and Title 19 of the Social Security Act. Nineteen seventy brought the introduction of a series of major legislative proposals for National health insurance and other types of assistance to cover the costs of medical care. In February of this year, the President sent to the Congress a major message relative to building a National health strategy. It now appears that the Nation is prepared to take a comprehensive view of the problems of delivering and financing health care as well as the associated problems of health, manpower, and research.

The American Association of Retired Persons and the National Retired Teachers Association applaud this recognition by the executive and legislative branches. Our experience with the elderly tells us that health programs are essential for all. We want the *best* program for all Americans. As spokesman for 3 million older Americans, we are deeply concerned with provisions of any health care program for the elderly.

Our basic position is that any health proposal must take into account the substantial out-of-pocket outlay that older people now make at a time when their income is apt to be fixed or diminished and their health care requirements increased.

Older Americans regard the issues of enough money to live on and securing the right kind of medical care at the right time in order to maintain health as their two most pressing problems. As they view the problems of securing medical care, they are confronted with a paradox: on the one hand, the United States has gone further than virtually any other country in terms of technological development and the availability of complex medical procedures; but, on the other hand, they know better than almost any segment of the population that the situation is critical in terms of delivering adequate medical care to older persons at a price they can afford or alternately at a price paid by government.

The supply of medical care is not uniformly available. Those who have sufficient resources to pay for care on a fee-for-service basis and who live in major urban communities have available to them one system of care. Those who have insufficient resources and who live at a distance from or who cannot travel to the urban communities do not have a system of care available and accessible. The rapid pace of rising costs of medical care is placing more elderly people into the "have not" category, the development of Medicare and some of the benefits of Medicaid notwithstanding.

In 1965, when Medicare legislation was passed, it was assumed that elderly people would be relieved of the bulk of their medical care cost burdens. However, the facts hold to the contrary:

Item: Elderly persons still carry one-third of their total medical expenditures in the aggregate.

Item: Elderly persons' total personal health care expenditures were \$791/yr. as compared to \$280/yr. for those under 65. (1970)

Item: Elderly persons out-of-pocket-outlay was \$228 compared to \$100 for those under 65.

Item: Median income for the elderly is half the median income for those under 65.

The rapid escalation in costs of medical care have hit the elderly no less than the general population, Medicare and Medicaid notwithstanding.

The National Advisory Commission on Health Manpower in its 1967 Report came to the conclusion that what was required was not merely more medical personnel but an overall structural change:

Unless we improve the system through which health care is provided, care will continue to become less satisfactory even though there are massive increases in costs and in numbers of health personnel.

Without citing the now familiar statistics about the distance the United States lags behind many other countries in life expectancy in general, in the mortality rates for middle-age males and infants, and the failure of life expectancy to increase significantly in almost a generation, it is safe to say that the present medical care system is inadequate to meet demands made upon it.

The elderly in particular have been hit hard by the general inflation. When added to the general increases in the cost of living, the still more rapidly rising cost of health care and the inability of the elderly who are on fixed incomes and who are among the most deprived population in the Country have emphasized the present inadequacies. By 1970, personal health expenditures¹ for every man, woman, and child in the United States reached \$280 per year. Those costs were rising at a rate exceeding 10% annually. As noted above, annual personal health care expenditures for the elderly population were \$791. The elderly are only too well aware that medical costs have been rising at a faster rate than virtually any other component of the price index. Since 1959 Doctor's fees rose at twice the rate of the consumer price index, while hospital charges soared at five times the rate. A better educated population has demanded more and more care and higher quality care. The system has been placed under severe pressure. While more and more people are covered by one form or another of some kind of health insurance, the fact of the matter is that the rise in the cost of health care is outpacing the budget increases of too many families. If this is true for the general population, it is, in spite of Medicare, especially true for the elderly.

The problem is complex. Demand has increased. The number of physicians is inadequate to meet the demand. While there has been a slight increase in the ratio of physicians to population since 1950, fewer physicians are directly engaged in patient care. Specialization has drawn a larger proportion of physicians out of the primary care role. Even if we could arrange for a rapid increase in the supply of practicing physicians, the demand would not be met. For the elderly, the problem is compounded by their increasing disadvantage economically in the competition for medical attention. By and large, the elderly are on fixed incomes, and the inflation of 6% or more per year places them in a disadvantageous position.

The inadequacies of the health care system—inadequate funding, maldistribution of service, insufficient personnel, inappropriate delivery systems, inattention to prevention—all converge on the aging population.

I. THE AARP-NARPA POSITION

The Associations are in agreement with the fundamental proposition reflected in virtually all major plans receiving attention in the current and most recent past sessions of the Congress: the medical care system requires substantial and major revision. These revisions will cover such categories as the benefits to be received by the user, the manner of delivery through which medical services are to be rendered, the quality of those services and care and financing of such a system.

The two plans receiving the major attention currently are the Partnership for Health Plan proposed by President Nixon and the Health Security Act sponsored by Senator Edward Kennedy. The Associations in developing their own position have evaluated these two plans on the basis of the benefits they would provide to the older person and the systems they propose for the delivery of health services.

While the Nixon plan holds the promise of many benefits for those under retirement age, we have found it totally lacking in provision for—in fact, discriminatory against—the individual 65 and over. In addition it omits provision for catastrophic illness for older people, perhaps the most feared eventuality for all persons. This plan also calls for the younger worker to pay only 25% of his health care premiums, while the older person would continue to be required

¹ Personal health expenditures exclude expenditures for health facilities construction, public health education expenditures, administrative expenditures not related directly to personal health care.

to pay 60% or more of his health costs. In other words, those with the greatest needs and the most limited means would be the least favored under this proposal.

The Kennedy bill, on the other hand, of all the proposals set forward to date, contains the broadest benefits for all Americans including those who have reached retirement age. It would provide comprehensive health care, including prevention and disease-detection services, care and treatment of illness, long-term care, and medical rehabilitation for all, regardless of age or ability to pay. We support this approach, viewing quality health care as the right of every American. However, we realize that immediate implementation of the Kennedy plan in full would be so costly that it could only be achieved through a sweeping reordering of national priorities, which we fear unlikely. It would be possible, though, to implement its provisions for the group most urgently in need of such coverage, namely those receiving Social Security. For those under Social Security age, the Nixon plan would achieve significant progress at a cost that would probably be more acceptable at this time.

On the vital subject of delivery of health care services, both the President's proposal and the Kennedy bill encourage health maintenance organizations (HMO's)—professional groups organized to provide comprehensive medical care on an on-going basis to the individual who holds a prepaid contract with the group. Numerous studies have shown that HMO's are cost-efficient and afford greater control of the quality of health care provided. In addition, they have the virtue of a built-in incentive to keep the patient well, not to just treat him when he is ill.

The President's proposal, in our view, makes great progress in the area of health care delivery, allowing the individual freedom of choice in selecting his source of medical assistance. This permits competition in the field, which is essential to the maintenance of high standards of health care, and would also serve as an inducement to the improvement of equally essential social services.

In essence, the Associations vigorously support the concept of a national health plan, but must reject any proposal which fails to meet the urgent needs of older people. We would enthusiastically endorse a plan which includes the comprehensive care benefits for the elderly contained in the Kennedy bill and the delivery of services system recommended in the Nixon proposal.

ELIGIBILITY FOR BENEFITS

The Associations support the proposition that a national health insurance program should extend its benefits to all residents of the United States, all non-resident citizens of the United States during the time such non-residents are in this country, as well as aliens admitted as permanent residents and living in the U.S. or admitted for employment in the U.S.

Eligibility for coverage must be all-inclusive. All persons meeting the U.S. residence tests and/or non-resident citizen tests shall be eligible regardless of Social Security beneficiary status or regardless of income or assets held. This means that there will be no requirement of past individual contributions as under the Social Security Old Age and Survivors Disability Insurance Program or any means test as under Medicaid.

BENEFIT STRUCTURE

The following represent the benefit structure proposed by the Associations:

1. *Physician services*

Physician services must include primary medical services furnished by physicians whether general practitioners or specialists, and specialized services furnished by appropriate specialists, including major surgery. No limitation is imposed upon the degree and scope of services furnished by physicians except as noted below. Physicians services should be available on a medical need basis, in and out of institutions, hospitals, long-term care facilities, or any other place. Psychiatric service to outpatients should be covered in any situation where an active, preventive, diagnostic, therapeutic, or rehabilitative service with respect to emotional or mental disorder is present and where service is furnished by a prepaid group insurance program, a hospital, a community mental health center, or a community mental health clinic furnishing comprehensive services, or a day care service approved by the administrative agency. Psychiatric services

furnished by an individual psychiatrist in solo practice would be limited to 20 consultations during a specified time. Unlimited psychiatric service might be provided through hospital or community mental health center programs.

2. Inpatient and Outpatient Services

Inpatient and outpatient services of general or psychiatric hospitals, skilled nursing homes, and home health services agencies should be provided on an unlimited basis depending upon medical need, except as noted below. Coverage includes all services generally provided in an institution including pathology and radiology service, laboratory service, physical therapy services, and any other necessary services.

With reference to long-term care, any health insurance program must ultimately move toward providing coverage on an unlimited basis for both skilled nursing home care and intermediate care. Long-term care is potentially the most expensive service, overall, that many older people will utilize. It is typically a service for which public community resources do not exist except in a diminishing number of county facilities. It represents a service which may be required for many many years; indeed for many patients it represents the terminal living arrangement. The Associations recognize, however, unlimited durational benefits at this time may be unrealistic in the absence of adequate standards, criteria for establishing medical and social need for long-term care, methods of patient assessment, effective utilization review, uniform accounting methodology and appropriate systems of reimbursement. Reimbursement systems must not produce incentives to keep people ill or disabled, and disincentives for rehabilitation (as is the case in many point count systems used for reimbursement under Medicaid).

Furthermore, introducing unlimited benefits at this time might have the effect of "locking in" some of the most unreasonable aspects present in long-term care. Accordingly, the Associations recommend that skilled nursing home care be provided for a period of 120 days during a year (or during a benefit period if such is established) with provision for extension of such duration under certain circumstances, as follows: extended duration should be provided in skilled nursing homes owned and operated by and as part of general hospitals or skilled nursing homes related to general hospitals in some other way (as for example through affiliation agreements), where it is clear that the nursing home is an aid to prevention of overutilization of hospital beds while at the same time provision is made for appropriate utilization of the nursing home. However, the issue of underwriting the costs of long-term care cannot be evaded indefinitely. We recommend, therefore, that full underwriting of costs of long-term care be available not later than 1976. During the next three years we recommend that the Social Security Administration, the Social and Rehabilitation Service, the Department of Housing and Urban Development, and the Department of Labor undertake a major study, linking for the first time the issues of quality of care, delivery mechanisms, financing of operations and construction, and manpower, with the objective of producing a comprehensive plan for making long-term care readily and appropriately available to all who require it.

The Association would limit coverage of psychiatric inpatient care to a similar period of 120 days provided that the patient is receiving active treatment for an emotional or mental disorder. We believe, however, that in the case of public institutions for the mentally ill where the vast bulk of psychiatric service for the elderly is provided, that the present financial support furnished through Title 19 by virtue of the so-called Long Amendments should not be withdrawn. To do so would wreak havoc on state mental hospital systems. However, the Associations recognize that there has been widespread abuse in making claims for patients under this particular part of the Title 19 Program. Accordingly, while we urge continued financial support for the states, we support it only where there is strict enforcement of the requirement that there be active treatment for emotional and mental disorders. Furthermore, we would support a position requiring specific staffing standards and specific program elements to be imposed by the Federal government as a condition for continued receipt of such funds. In the absence of strict enforcement of comprehensive regulations for elderly patients in state mental hospitals, we would urge the removal of the financial support currently given through the Medicaid Program. As noted above, payments in behalf of any patient in an institutional setting would be conditioned on continued medical need as certified by a physician and would cease

in any circumstance where medical need ceased or where a Utilization Review Committee found that further stay in the facility was not a medical necessity.

3. Dental Services

The Associations recognize the difficulties in initiating full coverage for dental services at the outset of the Program. If, however, the Health Insurance Program is initiated as we suggest for elderly people only, we would recommend full coverage for all elderly persons including preventive services, diagnostic services, and therapeutic services including restorative service such as provision of dentures and adjustment of dentures.

The Associations recognize, however, that achievement of this kind of coverage will be difficult if a general national program for all persons is enacted. In such an instance projected inordinate demands on dental personnel may require a priority phasing which furnishes full coverage to young children at the outset of the Program inasmuch as early preventive, diagnostic, and therapeutic work can have a demonstrable lifetime impact. In this instance, however, we would urge that no later than seven years after the effective date of the Act, that the administrative agency handling the Program establish a method whereby full dental services can be extended to the elderly.

4. Other Professional and Supportive Services

(a) Professional services of optometrists for eye examinations.

(b) Professional services of podiatrists for care of the feet.

(c) Diagnostic services of independent pathology laboratories, and diagnostic and therapeutic radiology furnished through independent radiology services.

(d) Day care services for patients receiving treatment for mental or emotional disorders where such day care is prescribed and under the supervision of a psychiatrist. Day care services, however, should be limited to 60 days except in such instances where the administrative agency may find that duration beyond 60 days but limited to some other period may be required to reestablish the individual on an independent footing.

(e) Ambulance and other emergency transportation and non-emergency transportation services essential to securing access to covered medical services. In addition to the above, supportive services such as psychological, physiotherapy, nutrition, social work, or health education services should be covered services when they are included as part of the institutional services furnished, or are a part of a Comprehensive Prepaid Health Insurance Program furnished by a Health Maintenance Organization (HMO) or Comprehensive Health Service Organization (CHSO).

5. Therapeutic Devices, Prostheses, Appliances and Devices.

Benefits should include a specific list of therapeutic devices, appliances, and equipment including eyeglasses, hearing aids, prosthetic appliances including walake cane, crutches, wheel chairs, braces, special orthopedic shoes, a hospital bed in the home, and so on when such are prescribed by a physician or order by a physician in order to maintain and restore health, or maintain or restore employability or self-management. The Associations recognize the potentials for abuse in such a benefit provision and would urge the development of appropriate regulations and controls to avoid such abuse.

6. Drugs

The Associations urge the inclusion of all prescription drugs as a benefit under a National Health Insurance Program. They recognize, however, the difficulties in maintaining controls, assuring reasonable utilization, and avoidance of runaway costs. Accordingly, we recommend coverage of drugs on the following basis at this time:

(a) Drugs furnished through hospital inpatient or outpatient departments.

(b) Drugs furnished in skilled nursing homes to patients receiving benefits while in a skilled nursing home.

(c) Drugs furnished through pharmacies operated by comprehensive Health Service Organizations or Health Maintenance Organizations.

(d) Drugs furnished for specified chronic diseases and conditions for which drug therapy because of duration and cost commonly imposes substantial financial hardship. The Associations recognize the necessity to establish limits at the outset on any drug benefit program. It would urge that rather than start with a broad list of diseases and conditions, that the list initially be one in which experience can be gained through observation and analysis of a limited

number of cases where conditions and requirements for drugs are relatively clear.

Administrative Methodology

Our constituency of 3 million elderly persons is comprised, almost entirely, of retired persons. We recognize significant differences in payment mechanisms in arranging health insurance for those in and those out of the labor force.

For those who are employed, we recommend a contributory insurance program. Employers would be required to make available a basic health care plan to employees and members of their families who have been employed for a minimum of 25 hours a week in 10 out of 13 weeks or 350 hours in 13 weeks. Employers would be required to furnish such a plan through a contract with a health maintenance organization or comprehensive health service organization,³ or through and for protection of the self-employed individuals.

a contract with an insurance carrier underwriting an employer-sponsored plan. For the self-employed small employers and certain other persons, insurance companies would be required to develop group policies for use by such employers

For unemployed persons, the poor and the elderly, individuals would have the option of selecting a Health Maintenance Organization or an insurance underwriter of their choice. For the employed, the payments would be made directly by the employer. The system of financing the Program in such plans would provide for contributions by the employee in an amount not to exceed 25% of the cost of the plan (35% during the first 2 years following passage of the legislation).

The self-employed would purchase contracts directly from HMO's or insurance underwriters.

For the elderly who are not employed it is proposed that the payment of premiums be made directly by the Social Security Administration to the third-party payer, or the HMO according to the election of the elderly person. Inasmuch as the benefit structure calls for no deductibles, no co-insurance, no cut-off dates, and no payments of any kind except for those services where benefits are limited in duration, numbers of visits, etc., it is contemplated that no devices are necessary to establish eligibility except an initial finding of age attainment. It is anticipated that this eligibility would be established through the Social Security office in the same manner as Old Age Insurance benefits are claimed currently.

For the unemployed under 62, however, it would be necessary to establish a Program to determine unemployment status and eligibility for payment to the fund (assuming one is established for a National Health Insurance Program) by a new Federal Medicaid Program.

The position of the Associations is that any National Health Insurance Program is to be Federally administered with uniform standards for eligibility throughout the United States. Furthermore, the Associations maintain the position that eligibility be established on the basis of an affidavit. In the same fashion that eligibility for Social Security benefits relies primarily on a retirement test, similarly it is recommended that the eligibility for assumption of payments for medical coverage by the Federal government be conditioned solely on unemployed status.

The above pattern of administration would result in the abolition of the Medicaid Program as we know it today. States would no longer be involved in the Medicaid Program either financially or administratively. The Medicaid Program would give way to a system of financing by the Federal government utilizing the HMO, or third-party payer on a more comprehensive scale than currently exists.

Because we firmly believe in the development of the HMO, the Associations support the requirement of utilizing the HMO option under public or private health insurance. Furthermore, we believe that this support should be implemented through planning grants to public and private potential HMO sponsors. In addition, we believe that loan guarantee programs must be established to finance initial capital and start-up costs for HMO's. Because of the importance to the development of HMO's generally, we support provision of supplemental grants to teaching hospitals to establish HMO's. Finally, it will be necessary to

³ These terms are synonymous. "Health maintenance organization" is the term used in the Administration proposal, while "comprehensive health service organization" is the term in the Kennedy bill. In the remainder of the paper, the term HMO, will be utilized as a convenience.

establish by law, Federal preemption of authority to regulate health insurance in order to override state legal barriers against development of the HMO.

Administration of the Program would take place through the Department of Health, Education and Welfare. It is anticipated that the Social Security Administration mechanisms would be employed. It is further anticipated that appropriate boards would be established to promulgate regulations, develop standards for utilization for methods of establishing costs, regulation of health insurance carriers and HMO's, and advising the Secretary generally on the administration of the Program.

Financing—Methods and Rates of Reimbursement

For the elderly, it is recommended that payments be made through the Social Security Trust Fund to whatever new fund is created for payments to HMO's. Ultimately, individuals might accumulate credits throughout their working lives to finance health services in retirement much as Medicare is financed today. For services provided to the elderly who have made no contribution and have never developed any credits of any kind, it is recommended that payment for these be covered by a contribution to the Social Security Trust Fund from general revenues; that is, it would be necessary to make a general revenue appropriation to cover costs not covered by collections under the new Program. To some extent this would be covered by current appropriations made to Medicaid which accrue to the benefit of elderly persons now. It is assumed that funds now included in the Health Insurance Trust Fund would be transferred to the new fund.

Payments to HMO's or third-party payers who organize a network of services or purchase from a HMO would be made directly by the Federal government or employers, as the case might be. All payments would be on a capitation basis for a year or portion of a year as regulations may determine. HMO's as well as third-party payers would be free to determine rates of payment to actual purveyors of service. Rates of payment, however, would have to be such as to assume the availability of service to the patient. It is contemplated that HMO's as well as third-party payers would assume risks for the costs of care which fact serves as an incentive toward efficient delivery mechanisms and efficient mixes of service.

Impact on Medicaid and Medicare

As noted above, so far as the elderly are concerned the position of the Associations is that Medicaid as a Federal-State Program would be abolished. The only remnant of Medicaid that would exist would be a Federalized Eligibility Determination Program for those who are unemployed and who are not elderly according to this definition. Medicare would be replaced by the new Program of purchase of comprehensive care from third-party payers or directly with HMO's.

II. SPECIAL CONSIDERATIONS ABOUT THE NEEDS OF THE ELDERLY IN NATIONAL HEALTH INSURANCE PROGRAMS

Consideration of the special needs of the elderly in developing a national health insurance program must spring from the economics of aging, the higher incidence of illness and chronicity, the problems of mobility, and special concerns about long-term care.

Elaine Brody in a comprehensive article on aging prepared for the 1971 edition of *The Encyclopedia of Social Work* points out, "By any measure the aged are the most economically deprived of any group. Almost $\frac{1}{4}$ have incomes below the poverty level and as many as an additional 15% may be on the borderline." She goes on to say that on the average the median income of people age 65 and over is less than $\frac{1}{2}$ the median income of those below 65. For many elderly people, poverty is a status achieved in old age. The problems are particularly acute for older persons living alone or with non-relatives. Indeed, in 1966 the median income for that group was \$1,443 per year. Mrs. Brody indicates that, "Illness and disability rates rise sharply with advancing age, as do hospital utilization and number of physician visits." This becomes particularly important when one considers that approximately $\frac{1}{3}$ of the elderly are between 75 and 84 and 6%, or more than 1 million individuals, are over 85. "The very old are increasing rapidly: those over 75 will continue to increase at twice the rate of the elderly as a whole." She points out that the 85 plus group will have grown by almost 80% by 1975.

The prospects for an even faster increase in the number of very old is considerable if anticipated major breakthroughs occur in controlling or eliminat-

ing cancer, stroke, heart disease, and major cardiovascular renal disease. Conquests in those areas, it is estimated, will add 15 years to present life expectancy at age 65. Thus, life expectancy at that age will be 28 years for men and 31 years for women!!! The significant of this increased life span even with these major breakthroughs occurring may not mean a decrease in medical costs. Indeed, they may represent much higher costs for long-term care and primary care as well as certain types of hospitalization for illnesses and disabilities in other disease and problem areas such as, for example, hip fractures and orthopedic problems, arthritis, etc.

In fiscal year 1970, the nation's personal health care bill totaled \$58 billion.* These expenditures include all expenditures for health and medical care services received by individuals. This estimate excludes expenditures for construction, research, general public health activities, the net cost of insurance, (the difference between premiums and benefits paid), and administrative expenses of certain public programs. Despite the fact that the elderly constitute approximately 10% of the population, 27% of the \$58 billion was spent in behalf of persons aged 65 and over. The averaged aged person has more and costlier illnesses than the average younger person: he is twice as likely to suffer from one or more chronic conditions, is much more likely to be limited in activity, is admitted to hospitals much more frequently, stays longer, and uses physicians' services to a greater extent.

While the average expenditure for all ages was \$280, the bill for the average aged person was nearly 6 and one-half times that for a young person (under age 19), and 2 and two-thirds that per person aged 19 to 64!! Medicare and Medicaid accounted for 87% of the \$15.7 billion spent in behalf of the Nation's elderly in fiscal year 1970. Other third-party payments, for example those from private health insurance, philanthropy, and industry, accounted for another 4%. While total third-party payments for all persons represented 60% of personal health care expenditures, for those aged 65 and over the third-party share amounted to 71%.

However, the out-of-pocket payments are significantly different for the aged and non-aged. The average medical care outlay for persons 65 and over amounted to \$791 in fiscal year 1970. While 71% of this amount was financed through third-party payments, \$226 was paid directly by the elderly person or his family. On the other hand, while persons under 65 paid a much larger proportion, the average out-of-pocket payment for the under-65 group was \$100, or approximately two-fifths that of the aged person.

The out-of-pocket expenditure for elderly persons was almost equal to the total medical bill for those under age 65.

The distribution of personal health care expenditures for the elderly by type of expenditure and source of funds is particularly useful in determining in what areas the heaviest burdens fall. For example, private expenditures accounted for 90.7% of total expenditures for dental care, 86.2% of drugs and drug sundries, and 99.2% for eye glasses and appliances. Major areas which represented a heavy drain on private resources included nursing home care—35.4%, and physicians' services—26.9% (See Table 1). (Appendix.)

It is important, too, to look at what happened within some of the components of Medicare. While total expenditures for nursing home care for the aged increased by 16% in fiscal year 1970, Medicare outlays for extended care services declined from \$367 million to \$295 million. This means that Medicare's share of the Nursing Home Bill dropped from 17% in 1969 to 12% in 1970.

Impact on Medicaid and Medicare

Per capita medical care outlays enable one to examine rising expenditures while eliminating factors of population growth. Per capita personal health care expenditures rose 16.3% per year during the past 3 years for the aged as opposed to roughly one-half that rate for the group aged 19 to 64. Increased expenditures resulting from higher utilization and improved techniques are arrived at by using constant 1970 dollars. For the aged, per capita constant dollars grew at a

* This estimate and those that follow are drawn from the article appearing in the May 1971 issue of the Soc. Sec. Bull. "Medical Care Outlays for Three Age Groups: Young, Intermediate, and Aged" by Barbara S. Cooper and Mary F. McGee. The figures differ somewhat from those used in both the Administration and Kennedy supporting materials. We rely on these, however, since they represent the official estimates prepared by the Division of Health Insurance Studies, Office of Research and Statistics of the Social Security Administration.

rate of 9.2%—triple the rate for younger persons and 8 times the rate for the group aged 19 to 64!!

While only 5% of the elderly are housed in long-term care institutions, nursing home care accounted for approximately one-sixth of the total expenditures for personal health care. The need for long-term care is regarded by the elderly as nothing short of disastrous. It signifies major physical, mental, and social insults to the individual and the financial impact that is inevitably catastrophic unless the person is very rich or virtually without means and receiving payments through the Medicaid system. However, Medicaid payments for long-term care vary radically from state to state, ranging from those states which provide nothing for long-term care to those which furnish payments on the basis of cost. Most states make payments at rates well below cost—Texas, for example, paying less than \$100 a month with other states ranging up and down the entire continuum of dollar costs.

The implications of the above for a National Health Insurance Program that will be of substantial benefit to the elderly are clear. Drugs, long-term care, physician services, eye glasses, and other devices are among the elements that make up the largest portion of the aged individuals out-of-pocket expense. Furthermore, as noted above, out-of-pocket expenses for the elderly are on the average equivalent to the total outlay for other age groups. This occurs in the face of an income situation where income is at a level of $\frac{1}{2}$ of the non-aged population.

Unless the income maintenance situation of the elderly is altered in order to have him arrive at some situation of parity with the younger person, it becomes imperative that some relief, in a substantial way, be found to secure health care equivalent to that of the remainder of the population. Furthermore, in terms of criteria noted below, it becomes important to do so through delivery modes and eligibility-determining modes that are equitable and acceptable. This means the furnishing of benefits without degrading means tests or other kinds of eligibility determinations. We deeply believe the first criterion set forth on p. 2745 is the essence of this position paper. A National Health Insurance Program should assure that adequate health care is within the financial reach of all (older) Americans.

III. CRITERIA FOR ASSESSING ALTERNATE PROPOSALS FOR NATIONAL HEALTH INSURANCE AS THEY AFFECT THE ELDERLY

The criteria as discussed below are based in large part upon the incisive analysis by Dr. Robert Eilers published recently in the April 22 and April 29, 1971, issues of *The New England Journal of Medicine*. Doctor Eilers' papers in the *N.E.J.M.* represent an important contribution to approaching matters of public policy.

The problems the United States confronts in the area of the Health Care System are serious and pervasive, while they affect virtually everybody in the population they fall with unusual severity upon the elderly. The major problems have been identified as follows:

1. A rapid inflation in costs. Currently the expenditures for health are approximately \$340 for every man, woman, and child in the country. As President Nixon pointed out in his message to the Congress, "In the last twelve months alone, America's medical bill went up 11% from \$63 billion to \$70 billion; in the last ten years, it has climbed 170% from the \$26 billion level in 1960." Ten years ago, we devoted 5.3% of the gross national product on health opposed to approximately 7% for the same purpose. Federal expenditures have risen substantially from \$3.5 billion in 1960 or 13% of the total to a current \$21 billion or about 30% of the Nation's spending on health. 60% of the increase in the last ten years represent rising costs while 40% represents an increase in quality and amount.⁴ Medical costs have gone up twice as fast as the cost of living. Hospital costs have risen 5 times as fast as other prices. As the President has pointed out and as the elderly know too well, the cost of medical care is moving beyond the reach of many Americans.

2. There is a geographic scarcity of resources. The Nation's health resources are badly distributed. In the middle Atlantic states there are 171 physicians per

⁴The difference between these figures and those cited above are accounted for by the definition of Health Expenditures. The figures used here are those used for all costs related to health, including capital, public and philanthropic administrative expenditures and those not directly related to provision of personal health services by a practitioner, institution, laboratory, pharmacy, etc.

100 thousand population whereas in the West north central states there are only 89. But even within regions the mal-distribution is serious. In some suburban areas there are 200 physicians per 100 thousand people while in the inner city areas there are only one quarter that number. Hospital beds are badly distributed with eleven beds per thousand persons in Vermont but one quarter that ratio in Utah.

3. Quality and responsiveness of care is uneven. The elderly are particularly aware of this. Long term care ranges from qualities that can only be described as medieval to the most modern up-to-date programs of physical and mental restoration and rehabilitation. Physician care for the elderly varies radically with the understanding and concern that primary physicians have when the elderly can reach a primary care physician. For the elderly, crisis care is more the rule than the exception. Routine medical care is often beyond the financial means and the transportation reach of many elderly persons. In many ways there seems to be a masking and hiding of the needs of the elderly for primary care.

4. There are significant financial barriers to care on account of income. While the elderly enjoy good hospital coverage by virtue of Medicare, the coverage for long term care, drugs, eye care, provision of prosthetic devices and appliances and dental care is virtually nil. Even with Part B of Medicare, the 20% co-payment on top of which may be added a physician's additional billing particularly where he will not take assignment has left the elderly in a particularly vulnerable situation. The rising inflation in medical costs has produced a worsening of the position of the elderly. Rising medical costs have occurred at the same time that inflation has devalued the fixed incomes that most elderly persons rely upon. As noted above under the special considerations about the needs of the elderly in any National Health Insurance Program, the criteria against which programs must be tested may be somewhat different for the elderly if their needs are to be met. Financial barriers to care are very significant for the elderly.

5. Inadequate emphasis on prevention. The President pointed out in his health message to the Congress that break-throughs are required to conquer some major diseases. He singled out cancer and sickle cell anemia. Cardio-vascular diseases and renal diseases are major killers among the elderly. Indeed, those two together with cancer rob the elderly, on the average, of 15 years of average life expectancy. Even beyond that, however, good primary care could have the affect of reducing hospital stays for the elderly, preventing suffering and in some cases extending life. Good primary care has the biggest pay-off in its preventive aspects at either end of the age spectrum. Prevention in old age has to do largely with early identification of malignancies, good maintenance of body function and body tone, control of pain, and maintenance of mobility. In the area of mental impairment, preventive techniques act to maintain social functioning and reduce depression and anxiety that are so often the terribly debilitating concomitants of old age and isolation.

An important consideration for the elderly has to do with the relationship among several systems that impinge upon the functioning of older people. Health care problems of the aged are frequently conditioned on the performance of a larger system of human services. There are interfaces and interdependencies of a health insurance program with a human service network that are critical to the status of the aged. For example, homemaker service, specialized housing, adequate nutrition, transportation, different levels of living arrangement such as family care homes, group residences, and retirement communities, counseling and similar services may be called into play when a health condition diminishes energy, mobility and social functioning. While a health insurance program cannot be expected to indemnify the elderly against the costs of this variety of services it must recognize the relationship that exists among them.

A second major area which any health insurance program for the elderly must confront is the challenge of alternate support to reduce unnecessary use of services such as in-patient care in hospitals and convalescent care and custodial care. Currently, long term care programs consume about 2½ billion dollars per year from all sources. In 1969 one-third of all Medicaid expenditures were for nursing home care. Long term care as we note above is of uneven quality and distribution. As the task force on Medicaid and related programs indicated in its report in 1970, piecemeal modifications of the Medicare and Medicaid programs cannot deal affectively with the long term care needs. Furthermore if a positive program is not developed to provide long term care services, the medical care programs will become increasingly distorted.

The following criteria are thus suggested by Eilers for evaluating National Health Insurance proposals. They have been modified to some extent in order to fit the special needs of elderly people.

1. Financial Accessibility—*"A National Health Insurance Program should assure that adequate health care is within the financial reach of all (older) Americans".*

The elderly have a median income of less than half that enjoyed by the population under 65. Today 67% of total personal health care costs of the elderly are covered by public and private third-party payers—Annual out-of-pocket expenses for the elderly average \$226—more than twice the out-of-pocket outlay for those under 65. While it is suggested that a National Health Insurance program covering all people in the United States should start out with coverage of 50% rising ultimately to 80% of total cost it is questionable whether an assumption of 50% of total cost by the elderly who are already severely financially disadvantaged is feasible. Furthermore the elderly living as they do, typically on fixed incomes, are hit hardest by inflation. The nature of the inflation is somewhat different for the elderly than for the rest of the population. One of the most severe areas of inflation has been that of medical care. The elderly are large consumers of medical care thus it can be reasonably argued that while the population may be laboring under a 6% inflation, the rising costs as they affect the elderly are considerably more than that. Eilers points out that even today private insurance, Medicare and Medicaid provide coverage for virtually everyone. "The issue is not the availability of some coverage but rather the availability of adequate coverage".

2. Delivery Acceptability—*"The delivery arrangements allowed and encouraged by National Health Insurance must be understandable and acceptable to a consumer"*

It is a fact of modern life that medical care is fragmented and hard to understand. The delivery systems are confusing. It is not unusual for a person with a particular condition to be referred to different physicians' offices, an X-ray laboratory, to a hospital for pathology studies and so on. The relationship between hospital care and primary care, not to mention convalescent care is confused and disorganized. The middle and upper-class groups are not significantly immune from this degree of confusion. For the elderly who have severe mobility problems the issue is particularly acute. As Eilers points out "the function of a National Health Insurance Program . . . goes far beyond the obvious pooling of total program costs over a wide population base. Such a program should stimulate the receipt of needed care, that is, the program should anticipate a health delivery system that produces greater use of all health services by some population segments, . . . greater use of some services, (e.g., preventive), by all populations segments, and less use of some services (e.g., in-patient hospital care), by most population groups."

He goes on to suggest that "consumer understanding of delivery arrangements, and the feeling of assurance that adequate care is available under National Health Insurance, will necessitate the delivery of the bulk of the care for an individual through one organization: that is, consumer understanding will be enhanced materially, and there may be economic advantages as well, if the consumer can select an organization through which he will receive most, if not all, services financed through the National Program."

3. Cost Efficiency—*"A National Health Insurance Program must directly encourage consumer use of delivery arrangements that will make the most efficient use of funds flowing through the program."*

The thrust of this criterion is related to reducing unnecessary use of health services and maximum utilization of those services which will prevent or avoid entirely subsequent high cost of modalities of treatment and care. Eilers points out that cost efficiency cannot be attained merely by providing a benefit structure which offers the availability of preventive services for example, or good primary care. He indicates that experience shows that making such services available may actually increase high cost hospital in-patient care. Thus, he suggests that achievement of a cost efficient system requires an orientation of the system that harnesses the incentives and the controls exercised by physicians. "The primary implication of this criterion is that health care professionals and institutions, particularly physicians and hospitals, must be made more accountable for the efficient use of funds as a consequence of the National Health Insurance".

There are some special problems in addressing this criterion to the elderly. The absence of standards for levels of care for different groups of the elderly limits the measurement of cost efficiency for the aged. Reliance on dollar costs as the measure of efficiency unmodified by effectiveness of treatment may result in avoiding expensive but necessary care in the interest of "cost efficiency". The measurement of appropriateness of care on a fiscal basis may be adverse to the best interests of the aging. For example, gross movement of the aged out of mental hospitals in the interest of "more efficient use" of these institutions has resulted in severe deprivation and indeed heightened mortality among elderly patients so moved. Similarly, the provision of nursing home care may be more "cost-efficient" than the mobilization of homemaker service, protective service, outpatient care, visiting nurse service, etc., in order to maintain a person in the community but less appropriate in terms of other values such as retaining maximum independence. There is an absence of standards for levels of care for different groups of the elderly. This limits severely the measurement of cost efficiency for care for the elderly.

A key to any proposal for National Health Insurance must be provision of adequate research for development of appropriate standards so that true cost efficiency and effectiveness can be evaluated. There is a legitimate concern that if physicians and providers are held responsible for costs they may be inhibited from practicing quality physical medicine employing the latest modalities of physical rehabilitation and restoration among the elderly. Unless there are disincentives established to discourage failure to use appropriate treatment modalities there is a legitimate concern that elderly people may be denied the full range of modern medicine because of the overriding concerns about maintaining cost efficiency.

The final consideration essential to rendering the systems cost efficient has to do with making ambulatory care for the elderly truly available. Provision of such care for the aged is conditioned on mobility of that population. Accessibility to transportation, homemaker and other supports are critical to the functioning of the health system focused on making ambulatory care benefits effective. Since 15 to 25% of the aged have serious physical mobility limitations and there may be an equally large group who are mentally immobilized, special consideration must be given to factors of transportation and distribution of physicians and medical services.

4. Phased Implementation

Criteria of delivery of accessibility, cost efficiency indicate a reorientation over a period of time, of the entire health delivery systems. Eilers suggests that a major re-orientation cannot be achieved overnight. In order to avoid severe opposition and organizational chaos he suggests that the "adjustment and delivery arrangements must proceed in deliberate fashion, and not be extended unduly". He also suggests that full implementation may have to occur over a period as long as a decade. He indicates a target of coverage of 80% of health care expenditures. Phased implementation is a criterion not to be lightly considered. However, it is suggested that the elderly because of their physical and financial dependency problems which are as severe as any group in the nation should move as quickly as possible to at least the 80% level Eilers suggests.

5. Minimization of Governmental Regulations—*"A National Health Insurance Program should stimulate accountability and self-regulation by the financing and delivery system and should minimize the need for extensive governmental regulations"*.

"Although certain types of governmental supervision will always be necessary, probably including specification regarding quality of care and general cost surveillance the arrangements precipitated through National Health Insurance should reduce if not remove the need for expensive governmental regulations".

Eilers goes on to suggest that a National Health Insurance Program which places responsibility for health maintenance at reasonable cost on providers and furnishes financial incentives and disincentives toward that end would undoubtedly be best achieved when market forces are enabled to come into play. Experience in Medicare and Medicaid however, particularly with reference to regulation of long term care facilities, indicates that competition alone does not guarantee adequate level of care. Accordingly it is suggested, at least in the area of long term care, perhaps more, rather than less, government regulation may be required. This is very much in line with Eiler's observation regarding the

need for continued regulation around quality and furnishing of adequate safeguards for the public through licensing statutes both of professions and institutions, proper safeguards on records, drug safety, and so on.

6. *Consumer Participation in Cost*—“The bulk of those covered by National Health Insurance should participate in paying for their services to the extent necessary to encourage their responsible use of services and to minimize the administrative costs associated with obtaining health care.”

While this criterion is a reasonable one for the population at large, the elderly whose income is so much less than that of the general population and whose prospects for income are poor, whose real income must be expected to diminish over the long term cannot and should not be expected to participate in the cost of care except through earlier contributions during the working years.

Even this must be modified, however, in order to blanket in the current elderly and those who may never contribute during their earlier years because they were never in the labor force as a result of disability, marital status, or some other reason. Thus, we would suggest that while consumer participation in costs is a good criterion for the general population, for the elderly consumer participation should not be an anticipated part of the National Health Insurance.

7. *Quality of Care*—“National Health Insurance Program should impose requirements that high quality care judged by professional and consumer standards should be provided.”

“A criterion concerning quality of care is easier to state in general than it is to specify in particular, and it is even more difficult to administer. This ensues in part as a consequence of meager professional notions concerning the quality criteria and because the consumers tend to be even less discerning than professionals in this regard. Nevertheless, the program should specify an increasingly rigorous surveillance of quality, with at least the basic guidelines for surveillance being set forth at the Federal level of Government.

“No program of National Health Insurance should rely on the concept of *caveat emptor*. A program should anticipate means of monitoring the quality of care, it should not be expected that the consumers will continue to defer completely the professionally set standards.”

IV. RELATED ISSUES INVOLVED IN DEVELOPING A NATIONAL HEALTH INSURANCE PROPOSAL

As noted above, five principal problems have been recognized concerning health care in the United States: rising costs, geographic scarcity of service, quality and responsiveness of care, inadequate emphasis on prevention and financial barriers to care. Any approach to a National Health Insurance Program must consider all of these. Simply providing a system of benefits is insufficient. There is an inseparability of national health insurance from the related consideration of manpower, distribution of services, the organization of delivery mechanisms, and research.

The major proposals before the Congress recognize this and provide in varying degrees for meeting these needs. The manpower issue is addressed in both the Kennedy and Nixon proposals as noted below. The analysis of the Nixon and Kennedy proposals in terms of the needs of the elderly and more generally in terms of the needs of all Americans are discussed in some detail.

In general both proposals provide for aid in training and increasing the supply of personnel, aid to educational institutions, provisions for development of new kinds of personnel, and arrangements to improve the distribution of personnel throughout the country. Both lay great stress, and properly so, on the development of prepaid group health programs which seek the fundamental shift away from solo fee-for-practice service to one stop medical care. In the areas of research as we note below both proposals beam in on particular problems in which research must be undertaken.

It is out of this holistic approach that the greatest benefits can accrue to all people. The time for piece-meal, patchwork approaches is past.

V. ANALYSIS OF THE NIXON AND KENNEDY PROPOSALS IN TERMS OF THE ELDERLY

On the attached sheets, there is a tabular comparison of the Nixon and Kennedy proposals. The principal concerns for the elderly revolve around the benefit structure. The Nixon proposals provide additional benefits for the elderly only to extent of relieving them of the monthly premium payment for Part B in the amount of \$5.60 per month. This, it is asserted, is equivalent to about a

5% increase in the average Social Security Benefit. Furthermore, it is alleged that this will return to the elderly approximately \$1.4 billion. On the other hand, it is pointed out that the co-payment provisions for inpatient hospital care will be changed to require a co-payment of \$5 per day after the twelfth day under the Medicare Program. This, it is estimated, will represent an additional cost to the elderly of approximately \$400 million. However, it should be pointed out that the result of these two changes is to provide considerable relief for those who are well, but to add an additional burden to those who are ill. The aged ill can hardly afford additional burdens. The Nixon proposal thus not only offers nothing real for the elderly facing sickness but in fact promises a "penalty" for having fallen ill.

The Kennedy proposal, on the other hand, offers very substantial benefits for the elderly. Full coverage is provided as we note on the attached sheet for many items which are not now covered under Medicare and in some cases only, may be provided under Medicaid. These areas include full coverage for physician care, inpatient care, services of optometrists, podiatrists, coverage of payments for eye glasses, hearing aids, prosthetic devices, and certain appliances, coverage for 120 days of skilled nursing care with provision under some circumstances for an extension beyond 120 days, coverage of inpatient and outpatient drugs furnished by hospitals, and coverage of drugs for certain chronic illnesses. The Kennedy proposal provides its benefits without any co-insurance, deductibles, waiting periods, or eligibility determination other than that of residence. Both programs except as noted above would not require additional costs for the elderly.

The specific comparisons follow on the attached sheets.

VI. SUMMARY

An exploration of two principal proposals for National Health Insurance in terms of the needs of elderly people, indicates that each has an important contribution in the view of our associations. The Kennedy bill contains the broadest benefits for all Americans including those who have reached retirement age. It would cover many costs that are not now covered by any program. While concern has been expressed that implementation of the Kennedy plan in full would be so costly that only a reordering of National priorities would make it possible, we would urge that in the event that objection is true its provisions be implemented for the elderly who currently are paying as much out-of-pocket for medical care expense as the rest of the population is paying for its total health care expenditure.

On the other hand, we believe that the Administration proposal carries the best promise for an effective delivery system. Freedom of choice in selecting one's source of medical help is an important element to provide healthy competition essential to maintenance of high-quality care.

Exploration of criteria against which any national health plan must be tested would indicate that this mixture of benefits and delivery system would be most appropriate for the elderly.

Our associations would enthusiastically endorse a plan which includes the comprehensive care benefits for the elderly contained in the Kennedy bill and the delivery services system recommended in the Nixon proposal.

TABLE 1.—ESTIMATED AMOUNT AND PERCENTAGE DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES FOR THE AGED, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FISCAL YEARS 1967-1970

Type of expenditure, 1970	Amount (in millions of dollars)					Percentage distribution				
	Private		Public			Private		Public		
	Total		Total	Medi- care ¹	Other	Total		Total	Medi- care	Other
Total	15,736	5,117	10,619	6,784	3,835	100.0	32.5	67.5	43.1	24.4
Hospital care	7,406	1,152	6,254	4,527	1,727	100.0	15.6	84.4	61.1	23.3
Physicians' services	2,715	729	1,986	1,776	210	100.0	26.9	73.1	65.4	7.7
Dentists' services	344	312	32	32	32	100.0	90.7	9.3	39.2	9.3
Other professional services	301	171	130	118	12	100.0	56.8	43.2	39.2	4.0
Drugs/drug sundries	1,680	1,418	232	232	100.0	86.2	13.8	8	13.8	13.8
Eye glasses/appliances	386	383	3	3	100.0	99.2	0.8	8	8	8
Nursing-home care	2,500	906	1,654	295	1,359	100.0	35.4	64.6	11.5	53.1
Other health services	343	18	327	68	259	100.0	4.7	95.3	19.8	75.5

¹ Includes premium payments under the supplementary medical insurance program.

TABLE 2.—Comparison of Two National Health Insurance Plans Before the 92d Congress: S. 3—The Health Security Act (Kennedy Bill) and H.R. 7741 and S. 1623—National Health Insurance Partnership Act (Nixon Administration Bill)

S. 3—HEALTH SECURITY ACT (KENNEDY)

General Approach

The proposal establishes National Health Insurance Program for all U.S. citizens and residents. The program would furnish uniform benefits, feature no deductibles, coinsurance, means tests, or waiting periods. It would be financed by payroll and unearned income tax and Federal General Revenues. Medicare and Medicaid are replaced by the program. Reliance for comprehensive care is placed on Comprehensive Health Services Organizations who receive premium payments on a capitation basis from the Federal Government.

H.R. 7741 AND S. 1623—NATIONAL HEALTH INSURANCE PARTNERSHIP ACT (ADMINISTRATION)

The proposal would utilize several devices to provide health care coverage for the population:

- (1) For all employed persons, employers would be required to furnish a basic health care plan purchased through insurance companies or directly from health maintenance organizations (HMO's). Employers and employees contribute to costs.
- (2) For the poor, family health insurance is provided with a sliding scale of expected contributions from low income families. Individuals and families may elect HMO or insurance carrier coverage. Medicaid is discontinued for families but is continued for aged, blind and disabled.
- (3) Coverage under parts A and B of medicare is combined, the monthly premium for part B is eliminated, but coinsurance for in-hospital is combined, the monthly premium for Part B is eliminated, but coinsurance for in-hospital is increased.

Deductibles and co-insurance. No costs sharing for families (of four) with income under \$3,000. Sliding scale for low income families with higher incomes.

Medicare—Same benefit structure as before—

Premium payments—Part B eliminated.

Coinsurance for in-patient hospital care—\$5 per day after 12th day.

Medicaid—Eliminated for all except the aged, blind and disabled benefits supplementary to medicare and other Federal program to be established by individual States at their option.

TABLE 2.—Comparison of Two National Health Insurance Plans Before the 92d Congress: S. 3—The Health Security Act (Kennedy Bill) and H.R. 7741 and S. 1623—National Health Insurance Partnership Act (Nixon Administration Bill)—Continued

S. 3—HEALTH SECURITY ACT (KENNEDY)

Administration

The administration of the Health Security program will be carried out by a five-member full-time Health Security board, appointed by the President with the advice and consent of the Senate. Members of the Board will serve 5-year terms, and will be under the authority of the Secretary of Health, Education, and Welfare.

A statutory National Advisory Council will assist the Board in the development of general policy, formulation of regulations, and allocation of funds. Members of the Council will include representatives of both providers and consumers of health care.

Field administration of the program will be carried out through the 10 existing HEW regions, as well as through the approximately 100 health subareas that now exist as natural medical market-places in the Nation. Advisory councils on matters of administration will be established at each of these levels. However, the Board will guide the overall performance of the program. It will coordinate its functions with State and regional planning agencies and it will account for its activities to Congress.

H.R. 7741 AND S. 1623—NATIONAL HEALTH INSURANCE PARTNERSHIP ACT (ADMINISTRATION)

Under National Health Insurance Standards Act:
Secy's of HEW approved plans of insurers and self-insurers.
Employers purchase plans through insurance carriers or directly with HMO's.

Under family health insurance plan:
Federal eligibility determination.
Federal payments and contracts with public and private agency or carrier to serve as fiscal intermediaries.
Federal payment directly to HMO's permitted.
Federal approval of plans
General: Federal preemptive authority of regulation of HMO's participating in the programs.

Payment of Providers

Providers of health services will be compensated directly by the Health Security program. Individuals will not be charged for covered services.

Hospitals and other institutional providers will be paid on the basis of approved prospective budgets. Independent practitioners, including physicians, dentists, podiatrists, and optometrists, may be paid by various methods which they may elect: by fee-for-service, by capitation payments, or in some cases by retainers, stipends, or a combination of such methods. Comprehensive health service organizations may be paid by capitations, or a combination of capitations and methods applicable to payments to hospitals and other institutional providers. Other independent providers such as pathology laboratories, radiology services, pharmacies and providers of appliances, will be paid by methods adapted to their special characteristics. Special provisions are made for foundations sponsored by medical societies or other non-profit organizations are recognized as a special class of providers.

Present methods under private insurance.

TABLE 2.—Comparison of Two National Health Insurance Plans Before the 92d Congress: S. 3—The Health Security Act (Kennedy Bill) and H.R. 7741 and S. 1623—National Health Insurance Partnership Act (Nixon Administration Bill)—Continued

S. 3—HEALTH SECURITY ACT (KENNEDY)

Coverage

All U.S. residents (including resident aliens) and U.S. nonresidents while in United States.

Benefit Structure

Full coverage of—physician service in-patient and out-patient hospital service; Home health services other professional services such as optometrist and podiatrist service; diagnostic and therapeutic radiologic service; Pathology laboratory service; Home health services; Eyeglasses, hearing aids, prostheses, and other appliances and services.

Limited coverage of—Long-term care, 120 days with possible extension in some cases; prescribed drugs provided through hospitals, CHSO's, or for chronic and long-term illness; Psychiatric consultation; Dental care (restricted to children—at a later date intended to cover all ages).

H.R. 7741 AND S. 1623—NATIONAL HEALTH INSURANCE PARTNERSHIP ACT (ADMINISTRATION)

Employed persons and their families under the National Health Insurance Standards Act.

Low-income families under family health insurance plan
Medicare coverage for elderly
Medicaid for aged, blind and disabled.

For the elderly, the only change is elimination of the premium for part B of medicare. The savings accrue to those who stay out of hospitals but will be offset in part by increased copayment in hospitals after the 12th day.

Under the National Health Insurance Standards Act (for employed persons and—

- (1) In-patient hospital care.
- (2) Physician service in hospital.
- (3) Emergency services.
- (4) Out-patient physician service.

Minimum total benefit coverage of \$50,000 per family member.

Deductibles and coinsurance:

Hospital room and board—first 2 days plus 25 percent of remainder for other services, plus \$100 plus 25 percent of remainder for other services.

Provided that after total benefits equal to \$5000 have been paid, no further deductibles or coinsurance.

Under family health insurance:

30 days inpatient hospital care; medical and surgical physician care; maternity care and family planning; well-child care; emergency services; diagnostic laboratory and X-ray.

Mr. BRICKFIELD. Thank you for making these documents a part of the record. To save time, I would like to read my statement which set our position, if this is agreeable.

Mr. ULLMAN. We would be happy to have you follow that procedure.

I want to say that the committee is very familiar with the organization you represent. They have been before this committee many times.

Mr. BRICKFIELD. Essentially, Mr. Chairman, as I start, we examined the major bills on health care and we took what, in our opinion, were the best provisions from Congressman Byrnes' bill and the best provisions from the Kennedy-Griffiths bill. While we are especially interested in the needs of the elderly, we are also concerned with the needs of all age groups.

Essentially we like the health benefit provisions of the Kennedy-Griffiths bill because they are the most comprehensive. We also like the delivery system of Mr. Byrnes' bill which, among other things, provides a freedom of choice for our older people.

We are recommending then, a combining of certain specific provisions of both these major bills.

Turning now to my statement: Our associations applaud the recognition by the executive and legislative branches of the need for major health reform in America. It now appears that our Nation is prepared to take a comprehensive view of the problems of delivering and financing health care, as well as the associated problems of health, manpower and research.

Our experience with the elderly tells us that health protection is essential for all. We want the best program for all Americans. As spokesman for 3,300,000 older Americans, we are deeply concerned with the impact of any national health insurance proposals on the elderly.

Our basic position is that any health proposal must take into account the substantial out-of-pocket outlay that older people now make at a time when their income is apt to be fixed or diminished and their health care requirements increased. We also believe that any health care proposal must recognize that the health needs of older people are significantly different from those of younger people.

The supply of medical care is not uniformly available. The elderly of America increasingly are denied adequate medical care, largely on economic grounds, medicare and medicaid notwithstanding. In 1965, when medicare legislation was passed, it was assumed that elderly people would be relieved of the bulk of their medical care cost burdens; however, the facts hold to the contrary:

Item: Elderly persons still carry one-third of their total medical expenditures in the aggregate.

Item: Elderly persons' total personal health care expenditures were \$791 per year as compared to \$280 per year for those under 65 (1970).

Item: Median income for the elderly is half the median income for those under 65.

The elderly are only too well aware that medical costs have been rising at a faster rate than virtually any other component of the price index. They still carry a large part of their doctors' fees. They still must cover their drug expenses. They still must cover, or if they are

poor have medicaid cover, their long-term care expenses. Many devices and aids are covered by neither medicare nor medicaid (such as oxygen in the home, positive pressure breathing apparatus, certain psychiatric benefits, certain physical therapy, certain essential health-related home care services, and so on).

The problem is complex. Demand is increased. The number of general practice physicians is inadequate to meet the demand. Distribution of medical services is inappropriate. Fewer physicians are directly engaged in patient care. The elderly face increasing disadvantage economically in the competition for medical attention.

Indeed, the inadequacies of the health care system—inadequate funding, maldistribution of service, insufficient personnel, inappropriate delivery systems, inattention to prevention—all converge on the aging population.

THE NRTA-AARP POSITION

The associations are in agreement with the fundamental proposition reflected in virtually all major plans receiving attention in the current and most recent past sessions of the Congress: the medical care system requires substantial revision.

In general, the associations propose virtual universal coverage of all elderly, and comprehensive benefits including a phased-in program of coverage for long-term care and drugs, without deductibles or co-insurance.

We support the development of health maintenance organizations (HMO's)—professional groups organized to provide comprehensive medical care on an on-going basis to the individual who holds a pre-paid contract with the group.

The basic delivery and insurance mechanisms outlined in H.R. 7741 (Representative John W. Byrnes) are preferable to other proposals in our view. They allow the individual freedom of choice in selecting his source of medical care services. This permits competition in the field, essential to the maintenance of high standards of health care. Furthermore, this delivery method will also serve as an inducement to the improvement of equally essential social services.

However, the benefit structure leaves the elderly out in the cold.

We recognize that the benefit structure we propose is a comprehensive one with major fiscal implications. We realize that immediate implementation of our benefit proposal (which closely parallels H.R. 10521, the Health Security Act introduced by Representative Martha W. Griffiths) would be so costly that it could be achieved only through a sweeping reordering of national priorities.

The associations take the position that from a standpoint of need and from the standpoint of administrative feasibility, if the total population cannot be covered ab initio, the program benefits should be extended to all persons aged 62 and over.

No group in the population faces a greater need with fewer resources than do the elderly.

ELIGIBILITY AND BENEFIT STRUCTURE

We have provided detailed recommendations on our position relative to eligibility, the benefit structure, payment mechanisms, and

methods of administration in our position paper which we have submitted for the record. However, the basic position of our associations on some of these points is as follows:

1. *Eligibility for benefits.*—The associations believe in virtually universal coverage.

2. *Benefit structure.*

(a) Physician care would be provided without limitation on degree or scope of services except for psychiatric service furnished by an individual psychiatrist in solo practice.

(b) Inpatient and outpatient services. Long-term care requires special attention. A health insurance program must ultimately move toward providing coverage on an unlimited basis for both skilled nursing home care and intermediate care. Potentially, long-term care is the most expensive service, over all, that many older people will utilize. We recognize, however, that unlimited durational benefits at this time may be unrealistic in the absence of adequate standards, criteria for establishing medical and social need for long-term care, methods of patient assessment, effective utilization review, uniform accounting methodology, and appropriate systems of reimbursement.

We believe that introducing unlimited benefits at this time might have the effect of locking in some of the most unreasonable aspects present in long-term care. Accordingly, we recommend that skilled nursing home care be provided for a period of 120 days during the year with provision for extension of such duration under certain circumstances. These might include provision of long-term care in skilled nursing homes owned and operated by and as part of general hospitals, or in situations where it is clear that nursing home utilization is an aid to prevention of overutilization of hospital beds. The issue of underwriting the costs of long-term care cannot be evaded indefinitely. We recommend, therefore, that full underwriting of such costs be available not later than 1976. During the next 3 years we recommend the Social Security Administration, the Social and Rehabilitation Service, the Department of Housing and Urban Development, and the Department of Labor undertake a major study, linking for the first time the issues of quality of care, delivery mechanisms, financing of operations, construction, and manpower with the objective of producing a comprehensive plan for making long-term care readily and appropriately available to all who require it.

We would recommend limitation of coverage of psychiatric inpatient care to a similar period of 120 days provided the patient is receiving active treatment for emotional or mental disorder. We believe, however, that in the case of public institutions, present financial support provided through title 19 by virtue of the so-called Long amendments should be withdrawn. However, we also recognize that there has been widespread abuse in making claims for patients under this program. Thus, while we urge continued financial support for the States, we urge it only where there is strict enforcement of the requirement that there be active treatment for emotional and mental disorders.

(c) *Dental services.*—We recognize the difficulty in initiating full coverage for dental service at the outset of the program. We believe that if the health insurance program is initiated as we suggest for

elderly people only, full coverage for all elderly persons including preventive services, diagnostic services, and therapeutic services including restoration, such as provision of dentures and adjustments of dentures should be provided. We recognize also, however, that this will be difficult if a general National program for all persons is enacted. In such an instance, therefore, we urge that no later than 7 years after the effective date of the act that the administrative agency handling the program establish a method whereby full dental services can be extended to the elderly.

(d) *Other professional services.*—We recommend full coverage for services provided by optometrists, podiatrists, pathology, and radiology labs, day care services for psychiatric disorders, ambulance services, psychological, physiotherapy, nutritional, social work, or health education services when the latter are provided as part of institutional services or part of a health maintenance organization program.

(e) *Therapeutic devices, prostheses, appliances, and devices.*—Benefits should include a specific list of therapeutic devices particularly including eyeglasses, hearing aids, prostheses such as walkers, canes, crutches, wheelchairs, braces, orthopedic shoes, hospital bed in the home, and so on. This would necessarily require accompanying strict regulation and control.

(f) *Drugs.*—The associations urge the inclusion of all prescription drugs as a benefit under national health insurance program. While we recognize the difficulties in maintaining controls, assuring reasonable utilization and avoidance of runaway costs, we recommend a phased-in program to include the following: Coverage for drugs furnished through hospital inpatient or outpatient departments, through skilled nursing homes, health maintenance organizations, and most particularly drugs furnished for specific chronic diseases and conditions for which drug therapy because of duration and costs commonly imposes substantial financial hardship. We would urge that rather than start with a broad list of diseases and conditions, that the list initially be one in which experience can be gained through observation and analysis of a limited number of cases where conditions and requirements for drugs are relatively clear.

ADMINISTRATIVE METHODOLOGY

Our constituency of 3.3 million persons is comprised almost entirely of retired individuals. We recognize significant differences in payment mechanisms in arranging health insurance for those in and out of the labor force.

For those who are employed, we recommend a contributory insurance program. Such a program would operate through employers required to furnish a plan through a contract with a health maintenance organization or with an insurance carrier underwriting an employer-sponsored plan. For the self-employed, small employers, and certain other persons, insurance companies would be required to develop group policies for use by such employers and for the protection of self-employed individuals. On the other hand, unemployed persons, the poor, and the retired elderly would have the option of selecting an HMO or an insurance underwriter of their choice. For the elderly

who are not employed, it is proposed that payment of premiums be made directly by the Social Security Administration to the third-party payer or the HMO according to the election of the elderly person.

The benefit structure we propose calls for no deductibles, no coinsurance, no cutoff dates, and no payments of any kind, except for those services where benefits are limited. Therefore, no devices are necessary to establish eligibility except an initial finding of age attainment. This, we believe, could and should be accomplished through the social security office in the same manner as old-age insurance benefits are claimed currently.

The position of the associations is that any national health insurance is to be federally administered with uniform standards for eligibility throughout the United States.

Furthermore, we maintain that eligibility be established on the basis of an affidavit in the same fashion that eligibility for social security benefits is determined. Eligibility for assumption of payments for medical coverage by the Federal Government should be conditioned solely on unemployed status.

The above pattern of administration would result in the abolition of the medicare and medicaid programs, as we know them today. States would no longer be involved in medicaid either financially or administratively. The medicaid program would give way to a system of financing by the Federal Government, utilizing the HMO or third-party payee on a more comprehensive scale than currently exists.

SUPPORTS FOR THE HMO

We firmly believe in the development of the HMO. We support the requirement of utilizing the HMO option under public or private health insurance. We believe that this support should be implemented through planning grants to public and private potential HMO sponsors. Furthermore, we believe that loan guarantee programs must be established to finance initial capital and startup costs for HMO's. Furthermore, we support provision of supplemental grants to teaching hospitals to establish HMO's. And we believe it would be necessary to establish by law Federal preemption of authority to regulate health insurance in order to override State legal barriers against development of the HMO. We recognize and support the variety of steps to be taken via planning grants, loan guarantees, and changes in insurance regulation to bring about the full development of the HMO.

SUMMARY

In summary, we believe that the bill before you, H.R. 7741, carries good promise for an effective delivery system. Freedom of choice in selecting one source of medical help is an important element to provide health competition essential to maintenance of high-quality care.

On the other hand, the limited benefit structure and the coinsurance and deductible features of this bill overlook the special needs of elderly people and fail to recognize that the elderly operate under severe disadvantage in securing health care.

Their income is half that of the under-65 population, and yet their out-of-pocket outlay is more than twice that of the under-65 population. This imbalance must be redressed.

We believe that our proposals offer the best opportunity for correcting the defects in the present bill.

We are not unaware that concern has been expressed that implementation of the benefit structure discussed and urged by us would be so costly that only a reordering of national priorities would make it possible. We would urge that in the event that that objection is true, that the provisions of the benefit structure be implemented for the elderly who currently are paying as much for out-of-pocket medical care expenditures as the rest of the population is paying for its total health care expenditures. Perhaps with experience with this special segment of the population, we can develop ways and means through employer-related systems for the bulk of the labor force, and hence the bulk of our population, where health care can be assured for all.

Our associations wish to express our appreciation to the committee for accordng us the opportunity to testify on this very important legislation. We wish to provide you with copies of our extended position paper, and request that it be published in the committee prints of these hearings.

Thank you, very much, Mr. Chairman.

Mr. ULLMAN. Thank you, Mr. Brickfield. Does that conclude your testimony?

Mr. BRICKFIELD. Yes.

Mr. ULLMAN. Are there questions?

Mr. CAREY. Mr. Chairman.

Mr. ULLMAN. Mr. Carey.

Mr. CAREY. Mr. Chairman, I just want to take this opportunity to welcome to our committee a very distinguished counsel who had extensive experience here when he worked on the House Judiciary Committee staff and performed yeoman work during periods of enormous legislative activity. He then served very valorously and diligently as our head legal officer in the Veterans' Administration.

I am so pleased that the 3,300,000, I believe the figure is, of retired people who have worked in Government, many of whom have worked as teachers, have his services available to them at this time. I think we can agree that their medical problems and their medical burdens are of primary interest to this committee, and a real challenge to us as to how we can make a national health insurance plan work for those who really have to depend on meager savings and annuities and a very limited flow of funds to cope with their medical expenses.

The testimony you have given us indicates that even our medicare plans and those things we have enacted so far do not go sufficiently far to limit the fear and anticipation of catastrophic illness and high expense from the senior citizen group.

Your organization has done wonders for telling other committees of Congress on which I have served of the plight and the needs of our senior citizens. I am very grateful that you came before us today.

Mr. BRICKFIELD. Thank you, Mr. Carey.

Mr. ULLMAN. Are there further questions? If not, thank you very much, Mr. Brickfield.

Mr. BRICKFIELD. Thank you.

Mr. ULLMAN. I understand that Mr. Herbert Green is not here but Mr. Zivalich is.

Mr. Zivalich, if you would further identify yourself and your colleague, we would be very happy to receive your testimony.

STATEMENT OF TONY ZIVALICH, GEORGIA COMMITTEE FOR NATIONAL HEALTH CARE; ACCOMPANIED BY ROLAND J. KNOBEL, PH. D., MEMBER

Mr. ZIVALICH. Thank you. My name is Tony Zivalich. I am with the Georgia Committee for National Health Care. This is Dr. Roland Knobel from Georgia State University.

I would like to read a brief statement, and he would like to supplement the remarks that we will make to the committee, sir.

Mr. ULLMAN. You are recognized.

Mr. ZIVALICH. Thank you, sir.

Mr. Chairman and members of the committee, I am appearing on behalf of the Georgia Committee for National Health Insurance to speak in favor of H.R. 22. We firmly believe that the spirit of this bill is of critical importance to our State and the Nation. It is the only bill under consideration by this committee which promises adequate health services as a basic right of all Americans, regardless of economic or social status.

The Georgia committee supports the health security bill because the people of our State are not getting the kind of health care that we know is technically feasible; and, furthermore, we are being forced to pay more than we can afford for what we are getting.

There are, of course, many reasons for the rising costs of care. We have been in an inflationary period, and health care costs could not have been expected to hold steady. They have, however, far out-run costs generally. In the past 10 years, while the cost of living rose 25 percent, physicians' fees rose nearly 50 percent, and hospital daily service charges rose 150 percent.

If I may digress from the testimony I would like to add a personal note. I had a son whom we discovered had leukemia in October of 1967. He died in July of 1968. He spent 70 percent of his time in the hospital. They were very nice and, belonging to the Teamsters Union, I think we have one of the most comprehensive health plans there is.

At the termination of his illness and upon his death and after we settled all the details I had to sit down and negotiate with the hospital and I was able to reduce what was outstanding in half and my wife tells me because she is the one who has been making payments to the bank because we made a cash settlement that sometime in April of 1973 we will be able to pay off our final payment.

If you take the average Georgia worker, I make a very good dollar and we had some good insurance and adequate care allegedly but one major illness has really wiped us out.

The increases in costs stem from basic problems of lack of organization. For example, there are currently no controls, based on need,

over how many hospitals in a given area will buy some high status, but extremely costly, piece of equipment.

Comprehensive health planning cannot, and will not, work without stronger teeth. Patients are often forced into costly treatment routes, including unnecessary hospitalization, because the cost of treatment is reimbursed by the insurance plan in a lot of cases only if done in the hospital. Many Georgians are forced to go to the hospital for treatment which could be performed more effectively on an outpatient basis because of the scarcity of physicians—especially specialists—in the rural portions of the State.

The insurance companies and Blue Cross-Blue Shield do not do the necessary job of forcing the providers of health services to be more efficient. They merely pass through the rising costs, taking their bite as the larger and larger sums of money funnel through.

In addition to the often devastating cost of health services, the people of Georgia are also especially hard hit by shortages in manpower. On a statewide basis, Georgia has only 70 percent of the national ratio of physicians to population.

In rural areas, the situation is much worse, with only about 40 percent of the national physician/population ratio in 75 percent of our counties. Two years ago in Georgia, there were nine counties without a single doctor, and there is strong evidence that the situation is getting worse.

In the city of Atlanta, we have some of the finest medical facilities in the world; but when you go outside of Atlanta, Savannah, Columbus, and other medium-sized cities, the services available are very, very limited.

The Georgia committee believes that the only legislation under consideration by this committee which will begin to solve the problems in our State is the health security bill.

There are many of those in Georgia and may I tell you that many of those are unorganized and therefore do not have a health group plan.

For these groups of people the cost of adequate private health insurance, and even the inadequate private health insurance proposed under the Nixon administration plan, is prohibitive. The health security bill will provide the means for each working individual to contribute a fair share to finance the program, yet it would cover the full range of necessary health services.

It would provide money and incentives for expansion of health services in rural areas. It is obvious that the old system of solo practice doctors will no longer work in the rural parts of Georgia or any other State.

A doctor who moves into a small town or rural area—and none of the young doctors do move into these areas anymore—can expect a grueling life. As the only physician, he will be on call 24 hours a day and will have no relief or backup support. Health security would provide the money to experiment with new ways of getting health services to rural areas. Perhaps that will mean physicians' assistants in very small communities, supervised by a group of physicians in a larger town, and that group, in turn, backed up by specialists in the regional medical centers. Perhaps it will mean new types of health centers on wheels, similar to our mobile libraries.

In any case, it is clear that new thinking and experimentation are needed if all the people of our State are to gain access to basic health services. The private insurance industry provides a great deal of diversity in the sale of insurance policies—but there is no flexibility or innovation in getting care to people when and where they need it. The only flexibility they provide is in how you pay for it.

Health security also includes provisions to safeguard the quality of care. The program will establish national standards for providers. Hospitals and other institutions will be eligible for participation only if they meet national standards.

This will mean that community hospitals no longer attempt to handle medical procedures which are too complex for their staff and equipment. But the program will provide the funds necessary for local hospitals to provide high-quality care at a level appropriate to their size. This would be of tremendous help to our Georgia hospitals, many of which are substandard and unsafe because the counties and communities at the present time cannot afford proper staffing or equipment.

In conclusion, Mr. Chairman, we of the Georgia committee believe that the health security plan would be the best program for the people of Georgia and for the health professionals of Georgia.

In a State with severe manpower shortages, we certainly would not support the enactment of a plan which would drive physicians out of practice and make services even harder to get. But we believe that the advantages health security gives to the providers of our State are substantial.

We believe that by their bill physicians and hospitals would be assured of payment no matter what the financial status of the patient; the physician could prescribe the right course of treatment without wondering if the family can pay; the professional supports provided for physicians will make it easier and more desirable to practice in rural areas; and the hospitals will know in advance each year that they have enough money to meet their payroll and provide quality services to their patients.

For these and other reasons, we urge this committee to give serious consideration to the enactment of the health security bill. Some people may consider it too drastic a solution. But the problems are very serious; and we are convinced that, unless a program as strong as health security is enacted very rapidly, far, far more drastic action will be necessary in a few years. This may well be our last chance to preserve the private status of the providers of our Nation's health services.

If I may digress for one more moment and then I will turn it over to Dr. Knobel.

About 8 months ago in the Atlanta Constitution there was a writeup of a man who died en route to Grady Hospital. He had been shot. He was just walking on the street and somebody shot him. The closest hospital was a private hospital. When he went to the private hospital the administrator or whoever was in the reception area at the hospital asked him if he had insurance. The man said no.

He was bleeding profusely at the time and he was instructed as were the police to move him down to Grady which is the county hospital of Fulton County. The man died on the way to the county hospital.

We think that everyone is entitled to medicare not just in emergencies but we think it is an American right that every citizen should have proper medical care regardless of his status or economic needs. Thank you.

STATEMENT OF ROLAND KNOBEL, PH. D.

Dr. KNOBEL. Mr. Chairman and members of the committee, my name is Roland Knobel, and I am a member of the Georgia Committee for National Health Care. I don't endorse any one bill but I have some ideas that I would like to see incorporated in any bill finally agreed upon.

Almost all of the bills presently under consideration stress the payment mechanism and attempt to relieve the consumer of the mounting costs of health care.

While these are important considerations, I feel the most important problem facing us is restructuring the health delivery system.

Some of the bills get good marks on this objective. However, all of these bills put major emphasis on how care will be financed.

This may lead to increased health costs, just opposite of what was intended. It is an economic fact that if you increase demand for a socially desirable commodity without increasing the ability to supply that commodity, its costs will go up and this is what I think will happen in the short run.

But how do we restructure the delivery system? First, I feel that we have to define the Nation's goal. I see this to be that every member of our society has a health professional who is accepted by both parties as his or her primary health deliverer.

This professional: (1) Serves as the point of entry into the health system.

(2) As the day-to-day health counselor and maintainer of health.

(3) Has the knowledge and the authority to freely refer the patient to higher levels of health care, that is, to specialists as needed.

These professionals would not have to be doctors. An experimental program now being conducted by Johns Hopkins employs nonprofessional health teams, and is an exciting innovation to the system. Its progress should be closely followed.

The program as developed should correct the marked neglect of such elements of mental health rehabilitation, family planning, dental care, and consumer education and I stress the last one.

I don't think the consumer is getting the information he needs to do a good job to purchase care in the present health system.

The next question is how will the consumer pay for this care—to an effective demander of health care. I opt toward controlled pooling of costs, but not on the national level.

There are methods of franchising health financiers, which will permit "selective intervention" to achieve standardized premiums and costs, community rating, and basic operational consistency.

Here the government, State or Federal, should be ready to step in and provide the financing mechanism if the private sector doesn't do the job.

The concept of franchising applies as well to groups of providers and health institutions. The planning and implementing of fran-

chises should operate at the State and local level to meet basic Federal guidelines of adequacy through the wheels of comprehensive health planning.

That is what we are doing in Atlanta and I think it is starting to work.

I stress the need for pluralistic alternatives, both in delivery and financing. We must develop methods to meet the needs of a host of heterogeneous groupings of people in our society.

These groupings have different perceptions of health, and how it should be delivered, as well as different concentrations of sickness or perceived sickness.

As an extreme example, it would be difficult to set up a Kaiser Permanente type prepaid group practice plan in southeastern Georgia, and achieve the effectiveness that such a plan might promise.

The economics, the population concentration, and the social as well as institutional patterns are just not there at this time to make it go.

It is important to recognize that we really know so little about the relative effectiveness of alternative ways of delivering care, particularly under varying demographic settings, that it would be premature to say that any one method is the best at this time.

I see danger in locking in on any one system of delivery and financing at this time. Prepaid group practice as a model has a great deal of promise, but it depends on population concentration to work well.

It is certainly a method that should be logically expanded, but as one of several alternatives, until we know more about the relative efficiencies and health outcomes it can provide.

My admonition here would be to keep the options open.

I might say also that our emphasis in funding of research has been essentially on clinical research and I think we need a heavy emphasis on delivery research to find out what makes this thing tick.

It may call for some change in priorities but it should be done now.

At the same time it is necessary that we provide a climate where alternative, innovative delivery systems can be developed. This will call for the elimination of archaic laws, that exist among the States in varying degrees, such as the one controlling "corporate practice of medicine", which was very good when Flexner's report went in and is certainly archaic now and is stopping us from the things we should be doing.

It is time now to review these laws and modify or abolish them, where they stand in the way of medical progress or perpetuate a fractured, cottage industry type of health delivery.

Changes in insurance benefits are essential to encourage use of outpatient care and health maintenance of patients.

We must also place proper emphasis on health education, both of consumers and providers. We must make the consumer a more informed demander of health care, and improve the consumer's capability to participate in health maintenance and the delivery system.

This involves such ideas as personal hygiene which should be started in school and carried all the way through, as well as instruction on how and when to enter the system and how to use the system.

In review—good health is not a function of money—but of the right health resources—serving an informed consumer population—with the right balance of health maintenance and therapy—and with specified levels of quality control.

This means that every consumer is matched with a day-to-day health provider who serves as the point of entry into the health network.

This provider need not be a physician, but should work under the supervision of a physician. Each consumer must have the ability to demand the services of this provider—and the health system that backs him up—without a payment at the time of use.

The consumer should have an option of plan—along the line of the Federal employees health benefits program.

Finally, providers should have the right to develop patterns of care without legal or payment mechanism restrictions.

At the same time delivery of care should be considered a national resource and the tools should be made available through incentives or decentralized regulation, that is, franchises, to assure that care is available to all members of our society, and that this care is properly provided.

I thank you.

Mr. ULLMAN. Thank you, Dr. Knobel and Mr. Zivalich.

You have given us some very interesting ideas and I think a fresh viewpoint with a very practical base. You have been very helpful.

I want to say that Congressman Landrum had hoped to be here. We were having a caucus on this side and he couldn't get back.

Mr. ZIVALICH. I just saw him in the hall, Mr. Chairman, and he told me that he has some pressing business.

Mr. ULLMAN. Thank you very much.

Are there questions.

If not, we appreciate your testimony very much.

Mr. ZIVALICH. Thank you, Mr. Chairman.

Mr. ULLMAN. Our next witness is Mr. Olson.

Is anyone here from the National Union of Hospitals and Nursing Home Employees.

If not, our next witness is Dr. Boyle.

Mr. PETTIS. Mr. Chairman.

Mr. ULLMAN. Mr. Pettis.

Mr. PETTIS. While Dr. Boyle is coming to the witness table I would like to take this opportunity of welcoming a fellow Californian to the committee this morning. I have known Dr. Boyle for a long time. I am glad personally to see him here this morning and look forward to his testimony.

Mr. ULLMAN. Dr. Boyle, if you would further identify yourself and your colleagues for the record we would be happy to hear you.

STATEMENT OF DR. JOSEPH F. BOYLE, CHAIRMAN, CONGRESS OF COUNTY MEDICAL SOCIETIES; ACCOMPANIED BY CHARLES JOHNSON, STAFF COORDINATOR; DR. MARSHALL DRIGGS, MEMBER, BOARD OF TRUSTEES; AND DR. MARVIN EDWARDS, EDITOR, JOURNAL OF PRIVATE PRACTICE

Dr. BOYLE. Dr. Joseph Boyle, of Los Angeles, Calif., chairman of the Congress of County Medical Societies.

I have with me this morning on my left Mr. Charles Johnson of our Los Angeles staff; on my far right Dr. Marshall Driggs from

Englewood, N.J., and Marvin Edwards, the editor of our Journal of Private Practice.

Mr. ULLMAN. We welcome you all here and you are recognized, Dr. Boyle.

Dr. BOYLE. Thank you very much, Mr. Chairman.

Our association is an association of county medical societies with approximately 75,000 member physicians. We appreciate this opportunity to testify before you this morning.

We are here to urge that any national health policy seek solutions for specific problems of specific populations and not destroy good working systems now serving the majority of citizens very well in the name of solving all problems for all people with one stroke of the legislative pen.

The editorial pages of both the Chicago Tribune and the New York Times have said, the case for a "National Health Care Crisis" is contrived at best. We agree.

Median American life expectancy, now nearly 75 years, increases progressively. Measurable parameters of health susceptible to medical technology steadily improve. Even frequently lamented data on infant mortality show a current rate one-sixth that of 50 years ago, down 7.7 percent.

This past year alone, in some States now barely over 14 per 1,000 live births. Some data for specific populations is not good. Though improving, mortality in some black communities exceeds that national average by 30-50 percent. One might logically ask why.

Some surely relates to poverty, poor nutrition, or accessibility to prenatal care, but some in depth studies correlate this excessive infant mortality primarily with the level of education achieved by the mother. An indictment of our educational system perhaps, not the health care system per se.

Other data reveal crises of an entirely different nature. Consider a few: California 1950 to 1968; ages 1-4 years, deaths from auto and other accidents increased from 31 percent up to 45 percent, deaths from influenza and pneumonia declined by 25 percent; between ages 15 and 24 years, accidental deaths, homicides, and suicides accounted for over 90 percent while death from cancer decreased by one-sixth. Tuberculosis disappeared entirely.

In 1968, deaths from communicable diseases were 18 percent of 1930, 30 percent less than 1950.

In summary, while admittedly in need of continuing improvement, the much maligned system in this country does serve the majority of the people well. We also note that of all institutions and professions, only medicine today evokes a vote of confidence from a majority of the public. I am sure you are all aware of a recent poll in which 61 percent of Americans expressed substantial confidence in medicine while fewer than one-third have similar confidence in organized labor, advertising, news media, Government, or even organized religion.

The system has been subject to a number of pointed criticisms. Some of these are alleged fragmentation, lack of formal structure and organization, accessibility, costs, financing through the private health insurance industry, and the need for quality control.

We are aware of and deplore specific instances of individuals frustrated by an inability to find a doctor or the right doctor at the right time in the right place, or instances of ineptitude, indifference, or apparent avarice. Our profession is dedicated to correct these deficiencies and transgressions. So far as the system is concerned, however, consider its strengths. How does it usually respond? At this very minute, a million or more people are being ministered to directly in doctors' offices, clinics, hospitals, diagnostic and treatment centers all over this country. In the average city, the average person with an established personal physician may be receiving consultation concerning an acute or chronic illness, advice as to how best to manage it, having an appointment made for further evaluation, referral to an appropriate specialist or facility, arranging emergency transportation, arranging home health care, physical therapy, psychiatric evaluation, a host of services generally available in most urban communities.

Although the many components of medical services and facilities may not always be neatly arranged on shelves in supermarket fashion, fragmentation is far more apparent than real, and the system is in fact frequently very well organized. For the person with access to this mainstream of medical care, it can and does most often respond well.

Two key words dominate the successful operation of our system: access and mainstream. Many people lack access to mainstream health care either from lack of education or lack of personal initiative to seek it. Here greater emphasis on health care education is needed. Others, lack access to mainstream health care because of geography or cost.

The problems of rural health are substantial but ought to be dealt with separately. The numbers of people are small and the geography vast. Fewer than 3 percent of the population reside more than 20 miles from some medical facility. It is likely that a transportation system has more to offer these people than redistribution of personnel or facilities.

Lastly, means need to be devised to provide access to health care for that 10 to 15 percent for whom the barrier currently is cost. In this regard, several points need emphasis:

First, there is no question but that reducing financial barriers to obtaining medical care results in the delivery of more and better health care services of better quality to more people.

Second, it is possible to provide mainstream health care to most disadvantaged people by introducing them into it. It is not necessary to move the mainstream.

Third, the sharp contrast between the implementation of title XVII and title XIX in most States should amply demonstrate that the direct administration of a totally free program of medical care by governmental agencies inevitably produces both astronomical costs and second class care.

In California, title XIX, covering 1 percent of the national population, now costs \$1.5 billion. Simple arithmetic might suggest that expansion to the entire population might require \$150 billion.

Though severely criticized of late, the private health insurance industry has performed exceedingly well, does protect most families from excessive loss, has steadily improved the coverage available and

has demonstrated its capacity to meet new challenges as they appear. At present, 89 percent of all people do have some form of health insurance, and nearly 40 percent of major medical or catastrophic coverage which is 10 times the number covered 15 years ago. Only such a flexible financing system could possibly meet the escalations of costs attended by inflation, increased demands for services, tremendous advances in medical technology, a doubling of wages for nurses and technologists, and many more and simultaneously permit the rapid application of advances in medical science as each becomes available.

In the past 5 years many have placed great emphasis on needs for quality control. We concur. Hospital medical and surgical audit and committees are familiar to you, I am sure.

The Joint Commission on Hospital Accreditation, State medical association survey programs, accreditation boards for specialists and of general practitioners by the American Association of Family Practice, certification of continuing education programs by the American Medical Association and specialty and State associations and other programs of real peer review under constant revision and improvement over many years attest to medicine's continuing voluntary commitment to deliver only the best medical care humanly achievable.

State and county societies have also addressed themselves to reviews of utilization and costs. I was pleased to note that your chairman, Mr. Mills, had an opportunity to observe a local medical society review committee. Prior to judging the ability of such committees to meet the challenges of peer review, we hope that all Members of Congress avail themselves of similar opportunities. In my county alone, each month approximately 800 doctors serving on approximately 75 such committees contribute over 3,000 man- and woman-hours to this tedious review process.

Much virtue has been attributed to the development of group practice as a means to deliver more care to more people at lower costs. Very recently a variation of this theme has been introduced, called health maintenance organizations. In this regard, we have several observations.

First, some very good groups do exist. Some very bad ones exist.

Second, when cost containment is paramount issue, closed panel, prepaid, capitation groups come to the fore, but in those multispecialty groups best known for medical progress and excellence of care such as Mayo, Cleveland, Leahy, Ochsner, Scripps, Sansom, Palo Alto, and others, fee for service, freedom of choice, and individual responsibility dominate. I cannot emphasize that too much for you.

Third, much of the cost savings by closed panel prepaid groups is effected by curtailment of some services and community responsibility.

Fourth, in most medical communities, the very best physicians simply will not join such groups.

Lastly, regardless of what the Federal Government does in this area, many large business corporations, insurance companies, and financial institutions have entered the health care field for the purpose of merchandising, marketing, and delivering medical, hospital-related health services to some segments of the population.

This will continue with or without the infusion of large sums of tax dollars. In our opinion, artificially structured, closed panel, prepaid group medicine, attempting to provide medical services within the structures required by Federal subsidy will fall of their own weight and will prove to be extraordinarily expensive experiments.

We question the wisdom of expanding this concept until the results of the several pilot projects can be evaluated.

In conclusion, members of the committee, we submit that despite its shortcomings, the American health care system developed in a voluntary system of free enterprise, under constant voluntary review, revision and improvement, supported by a healthy voluntary health insurance industry, providing a multiplicity of delivery and funding, options for the public to choose among, free till now from bureaucratic structures, rigidity and restraint, flexible enough to meet changing needs and times has, on the record, served the American people well, does still provide the highest quality of medical care of any nation in the world and will continue to do so in the future.

As your committee seeks means to assure access to first-class mainstream health care for all people, we urge that the mechanism devised not disrupt the system under which 90 percent of our patients now receive their medical care, but that you build upon its strengths, make maximal use of private endeavor, provide maximal incentive to the private sector to meet the needs of the entire population with minimal interference on the part of Government, and that solutions be sought only for real needs of real people not as an exercise in grandiose social theory.

Thank you very much.

The CHAIRMAN. Thank you, Dr. Boyle.

We appreciate very much your very fine statement and appreciate you having those at the table here with you.

Are there any questions of Dr. Boyle? Mr. Pettis?

Mr. PETTIS. Mr. Chairman.

I join you in observing that this has been a very stimulating experience. I would just like to point out to Dr. Boyle because he was in the audience earlier that we certainly have a variety of plans submitted to the committee. We have had one proposal this morning to the point that the Kennedy-Griffiths bill was only a half a loaf and we ought to go far beyond that. So obviously there are many proposals as to how we should distribute medical care more equitably and in a better fashion.

I was just wondering how you would respond specifically to some of the suggestions that were made earlier today on the point of providing medical services in two areas of great need; namely, the rural and the ghetto.

You did refer briefly as to how we might accomplish something in the rural areas by improving transportation. How would you propose solving this real problem in the ghetto where it is very difficult to keep physicians.

Dr. BOYLE. I commented on both areas, Mr. Pettis.

First of all, so far as rural medicine is concerned, there are systems that are developing which have great promise. In California there is a program in King City where the doctors in the King City medical

group have developed a mechanism of sending nurses out into the field for continuing health supervision to find people who need to be brought into the city to receive care for their ongoing problems.

They also provide an emergency service with which some of these people can be reached very rapidly. For certain other populations it is going to be necessary to provide very rapid emergency care.

Whether this is with the use of a health care assistant or someone else who is going to provide that immediate care right now I think remains to be determined as these programs evolve.

For concentrations of people in rural areas there is a program in Oklahoma in which a clinic has been built, a small number of hospital beds provided and the physicians working there are members of the faculty of Oklahoma State Medical School.

They commute back and forth weekly so that they are a part of the general medical community. There are things such as this that will help. One thing that might help would be to use the kind of incentive that was used to bring people into Puerto Rico some little while back where they were given tax exemption for a certain amount of their income.

If you were to provide that kind of incentive you might persuade groups of doctors to go out and stay in a rural area for longer periods of time.

With respect to health care in the ghetto or inner city, we have had a good experience with that in Los Angeles. Up until 1965, the area known as Watts Willow Brook which is south central-southeast Los Angeles approximately 25 square miles with a population of about 225,000 people had eight doctors and no accredited hospitals.

Since these people were in 1965-1966 brought into the mainstream of medical care in California, there are now about 80 doctors practicing in that same area.

Some of the facilities have been improved so that they can be accredited. Approximately half of those doctors are board-certified men.

The same happened in east Los Angeles where many young well-trained family practitioners and specialists moved into the east Los Angeles area because they were now able to take care of these people.

It is not simply because they are able to be reimbursed but they are able to rent an office, pay for the equipment they have to have, able to put them in a hospital and follow through their illness, able to take them through a diagnostic facility.

They are able to continue their care and it is not fragmented by virtue of having to send them to a county hospital or some facility far away. In 1969 and 1970 the State government began putting more and more restrictions on the program so that it became less possible to continue the care of these people.

Hospitalization became more difficult and it is even more difficult now than it was then.

As a consequence, now that immigration has stopped and some of these people are now moving out. So that I say it is possible to move people into the mainstream if through one mechanism or another one is able to remove the financial barrier.

Doctors will go and take care of those people in those areas.

Mr. PETTIS. I think that is a rather fascinating story to go from eight to 80 physicians in a short period of time in an innercity program. It is something to which this committee should give some consideration.

Dr. BOYLE. They could give care on a one-to-one basis to most people they wanted to take care of.

Mr. PETTIS. Thank you, Mr. Chairman.

The CHAIRMAN. Are there any further questions?

If not, we thank you, Dr. Boyle for coming.

Dr. BOYLE. Thank you.

The CHAIRMAN. The American Association of Clinical Urologists, Dr. Russell Carson and Dr. Charles A. Hoffman.

If you will identify yourselves and the gentleman at the table with you for the record we will be glad to recognize you, sir.

**STATEMENT OF DR. RUSSELL CARSON, SECRETARY-TREASURER,
AMERICAN ASSOCIATION OF CLINICAL UROLOGISTS; ACCOMPANIED BY DR. CHARLES A. HOFFMAN**

Dr. CARSON. Mr. Chairman and members of the committee, I am Dr. Russell Carson of Fort Lauderdale, Fla.

With me here at the table is Dr. Charles A. Hoffman of Huntington, W. Va.

We regret that Dr. Tom Nesbit had a previous speaking engagement this morning and could not come. He sends his regrets also to Representative Fulton.

The CHAIRMAN. We are glad to have you with us, both of you, and you are recognized.

Dr. CARSON. I am a practicing urologist in private practice. I am also the secretary-treasurer of the American Association of Clinical Urologists, board certified, and a member of the American Urological Association, the International Society of D'Urologie, and so forth.

Dr. Hoffman is also a practicing urologist, also a past president of the American Association of Clinical Urologists, past president of the American Urological Association, and currently president-elect of the American Medical Association.

As representatives of the specialty of urology, we would like to make recommendations to you about the form of health insurance legislation which we believe would be most beneficial for the average American. Our governing body has determined that the needs of our patients would be best met by certain provisions of the American Medical Association's medicredit bill, H.R. 4960. While we will not comment on the specific financing mechanism, that is, tax credits, we wish to support the basic concepts as provided in the medicredit bill which will offer health care protection in the best interests of our patients.

Our reason for not commenting on tax credits is because our group does not possess sufficient knowledge in this area so that we might offer worthwhile testimony as to the best about financing. We do, however, feel that the use of voluntary participation and of the private health insurance industry for administration are worthwhile attributes of their plan. The features of the medicredit proposal which provide

insurance protection for the medically needy and catastrophic coverage for all, will meet the special situations of medical need and occasional medical hardship of the patients we serve.

Gentlemen, we as urologists, approximately 6,000 strong, represent an important specialty in medicine having concern primarily with diseases of the vital kidney and urinary tract which affects persons at the two extremes of life span. Our specialty has developed the sub-specialty of pediatric urology. In the fall years of life we are confronted with the geriatric, degenerative diseases of the kidney, prostate, and so forth. Both of these age periods are of especial interest to you of this committee in your concern for the providing of and continuing availability of adequate, fair and reasonably priced medical care for all who need the care. As urologists we are concerned with congenital defects of the urinary tract, a system of organs subject to more, and certainly as serious, birth defects as any organ system of the body and with critical life threatening infections of infancy and childhood, and with disease such as nephrosis and nephritis which cripple the child for the remainder of life.

We are concerned with the conditions of the aging person such as high blood pressure, pyelonephritis—infections of the kidney—kidney stone disease, and with the most frequent cancer of the adult male, and so forth, that involving the prostate gland. We are vitally involved in organ preservation and transplantation. The major long-term life-providing success in this area has been that of kidney transplantation.

To illustrate the problems which confront some of our patients, may I give you a couple of examples. Take the case of the young family with two children like the one I visited in the University of Florida a month ago where the 8-year-old youngster is now enrolled and doing well in grade school, his sister is 12 and just going into high school, his mother is in nursing training and his father is studying at the University School of Architecture.

This family came to me 7 years ago with a child whose congenital defect had practically destroyed both kidneys, I have seen him almost every month for 7 years until the last year. This is the 8-year-old child I have just referred to. It has taken nine operations and about a year and a half of hospitalization to salvage this youngster, at a cost of approximately \$15,000. He is now doing well in his grade school. Financing in this case was no problem because the father was in the Army and the medical care needed was subsidized for the family by the military service. This would have hardly been possible in any other circumstance or it would have been a financial burden too great for any young family to have afforded. We are happy that the Mediredit bill which we support has a catastrophic provision which would take care of an example such as this.

Let me give you another example at the other end of the lifespan. It is an example of a gentleman of 81 years who, for the past 5 years, has been under constant treatment by radical surgery, cobalt therapy and medication, and so forth for the control of a cancer of the prostate. This man, who is dependent on his social security and a small life savings and who is without a retirement fund, and who does not qualify for medicaid, has been able to receive adequate treatment, pay his doctor bills, and maintain his dignity through the assistance of

medicare. Here again the medicredit proposal will maintain this portion of the health care package; it does not seek to repeal medicare.

We are appearing before you today with a request, a plea to make it possible for all Americans to obtain truly needed health care, but at the same time protect the taxpaying citizen by not giving away that which is not needed.

Ideally we need recipients who are sufficiently informed about how to use the health care which is available to them.

We do not believe that the Federal Government should be involved in the direct delivery of health care, but should be limited in its activities to assisting in the financing, when necessary, of such health care facets as—

(1) The financing of basic and catastrophic health care.

(2) Assisting in the development of and distribution of health care personnel by incentives and adequate supply; that is, manpower legislation.

(3) Assisting in providing for adequate health facilities; that is, the Hill-Burton Act and others; and

(4) Providing for basic health education, disease prevention, and physical fitness which are the real bases of preventive medicine.

We deplore any nationalized conception and forced labor approach to medical care. Ask my patient who arrived from Havana, Cuba, last Monday how he fared with his free government medicine. Ask not the system, but the housewife of South Hampton, England, or Upsalla, Sweden, which she would prefer, the clinic line and 3-minute consultation or a visit to her own family doctor in Hagerstown, Md., or some other town in the United States. I did just that years ago.

Mr. Chairman, we appreciate the opportunity afforded our association to comment on the problem before you. If our association can be of assistance next year when your committee is engaged in executive sessions, please don't hesitate to call on us.

We thank you very much.

The CHAIRMAN. Dr. Carson, we thank you, sir, for your very fine statement. We appreciate what you have said.

Are there any questions of Dr. Carson? If not, we thank you again, sir.

Dr. CARSON. Thank you very much.

The CHAIRMAN. Dr. Murray Elkins.

Dr. Elkins, if you will identify yourself for our record we will be glad to recognize you, sir.

STATEMENT OF DR. MURRAY ELKINS, QUEENS COUNTY, N.Y.

Dr. ELKINS. Mr. Chairman and members of the committee, my name is Dr. Murray Elkins. I am president-elect of the Medical Society of the County of Queens, New York City. I am a graduate of the Jefferson Medical College of Philadelphia, class of 1933.

Although I am president-elect of the Medical Society of the County of Queens in New York City my remarks will not be as its spokesman. I shall speak as an individual, as a general practitioner, as a family physician for more than 35 years.

With the exception of 3½ years as a captain in the Medical Corps of the Army of the United States in World War II, I have served my

patients in the low- and medium-income community of Howard Beach. I have office hours. I treat my patients in Peninsula Hospital Center when they require hospital care. I have delivered more than 1,500 babies. I make house calls.

This presentation will cover five areas.

1. The so-called national health crisis: During the past two decades when demand for every day all inclusive medical care has risen rapidly the supply of family physicians has steadily declined. Approximately 8,500 new physicians have been graduated from our medical colleges per year. With present increased enrollment there should be about 12,000.

Since less than 3 percent enter general practice there will only be about 360 new family physicians graduated per year, about seven per State, hardly enough to replace the older age group being lost by retirement and death. If the enrollment of new physicians were doubled or trebled, there would still be a paucity of family physicians whether practice were to continue in its present form, under national control, or by group practice.

There is hardly a medical delivery care problem that could not be solved by adequate numbers of family physicians available to give all people the primary care they urgently require and deserve.

Who is going to make the house calls sick people need? The present generation of general practitioners, family physicians if you will, are vanishing Americans, retiring out and dying out after many decades devoted to individual and family service. They are an army of foot soldiers being decimated by attrition and death without numerical replacements.

Mr. Chairman, it is gratifying for me to note that in the past 2 weeks since this was prepared, Congress has passed legislation to encourage physicians to enter family practice.

2. The incredible waste of hundreds of millions of dollars in the medicaid program:

(a) Medicaid in New York City pays from about \$13 to \$65.41 per patient per visit to a hospital clinic. The average is about \$35.

(b) The same clinic physician treating the same patient providing the same medical service in his office receives \$4.80 less a 20-percent coinsurance feature now in effect, or \$3.84.

(c) It requires only simple arithmetic to ascertain that for every million medicaid clinic visits compared with the same visits to doctors' offices the net savings in medicaid funds would be more than \$30 million. This does not include the additional huge sums paid to out-patient clinic physicians working on a \$15- to \$30-per-session basis.

(d) The great majority of medicaid patients return to clinics for routine, repeated, and frequently unnecessary expensive laboratory and X-ray examinations.

(e) Add the unnecessary visits these patients make merely for refills of their allowed monthly supply of medication (again at an average of \$35 per clinic visit).

(f) A taxpayers' suit was reported in the public press to prevent busing of schoolchildren eligible for medicaid to a private hospital for routine medical examinations. The cost at school was \$3.50 per child. The same physical examination at the hospital clinic was a mere \$35.57.

These facts and figures are well known to medicaid and health officials in New York City. They were sent to four city councilmen. I offered them as testimony at a congressional hearing on June 5, 1971, in Queens. They are part of the Congressional Record. I forwarded the information to three U.S. Congressmen but none seemed to really listen or care. Only one replied to my letters.

3. Ghetto medicine: Much has been written and said concerning lack of access to medical care by people living in slums and ghettos. This is untrue. Medical services are available to all whether in physician's office, clinic, health center, or hospital emergency room.

Critics quote statistics revealing increased incidence of disease and higher mortality figures in ghettos. Mortality statistics of whites to nonwhites are shocking: 6 years' shorter life expectancy, twice the infant mortality, a greater maternal mortality. It is deplorable and appalling to have slum areas without a doctor. But change in the system of delivering medical care will not reduce these figures. The problem is hardly soluble by encouraging or forcibly compelling physicians into these slums. The rational solution is elimination of the slums, demolition of the ghettos, transplantation of our underprivileged people from the unclean, from the abominable, from the contaminated, where disease and deprivation are rampant, to the clean, the livable, the healthy.

How can a devoted physician and his family brave the dangers lurking in the ghettos? Physicians are being mugged, robbed, stabbed, shot, murdered. They are being mugged making house calls, they are being robbed in their offices, they are being murdered by the very ghetto dwellers they dedicate themselves to serve.

The number of physicians practicing in Queens and in our neighboring county of Brooklyn has been drastically reduced because of this threat. Many doctors' offices are locked. Some have security guards at the door. Others have permits for and carry guns. Those who have moved out have done so to protect themselves and their families from attack.

4. Group practice:

Many are convinced that comprehensive prepaid group practice is the most desirable, most economic method of delivering highest quality medical care to the people of the United States. The Kaiser-Permanente plan in the West and the health insurance plan in the East are frequently mentioned as the epitome of medical practice, as the master plans after which future medical practice should be patterned. Yet, though there has been open enrollment for many years and frequent advertisements in the press, a relatively small percentage of the public has chosen the golden opportunity to avail itself of these closed panel panacea-promising medical care plans.

Where employees have been coerced or otherwise mandated into a closed panel group by their employers, many continue to utilize it for only routine, relatively minor conditions, but seek "their own physician or surgeon" when major illness strikes.

The Kaiser Foundation health plan in northern California has raised its rates 9 percent, the third raise in less than 2 years. The big closed panel considered to be a model of cost effectiveness by some governmental advocates increased rates 7.5 percent early in 1970 and

18 percent in 1969. This representative model of management, organization, and efficiency, then, raised its rates 34 percent since 1969. It is understood to be requesting still further increases now.

Data compiled by the Social Security Administration from bills paid by medicare intermediaries is most informative and significant. The medicare experience with prepaid group practice concerns enrollees in the health insurance plan in 1969.

It revealed that for the medical insurance part of medicare, the HIP experience was 35 percent higher than the medical insurance per capita costs for non-HIP enrollees. And the total per capita medicare reimbursements of HIP enrollees was 11 percent higher than for other New York area enrollees.

Experience in New York City is particularly significant. City employees were originally compelled to accept HIP for their health care. As years passed, the dissatisfaction of coerced subscribers reached such intensity that their unions finally forced municipal government to permit these employees free choice of plan and facility. Of 400,000 HIP enrollees, 230,000 or 57 percent left this fully prepaid group capitation practice to join Blue Shield, GHI, or other health insurance plans. Teachers, firemen, policemen, sanitation men, and others, under great duress from their superiors, broke the shackles binding them to a plan they found offensive or unsatisfactory. They accepted the obligation willingly to pay the differential between their chosen plan allowance and their physician's normal fee as small price for medical liberty. More recently, the flow has been as follows: Of those who chose the various plans, 2,300 have chosen UMS, 2,000 have chosen GHI, and only 400 transferred into HIP.

5. The hospital cost component of health care: The press and media headline the high cost of health care, yet fail to differentiate between the hospital cost component and physician cost component. Such a separation is indispensable to place costs in their proper perspective.

I will deviate from my prepared sentences, because I have more recent figures from Social Security Administration which I believe are more significant.

Of the bills spent for health care, 63 percent went for hospital and nursing home care, 14 percent went for physicians' fees, and 22 percent for other expenses such as drugs, dentist services, eyeglasses, administration, and other professional services.

So that out of the total cost dollar, 14.7 percent went for physicians' services.

Hospitals have taken aggressive advantage of the cost-plus formulas by which they are Blue Cross or Government funded. They employ extra personnel at will to augment their stature and expand facilities not directly essential to patient care. These unnecessary costs contribute to the high hospital daily rate.

A hospital bill is submitted, and, gentlemen, you will find it just past the summary remarks, past No. S-6. This is being submitted to illustrate the high cost of health care. It is a usual and not extraordinary bill. It is of a patient admitted for treatment necessitating a surgical operation requiring a moderate number of blood transfusions. The fees for laboratory tests alone total \$781. These are done in bulk,

utilizing laboratory automated apparatus by salaried technicians, yet the hospital charges Blue Cross for each test. X-ray charges in this not unusual case amount to \$412.

The amount for laboratory and X-rays totals \$1,200. The hospital bill for this 21-day admission, exclusive of medical care, was \$4,660. It is from a hospital in the borough of Manhattan.

I do not mean to imply that all is well and healthy with the medical profession, or that any one system is best for all. I am certain that physicians shall continue to improve the quality of medical care for their patients. No one system will solve all the problems. Expenditure for medical care has been called "a bottomless pit." Senator Kennedy's and similar plans would have this country plunge into the inextricable depths of that bottomless pit to unquestionable bankruptcy.

I believe a new national health insurance law is indispensable. I firmly believe that the Nation's health interest must be served by total, comprehensive, all-inclusive, prepaid insurance coverage every ailment to which the human race is heir. There must be complete prepaid-in-full hospitalization for all. But the people of the United States must retain the freedom to choose the system of care they prefer. Let those who desire closed panel group practice have it, but do not deprive others of retaining the present intimately personal method. Do not exclude their democratic option. Do not deny them the freedom of alternative.

Mr. Chairman, my recommendations in short are as follows:

1. That Government should urge medical colleges to establish special departments and programs in the field of family practice.

If Congress would pass such a bill, which I understand it has, I would certainly strongly urge its rapid implementation, because it takes 5 or 6 or 8 years to produce a family physician, and the medical colleges of this country have not cooperated sufficiently to encourage their students to go into family practice.

2. I believe investigation is advisable and measures should be taken to eliminate the incredible waste of hundreds of millions of dollars in the medicaid program.

I did not include in this, Mr. Chairman, the horrendous waste of medicaid funds in nursing homes. There are tens of thousands of people who don't need care in nursing homes until the time they die, but are left there because of the fact that families have been absolved of responsibility of caring for them.

I am in contact closely with two nursing homes. I visit them frequently. I see these people. I am on the medical review committee of both these nursing homes, and I assure you that with proper investigation a sizable percent of these people for whom the Government is paying \$225 to \$250 a week could be discharged to their homes.

3. Medical care for the underprivileged and poor requires total elimination of the ghettos.

Mr. Chairman, I do believe that, if all the money that was being wasted in medicaid and in some welfare programs were to be mobilized, the ghettos of the United States could be eliminated.

4. I further believe that we should allow the people to choose the system of medical care they prefer.

5. Federal, State, and local studies are indicated to reduce the unnecessarily high cost of hospital care.

6. Physicians actively engaged in practice should be consulted concerning the health needs of their patients.

Mr. Chairman, members of the committee, it seems to be almost ridiculous, in my opinion, for many agencies on all levels, when they are formulating plans for health, to contact lawyers, engineers, health administrators, and deans of medical colleges, and forget to contact the man in the field who is actually practicing medicine, and our group of medical practitioners is just not contacted.

I have added a seventh recommendation, Mr. Chairman, and that is that any and every national health insurance law should include a deductible and a co-insurance feature to minimize overutilization and prevent financial failure. Any plan, which gives the people the right to seek every type of medical care any time they want it is going to be defeated by the very people for whom it is intended. It is natural for them to overutilize it, and when they do, they will be depriving sick individuals of the care they need.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Elkins, for a very fine statement.

Without objection, the material appended to your statement will be made a part of the record at this point.

(The material referred to follows:)

Description	Code	Posting date	Total charge	3003	Amount payable by patient
Daily care.....	1743 SP	Sept. 1	97.00	37.00	60
Do.....	1743 SP	Sept. 2	97.00	97.00	
Packed red cell S-1 ut.....	1102	do.	25.00		25
Do.....	1022	do.	25.00		25
Do.....	1102	do.	25.00		25
Do.....	1102	do.	25.00	25.00	
Do.....	1102	do.	25.00	25.00	
Do.....	1102	do.	25.00	25.00	
Blood prep-1 unit.....	1121	do.	20.00	20.00	
Do.....	1121	do.	20.00	20.00	
Do.....	1121	do.	20.00	20.00	
Do.....	1111	do.	20.00	20.00	
Do.....	1121	do.	20.00	20.00	
Do.....	1121	do.	20.00	20.00	
Electrocardiogram.....	4760	do.	22.00	22.00	
Cash payment.....	477004	do.			Cr 70
Daily care.....	1743 SP	Sept. 3	97.00	97.00	
Coulter package.....	0001	do.	4.40	4.40	
Differential.....	0005	do.	3.30	3.30	
Platelet count.....	0006	do.	5.10	5.10	
Sedimentation rate.....	0007	do.	2.20	2.20	
Reticulocyte count.....	0008	do.	5.10	5.10	
Plasma prothrombin.....	0012	do.	4.10	4.10	
Urea nitrogen.....	0052	do.	2.80	2.80	
Creatinine.....	0053	do.	6.60	6.60	
Total protein.....	0055	do.	2.80	2.80	
Albumin and globulin.....	0056	do.	2.80	2.80	
Total bilirubin.....	0059	do.	6.60	6.60	
Bilirubin fractions.....	0060	do.	6.60	6.60	
Transaminase SGO.....	0066	do.	5.00	5.00	
Transaminase SGP.....	0067	do.	5.00	5.00	
Calcium determination.....	0070	do.	5.50	5.50	
Phosphorus inorganic.....	0071	do.	7.70	7.70	
Phosphatase alkaline.....	0072	do.	7.70	7.70	
Lactic dehydrogenase.....	0074	do.	5.00	5.00	
Sodium determination.....	0075	do.	2.80	2.80	
Potassium deter.....	0076	do.	2.80	2.80	
Chloride deter.....	0077	do.	2.80	2.80	
CO ₂ content.....	0078	do.	2.80	2.80	
Urinalysis.....	0115	do.	1.10	1.10	
Creative P-kinase.....	0153	do.	9.90	9.90	

Description	Code	Posting date	Total charge	3003	Amount payable by patient
Special medical tubes.....	0856	do.	1.10	1.10	
Do.....	0856	do.	1.10	1.10	
Phosphatase alkaline.....	0072	do.	7.70	7.70	
Sherology test.....	0250	do.	10.60	10.60	
IV pyelogram XR.....	0400	do.	75.90	75.90	
Intravenous solutions.....	1951	do.	5.00	5.00	
Do.....	1951	do.	5.00	5.00	
Do.....	1951	do.	5.00	5.00	
Do.....	1951	do.	5.00	5.00	
Daily care.....	1743 SP	Sept. 4	97.00	97.00	
Urinalysis.....	0115	do.	1.10	1.10	
Do.....	0115	do.	1.10	1.10	
Transaminase SGP.....	0067	do.	5.00	5.00	
Phosphatase alkaline.....	0072	do.	7.70	7.70	
Berium enema XR.....	0401	do.	82.50	82.50	
Intravenous solutions.....	1951	do.	5.00	5.00	
Pharmaceuticals.....	1977	do.	3.25	3.25	
Daily care.....	1743 SP	Sept. 5	97.00	97.00	
Do.....	1743 SP	Sept. 6	97.00	97.00	
Do.....	1743 SP	Sept. 7	97.00	97.00	
Coulter package.....	0001	do.	4.40	4.40	
Serum iron.....	0215	do.	8.80	8.80	
Iron binding capacity.....	0216	do.	8.80	8.80	
Coulter package.....	0001	do.	4.40	4.40	
Differential.....	0005	do.	3.30	3.30	
Bact routine culture.....	0226	do.	16.70	16.70	
Blood credit—oie unit.....	1111	do.	Cr 25.00	Cr 25.00	
Do.....	1111	do.	Cr 25.00	Cr 25.00	
Do.....	1111	do.	Cr 25.00	Cr 25.00	
Pharmaceuticals.....	1975	do.	3.68	3.68	
Do.....	1981	do.	3.00	3.00	
Coulter package.....	0001	do.	4.40	4.40	
Reticulocyte count.....	0008	do.	5.10	5.10	
GI series and small int.....	0506	do.	126.50	126.50	
Intravenous solutions.....	1951	do.	5.50	5.00	
Packed red cells—1 ut.....	1102	do.	25.00	25.00	
Do.....	1102	do.	25.00	25.00	
Blood prep—1 unit.....	1121	do.	20.00	20.00	
Do.....	1121	do.	20.00	20.00	
Pharmaceuticals.....	1975	do.	4.80	4.80	
Do.....	1975	do.	3.20	3.20	
Blood credit—1 unit.....	1111	do.	Cr 25.00	Cr 25.00	
Do.....	1111	do.	Cr 25.00	Cr 25.00	
Daily care.....	1743 SP	Sept. 8	97.00	97.00	
Do.....	1743 SP	Sept. 9	97.00	97.00	
2 Hematocrits.....	2094	do.	6.38	6.38	
Coulter package.....	0001	do.	4.40	4.40	
Reticulocyte count.....	0008	do.	5.10	5.10	
Coulter package.....	0001	do.	4.40	4.40	
Reticulocyte count.....	0008	do.	5.10	5.10	
Pathological exam.....	0301	do.	44.00	44.00	
Packed red cells—1 ut.....	1102	do.	25.00	25.00	
Do.....	1102	do.	25.00	25.00	
Blood prep—1 unit.....	1121	do.	20.00	20.00	
Do.....	1121	do.	20.00	20.00	
Do.....	1121	do.	20.00	20.00	
Coulter package.....	0001	do.	4.40	4.40	
Plasma prothrombin.....	0012	do.	4.10	4.10	
1 unit of blood.....	1100	do.	25.00	25.00	
Do.....	1100	do.	25.00	25.00	
Do.....	1100	do.	25.00	25.00	
Do.....	1100	do.	25.00	25.00	
Do.....	1100	do.	25.00	25.00	
Do.....	1100	do.	25.00	25.00	
Blood prep—1 unit.....	1121	do.	20.00	20.00	
Do.....	1121	do.	20.00	20.00	
Do.....	1121	do.	20.00	20.00	
Do.....	1121	do.	20.00	20.00	
Do.....	1121	do.	20.00	20.00	
Electrocardiogram.....	1460	do.	22.00	22.00	
Pharmaceuticals.....	1975	do.	3.05	3.05	
Do.....	1977	do.	3.55	3.55	
Intravenous solutions.....	1951	do.	5.00	5.00	
Pharmaceuticals.....	1975	do.	3.30	3.30	
Daily care.....	1439 SP	Sept. 10	140.00	140.00	
Do.....	1439 SP	Sept. 11	140.00	140.00	
Coulter package.....	0001	do.	4.40	4.40	
Do.....	0001	do.	4.40	4.40	
Nonallergic tape.....	0921	do.	.60	.60	
Do.....	0921	do.	.60	.60	

Description	Code	Posting date	Total charge	3003	Amount payable by patient
Operating room to 3 hr.	1502	do.	375.00	375.00	
Sterile catheter	1536	do.	1.40	1.40	
Do	1536	do.	1.40	1.40	
Do	1564	do.	2.50	2.50	
Do	1564	do.	2.50	2.50	
Do	1564	do.	2.50	2.50	
Do	1564	do.	2.50	2.50	
Underwater drain, tubl.	1883	do.	1.40	1.40	
Blenderm tape	1893	do.	.50	.50	
Recovery room to 4 hrs	1924	do.	100.00	100.00	
Pharmaceuticals	1975	do.	3.35	3.35	
Do	1975	do.	3.95	3.95	
7 blood gas procedure	2088	do.	55.40	55.40	
5 hematocrits	2097	do.	15.80	15.80	
Urea nitrogen	0052	do.	2.80	2.80	
Erylase	0068	do.	11.60	11.60	
Sodium determination	0075	do.	2.80	2.80	
Potassium deter	0076	do.	2.80	2.80	
Chloride determ	0077	do.	2.80	2.80	
CO ₂ content	0078	do.	2.80	2.80	
Pathological exam	0301	do.	44.00	44.00	
Venous pressure set	0900	do.	6.00	6.00	
Sterile catheters	1030	do.	2.50	2.50	
Do	1030	do.	2.50	2.50	
Blood credit—1 unit	1111	do.	Cr 25.00	Cr 25.00	
Do	1111	do.	Cr 25.00	Cr 25.00	
Do	1111	do.	Cr 25.00	Cr 25.00	
Do	1111	do.	Cr 25.00	Cr 25.00	
Intravenous solutions	1951	do.	5.00	5.00	
Do	1951	do.	5.00	5.00	
Do	1951	do.	5.00	5.00	
Do	1951	do.	5.00	5.00	
Pharmaceuticals	1975	do.	4.75	4.75	
Do	1975	do.	3.90	3.90	
Daily care	1439 SP	Sept 12	140.00	140.00	
2 blood gas procedure	2083	do.	15.80	15.80	
Daily care	1439 SP	Sept 13	140.00	140.00	
Urea nitrogen	0052	do.	2.80	2.80	
Sodium determination	0075	do.	2.80	2.80	
Potassium deter	0076	do.	2.80	2.80	
Chloride determ	0077	do.	2.80	2.80	
CO ₂ content	0078	do.	2.80	2.80	
Pharmaceuticals	1975	do.	3.00	3.00	
Do	1975	do.	3.15	3.15	
Urea nitrogen	0052	do.	2.80	2.80	
Sodium determination	0075	do.	2.80	2.80	
Potassium deter	0076	do.	2.80	2.80	
Chloride determ	0077	do.	2.80	2.80	
CO ₂ content	0078	do.	2.80	2.80	
5 blood gas procedure	2086	do.	39.60	39.60	
Chest therapy halfhou	3400	do.	10.00	10.00	
Do	3400	do.	10.00	10.00	
Chest XR	0406	do.	31.90	31.90	
Special medical tubes	0856	do.	1.10	1.10	
Do	0865	do.	1.70	1.70	
Cont venous press SE	0882	do.	7.70	7.70	
Blood credit—one unit	1111	do.	CR25.00	CR25.00	
Do	1111	do.	CR25.00	CR25.00	
Oxygen mask admin.	2051	do.	15.80	15.80	
Oxygen catheter admi	2062	do.	15.80	15.80	
Throat suction	2064	do.	4.70	4.70	
Chest therapy halfhou	3400	do.	10.00	10.00	
Urinalysis	0115	do.	1.10	1.10	
Bact routine culture	0226	do.	16.70	16.70	
Do	0226	do.	16.70	16.70	
Special medical tubes	0856	do.	1.10	1.10	
Do	0856	do.	1.10	1.10	
Pharmaceuticals	1975	do.	4.00	4.00	
Intravenous solutions	1953	do.	15.00	15.00	
Pharmaceuticals	1981	do.	3.25	3.25	
Oxygen mask admin.	2051	do.	15.80	15.80	
Daily care	1467 SP	Sept 14	97.00	97.00	
Do	1467 SP	Sept 15	97.00	97.00	
Coulter package	0001	do.	4.40	4.40	
Do	0001	do.	4.40	4.40	
Platelet count	0006	do.	5.10	5.10	
Urea nitrogen	0052	do.	2.80	2.80	
Do	0052	do.	2.80	2.80	
Sodium determination	0075	do.	2.80	2.80	
Do	0075	do.	2.80	2.80	

Description	Code	Posting date	Total charge	3003	Amount payable by patient
Potassium deter.....	0076	..do..	2.80	2.80	.....
Do.....	0076	..do..	2.80	2.80	.....
Chloride determ.....	0077	..do..	2.80	2.80	.....
Do.....	0077	..do..	2.80	2.80	.....
CO ₂ content.....	0078	..do..	2.80	2.80	.....
Do.....	0078	..do..	2.80	2.80	.....
Urea nitrogen.....	0052	..do..	2.80	2.80	.....
Sodium determination.....	0075	..do..	2.80	2.80	.....
Potassium deter.....	0076	..do..	2.80	2.80	.....
Chloride determ.....	0077	..do..	2.80	2.80	.....
CO ₂ content.....	0078	..do..	2.80	2.80	.....
Pharmaceuticals.....	1975	..do..	3.10	3.10	.....
Daily care.....	1467 SP	Sept. 16	97.00	97.00	.....
Coulter package.....	0001	..do..	4.40	4.40	.....
Blood culture.....	0240	..do..	26.40	26.40	.....
Special tubing.....	0823	..do..	4.70	4.70	.....
Pharmaceuticals.....	1975	..do..	3.30	3.30	.....
Daily care.....	1467 SP	Sept. 17	97.00	97.00	.....
Coulter package.....	0001	..do..	4.40	4.40	.....
Abdomen XR.....	0405	..do..	31.90	31.90	.....
Chest XR.....	0406	..do..	31.90	31.90	.....
Coulter package.....	0001	..do..	4.40	4.40	.....
Urea nitrogen.....	0052	..do..	2.80	2.80	.....
Sodium determination.....	0075	..do..	2.80	2.80	.....
Potassium eter.....	0076	..do..	2.80	2.80	.....
Chloride determ.....	0077	..do..	2.80	2.80	.....
CO ₂ content.....	0078	..do..	2.80	2.80	.....
Abdomen XR.....	0405	..do..	31.90	31.90	.....
Chest XR.....	0406	..do..	31.90	31.90	.....
Urinalysis.....	0115	..do..	1.10	1.10	.....
Pharmaceuticals.....	1976	..do..	6.80	6.80	.....
Do.....	1976	..do..	6.80	6.80	.....
Daily care.....	1467 SP	Sept. 18	97.00	97.00	.....
Blood culture.....	0240	..do..	26.40	26.40	.....
Pharmaceuticals.....	1975	..do..	2.85	2.85	.....
Do.....	1975	..do..	2.85	2.85	.....
Daily care.....	1467 SP	Sept. 19	97.00	97.00	.....
Do.....	1467 SP	Sept. 20	97.00	97.00	.....
Coulter package.....	0001	..do..	4.40	4.40	.....
Nonallergic tape.....	0922	..do..	.60	.60	.....
Do.....	0922	..do..	.60	.60	.....
Do.....	0922	..do..	.60	.60	.....
Do.....	0922	..do..	.60	.60	.....
Pharmaceuticals.....	1976	..do..	6.80	6.80	.....
Urea nitrogen.....	0052	..do..	2.80	2.80	.....
Sodium determination.....	0075	..do..	2.80	2.80	.....
Potassium deter.....	0076	..do..	2.80	2.80	.....
Chloride determ.....	0077	..do..	2.80	2.80	.....
CO ₂ content.....	0078	..do..	2.80	2.80	.....
Pharmaceuticals.....	1977	..do..	7.45	7.45	.....
Daily care.....	1467 SP	Sept. 21	97.00	97.00	.....
Total.....			4,660.91	4,525.91	65

I am a graduate of the Jefferson Medical College of Philadelphia, class of 1933. Although I am President-Elect of the Medical Society of the County of Queens in New York City my remarks will not be as its spokesman. I shall speak as an individual, as a general practitioner, as a family physician for more than thirty-five years. With the exception of 3½ years as a Captain in the Medical Corps of the Army of the United States in World War II I have served my patients in the low and medium income community of Howard Beach. I have office hours. I treat my patients in Peninsula Hospital Center when they require hospital care. I have delivered more than 1,500 babies. I make house calls.

This presentation will cover five areas.

I. THE SO-CALLED NATIONAL HEALTH CRISIS

For some time and with increasing frequency and prominence there has been profound criticism of the medical care available to the people of this country. Physicians in general and neighborhood practicing physicians in particular have been slandered and defamed because of apparent unavailability twenty-four hours a day, seven days a week, 365 days a year. They have been maligned and vilified for apparent unavailability on Wednesdays and weekends. There are charges and accusations for refusal to make house calls. Yet few critics lay the blame where it belongs.

During the past two decades when demand for every day all inclusive medical care has risen rapidly the supply of family physicians has steadily declined. The family physician, the general practitioner, is a vanishing American. He is dying out and being only fractionally replaced. For example, in some New England states only 20% of General Practitioners are under fifty years of age while 80% are over 50. More significantly, in the younger age group, only 6% are aged 30-39 while there are less than 1% under 30.

Approximately 8500 new physicians have been graduated from our medical colleges per year. With present increased enrollment there should be about 12,000. Since less than 3% enter general practice there will be only about 360 new family physicians graduated per year, about 7 per state, hardly enough to replace the older age group being lost by retirement and death. If the enrollment of new physicians were doubled or trebled, there would still be a paucity of family physicians whether practice were to continue in its present form, under national control, or by group practice. Governor William T. Cahill of New Jersey recently indicated that community health care must take precedence and priority over the training of specialists and researchers. Succinctly, he stated "There are not enough general practitioners of medicine. 75% of medical school graduates now go into specialties that have little or no relevancy to the immediate needs of cities. A New England report concludes "the steady and rapid decline in numbers during recent years leaves little doubt that the general practitioner will become increasingly rare and will, for practical purposes, soon disappear. Congress approved a bill to provide \$425 million over a five year period for grants to medical schools and hospitals to assist them in establishing special departments and programs in the field of general practice. President Nixon's veto of this beneficial measure was truly inopportune and unfortunate.

There is hardly a medical delivery care problem that could not be solved by adequate numbers of family physicians available to give all people the primary care they urgently require and deserve.

Who is going to make the house calls sick people need? The present generation of general practitioners, family physicians if you will, are vanishing Americans, retiring out and dying out after many decades devoted to individual and family service. They are an army of foot soldiers being decimated by attrition and death without numerical replacements.

Many and varied statistics have been published, copied and recopied purporting to indicate that morbidity and mortality statistics in the United States suffer by comparison with those of foreign nations. By inference it is suggested the fault lies with the medical profession and the present health care system. Yet the major preventable deaths are hardly the result of the system but of the behavior, habits and recklessness of the individuals involved. For example, cancer of the lung directly related to cigarette smoking is the most common cancer in men. Its incidence in women, rare at the turn of the century, is increasing so rapidly in this country that it has doubled in the past ten years. Its curability even with the earliest detection is less than 10%. Heroin fatalities are now the leading cause of death in teen agers. Automobile and industrial accidents, suicide and homicide and drowning accidents are the most common causes of deaths in the 20-24 year age group. Many people do not seek and will not seek proper medical assistance no matter if the finest system of medical care is available because of negligence and apathy.

Many legislators, public health officials, deans of medical colleges, and other non-practicing physicians err in the belief that the most decisive, essential solution is to spend more money—lots and lots of it. It would certainly be a single cure, but the same mistake has been made in the past and is indeed being made today. Unfortunately, excellent or even good medical care cannot be mandated merely by allocating millions and billions of dollars to a program. In spite of the huge sums spent for the Medicaid program the quality of medical care has not been upgraded.

Early in 1971 the California Medicaid program faced a \$200 million deficit for the fiscal year caused by a budget that was declared unrealistic at the onset and vastly compounded by short-sighted estimates of the increase of Medi-Cal caseload, which is up 35% over last year. Is it the fault of the present method of delivery of medical care that the Medi-Cal caseload is up 35% in one year or is this an economic fact of life? Is the economic, social and medical failure of the abject shambles of a Medicaid program in the State of New York curable by

more bureaucratic control and inefficiency? Would spending more and still more money solve New York's or California's or any other state's Medicaid program health problems? Would it upgrade the medical care citizens receive or reduce morbidity or mortality statistics?

Training more doctors, nurses or paramedical personnel, although helpful, is not the answer either. In spite of the huge sums of money spent, the quality of medical care has not been upgraded. Medicaid patients still sit on the same clinic benches, have the same status, and receive the same care they received under the Welfare system.

II. THE INCREDIBLE WASTE OF HUNDREDS OF MILLIONS OF DOLLARS IN THE MEDICAID PROGRAM

Legislators have no primary knowledge of the basic principles of medical practice. Inspections, executive reports, surveys and investigations cannot provide the simple truths necessary to transfer deserved medical care from the physician provider to the needy patient recipient. Neither does an M.D. degree make an individual qualified to assess the methods of or make the rules for supplying such care. Public health officials, municipal, state and federal, trained in problems of public health are no more qualified to assess proper delivery of everyday clinical medical services than an allergist to perform brain surgery.

One cannot make the rules for good medical care unless he has been and is intimately connected with the treatment of patients on a day to day basis. It is incredible, but true, that public health officials and other appointees including Health Service Administrators, have made the rules without consulting the practicing physicians who have the know-how and devote all their time solving patient problems. Practicing physicians have not only not been consulted but deliberately and conscientiously ignored. A physician working in the clinic, in the best position to know the facts, could supply vitally interesting, simple arithmetical answers to the problems, such as:

1. Medicaid in New York City pays from about \$13.00 to \$65.41 per patient visit to a hospital clinic. The average is about \$35.00.

2. The same clinic physician treating the same patient providing the same medical service in his office receives \$4.80 less a 20% co-insurance feature now in effect, or \$3.84. It is distressing to imagine a physician saying to his indigent Medicaid patient, "In view of the 20% coinsurance feature now in effect, please pay me 96 cents the state legislative reduction does not allow."

3. It requires only simple arithmetic to ascertain that for every million Medicaid clinic visits compared with the same visits to doctors' offices the net savings in Medicaid funds would be more than \$30 million. This does not include the additional huge sums paid to out patient clinic physicians working on a \$15.00 to \$30.00 per session basis.

4. The great majority of Medicaid patients return to clinics for routine, repeated and frequently unnecessary expensive laboratory and x-ray examinations.

5. Add the unnecessary visits these patients make merely for refills of their allowed month's supply of medication (again at an average of \$35.00 per clinic visit). The waste in public funds squandered by this shambles of an illogical politically legislated ineffective Medicaid program reaches astronomical figures.

6. A taxpayers suit was reported in the public press to prevent busing of school children eligible for Medicaid to a private hospital for ROUTINE medical examinations. The cost at school was \$3.50 per child. The same physical examination at the hospital clinic—a mere \$35.57.

These facts and figures are well known to Medicaid and Health officials in New York City. They were sent to four City Councilmen. I offered them as testimony at a Congressional hearing on June 5, 1971. They are part of the Congressional Record. I forwarded the information to three U.S. Congressmen but none seemed to really listen or care. Only one replied to my letters.

II. GHETTO MEDICINE

Much has been written and said concerning lack of access to medical care by people living in slums and ghettos. This is untrue. Medical services are available to all whether in physician's office, clinic, health center or hospital emergency room. A prime cause of preventable morbidity and mortality in these areas is not medical unavailability but negligence. Many fail to seek or bring their children to

these facilities. The most paramount cause is the very ghetto into which our people are condemned.

Critics quote statistics revealing increased incidence of disease and higher mortality figures in ghettos. Mortality statistics of whites to non-whites are shocking: 6 years shorter life expectancy, twice the infant mortality, a greater maternal mortality. It is deplorable and appalling to have slum areas without a doctor. But change in the system of delivering medical care will not reduce these figures. The problem is hardly soluble by encouraging or forcibly compelling physicians into these slums. The rational solution is elimination of the slums, demolition of the ghettos, transplantation of our underprivileged people from the unclean, from the abominable, from the contaminated, where disease and deprivation are rampant, to the clean, the livable, the healthy.

How can a devoted physician and his family brave the dangers lurking in the ghettos? Physicians are being mugged, robbed, stabbed, shot, murdered. They are being mugged making house calls, robbed in their offices, murdered by the very ghetto dwellers they dedicate themselves to serve.

The number of physicians practicing in Queens and in our neighboring county of Brooklyn has been drastically reduced because of this threat. Many doctors' offices are locked. Some have security guards at the door. Others have permits for and carry guns. Those who have moved out have done so to protect themselves and their families from attack.

Could individuals or businessmen operate a facility in a neighborhood where their personnel and loved ones live in constant fear of physical harm, violence or death? The remedy for the ghettos is no less than their total elimination.

If the hundreds of millions dissipated in fraudulent or unnecessary Medicaid, Welfare and other governmental waste, were mobilized, the slums of the United States could be rapidly eradicated.

IV. GROUP PRACTICE

There are multiple solutions of the so-called national medical crisis. Many senators and congressmen have plans. State legislators have plans. Unions, hospital associations, labor unions, politicians, governmental agencies, have plans. Everyone seems to have a plan. Many are convinced that comprehensive prepaid group practice is the most desirable, most economic method of delivering highest quality medical care to the people of the United States.

The Kaiser-Permanente plan in the West and the Health Insurance Plan in New York are frequently mentioned as the epitome of medical practice, as the master plans after which future medical practice should be patterned. Yet, though there has been open enrollment for many years and frequent advertisements in the press a relatively small percentage of the public has chosen the golden opportunity to avail itself of these closed panel panacea-promising medical care plans. Where employees have been coerced or otherwise mandated into a closed panel group by their employers many continue to utilize it for merely routine, relatively minor conditions but seek "their own physician or surgeon" when major illness strikes.

The Kaiser Foundation Health Plan in Northern California has raised its rates 9%, the third raise in less than two years. The big-closed panel plan considered to be a model of cost effectiveness by some governmental advocates increased rates 7.5% early in 1970 and 18% in 1969. This representative model of management, organization and efficiency, then, raised its rates 34% since 1969. It is understood to be requesting still further increases now. It has been reported that Kaiser's low efficiency cost ratio of services is relative lower because $\frac{1}{3}$ of all care is obtained by members outside the plan at their own expense. My experience is similar. I treat many HIP enrollees who willingly pay a fee for service than tolerate the delays and medical and secretarial indignities a closed-panel system imposes upon them.

Do you gentlemen members of this committee go to a clinic for your medical care or do you prefer your own physician in whom you have implicit confidence? Would you like to wait on a clinic bench or seat until you are ushered into a strange physician's clinic examining room or do you prefer an appointment? Please bear in mind that when the citizens of this great country relinquish their medical freedom, their liberty to choose their physician and facility, this unrestricted privilege shall be irrevocably and irretrievably lost.

It has been said that Americans should have a system of universal public medicine to do for us what the Scandinavian and British systems have done for their countries. Such proponents fail to mention the almost complete lack of slums in Scandinavia. Nor do they mention that their suicide rate is one of the highest in the world. And what is so great about the British system where patients receive about two minutes of time for the average office consultation; where hospitals are hopelessly backlogged; where medical care is for the most part impersonal; where dissatisfied citizens have initiated a great resurgence to private practitioners outside the national health system for which they prefer to pay a fee for service; where large numbers of physicians have emigrated throughout the world to practice Medicine as free men in a free society in another country?

Data compiled by the Social Security Administration from bills paid by Medicare intermediaries is most informative and significant. The Medicare experience with prepaid group practice concerns enrollees in HIP in 1969. It revealed that for the medical insurance part of Medicare, the HIP experience was 35% higher than the medical insurance per capita costs for non HIP enrollees. And the total per capita Medicare reimbursements for HIP enrollees were 11% higher than for other New York area enrollees.

Senator Kennedy's plan not only encourages comprehensive prepaid group practice but provides broad authority for government to put doctors on salary. It provides payment for medical services rendered by full time physicians in hospitals or those practicing in prepaid groups. But patient services by physicians in private practice would be reimbursable only if adequate funds remained.

New York State Assemblyman Albert H. Blumenthal, deputy minority leader, has introduced a bill with two basic plans. The first would provide full group medical and hospital coverage for in and out patient care with no limit to the amount of treatment, doctors visits, days in hospital or prescriptions filled in participating pharmacies. The second basic plan would provide medical and hospital services for those who preferred a private physician not affiliated with a medical group. Those who joined this group would pay the first \$50.00 of treatment with a maximum of \$150.00 a family and for 20% of the cost of care under payment schedules arranged by the proposed New York State Health Insurance Corporation.

Could it be that those proponents of various plans, completely lacking in medical proficiency and experience are however uniquely qualified to pass national medical judgment without consultation or benefit of physicians in actual practice? Could it be that by their years of activity in government, law, business, public health or hospital administration, they are expert and "qualified" to choose the best method of providing the health care delivery system the great majority of the American people desire? Could it be that the people of this great country, reared by, taught and convinced of the principles of freedom and democratic selection prefer to retain and exercise their present right of free choice of physician? Could it be that the intelligent, discriminating John Doe of the United States prefers to preserve his inalienable right to his medical destiny than relinquish it to government control to which he will ultimately irrevocably subject?

Experience in New York City is particularly significant. City employees were originally compelled to accept HIP for their health care. As years passed the dissatisfaction of coerced subscribers reached such intensity that their unions finally forced municipal government to permit these employees free choice of plan and facility. Of 400,000 HIP enrollees, 230,000 or 57% left this fully prepaid capitation practice to join Blue Shield, G.H.I. or other health insurance plans. Teachers, firemen, policemen, sanitation men and others, under great duress from their superiors, broke the shackles binding them to a plan they found offensive or unsatisfactory. They accepted the obligation willingly to pay the differential between their chosen plan allowance and their physician's normal fee as small price for medical liberty. More recently, the flow has been as follows: 2300 have chosen U.M.S., 2000 have chosen G.H.I. and only 400 transferred into H.I.P.

If state or national medical compulsory group practice with fixed salary is mandated it would seem patently equitable to expect that every other service, group, industry or profession be similarly required to acquiesce and concur. Let there be uniform obligatory fixed salary conformity for the professions of law and engineering. Let there be complete consistency by providing equal, compulsory, standardized housing for all with landlords on fixed legislated salaries.

Let there be a ceiling on annual remuneration for corporate presidents and chairmen of the board. Let there be salary equality and ceiling in the fields of recreation. Let there be a minimum and maximum for radio and television commentators, for actors and actresses, artists, writers and composers, for entertainers, baseball, football players, golfers and heavyweight prize fighters. And let there be equality of housing so many may not exist in slums and ghettos while others luxuriate in expensive clothing and furs.

Governmental enactment of a coercive or compulsory group plan penalizing physicians desiring to practice as free men in a free society must inevitably result in disservice to the people for whom beneficial legislation is intended. The ultimate tragedy and evil shall not be the killing of the free practice of Medicine for the physician but rather the deprivation of the free people of these United States of the alternative to compulsion. They shall bear the ultimate punishment rather than harvest a blessing. They shall have forfeited and been deprived of the right to forever control their own medical welfare and destiny.

V. THE HOSPITAL COST COMPONENT OF HEALTH CARE

The press and media headline the high cost of health care yet fail to differentiate between the hospital cost component and physician cost component. Such a separation is indispensable to place costs in their proper perspective. In fiscal 1970 the largest single item of health expenditure, totaling \$25.6 billion was for hospital care, an increase of 15% over 1969. In the same period health expenditures for physicians was \$12.9 billion with a 7.2% increase of physicians fees. This figure includes payment for hospital, office and home services.

Hospitals have taken aggressive advantage of the cost plus formulas by which they are Blue Cross or government funded. They employ extra personnel at will to augment their stature and expand facilities not directly essential to patient care. These unnecessary costs contribute to the high hospital daily rate.

A hospital bill is submitted to illustrate the high cost of health care. It is usual and hardly extraordinary. It is of a patient admitted for treatment necessitating a surgical operation requiring a moderate number of blood transfusions. The fees for laboratory tests alone total \$781.00. These are done in bulk utilizing laboratory automated apparatus by salaried technicians yet the hospital charges Blue Cross for each test. X-ray charges in this not unusual case amount to \$412.00. The amount for laboratory and x-rays totals \$1200.00. The hospital bill for this 21 day admission, exclusive of medical care, was \$4660.00. It is from a hospital in the borough of Manhattan.

Finally, I do not mean to imply that all is well and healthy with the medical profession or that any one system is best for all. I am certain physicians shall continue to improve the quality of medical care for their patients. No one system will solve all the problems. Expenditure for medical care has been called "a bottomless pit". Senator Kennedy's and similar plans would have this country plunge into the inextricable depths of that bottomless pit to unquestionable bankruptcy.

I believe a new national health insurance law is indispensable. I firmly believe that the nation's health interest must be served by total, comprehensive, all-inclusive prepaid insurance covering every ailment to which the human race is heir. There must be complete prepaid-in-full hospitalization for all. But the people of the United States must retain the freedom to choose the system of care they prefer. Let those who desire closed panel group practice have it but do not deprive others of retaining the present intimately personal method. Do not exclude their democratic option. Do not deny them the freedom of alternative.

The CHAIRMAN. Are there any questions of Dr. Elkins?

Mr. Byrnes.

Mr. BYRNES. Is it your feeling that the medical schools themselves are really responsible for students moving into the specialties, particularly surgery, to the neglect of primary care practice?

Dr. ELKINS. You are absolutely right, Mr. Byrnes. The medical schools at the present time start their students on clinical practice in their sophomore year, in the second year. They are not exposed to family practice at all. They are exposed to specialization immediately.

There is no one to urge them or to show them any advantages of family practice.

But the medical schools are not the only ones who are at fault. Hospitals have been at fault. They have excluded family physicians from their staffs. If they had them on their staffs, they eliminated them, and refused them reassignment.

On every level in hospitals, the family practitioner over the last 20, 25, or 30 years has been eliminated, and we are now reaping the results of that elimination. As I tried to show, my age group and the age group ahead of me has either died out or retired. There are no replacements.

If you have seven doctors per State, if that is the average who are going to try to replace those who are dying and are retiring, it is like having a battalion of infantry that has been decimated in battle without sending any infantrymen back in.

That is, in my opinion, the big problem not only in the ghettos but also in rural areas, because if you had a sufficient number of primary physicians, there would be too many of them in the cities, and they would gravitate back into the rural areas, particularly if there were two or three of them, so that instead of working a horrendous 24-hour day 365 days a year, they would be able to relieve each other.

But we find the small towns in this country where the old doctor is dying out and taking down his shingle, and there is no one to replace him.

Mr. BYRNES. It certainly goes against the very idea of having some kind of a competitive atmosphere in the medical service area.

Dr. ELKINS. Yes, sir.

Mr. BYRNES. Which I think is always essential if you are going to keep prices or costs within reasonable limits, also.

Dr. ELKINS. Yes.

Mr. BYRNES. I am wondering if you have more of a recommendation than the one you made with respect to the universities giving special courses and changing their emphasis a little bit.

Dr. ELKINS. Mr. Byrnes, in the State of New York a law was passed to encourage family practitioners. Of the medical colleges in New York State, as far as I know, only one implemented that in the past 2 years.

I know my alma mater, Jefferson, has begun to stimulate graduation of family practitioners. I saw that in one of their recent bulletins, but by and large I think it is just in its infancy, and you are not going to be able to get family practitioners for another 6 years, and when you do get them, they are going to have to serve 2 years in the service, so that it is a long-range proposition.

Mr. BYRNES. Thank you, Doctor.

Mr. ULLMAN (presiding). Are there other questions?

Mr. CONABLE. Yes, Mr. Chairman.

Mr. ULLMAN. Mr. Conable.

Mr. CONABLE. How in the world does HIP survive, Doctor, in the light of the statistics you have given us?

Dr. ELKINS. It survives for a certain number of reasons. The city and its agencies still encourage people to go into HIP.

Mr. CONABLE. Do you have any idea what the total number of people still covered by HIP is? It apparently has been pretty much cut in half.

Dr. ELKINS. It has been cut in half. I don't know what the reduction is, but I certainly could get it for you.

Mr. CONABLE. I am just wondering. It must be in very shaky condition.

It was really an eye opener for me to have you say what you did about what has happened recently with respect to HIP because, of course, many people on the Federal level consider this sort of plan the wave of the future, and what you have said has given us reason to question that.

I thank you very much for the information you brought. It is extremely helpful.

Dr. ELKINS. Thank you.

Mr. ULLMAN. Are there further questions?

If not, you have been very helpful. Thank you very much, Doctor. Our next witness is Dr. Vizer.

Doctor, if you would further identify yourself for the record, we would be very pleased to recognize you.

STATEMENT OF DR. JAY VIZER, NARBERTH, PA.

Dr. VIZER. Mr. Ullman, my name is Dr. Jay Vizer. I am here as a fair medical services advocate.

It seems to me I have heard of many organizations being here, groups, and it is time for the people to be here. I am a person. I practice, as you see by my testimony that is written, as a podiatrist for the past 25 years. My experience in health care is documented.

I have written that I am a representative for 20 million people. I found out yesterday that actually I am representing 26 million people under social security, plus future multimillions.

This week, I received the endorsement of the executive vice president of the National Retirement Plans of America. He is the father of the plan to the American Association of Retired People and National Retired Teachers Association.

I may deviate for a moment from normal protocol. I may be wrong, Mr. Ullman, but if I am wrong, please correct me, and I will continue until I get to my conclusion.

Mr. ULLMAN. Would you like to have your statement in the record in full?

Dr. VIZER. The statement as printed is to be in the record in full, and the deviation may be in the record in full, please.

Mr. ULLMAN. We will put the statement in the record, and you may proceed in any way you desire.

(The statement referred to follows:)

STATEMENT OF DR. JAY VIZER, NARBERTH, PA., REPRESENTATION FOR 20,100,000 ENROLLEES UNDER TITLE XVIII HEALTH SERVICES FOR THE AGED, PART B, OF THE ACT OF AUGUST 14, 1935, 74TH CONGRESS

PROFILE

I am a practicing podiatrist for 25 years, and completed the earning of my degree from Temple University, Philadelphia, Pa., in 1946 after service in the Army Medical Corps. I also earned the degree of Doctor of Podiatric Medicine at the Pennsylvania College of Podiatric Medicine in 1970.

EXPERIENCE IN HEALTH CARE

I am a participating physician under Title XVIII Health Insurance for the Aged, Part B, and we accept all patients on an assignment account basis. I am a student in depth of the Medicare Act with full cooperation in receiving information from Jesse L. Lynn, Regional Representative of the Bureau of Health Insurance of HEW, Region III. I have been on a fact seeking interview to Pennsylvania Blue Shield at Camp Hill, concerning administration of Medicare. I have testified at hearings before the Commissioner of Insurance of Pennsylvania concerning inequities in the administration of the Act, and I have attended hearing procedures with a "Fair Hearing Officer" and received written, and often controversial, opinions.

PURPOSE OF TESTIMONY

I commend the enactment of Title XVIII and its generally excellent administration by Blue Shield of Pennsylvania and recommend broadening of its scope to include citizens of all ages. Medicare has been able to offer an increased amount of health care to the geriatric patients which has made life more enjoyable: "For all the happiness mankind can gain, it is not in pleasure, but in rest from pain" (John Dryden). There are, however, inequities that have gradually developed to the detriment of the patient's health and difficulty in the administration of good care by physicians.

Section 1801 of the Act specifies that no federal employee or agent may interfere with the practice of medicine. The Bureau of Health Insurance in Intermediary Letter No. 319; April 1968, "Subject: Carrier responsibility for utilization safeguards" refers to section 1842 and section 1802 of Title XVIII. Covered services and exclusions states: "The provisions of the law, and the general guidelines issued by the Social Security Administration for their implementation, should in no way be construed as requiring the establishment of control over, or interference with, the practice of medicine or the manner in which medical services are provided." Another communication from the Department of HEW in the Part B Intermediary Letter No. 70-5, dated February 1970, "Subject: Carrier activity to control over utilization of medical services. Whatever system a carrier may have developed, the controls set down in the discussion which follows should be built into the carrier system as a bare minimum * * * normal differences in practice and judgment must be built into the system (flags) serving to reflect a substantial departure from the acceptable practice."

There has now been created a set of guidelines that often denies a patient the right to care as it is considered a "noncovered service" based often only on one or two medical opinions. This is so documented. Case 1—Miss Mamie Althouse, H.I. #197-09-0127-A. Control #07-029-100-22-0, hearing decision rendered June 25, 1971, by Arthur Tress, Fair Hearing Officer, Medicare, Pennsylvania Blue Shield. This decision is based upon the probability of restoration of functions could not be achieved. The presence of pain was not acknowledged as a medical necessity. This patient therefore was covered only for three treatments and was denied three additional treatments. Case 2 is that of Father Coniff, H.I. #194-44-4490-T, Control #70-161-801-06-0—coverage was denied again for services, disregarding the presence of pain, on the premise that therapy was not restorative.

It is claimed that there is no judicial appeal from the decision of a "Fair Hearing Officer" as referenced to Section 1869 of the Act. This appears to be in conflict with the Constitution of the United States of America, Amendments adopted December 15, 1791, Article I. "The right of the people to petition the government for a redress of grievances" and Article VII. "In suits at common law where the value in controversy shall exceed \$20 the right of trial by jury shall be preserved and no fact tried by a jury shall be otherwise reexamined in any other court of the United States than according to the rules of the common law."

Section 1875(a)(2): "Methods for encouraging the further development of efficient and economical forms of health care that are a constructive alternative to inpatient hospital care." This seems to be in contradiction to the following statements of policy of Blue Shield of Pennsylvania concerning surgical debridement. "Unrelated surgical procedures are those surgical procedures performed on the same organ but on different days during one period of hospitalization." However, Blue Shield of Pennsylvania has established the guideline that surgical debridement of outpatients shall only be payable as such on the first visit and all subsequent debridements are classified as brief office or home visits. Documented

cases are Herbert Herskowitz, M.D., H.I. #175-28-1900-A, Control #71-188-189-34-0; and Bessie Dublin, H.I. #178-30-6318-A, Control #70-362-206-16-0. Additional testimony is documented in part of a Blue Shield letter dated August 11, 1971, to P. Gardiner from J. Hartman, utilization representative for Medicare in Pennsylvania.

"On June 28, 1971, with Dr. Vizer, I visited Bessie Dublin. I found her pleasant and cooperative and a reliable source of information. She is suffering from rheumatoid arthritis of both feet. Both feet are completely deformed and she needs the quad-cane constantly to get around her small apartment. She also suffers from diabetes mellitus which causes severe diabetic ulcers and, at one point, the ulceration almost became gangrenous. At this time, Dr. Vizer was visiting her two or three times a week and controlled the condition to the point that now he has to visit her only once a week for the diabetic ulcers. Mrs. Dublin stated that her family physician, Dr. Dale, told her Dr. Vizer saved her feet from amputation with his conscientious txs. Mrs. Dublin also suffers from peripheral vascular disease of the lower extremities."

RECOMMENDATION FOR NATIONAL HEALTH INSURANCE PROGRAMS

1. Insurance programs for all citizens should be patterned similarly to that of Medicare but with particular care to prevent "overcontrol" of participating physicians so that patients may not be deprived of medical care.

2. It is recommended that it be mandatory for participating physicians to accept assignment for services to families earning less than an amount to be specified by Congress.

3. The right of the patient to be relieved from pain shall be reserved at all times. Patients should not be denied the benefits of the full scope of the ability of practicing physicians.

4. Participating physicians shall be protected from negligence suits by insurance premium payments to agents appointed by the Federal Government, with participation in defence of physicians accepting assignments by the Federal Government.

5. Because carriers now act as interpreters of the law, administrators, jury and judge all combined, a Fair Hearing Officer should be an employee of the Federal Government under HEW.

6. The right to judicial appeal should be reserved by enrollees, both patients and physicians, of any Act.

7. Prescription drugs should be included as a covered item.

8. Funding shall be through equal participation of employer and employee. It shall be mandatory as under the Social Security Act. Premiums paid by employer should be deductible from Federal Income Tax as a business expense.

CONCLUSION

"New programs to encourage better preventive medicine, by attacking the cause of disease and injury, and by providing incentives to doctors to keep people well rather than just to treat them when they are sick." President Nixon, State of Union address, January 22, 1971.

"* * * see the American in need of medical care have the right to obtain * * * we must keep the doctors free of the terrible pressing burden of bureaucracy." President Nixon, American College of Cardiology, February 4, 1971.

Dr. VIZER. The deviation is: May I ask the committee questions?

Mr. ULLMAN. I am afraid that is not allowable under the rules.

Dr. VIZER. OK. If it is not allowable, then, that takes care of the record. I will go right into it. I will not keep you too long.

Mr. CONABLE. Mr. Chairman.

Mr. ULLMAN. Mr. Conable.

Mr. CONABLE. I think we might explain why that is. This committee is holding hearings, and we don't have any committee position at this point. The purpose of the hearings is to try to receive such information so that we can achieve a position. Nobody can speak for the committee at this point. If we had a position, we wouldn't have hearings. That is the difficulty.

Dr. VIZER. When I say I am asking the committee, I am not asking for information. I might be asking for individual opinion.

Mr. ULLMAN. We will not get a response, but we would be very happy to have your questions read into the record.

Dr. VIZER. With no answers?

Mr. ULLMAN. Well, the question itself.

Mr. CONABLE. I suspect that many of us have not taken a position yet.

Dr. VIZER. Yes, there is no position to take, yet.

Mr. ULLMAN. We will allow you to read your question into the record, and at least it will give us some insight into your thinking.

Dr. VIZER. All right, sir.

First, I do commend the enactment of title XVIII, and its generally excellent administration in Pennsylvania by Blue Shield as such. There are inequities, or there are differences in opinion, as to administration of the guidelines.

That is part of the record, and it is so printed.

I am going to ask this question because these are some of the guidelines that have been made as far as I am concerned as a fair medical services advocate and representing the people. I am not representing physicians. I am representing enrollees under any national health services act which I am definitely for, in virtually any of its forms. Specifically, I don't know the forms.

But we do feel that we should broaden the Medicare Act to include all people, and the question I am going to ask is: One, do you believe that under the title XVIII and any other act in the future, the treatment of a patient that is suffering from pain be allowable medical procedure?

Mr. ULLMAN. Why don't we get your judgment on that?

Dr. VIZER. All right. Good. I will come to my judgment on that.

Two. Do you not believe that it would be best for us to encourage outpatient surgical care for the good of the patient?

There is often much minor surgery that can be done that the patients need not be hospitalized, need not be taken from their environment, from their family, which may be done in the office, and they can be returned to their homes within the same day, within a matter of hours, and they may have not only good but possibly better nursing environment of that type, because of the family's interest in that patient. Don't you think that should be encouraged?

Mr. ULLMAN. Let me say that we have a great deal of testimony, of course, supporting that position, and I personally strongly support that position.

Dr. VIZER. Thank you, sir.

I have a third, the constitutionality of part of the Medicare Act. I use that, and it is a strong phrase, I understand, today. In fact, when you mention it, it sounds almost like a word you are not supposed to use in polite company, unconstitutional, but on a hearing where a patient goes to be reviewed on a denied service, it is claimed, and we have documents, that there is no further allowance to be reviewed as to the decision of that fair hearing officer. There is no right to appeal his decision.

In my testimony, I mention here that this seems to violate article 1 and article 7 of the Constitution, the amendments of the Constitution.

I will just bring that in for consideration, for the committee to become involved in in the future of all medical plans. It is so written in the Medicare Act.

Mr. ULLMAN. The questions are helpful in the record, and if you wish to proceed with your statement, we would be glad to hear you, sir.

Dr. VIZER. I would just like to conclude my statement and then I will tell you why I mentioned those questions.

The conclusion is this: The act should include the following:

Insurance programs for all citizens should be patterned similarly to that of medicare, but with particular care to prevent "overcontrol" of participating physicians, so that patients may not be deprived of medical care.

It is recommended that it be mandatory for participating physicians to accept assignment for services to families earning less than an amount to be specified by Congress.

At this moment, less than one-third of the physicians are accepting assignments, not 66 percent. I have this documented from HEW as of this past summer.

The right of the patient to be relieved from pain shall be reserved at all times. Patients should not be denied the benefits of the full scope of the ability of practicing physicians.

Participating physicians shall be protected from negligence suits by insurance premium payments to agents appointed by the Federal Government, with participation in defense of physicians accepting assignments by the Federal Government.

I understand yesterday that the President of the United States appointed a commission to see what can be done about malpractice.

I have recommended this for any provision of health insurance. I think you will find that this will help, if you use the phrase, to sweeten the pot, to allow more physicians, or have more physicians participate, and to provide more services for the patients.

Because carriers now act as interpreters of the law, administrators, jury, and judge, all combined, which is so, the fair hearing officer should be an employee of the Federal Government under HEW.

At this point, he is appointed by the carrier, which does not seem to make much sense, judiciously.

The right to judicial appeal should be reserved by enrollees, both patients and physicians, of any act.

At this point, there is no right to appeal.

Prescription drugs should be included as a covered item, and I am sure you have heard that over and over before.

Funding shall be through equal participation of employer and employee. It shall be mandatory, as under the Social Security Act. Premiums paid by employer should be deductible from Federal income tax as a business expense.

CONCLUSION

New programs to encourage better preventive medicine, by attacking the cause of disease and injury, and by providing incentives to doctors to keep people well rather than just to treat them when they are sick.

President Nixon, State of the Union Address, January 22, 1971.

* * * see the American in need of medical care have the right to obtain it . . . we must keep the doctors free of the terrible pressing burden of bureaucracy.

President Nixon, American College of Cardiology, February 4, 1971.

The excuse is given, and is documented, that the relief for pain is not sufficient cause for treatment, or a covered service is not accepted standard of medicine or medical practice.

I would like to introduce this into the oral testimony: That the treatment of the insane was to commit them to the institution, without therapy, virtually as criminals, less than 100 years ago, was accepted medical practice.

In the bubonic plague, during that time, the accepted standard treatment was cupping and leeching.

In normal childbirth, a mother was kept in bed for 1 week, not more than a generation ago.

In appendectomy, patients were confined to bed for 1 week.

Aortic grafts were not accepted at all as standard medicine, nor were kidney transplants during the past decade.

Edward Jenner, who introduced vaccination, by today's definition would not have had this accepted as standard practice, therefore not covered under medicare.

We must be careful in all future acts that this is allowable.

Yet, yesterday, November 16, 1971, there was introduced and reported by the Pediatrician Infectious Committee that smallpox vaccination may no longer be necessary, and may do more harm than good.

There is a sudden change in customary practices. The patients must have the right to be treated. The patient shall not have the right to be treated violated by an interpretation by individual States, even though as in only a few experiences the States are doing an excellent job as carriers.

They base it on one thing that is in the law which I have quoted, in the medicare law, which says that their therapy should be restorative or medically necessary.

Well, sometimes you cannot restore areas in diseases. You cannot restore in diabetes and kidney diseases, in emphysema. You cannot restore abnormal joints to a patient suffering from degenerative joint diseases. But you can relieve the pain, and keep them under control.

Any future health plans should incorporate those suggestions.

I will end with the quote, that "For all the happiness mankind can gain, it is not in pleasure but in rest from pain."

Mr. Ullman, thank you. I see we have a complete committee of two. Are there any questions at this point?

Mr. ULLMAN. The House is now in session, as you probably understand.

Dr. VIZER. Yes; I heard.

Mr. ULLMAN. Are there questions?

Mr. CONABLE. I have no questions.

Mr. ULLMAN. Dr. Vizer, we appreciate you coming before the committee. Thank you very much.

Mr. CONABLE. I think we owe you special thanks, sir, because of the citizen's initiative that brought you here. Many people come here representing organizations, and performing a job. You came as a citizen.

Dr. VIZER. Mr. Conable, I appreciate those remarks, because it is a personal type of thing I am carrying out.

Mr. ULLMAN. You paid your own way down?

Dr. VIZER. Both ways, printing costs, and research costs.

Mr. ULLMAN. Thank you.

Dr. VIZER. Thank you.

Mr. ULLMAN. Our final witness today is Jesse Olson.

Mr. Olson, if you would further identify yourself and your colleague, we would be happy to recognize you.

STATEMENT OF JESSE OLSON, VICE PRESIDENT, NATIONAL UNION OF HOSPITAL & NURSING HOME EMPLOYEES, AFL-CIO; ACCOMPANIED BY ALAN P. BROWNSTEIN, HEALTH POLICY RESEARCH ANALYST

Mr. OLSON. I am Jesse Olson. I am vice president of the National Union of Hospital & Nursing Home Employees, RWDSU, AFL-CIO, and executive vice president of the union's largest local, Local 1199, in New York City.

With me is Alan Brownstein, who is our research director of Local 1199.

Mr. ULLMAN. We welcome you both before the committee, and you may proceed.

Mr. OLSON. Thank you.

I will be speaking on behalf of our president, Leon J. Davis. Since the AFL-CIO convention opens today in Miami Beach, it is impossible for him to testify in person.

Our union represents over 60,000 hospital workers in 10 States. The greatest concentrations of members are in New York City, Connecticut, New Jersey, Baltimore, Pittsburgh, and Charleston, S.C.

The union represents many different categories of hospital workers, including service and maintenance workers, clerical workers, technical workers, and certain professionals such as psychologists, social workers, and licensed practical nurses. We also represent 6,000 pharmacists and drugstore workers. We do not represent physicians or administrative personnel. We are working on that, now.

Local 1199 in New York City is the oldest and largest local of the national union. It has collective bargaining agreements covering workers in more than 40 voluntary (private nonprofit) hospitals in New York City. These hospitals comprise about two-thirds of the city's voluntary hospital beds. They include a wide variety of hospitals, including community hospitals in both middle-class and ghetto neighborhoods, teaching hospitals, and medical school hospital centers.

ANALYSIS OF CRISIS

I know that this committee is well briefed as to the dimensions of the health crises. It is difficult to ignore shocking statistics that reveal that men live longer in 18 other countries, and women live longer in 11 other countries than in our own.

Although our medical knowledge and sophisticated equipment cannot be matched elsewhere, among the industrialized countries of the

world we rank as an undeveloped nation in our delivery of medical care to our people.

Ours is the only major industrial nation that has neither a moral commitment to provide health care for all of its citizens nor a rational system for the delivery of such care. Organization of health care is chaotic. Manpower and facilities are inadequate and poorly distributed.

The poor, minority groups, and the elderly are most seriously short-changed by our wasteful "nonsystem."

Just last month, the Census Bureau reported that the life expectancy for blacks decreased between 1960 and 1968, while for whites life expectancy increased. The infant mortality rate and the maternal death rate continue to be three times as great as it is among whites.

On the average, the elderly must live on less than one-half the income available to young couples or a single person. Yet, their medical expenditures are six times that for a youth and two and one-half times that for a person between the ages of 19 and 64.

A poor child in the United States is three times more likely to be mentally retarded, 15 times more likely to be defected at birth, and three times more likely to be prematurely born.

More money alone is not enough. More manpower alone is not enough.

I am speaking here from our own unfortunate experience with our own self-administered comprehensive health plan, covering some 150,000 people.

Our members have purchasing power for a comprehensive array of health services. Although New York has twice as many doctors per capita, many of our members do not get first-rate medical care, because it is not possible in their neighborhoods. Many of our members are black and Puerto Rican, and are confined to ghettos in which there is only one doctor for 10,000 people.

Even with coverage, care is so inadequate, because medical service in the ghettos is so difficult to get, that people go for care only when the needs become catastrophic.

From this we see that our problems go beyond financial access. Our health care delivery system needs a major overhauling, not merely the "right size patch," as suggested by Secretary of HEW Elliot Richardson last April.

LOCAL 1199 STATEMENT OF PRINCIPLES ON HEALTH CARE

The following is a "Statement of Principles on Health Care," which was submitted by the Local 1199 Executive Council and the Local 1199 Health Care Committee to 300 members attending our annual health care conference last June. The statement was unanimously adopted:

We need a national policy committed to the principle that every American is entitled—as a matter of right—to the best health care that our nation's skill and technology can command. We need a delivery system that assures the availability of health services to all citizens. Such a system must include:

A. Universal and Comprehensive Coverage that is distributed in one system for all. Everyone must be entitled to care, regardless of race, income, sex, age, religion, or any of the barriers that now create inequalities. Comprehensive care should include doctors, hospitals, medication, dental care, mental health care,

nursing home and convalescent care, and home health services. These services and facilities should be used to maintain health and prevent illness as well as to treat sickness.

B. Equitable Financing: Health care should be removed from the profit-making arena and financed by the Federal Government from general revenues.

C. Sound Organization: To develop a national system for the delivery of health care, it is necessary to:

1. Create an organized service in which the providers of medical care work together with Government and the community for common objectives.

2. We call for the establishment of neighborhood medical facilities and community medical centers easily accessible to the people they serve and controlled by duly elected community boards.

3. We seek to encourage the development of comprehensive group medical and dental practice with effective consumer participation.

4. We are looking to finance a recruitment and training program to meet health manpower needs and support medical and health research requirements.

We realize that the problem of the Nation's health goes beyond what can be done to improve the delivery of medical care. To assure good health also means to provide decent food and housing, clean air, and pure water.

We believe that our Nation has the material and human resources required to fulfill these essential objectives. We believe that a national health budget must be adopted that makes the delivery of health care a matter of top destruction to the preservation of life.

NATIONAL HEALTH INSURANCE—AN "IDEA WHOSE TIME HAS COME"

Using these principles as a yardstick, I will now attempt to evaluate the national health insurance proposals under consideration by your committee.

National health insurance is supposed to be an "idea whose time has come." In fact, several organizations have developed their own legislative proposals designed to serve their own narrow professional and/or profit interests. The American Medical Association and the Health Insurance Association of America, representing the health insurance industry, are examples of two such organizations.

A. AMERICAN MEDICAL ASSOCIATION (AMA)

The "medicredit" (H.R. 4960) proposal developed by the AMA is a plan designed to encourage more Americans to voluntarily purchase private health insurance through the use of income tax credits.

This is a limited self-serving financing mechanism that offers no significant change in the current system.

I have great respect for the medical profession and the great things they have been and are capable of doing. Most doctors are committed professionals dedicated to healing the sick. Unfortunately, the selfish interests of some, as expressed by the AMA, have distorted the medical profession's contributions to our citizens.

The AMA medicredit proposal is an insult to the American health consumer, and I trust will not be given serious consideration by this body.

B. HEALTH INSURANCE INDUSTRY

The "healthcare" (H.R. 4349) proposal developed by the health insurance industry is a tax incentive plan for individuals and employers

to voluntarily purchase private health insurance with direct Government subsidies to the industry in order to cover high-risk categories—the poor, near-poor, and “uninsurables.”

This proposal is also a limited, self-serving financing mechanism that does not deal with providing medical care to the American people. It does not contribute to the organization or delivery of health care.

The health insurance industry exists to collect and distribute medical care funds, and charge a fee for this service. The healthcare proposal would expand their function as third-party intermediaries, expand their profits, and thereby perpetuate the same wasteful nonsystem that now exists.

The private insurance industry is not involved in providing health, nor is their healthcare proposal. I sincerely hope that H.R. 4349 will not be given serious consideration by this committee.

C. CATASTROPHIC HEALTH INSURANCE

Several bills have been introduced with the intent of providing protection against the enormous costs of a serious illness. It is unfortunate that Senator Long and others have seen fit to even introduce such a bill, since this approach totally fails to meet the essential needs of our people. All of these bills have staggering deductibles and coinsurance features.

The very notion of “catastrophic” costs varies according to one’s income. To a corporation executive, a \$2,000 medical bill would not be catastrophic. But, to a \$130-a-week hospital worker in New York, this would be a disaster.

Passing a catastrophic health insurance bill would be a catastrophe for the American people.

Mr. ULLMAN. Mr. Olson, excuse me a minute.

We have to recess at half past 12. At the rate you are proceeding, you are not going to have your paper completed. If some of it could be summarized, we will put it all in the record.

(The statement referred to follows:)

STATEMENT OF JESSE OLSON, VICE PRESIDENT, NATIONAL UNION OF HOSPITAL AND NURSING HOME EMPLOYEES, RWDSU, AFL-CIO

(1) ORGANIZATION AND MEMBERSHIP

I am Jesse Olson, Vice-President of the National Union of Hospital and Nursing Home Employees, RWDSU, AFL-CIO, and Executive Vice-President of the union’s largest local, Local 1189 in New York City. I will be speaking on behalf of our President, Leon J. Davis. Since the AFL-CIO convention opens today in Miami Beach, it is impossible for him to testify in person. Our union represents over 60,000 hospital workers in ten states. The greatest concentrations of members are in New York City, Connecticut, New Jersey, Baltimore, Pittsburgh and Charleston, South Carolina. The union represents many different categories of hospital workers including service and maintenance workers, clerical workers, technical workers, and certain professionals such as psychologists, social workers, and licensed practical nurses. We also represent 6,000 pharmacist and drug store workers. We do not represent physicians or administrative personnel.

Local 1189 in New York City is the oldest and largest local of the National Union. It has collective bargaining agreements covering workers in more than forty voluntary [private, non-profit] hospitals in New York City. These hospitals comprise about two-thirds of the city’s voluntary hospital beds. They

include a wide variety of hospitals, including community hospitals in both middle-class and ghetto neighborhoods, teaching hospitals and medical school hospital centers.

(2) ANALYSIS OF CRISIS

I know that this committee is well briefed as to the dimensions of the health crisis. It is difficult to ignore shocking statistics that reveal that men live longer in 18 other countries and women live longer in 11 other countries. Although our medical knowledge and sophisticated equipment cannot be matched elsewhere, among the industrialized countries of the world, we rank as an undeveloped nation in our delivery of medical care to people. Ours is the only major industrial nation that has neither a moral commitment to provide health care for all of its citizens nor a rational system for the delivery of such care. Organization of health care is chaotic; manpower and facilities are inadequate and poorly distributed.

The poor, minority groups and the elderly are most seriously short-changed by our wasteful "non-system".

Just last month, the Census Bureau reported that the life expectancy for blacks decreased between 1960 and 1968 while for whites, life expectancy increased. The infant mortality rate and the maternal death rate continues to be three times as great as it is among whites.

On the average, the elderly must live on less than $\frac{1}{2}$ the income available to young couples or a single person, yet their medical expenditures are six times that for a youth, and $2\frac{1}{2}$ times that for a person between the ages of 19 and 64.

A poor child in the U.S. is 3 times more likely to be mentally retarded, 15 times more likely to be defected at birth, and 3 times more likely to be prematurely born.

More money alone is not enough! More manpower alone is not enough! I am speaking from our unfortunate experience with our own self-administered comprehensive health plan, covering some 150,000 people. Our members have purchasing power for a comprehensive array of health services. Although New York has twice as many doctors per capita, many of our members do not get first rate medical care because it is not available in their neighborhoods. Many of our members are black and Puerto Rican and are confined to ghettos in which there is only one doctor for 10,000 people. Even with coverage, care is so inadequate, because medical service in the ghettos is so difficult to get, that people go for care only when the needs become catastrophic. From this we see that our problems go beyond financial access. Our health care delivery system needs a major overhauling, not merely the "right size patch", as suggested by Secretary of HEW Elliot Richardson last April.

(3) LOCAL 1199 STATEMENT OF PRINCIPLES ON HEALTH CARE

The following is a "Statement of Principles on Health Care", which was submitted by the Local 1199 Executive Council, and the Local 1199 Health Care Committee to 300 members attending our Annual Health Care Conference last June. The statement was unanimously adopted.

"We need a national policy committed to the principle that every American is entitled—as a matter of right—to the best health care that our nation's skill and technology can command. We need a delivery system that assures the availability of health services to all citizens.

Such a system must include:

A. Universal and Comprehensive Coverage.—Health care must be a matter of right, not privilege. There must be one system for all. Everyone must be entitled to care regardless of race, income, sex, age, religion, or any of the barriers that now create inequalities. Comprehensive care should include doctors, hospitals, medication, dental care, mental health care, nursing home and convalescent care and home health services. These services and facilities should be used to maintain health and prevent illness as well as to treat sickness.

B. Equitable Financing.—Health care should be removed from the profit-making arena and financed by the federal government from general revenues.

C. Sound Organization.—To develop a national system for the delivery of health care it is necessary to:

1. Create an organized service in which the providers of medical care work together with government and the community for common objectives.

2. Establish neighborhood medical facilities and community medical centers easily accessible to the people they serve and controlled by duly elected community boards.

3. Encourage the development of comprehensive group medical and dental practices with effective consumer participation.

4. Finance a recruitment and training program to meet health manpower needs and support medical and health research requirements."

We realize that the problem of the nation's health goes beyond what can be done to improve the delivery of medical care. To assure good health also means to provide decent food and housing, clean air and pure water.

We believe that our nation has the material and human resources required to fulfill these essential objectives. We believe that a national health budget must be adopted that makes the delivery of health care a matter of top priority. Our national emphasis must change from war and destruction to the preservation of life.

(4) NATIONAL HEALTH INSURANCE—AN IDEA WHOSE TIME HAS COME

Using these principles as a yardstick, I will now attempt to evaluate the national health insurance proposals under consideration by your committee.

National health insurance is supposed to be an "idea whose time has come". In fact, several organizations have developed their own legislative proposals designed to serve their own narrow professional and/or profit interests. The American Medical Association and the Health Insurance Association of America representing the health insurance industry, are examples of two such organizations.

(A) American Medical Association (AMA)

The "Medicredit" (H.R. 4960) proposal developed by the AMA is a plan designed to encourage more Americans to voluntarily purchase private health insurance through the use of income tax credits.

This is a limited self-serving financing mechanism, that offers no significant change in the current system.

I have great respect for the medical profession and the great things they have been, and are capable of doing. Most doctors are committed professionals dedicated to healing the sick. Unfortunately, the selfish interests of some, as expressed by the AMA, have distorted the medical profession's contributions to our citizens. The AMA Medicredit proposal is an insult to the American health consumer, and I trust will not be given serious consideration by this body.

(B) Health Insurance Industry

The "Healthcare" (H.R. 4849) proposal developed by the health insurance industry is a tax incentive plan for individuals and employers to voluntarily purchase private health insurance, with direct government subsidies to the industry in order to cover high risk categories—the poor, near-poor, and "uninsurables".

This proposal is also a limited self-serving financing mechanism, that does not deal with providing medical care to the American people. It does not contribute to the organization or delivery of health care.

The health insurance industry exists to collect and distribute medical care funds, and charge a fee for this service. The Healthcare proposal would expand their function as third party intermediaries, expand their profits, and thereby, perpetuate the same wasteful non-system. The private insurance industry is not involved in providing health, nor is their Healthcare proposal. I sincerely hope that H.R. 4849 will not be given serious consideration by this committee.

(C) Catastrophic Health Insurance

Several bills have been introduced with the intent of providing protection against the enormous costs of a serious illness. It is unfortunate that Senator Long and others have seen fit to even introduce such a bill, since this approach totally fails to meet the essential needs of our people. All of these bills have staggering deductibles and coinsurance features.

The very notion of "catastrophic" costs varies according to one's income. To a corporation executive a \$2,000.00 medical bill would not be catastrophic. But, to a \$180.00-a-week hospital worker in New York, this would be a disaster. *Passing a Catastrophic Health Insurance bill would be a catastrophe for the American people!*

(5) NATIONAL HEALTH INSURANCE PARTNERSHIP

Two proposals appear to be at the center of the NHI debate. The Griffiths-Corman Health Security Program (H.R. 22), and the Nixon Administration's National Health Insurance Partnership proposals embodied in H.R. 7741 and H.R. 5615. First I will examine the Nixon Health package.

The Administration's proposal, H.R. 7741, provides two health insurance plans to the under-65 population. The first one, the National Health Insurance Standards Act (NHISA) requires employers to offer an employer/employee purchased private health insurance plan that would meet minimum, Federally-mandated benefits. The second package, the Family Health Insurance Plan (FHIP), would provide a Federally-subsidized health insurance program for low income families. In addition, the use of Health Maintenance Organizations (HMO) would be encouraged by including an HMO option for insured persons. A companion bill, H.R. 5615, provides some funds for HMO development.

A—Would H.R. 7741 Provide Universal Coverage? The Nixon health program does not attempt to provide one standard of health care for all Americans.

1. There is *no* coverage for the unemployed, part-time and seasonal workers, the unmarried and couples without children who are poor, state and local government employees, domestic workers, and employees of religious organizations. This is shameful!

2. There would be further fragmentation of our present two-class system of health care: National Health Insurance Standards Act (NHISA) which is a plan for employer/employee purchase of private health insurance (employers would only be required to offer the plan to their employees, it would not be compulsory); Family Health Insurance Plan (FHIP) which would provide health insurance to the "able-bodied" poor based upon a demeaning semi-annual means test; Medicaid would be preserved for the blind, disabled and the elderly; Medicare would remain for the aged; and a vast array of private supplemental health insurance schemes would remain available for those who could afford it.

B—Would H.R. 7741 Provide Comprehensive Coverage? Administrative and consumer confusion is added to the Nixon Plan by providing different benefits with different cost-sharing features for NHISA and FHIP. NHISA and FHIP exclude drugs, dental care, mental health, and other services considered to be part of comprehensive care. Most presently available group contracts offer better health care. The enormous deductibles and copayments under NHISA, would have workers pay large out-of-pocket costs and consequently would serve as an economic barrier to early diagnosis and treatment. While a poor family of 4 would receive free benefits under FHIP if income falls below \$3,000, this same family would be subjected to deductibles and other cost-sharing barriers if their income were to rise to the \$3-5,000 level. What is an even greater travesty, is that the poor would be limited to 30 days of hospitalization and eight doctor visits with FHIP. Also the poor are not protected from catastrophic illness costs, while the non-poor under NHISA are. The poor in many states would receive fewer benefits with FHIP than they presently do with Medicaid.

C—Would H.R. 7741 Provide for Equitable Financing? The Nixon plan would use a regressive employer/employee payroll financing mechanism with the workers paying 35% which would be reduced to 25% at a future date. The worker-employer contribution would be used to purchase private health insurance. With FHIP, Federal monies would be handed to the insurance industry to administer the program. This would be a costly repeat of the mistake we made with Medicare, and would dilute the amount of return we receive from our medical care dollar. A "partnership" between the federal government and the private insurance industry would be very costly to the American people.

D—Would H.R. 7741 Encourage Sound Organization? The Health Maintenance Organization (HMO) is the Administration's principal strategy for improving the organization of health care services. While I would support the concept of comprehensive non-profit prepaid group practice, the Administration's HMO bill H.R. 5615, is much too vague. It would permit "non-profit, cooperatives or other agencies" to establish HMO's. This could include non-group medical foundations, and various for-profit set-ups of various sizes or shapes. Until the Administration's HMO concept is more clearly defined, I cannot make a responsible judgment.

The Administration's bill would not change the costly practice of reimbursing doctors and hospitals with blank checks. Costs will continue to soar.

The Administration's bill would not provide any voice for the consumer.

E.—Summary: In summation, paraphrasing your own words Mr. Chairman, the Administration proposes new programs using the old ineffective "non-system" of organized chaos. This is a step backward that would further categorize the American people into different health classes with different health benefits. This would only serve to proliferate more programs, which would only add to our current problems, and improving the health care of few. The Administration's proposal is woefully inadequate. It's hard to believe that President Nixon's Health Message included the principle that "good health care should be readily available to all of our citizens."

(6) HEALTH SECURITY PROGRAM

Next, I would like to discuss a bill that comes close to meeting our criteria for a national health program. I am referring to H.R. 22, which was introduced by five distinguished members of this committee—Mrs. Griffiths, Mr. Corman, Mr. Burke, Mr. Vanik, and Mr. Green.

The Health Security Program is the most comprehensive proposal before this committee. It would create a universal federal health program financed by a payroll tax and general revenues. H.R. 22 includes numerous provisions designed to contain costs, improve quality, and restructure the delivery of health care.

A—Does H.R. 22 Provide Universal Coverage? H.R. 22 would create a non-categorical, universal health program, establishing one system of health care for all, as a right. The patient would not be billed, thus removing financial transactions from the doctor-patient relationship.

B—Does H.R. 22 Provide Comprehensive Coverage? Health Security would provide the full range of personal health needs, with an emphasis on comprehensive health maintenance, rather than episodic sickness treatment. There would be no means test. No coinsurance or deductibles, preexisting conditions would be included, no waiting periods, and with few exceptions, no cut-off points in dollars or number of days of service.

Criticisms.—The proponents of H.R. 22 point out that Health Security covers 70% of costs for personal health services. In the realm of the uncovered 30% would remain a two-class system of care. Much of the 30% is in the area of excluded services—dental care for adults and certain drugs, and limitations on custodial nursing home and psychiatric care. Since many of the elderly are on fixed incomes, they would be particularly hard hit by the limitations on nursing home care and the exclusion of dental care. Our Union believes all services should be included, without any cost to the consumer at the time of illness.

C—Does H.R. 22 Provide for Equitable Financing? Health Security would be financed through a "Health Security Trust Fund", made up equally of Federal general revenues and social security monies earmarked for this fund. Employees would contribute 1% of earnings up to \$15,000, employers would contribute 3½%, and the self-employed 2½%. Including a 50% contribution from federal revenues, raising the employee contribution ceiling to \$15,000, and having the employer paying the bulk of the payroll tax, provides us with a more equitable tax structure than our present social security mechanism.

Criticism.—However, a social security-type tax, is still regressive. The program should be funded by a more equitable formula, such as full general revenue financing, or some other progressive tax structure.

D—Does H.R. 22 Encourage Sound Organization? More than any proposal currently before this Committee, H.R. 22 makes a serious stab at restructuring the health care system. Health Security would be a publicly administered program. National health policy would be established by a full-time, five-member, president-appointed "Health Security Board" (HSB). Program administration would be decentralized to the regional, and subregional level. Advisory councils at all levels, with consumer majorities would monitor the program.

H.R. 22 would stress maintaining good health with an emphasis on ambulatory care. A "Resource Development Fund" would provide substantial financial supports toward the development of comprehensive prepaid group practice and other delivery systems that would assure the availability of services to under-served areas. This would include manpower training funds and income guarantees for an increase, more even distribution, and more efficient use of health manpower.

H.R. 22 would establish national standards for participating professional and institutional providers.

Funds would be distributed on a capitation basis, with provisions for regional adjustments. Institutional providers must be non-profit, and would be reim-

bursed on a pre-negotiated budget basis. Private insurance coverage would be eliminated for services covered by the program.

Criticism

1. *The Role of the Consumer.*—The Griffiths-Corman bill provides for the creation of national, regional and local advisory councils with consumer majorities. However, upon closer examination, the loosely-defined consumer appears to be far removed from the decision-making apparatus.

While the administration of the program is decentralized, decision making authority is heavily centralized in the five-member, president-appointed Health Security Board, with few provisions for discretionary powers and autonomy at the local or regional level. There is no mandate for consumer representation on the Health Security Board. The only requirement, is that no more than 3 appointees may be members of the same political party. Certainly, a president would be able to stack the Health Security Board. The appointed Advisory Councils have a consumer majority and would provide some input. However, they would only be able to offer advice and make recommendations—not formulate policy.

With the exception of required consumer "consultations" in HMO's, there is no provision for consumer input at the community or direct service level. Neighborhood medical facilities should be under the joint control of duly elected consumers, and providers. H.R. 22 should require all new industries to have a board comprised of local residents. Existing facilities should be given a specific timetable in which they would be required to include local consumers in policy-sensitive positions.

If we want our health care system, and our medical institutions, to be socially responsive and publicly accountable, the consumer must be able to participate in parity with providers at all levels.

2. *Health Care Delivery.*—Although H.R. 22 exceeds all other proposals in its attempt to restructure the health care delivery system, the wording in the bill is too weak to assure adequate redistribution of manpower and facilities; funding is not sufficient for extensive HMO development; there are not enough disincentives to discourage the inefficiencies of fee-for-service solo practice; and until all health care needs are covered, opportunities for practicing outside the system will continue to exist.

3. *Manpower.*—Providing funds for the training and redistribution of health manpower is not enough. Restructuring the delivery of health care should include incentives for restructuring manpower training, so as to encourage upward mobility, rather than creating more dead-end jobs.

E—Summary: While falling short of mandating an all-inclusive national health program, H.R. 22 is the only bill before this committee that offers a rational alternative to our present inefficient system of delivering health care. Although it has weaknesses that should be corrected, Health Security is the only proposal that deals with providing comprehensive health care as a right—not as privilege of financial means.

(7) WHO WOULD BEAR THE COST OF MEDICAL CARE?

Up to now, I have made little mention of the costs of the various proposals before this committee. Many have argued in this chamber that their particular program would be less expensive than the next. However, what they really mean is that their program would initially be less costly to the Federal government by providing fewer health services, and requiring larger out-of-pocket expenses for the consumer.

A—Private vs. Public Medical Care Dollar: A recent HEW study projected cost estimates for the numerous national health insurance proposals for 1974. Even though the accuracy and methodology used to compute these costs has been challenged by the Committee for National Health Insurance, the Administration's own department findings are quite revealing.

Under the Nixon proposal, the Federal government would contribute \$34.6 billion, and individuals would have to kick in the balance—about \$62.6 billion. Under the Griffiths-Corman program, the Federal share would be \$91.4 billion, but the cost to the consumer would only be about \$15.9 billion. When considering the total health care cost, public and private, the HEW report shows little difference—the Nixon plan would cost \$107.2 billion, against \$118.8 billion for the Health Security plan.

Considering the difference in the benefit packages, comprehensiveness and scope of these programs, the differences in costs are truly slight. The disparity between the government's share is a matter of *who pays the bill*—direct payment, or indirect government and consumer payment to profit-making third-party intermediaries and out-pocket-costs. Medical care cannot be properly organized and effectively provided without control of the medical care dollar. Under Nixon's proposal, the health dollar is distributed mostly by private insurance companies. Private carriers have demonstrated that they are incapable of guaranteeing the efficient distribution of medical care.

By eliminating the third-party middle-man, H.R. 22 would deliver more health care for the dollar. The point is that the Nixon Plan and other NHI proposals cost less because they have much fewer benefits, increasing out-of-pocket expenses to the consumer.

B—Consumer out-of-pocket costs: Let me illustrate how these 2 proposals would effect the health consumer.

1. Mr. Thomas is a maintenance worker in a Brooklyn hospital earning \$130.00 per week, and his wife and two children get the flu. Dr. Smith examines them all at his office and writes drug prescriptions for them. The family's doctor bill comes to \$40.00, and prescription cost \$20.00. The total bill is \$60.00. H.R. 22 would pay \$40.00 (\$20.00 cost for drugs would also be covered if medical services are provided in an H.M.O. setting). The Nixon Plan would pay nothing.

2. Mrs. Smith, a Licensed Practical Nurse, earns \$156.25 a week. Mrs. Smith falls on her way to work and injures her back. She is hospitalized for 10 days. When she returns home, a physical therapist works with her for 4 weeks. Her hospital bill comes to \$1,000.00, doctor bill is \$400.00, and the therapist's bill is \$400.00. Total cost is \$1,800.00. The H.R. 22 formula pays \$1,800.00; Nixon Plan pays \$1,200.00.

3. Mrs. Jones is a part-time clerical worker at a Manhattan hospital, her husband, Mr. Jones runs a neighborhood grocery on Manhattan's Westside. Mr. Jones suffered a heart attack and later a stroke. He is hospitalized for 4 months and runs up a \$16,000.00 bill (hospital—\$12,000.00, and doctor \$4,000).

When he is discharged, he is partially paralyzed. Mrs. Jones quits her job to run the store, and hires a nurse's aide to attend him during the day. The aide's fee for the next eight months runs to \$7,800.00. Meanwhile, routine doctor bills for Mrs. Jones and her two children run a \$100.00 each, totalling \$300. Total family medical bill is \$25,000. Griffiths plan pays the full amount. Nixon plan pays \$23,525.00.

The gaps in the extent of coverage among these different plans are obvious. The deductible and coinsurance features of the Nixon proposal would create barriers to needed care, increasingly so for lower income families. Even a recent Blue Cross/Blue Shield study showed that "deductibles, coinsurance and copayment do have a definite impact on utilization," and these provisions "could act as economic barriers to needed care." *H.R. 22 is the only proposal that provides care on the basis of need, rather than on one's ability to pay.*

(8) CONCLUSION

In the 1966 Comprehensive Health Planning Act, Congress articulated the principle "that fulfillment of our national health purpose depends on promotion and assuring the highest level of health attainable for every person" and the commitment "to assure comprehensive health services of high quality for every person".

Five years later, we are now attempting to identify ways in which to fulfill this promise. There is no doubt that we will do the sensible thing—but will it take 2 years or 50 years? There is no doubt that we are capable of doing the right thing, after all, we have the material and human resources—but do we have the moral courage and commitment to say that we will guarantee medical care to every American now?

A financial mechanism alone would only pump more money into the same system, and medicine would remain in the market place. Money should not be a barrier between the sick and a physician. We need a national program of health care, not a national program of health insurance.

The Health Security proposal, with a few improvements, would be a significant step towards achieving an all-inclusive national program of health care.

The problem with the formulation of social programs is that they develop through compromises until the main objectives become so diluted that the results

do not meet, to any serious extent, our needs. We have learned this sad lesson from the social security program, OEO, medicare and medicaid. The question is—can Congress on this occasion, rise to meet this challenge head-on, by enacting at this time, the legislation best suited to the needs of the American people?

Mr. OLSON. Let me deal with what is actually the meat, the two bills that are in contention, and some of our feelings about both of them.

The one, of course, is the Griffiths-Corman health security program, H.R. 22, and the Nixon administration's national health insurance partnership proposals embodied in H.R. 7741 and H.R. 5615. I believe you know what those proposals are. I will not repeat them.

We have some questions. For instance, would H.R. 7741 provide universal coverage?

The Nixon health program does not attempt to provide one standard of health coverage for all. There is no coverage for the unemployed, part time and seasonal workers, the unmarried and couples without children who are poor, State and local government employees, domestic workers, and employees of religious organizations.

There would be further fragmentation of our present two-class system of health care, the National Health Insurance Standards Act and the Family Health Insurance Act, which would provide health insurance for the able-bodied poor. Medicaid would be preserved for the blind, disabled, and elderly.

Medicaid would remain for the aged, and a vast array of private health insurance schemes would remain available for those who could afford it.

Would H.R. 7741 provide comprehensive coverage?

The administrative and consumer confusion is added to the Nixon plan by providing different benefits with different cost-sharing features.

NHISA and FHIP exclude drugs, dental care, and mental health, and other services considered to be a part of comprehensive care. Most plans offer better health care.

The enormous deductibles and copayments would make workers pay higher costs and serve as an economic barrier to early diagnosis and treatment.

Still another question: Would H.R. 7741 provide an equitable financing?

The Nixon plan would use a regressive employer-employee payroll financing mechanism, with the workers paying 35 percent, which would be reduced to 25 percent at a future date. The worker-employer contribution would be used to purchase private health insurance.

With FHIP, Federal moneys would be handed to the insurance industry to administer the program. This would be a costly repeat of the mistake we made with medicare, and would dilute the amount of return we receive from our medical-care dollar.

A partnership between the Federal Government and the private insurance industry would be very costly to the American people.

Would H.R. 7741 encourage sound organization?

We feel it would not. While I would support the concept of comprehensive, nonprofit, prepaid group practice, the administration's HMO bill is much too vague. It would permit nonprofit cooperatives or other agencies to establish HMO's that could include nongroup medical foundations and various for-profit setups of various sizes and shapes.

In summation, paraphrasing your own words, Mr. Chairman, the administration proposes new programs using the old ineffective "non-system" of organized chaos. This is a step backward that would further categorize the American people into different health classes with different health benefits.

This would only serve to proliferate more programs, which would only add to our current problems, and improving the health care of few. The administration's proposal is woefully inadequate.

Next, I would like to discuss in the few remaining minutes a bill that comes close to meeting our criteria for a national health program, dealing, of course, with H.R. 22.

Does H.R. 22 provide universal coverage?

H.R. 22 would create a noncategorical, universal health program. I am cutting, for time.

Would it provide comprehensive health insurance?

It would take a major step toward that end. However, I wish to point out that this proposed legislation is not without shortcomings.

The proponents of H.R. 22 points out that health security covers 70 percent of costs for personal health services. In the realm of the uncovered 30 percent would remain a two-class system of care.

Much of the 30 percent is in the area of excluded services—dental care for adults, and certain drugs, and limitations on custodial nursing home and psychiatric care.

Would it provide an equitable financing?

We feel that it would, if made up equally by Federal general revenues and social security funds earmarked for this. However, a social security tax is still regressive.

This program should be funded by a more equitable formula, such as full general revenue financing, and some other progressive tax structure.

Does it encourage sound organization?

More than any other proposal before this committee.

Again, some of the criticism:

The Griffiths-Corman bill provides for the creation of national, regional, and local advisory councils with consumer majorities. However, upon closer examination, the loosely-defined consumer appears to be far removed from the decisionmaking apparatus.

We propose that any legislation include more participation of the consumer.

In summary, while falling short of mandating an all-inclusive national health program, H.R. 22 is the only bill before this committee that offers a rational alternative to our present inefficient system of delivery health care.

Although it has weaknesses that should be corrected, health security is the only proposal that deals with providing comprehensive health care as a right—not as privilege of financial means.

I just want to conclude.

We have indicated in the text where we compare private plans and how this would affect the consumer. We have examples of how both the proposed major legislative items would actually affect the consumer. I will skip through that, and just conclude that in the 1966 Comprehensive Health Planning Act, Congress articulated the prin-

ciple "that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person," and the commitment "to assure comprehensive health services of high quality for every person."

Five years later, we are now attempting to identify ways in which to fulfill this promise. There is no doubt that we will do the sensible thing—but will it take 2 years, or 50 years?

There is no doubt that we are capable of doing the right thing. After all, we have the material and human resources—but do we have the moral courage and commitment to say that we will guarantee medical care to every American now?

A financing mechanism alone would only pump more money into the same system, and medicine would remain in the marketplace. Money should not be a barrier between the sick and a physician. We need a national program of health care, not a national program of health insurance.

The health security proposal, with a few improvements, would be a significant step toward achieving an all-inclusive national program of health care.

The problem with the formulation of social programs is that they develop through compromises until the main objectives become so diluted that the results do not meet, to any serious extent, our needs. We have learned this sad lesson from the social security program, OEO, medicare, and medicaid.

The question is, gentlemen: Can Congress on this occasion rise to meet this challenge head-on, by enacting at this time the legislation best suited to the needs of the American people?

Thank you very much.

Mr. ULLMAN. Thank you, Mr. Olson, for cooperating with us in shortening your testimony.

We appreciate both you and Mr. Brownstein being here. You have had a very well thought out paper, and presented your arguments well.

Are there questions?

Mr. BROWNSTEIN. I would like to add that you have copies of a recent issue of the 1199 News, and it details and describes a recent health care conference that was held and participated in by union members at the union headquarters.

I would hope that the section that describes the health care conference could, with the text, be submitted for the record to indicate the interest of workers in our union.

Mr. ULLMAN. Do you have that available?

Mr. BROWNSTEIN. I thought it was distributed.

Mr. ULLMAN. Make it available to us, and, without objecting, it will appear in the record.

(The material referred to follows:)

HEALTH CARE: A DISASTER AREA

[From the 1199 News, July 1971]

Before it was over it was being referred to as the first *annual* Local 1199 Health Care Conference.

It took place on a sunny Saturday, June 12, 1971, in the union's Martin Luther King Jr. Labor Center at 310 West 43rd St., New York City. It came as no

surprise to the members of 1199 that there is a health care crisis in the United States. The members of the union see the crisis every day on the job. They came together that Saturday—300 of them—to see what could be done about the problem. By the time they left the conference they know things were worse than they had imagined. The health care situation in the United States is more than a crisis. It's a disaster.

The man who laid it out for them at the very outset of the conference was Dr. John L. S. Holloman Jr., medical director of the multiphasic screening program of the Health Insurance Plan of Greater New York. After they heard Dr. Holloman—and after they discussed the problem in panels—the participants knew they were into something that not only was going to be a long fight but which went to the heart and soul of the union's commitment to the cause of health.

Dr. Holloman, one of the nation's leading black physicians, pulled no punches in his keynote address. "Good health and health care services," he said, "are basic and universal human rights. Health as a human right has meaning only when health is understood to be a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health is an all-inclusive term which must be related directly to the quality of life."

There is, he said, a "serious imbalance in the availability of health care to all segments of the total American populations."

He socked the audience with hard statistics—75,000 newborn babies die in the United States each year. Fourteen other countries have a lower infant mortality rate than the U.S. He noted the fact that non-white American babies die at a rate nearly double that of white American babies. American males of any color have a shorter life expectancy than males in 19 other industrial nations.

Health, he said, "cannot be divorced from the environment just as it cannot be divorced from heredity."

And he did not confine himself to generalities. He talked in the specifics of today's problems.

"We have watched the perversion of Medicaid in our city and state. Less than two years ago we saw the New York state Legislature—in concert with the federal government—arbitrarily drop—in New York City alone—1,300,000 medically indigent people from Medicaid rolls."

Dr. Holloman charged that "85 percent of the physicians in New York refuse to see any medicaid patients at all." He said that hospitals—municipal as well as voluntary—have "joined in this conspiracy against the medically indigent."

Planning for the conference involved the efforts of a 30-member rank and file committee and staff personnel.

MINORITIES: GOOD CARE MUST BE AVAILABLE TO ALL

The scandalous neglect of health care delivery for minority groups, the poor and the elderly can only be corrected if the victims organize and make themselves heard politically and in their communities.

This was one of the major themes developed in the 1199 Health Care Conference panel discussion on "Health Care Delivery and Minority Groups, the Poor and the Elderly."

Panelists introduced by Chairman Jesse Olson, 1199 executive vice president, were Dr. Bernard Challenor, deputy director of the Columbia affiliation at Harlem Hospital, and Dr. Michael R. McGarvey, assistant to the president of the New York City Health and Hospital Corporation.

The mood for both speakers' remarks was set in introductory remarks by Louise Evans, NYU nurses aide and a member of the 1199 Health Care Committee.

"I live in Bedford Stuyvesant, and I'm here today to see if the kind of care given patients at NYU Medical Center can also be given to my neighbors in Bedford Stuyvesant."

Dr. Challenor called medical conditions in Harlem "bleak".

"Of Harlem's 400,000 residents, one-third are medically indigent," he said. "There are less than 100 private practice physicians, most of them elderly and about to retire. As a result, Harlem Hospital's emergency room and out patient clinics have become family physicians for much of the community."

The problem is made worse by the fact that there are no nursing homes in central Harlem, Dr. Challenor added. Some 10 percent of Harlem Hospital's beds are thus occupied by elderly people who don't actually need to be there but have no other place to go, he said. This sometimes results in the turning away of people who come to the hospital with acute illnesses. Dr. McGarvey told the panel the 18 hospitals in the City Hospital Corporation are striving to create a "uniform standard of care" for all New Yorkers.

Evidence he cited includes new hospital construction either completed or planned at Harlem, Lincoln and Fordham Hospitals. Also a system of neighborhood family care centers; and increased decentralization and public accountability through proposed community advisory boards on which 51 per cent of the members will have to be users of the Corporation hospital in their community.

1199 Pres. Leon Davis, in a comment from the audience, suggested, "Even with the best of intentions by the Corporation, any service—be it housing, schools or hospitals—if it is designed to take care of the poor, it becomes a poor service." The double standard in health care will only be cured when poor and rich patients are treated in the same hospitals, Davis said.

Other speakers from the audience made the following points: More hospital beds are needed for narcotics addicts. The RN shortage should be handled by upgrading LPNs, not importing nurses from abroad. Educational requirements that prevent upgrading should be reduced. Hospital Corporation headquarters should not have such "lavish furnishings." (Dr. McGarvey denied they are lavish.) Old people need better housing and homemaking care to keep them out of terminal facilities. Doctors too often don't understand or have sympathy for the cultural background of poor and black patients. Neighborhood health centers should be built before new Corporation hospital buildings. And Corporation executives should visit their own emergency rooms at least once a week.

Several speakers referred to state budget cuts that cripple health care, urging community pressure groups and political action to fight for health care funds.

"In the past, unfortunately, sick people have not been a good political constituency, and health lost out when resources were allocated. This must change," said Dr. McGarvey.

THE COMMUNITY: IT MUST HAVE A VOICE

If one person had been able to sit in on all four panels of the Local 1199 Health Care Conference on June 12 that person would have recognized the same or similar subjects and suggestions cropping up in each of the panels, despite efforts of the planners to divide up the subject matter of the conference into four parts.

The panel, for example, on health care delivery and the role of the community found itself discussing matters that were touched on also in the minorities panel, in the manpower panel and in the panel dealing with comparative systems for health care.

The overlap was perfectly understandable, however, because each panel was up against the same basic problem—the structure (or non-structure, as one speaker put it) of medical care service in the United States.

The panel on health care delivery and the role of the community, which was chaired by Exec. Vice-Pres. Doris Turner, found itself discussing many of the same things as the manpower panel because the subject of lack of a community voice in the health care of the community was a major factor in both discussions.

Anibal Garcia, the health care committee member who introduced the discussion, said his conclusion after 15 years in the hospital-medical field was that the community that is supposed to receive health care has no role to play outside of that of patient. "The ugly truth," he said, "is that they have had nothing to say. Non-residents of the community have made all the decisions as to what's good for the community. No member of the hospital board of trustees has to use the hospital clinics or emergency rooms."

The panel's two experts, Ana O. Dumois, director of the Community Health Institute, and Dr. Lewis M. Fraad of the Albert Einstein College of Medicine, brought the problem down to a question of priorities—and that was a word heard in most of the other panels, too.

Mrs. Dumois said the health care crisis is "primarily a crisis of priorities."

Dr. Fraad said, "If we're going to change the priorities, then we're going to have to take the decision-making away from the doctors and the administrators

and give it to the consumer. I am a doctor, and I know that doctors are not going to change the priorities. They will have to be forced to."

Mrs. Dumois said the way health dollars are spent is wrong. Too often hospitals give priorities to research and teaching at the expense of patient care. There is no continuity for patients. When they come to clinics or emergency rooms they see someone different every time. She made the point—also made in other panels—that emergency rooms have become the "family physician" for many people in poor communities.

One of the biggest problems, as Dr. Fraad sees it, "is defining the community and its spokesman. Are the Young Lords the spokesmen? Are the preachers, the businessmen, the 'safe' people, the people with the government and foundation grants?"

"Until we get people who really speak for the community, who can set priorities and who live in the community—who are consumers—we are in trouble."

A lively discussion ensued that could easily have lasted the remainder of the afternoon.

MANPOWER: A NEED TO TRAIN THOUSANDS

A revolution is needed to move the medical education establishment out of its 50-year-old rut.

That rut leads to the training of mainly well-to-do and middle class whites to be solo practitioners who control the delivery and the price of health care. The resulting inefficiency and racial and class discrimination can best be turned around by the consumers of health care asserting their rightful voice in health policies. And the members of Local 1199 should act on this problem as consumers who have the special insights of people who also provide health care.

These were the main ideas that emerged from the panel discussion on health care delivery and manpower at 1199's Health Conference. The panel, chaired by Guild Division Organizer Judy Berek, was led by Dr. Peter Rogatz, professor of community medicine at Stony Brook State University and former head of Long Island Jewish Hospital, and Stella Zahn, director of training at the Martin Luther King Health Center in the Bronx.

The panel convened after the opening general session had been told the nation now suffers from a shortage of 48,000 physicians and 17,800 dentists. There is also a shortage of 150,000 nurses and 267,000 allied health workers. By 1980 these figures will be much worse.

The session was kicked off by Howard Reitman, a social worker at Beth Abraham Hospital, with two questions: What is the reason for the great shortage of physicians and other health workers, and how do we close the gap? What has been learned from pilot neighborhood health centers like the King Center, and are the lessons useful in meeting the need for a good medical care system in the U.S.?

The main reason given by Dr. Rogatz for the health worker shortage was that the advent of Medicare and Medicaid enabled thousands of people to get care who couldn't afford it before, but the system didn't have enough health workers or facilities to meet the demand. The millions of government dollars that poured into the system thus have resulted in a tremendous inflation of medical costs.

Part of the solution, he said, is to train more doctors, but this is far from a complete answer, which lies in changing the system. "As long as doctors retain control of the system, they will continue to treat people on a piece-work basis because that's the way to get rich. As they say, 'One ill, one pill, one bill.'" The patient's interest, he said, would be best served through a pre-paid instead of a fee-for-service arrangement. This is so from both the standpoint of cost and better health because a pre-paid system gives more incentives for preventive care.

The training of doctors, too, needs basic changes—Rogatz used the word "revolution" in this connection. The enormous expense—about \$10,000—to train one physician makes it almost impossible for any but the affluent to afford such education. This effectively leaves out minority group members. The answer here, the doctor said, is to open medical education up to all, with ability the only standard for admission. Since health is a national resource, the training of health workers as well as the delivery of health care should be paid out of the taxes of all Americans.

He favorably mentioned the trend toward developing physicians' assistants. Dr. Rogatz conceded the risk that poor people would end up getting second-rate

care from physicians' assistants performing as substitute doctors, but he doubted that this would happen.

On training policy for health workers other than physicians, the doctor said people should not be limited to one field. "Training in one area should be just the start," he said. "If a person wants to, he or she should be able to go back to school to learn anything he can handle." He also advocated that prior training and experience should be credited towards the achievement of higher skills.

Mrs. Zahn, director of training at the Martin Luther King Health Center in the South Bronx, said such a center works well both to keep people healthy and train them for this purpose.

By involving community residents in its work, the Center is able to add a human touch that is often lacking in strictly professional care. The King Center already does this to some extent, but the need is far from being met, she said.

The Center, a pilot operation affiliated with Montefiore Hospital, is about four years old. It started out with the idea that good health requires more than medical care alone. Following from this was the need to train community residents to help identify and take care of both community problems and medical ones. So the Neighborhood Health Center is also a training center, which graduates as many as 100 students a year with skills ranging from file clerk to dental assistant. The Center gets funds from the Office of Economic Opportunity.

The Center works through health teams including an internist, a pediatrician, public health nurse, a family health worker, a community health advocate, a psychologist and a health education specialist. The family health worker, the community health advocate and the education specialist are the all-important links with the 45,000 people who live in the 55-block area covered by the King Center.

These community links are two-way operations. Not only do they help educate the local people about health care but they tell the professionals what the people need.

The center has found it needs to re-educate doctors and other professionals to the need to work together to meet such varied problems, and, she emphasized, to listen to the patients.

To enlarge on this success, even to keep the center going and develop more of its kind, is going to take political action, however. "Unless there is an ongoing commitment by government to the neighborhood health center idea, it will fail," she said.

HEALTH CARE PLANS . . . THE U.S. IS FAR BEHIND

One of the most frequently heard comments about 1199's Health Care Conference on June 12 is that everyone learned a lot. This was particularly true of the panel on Comparative Delivery Systems, which is "medicalese" for the various kinds of health care methods that exist in other countries and in other parts of the U.S.

The members who attended the panel learned just how far behind the United States is when compared to countries like England, Sweden and the Soviet Union. They heard Dr. H. David Banta, professor of community medicine at Mt. Sinai School of Medicine, call the present U.S. system "a mess . . . hardly a system at all."

They also heard him predict: "There is no question we will have some form of national health insurance within five years, perhaps sooner." He declared health care will be one of the top issues in the 1972 presidential election. But the members attending the panel left with the impression the U.S. still will be far behind.

The panel, chaired by Vice Pres. David White of the Guild Division and introduced by Morton Rephen of the Health Care Committee and the Drug Division, included, in addition to Dr. Banta, Dr. Victor W. Sidel, chief of the division of social medicine at Montefiore Hospital. Dr. Banta dealt with domestic delivery systems while Dr. Sidel presented comparative material on foreign systems.

Actually, as Dr. Banta pointed out, the federal government already is investing heavily in health care in the United States, but it isn't getting very much for its money. The government, he said, now pays 45 percent of all medical costs but has "very little quality control." The effect, he noted, is that the government "has only put money into the mess and made things worse."

Dr. Banta's key point—and it was made in the other panels also—was that the fee-for-service concept is negative and "encourages laziness" and profit-taking

whereas some system of "per capita­tion"—that is a set fee for caring for a number of people—works to the physician's advantage if he keeps people well. The solo general practitioner—the old family doctor who made house calls—is "almost dead" and that fact of life has to be accepted. Group practice, specialization, and some form of hospital linked to group practice are fundamental necessities, he declared, along with a consumer control factor. Consumer control was one of the themes that cropped up in every panel.

The Kaiser Pre-paid Group Plan, Dr. Banta pointed out, has one major weakness—no consumer voice or control.

Dr. Sidel opened up a considerable vista for those attending the panel. They learned that in other countries—most notably Great Britain, Sweden and the Soviet Union—any citizen can obtain—virtually for nothing—medical services that would bankrupt even a middle-income family in the United States and that would be utterly beyond the reach of poor people.

The 1199 members attending the panel were given thus a yardstick—a basis of comparison—for what exists in this country. The Soviet Union has 24 doctors per 10,000 population to our 15. The USSR has about the same number of medical schools as the U.S. but their classes average 330 to our 88. They use their resources better. Here again that frequent word—priorities—cropped up. "It isn't," Dr. Sidel said, "enough just to end economic barriers."

The delivery problem precipitated the participants into a debate that occurred also in other panels—about assistant doctors or so-called physician's assistants. Pres. Leon J. Davis of 1199, who was present at this phase, declared his oft-stated fear that assistant doctors might wind up providing inadequate medical care for poor people while the rich received better care. Dr. Sidel told Davis he thought "a very careful job description" of an assistant doctor's duties would eliminate Davis' fears.

There wasn't enough time to discuss the various health care bills before Congress, but the panel participants left better armed to continue the fight.

1199' STATEMENT OF PRINCIPLES

The 1199 Health Care Conference on June 12 adopted a statement of principles on health care submitted by the Local 1199 Executive Council and the Local 1199 Health Care Committee. The text follows:

As a union whose 50,000 members are consumers and providers of health services, we add our voice to the national debate on how to meet the worsening crisis in medical care.

Ours is the only major industrial nation that has neither a moral commitment to provide health care for all of its citizens nor a rational system for the delivery of such care.

We need a national policy committed to the principle that every American is entitled—as a matter of right—to the best health care that our nation's skill and technology can command. We need a delivery system that assures the availability of health services to all citizens.

Such a system must include:

Universal and Comprehensive Coverage.—Health care must be a matter of right, not privilege. There must be one system for all. Everyone must be entitled to care regardless of race, income, sex, age, religion or any of the barriers that now create inequalities. Comprehensive care should include doctors, hospitals, medication, dental care, mental health care, nursing home and convalescent care and home health services. These services and facilities should be used to maintain health and prevent illness as well as to treat sickness.

Equitable Financing.—Health care should be removed from the profit-making arena and financed by the federal government from general revenues.

Sound Organization.—To develop a national system for the delivery of health care it is necessary to:

(a) Create an organized service in which the providers of medical care work together with government and the community for common objectives.

(b) Establish neighborhood medical facilities and community medical centers easily accessible to the people they serve and controlled by duly elected community boards.

(c) Encourage the development of comprehensive group medical and dental practice with effective consumer participation.

(d) Finance a recruitment and training program to meet health manpower needs and support medical and health research requirements.

We realize that the problem of the nation's health goes beyond what can be done to improve the delivery of medical care. To assure good health also means to provide decent food and housing, clean air and pure water.

We believe that our nation has the material and human resources required to fulfill these essential objectives. We believe that a national health budget must be adopted that makes the delivery of health care a matter of top priority. Our national emphasis must change from war and destruction to the preservation of life.

Our union pledges to promote actively and work for federal, state and local legislation that is most consistent with the goals set forth in this statement.

Our union pledges to work together with the AFL-CIO, the Committee for National Health Insurance and other organizations and groups actively engaged in the campaign for comprehensive national health care protection for all Americans.

We also pledge to continue to be mindful of our responsibilities as human beings and as union members in taking care of the sick, the aged and the infirm.

HEALTH MUST BECOME A PRIORITY

The task of placing the problem of health care in perspective in terms of the nation's priorities at 1199's June 12 Health Care Conference fell to Rep. Bella Abzug (D-N.Y.), the forthright Congresswoman who represents the district in which the union's headquarters are located.

Mrs. Abzug did that in typical Abzug style.

"What is wrong with the state of health care services is what is wrong with everything else in this country. Health care is one of the most painful examples. There is an everwidening gap between what people need and what is, a gap even wider, if possible, than the one between President Nixon and his credibility."

Furthermore, she declared, the people increasingly are demanding a change.

"The shortage of manpower, the shortage of facilities, most of all the shortage of funds—these problems are not new. And the solution is not new either. The resources are there. They're just in the wrong place.

"The real difference is in the minds of a majority of the people of the United States, who are saying in every way they know how that it's time to change our priorities—away from war, away from profiteering by big business and toward peace and meeting the needs of the people."

In terms of cost, she asked, "... can we continue in the business of marketing weapons of death around the world and continue to ignore the fact that we rank 14th in infant mortality?"

Mrs. Abzug did not confine herself to health care. Her comments ranged over many subjects, including her proposal that New York City become a separate state. She also had some nice things to say about 1199.

"I am happy," she said, "to be here again, speaking to a union that knows how to fight—and how to win. That's a good combination.

"As a group that has systematically been excluded from protective labor legislation for more than 35 years, you've broken through the system that decreed no strike for public service workers and thus condemned them to subsistence wages.

"By your unity and your strength you have succeeded in establishing a tradition whereby black, white and brown together have won unity and recognition of the fact that working people have a right to decent pay and working conditions."

It was the kind of a speech that brought the conference to a rousing conclusion with the adoption of the policy statement on the opposite page.

MEMBERS REACT

Members of 1199 who participated in the Health Care Conference were generally enthusiastic, and many of them left wanting more. The prospect that the conference will become an annual event, forecast by Exec. Sec. Moe Foner at the closing session, was applauded enthusiastically.

Many members put their comments in writing. The most frequent criticism was that everyone didn't get to hear everything—that is, participate in all the panels or at least hear reports from the panels. (The reports on the preceding pages are designed to meet that request). A number would have liked more detail on health care legislation now pending before Congress.

Thomasina Jefferson, a member of the committee that planned the conference said "The conference as a whole was very rewarding and educational. I would like to see—if at all possible—a follow-up conference held once a year."

Mr. ULLMAN. You do represent the health workers. You do represent people who are closely associated with the health industry, and your opinions are very valuable to the committee.

Thank you very much.

The committee will stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 12:30 p.m., the committee adjourned, to reconvene at 10 a.m., Thursday, November 18, 1971.)

NATIONAL HEALTH INSURANCE PROPOSALS

THURSDAY, NOVEMBER 18, 1971

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Al Ullman presiding.

Mr. ULLMAN. The committee will be in order.

Some of the witnesses this morning have called us because of the pressing business in the Congress. The Senate is having a vote at the present time and they have asked that their statements be inserted in the record. There are some that will not be able to come until 2 o'clock this afternoon.

Are any of the following present?

Senator Kennedy, Senator McIntyre, Senator Hansen, Congressman Hall, Congressman Eckhardt, Congressman Koch, Congressman Crane, Congressman Ryan, Congressman Fraser?

Without objection, any or all of these members will be given permission to insert their statements in the record.

A number of these members have indicated that they can be here at 2 o'clock this afternoon.

It is my understanding that one of the members is on his way. We will await his appearance in the committee room at this time.

(A short recess was taken.)

Mr. ULLMAN. The committee will be in order.

We are very pleased this morning to have our friend from Missouri, a distinguished physician in his own right, one for whom the members have a great deal of respect and who knows a lot about the problem of health from firsthand experience from his outstanding experience as a surgeon.

So, it is with a great deal of pleasure that we welcome you before the committee, sir.

STATEMENT OF HON. DURWARD G. HALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. HALL. Thank you, Mr. Chairman.

I apologize if I have held you up. I have been in another committee meeting and thought, according to the schedule which I received from your very excellent staff, that it would be considerably later. Otherwise, I would have been here on time.

I surely want to congratulate this hard-working committee for having scheduled 5 weeks of morning and afternoon public hearings on

this important subject of national health insurance. To me it is a legislative search for solutions to the health problems of America.

As a member of the House Committee on Armed Services, from which I have just come a little breathless, and with assigned duties on the floor of the House, plus the House-Senate joint committee on continuing congressional operations, I have enough to do to occupy my time. But as you say, Mr. Chairman and members of the committee, as a physician I have deep concern in the area of your committee's jurisdiction. I will never lose interest in my profession and the problems of quality care of patients.

In the last Congress, as you may recall, I introduced a health proposal identical to H.R. 177 of this Congress. The current bill has been joined in by approximately 40 cosponsors from both political parties.

I won't impose upon your time by again detailing the proposal. Generally, the bill attempts to accomplish just two things. First, it seeks to rewrite title XIX so that equal medical benefits are available to individuals regardless of their State of residence whether it be New York or Mississippi. The proposal provides that the Federal Government would bear 85 percent of the total cost of the program, all of the costs of good, basic, health coverage. This would leave the States with the task of providing only catastrophic insurance to the poor. This responsibility should not cost the States more than the remaining 15 percent of the Federal payment, thus relieving their hard-pressed treasuries from most of the burden of public assistance medical care, and give both, that is the States and the Federal Government, a sound planning base.

The insurance industry—the commercials and the blues—would administer the program as I envisage it through the mechanism of honoring vouchers issued to the needy by State welfare agencies for the purchase of said health insurance a form of preinsurance. Federal minimum standards of basic coverage would be established. In addition, catastrophic health insurance coverage would be provided all Americans above the category of the poor. This proposal would guarantee that in the future no American would stand the danger of losing his life savings or his home, or face bankruptcy perhaps due to long and expensive accident or illness.

Surely these two goals must be your first priority. Mr. Chairman and members of this committee, in any legislation this committee might develop. The catastrophic insurance would be financed by a payroll tax of four-tenths of 1 percent, from both the employer and the employee, on earned income based upon the social security maximum tax base at any given time. The total cost of the catastrophic proposal, according to Bob Myers, whom we all know as the former actuary of social security, would not exceed \$2.5 billion, none of which would come from general revenues. The cost to the Federal Government of the first portion of my bill would not exceed more than the States' present share of the current title XIX program, plus something less than an additional billion dollars to equalize benefits across the Nation and among the States. Certainly, this is by far the most inexpensive approach compared with other legislation being suggested to you, even though you choose to add incentives for self-insurance on the part of those not yet eligible for medicare, if that be your wisdom and final decision.

Like you of the Committee on Ways and Means, I have been reading and listening to a considerable number of commentaries in the media about our health needs. A good deal of it is not pertinent, having been presented by persons with little knowledge of the health care field. Some of them would have you believe that the present health care system should be torn down and a complicated, expensive, and perhaps untried system erected.

I agree that the present health care system needs improvement. There has never been a time in the history of any new people-serving program when this was not true. But look at the improvements and the progress made to our health care system by the old system, just since the end of World War II. Sure, there are things that should be done to the system. And the Congress quite properly, in my opinion, is concerning itself with these problems. But if Government is to perform a service to the health care system, it must set itself some priorities. And some of these priorities seem obvious.

In talking with my colleagues who know firsthand the attitudes of their constituency, who know what is bothering their State officials, who have studied the 60 some questionnaires taken by our colleagues on this subject, who are familiar with some of the results of polls that have appeared this year in the Congressional Record, they know that the construction of a new title XIX rates as the No. 1 health priority.

If this committee would call the caseworkers of every Congressman before it, you would quickly discover the frustrations of attempting to help constituents with long and expensive illnesses under our present system. Aside from some spotty insurance coverage for the well-to-do, catastrophic insurance just doesn't exist, and this is a paradox in a nation that has done as much as we have if I may say so parenthetically. These are the headline cases that we read about and that are newsworthy but, Mr. Chairman, they are relatively care. They certainly can be covered by a minimal of advance planning and therefore the great foundations such as the Cancer Society, the Kidney Foundation, and others, are spending large sums for research, but are not capable of helping out with the misfortunes of individuals. I think perhaps only we can do that.

So when people, good, hardworking people, can't do for themselves, they have every right to move progressively up to the Federal Government for assistance. Make no mistake. The need in this country for catastrophic insurance rates very high indeed, perhaps a second priority.

For example, you have had before your committee testimony from witnesses who have detailed to you the efforts being made in the cost problem for kidney disease treatment. We all remember the misfortune of our own colleague "Fats" Everett of Tennessee.

Another priority, of course, is cost controls. But then you have already faced up to this problem in H.R. 1. On the Senate side, Senator Bennett has his amendment, so I will do no more than agree with your decision to give cost control a high priority. I hope it can be done through professionals without damage to quality medical care to people.

This committee has been discussing different modes of health delivery, and I certainly endorse your action in providing authorization for the bio and sociomedical research programs now under way.

Congress, through acting on the prescription and direction of other committees, has faced up to the shortage of medical and allied health personnel. The manpower bill, as you know, has been sent to the President for signature. I believe this far-sighted legislation had the vote of every member of this committee, and it had mine.

Last in my ordering of health priorities is the problem of getting middle class Americans covered with basic health insurance. Over 90 percent of this group is presently covered by their own sagacity, their own desire to secure their own futures.

In my opinion, the only immediate concern this committee should have for middle class America is in assisting it in the area of catastrophic insurance.

Now a final point, Mr. Chairman, and a very important one in my opinion. I have pointed out a number of problem areas in this country's health care delivery system and banked them for you in what I consider an order of priority. But, some people who have appeared before you, have pointed out another area which they believe deserved priority treatment, middle class America. I am not sure what classes we have in America but I think we all know whereof we speak.

Aside from providing this large group of Americans with insurance protection for catastrophic illness, it is inconceivable for me to believe that this committee, the last half of which name is "means," would consider putting families with an income of say \$10,000 per annum or more, on some sort of public health care "dole," when our National Reserve and Federal Treasury is gone.

These people in middle class America are taxpayers and if you are concerned with giving them something, who is going to pay the taxes? You need to take from somebody and obviously we don't tax the poor. This is another way of saying let's help those who need help.

Let me give you an example of what I am talking about. Our colleague John (Representative John W. Byrnes), the ranking minority member of this committee and Secretary Laird and Secretary Richardson were out to Wisconsin a couple of weeks ago and visited the Marshfield Clinic. I know the operation well and visited with Dr. Custer on that clinic staff only last Friday. That clinic has recently started a prepaid comprehensive group practice program that has already enrolled some 9,000 persons out of a possible total of 40,000.

Now it's my understanding that the doctors running that program told you and the two secretaries that many families in that area who are in an income bracket of \$3,700 to \$7,000 per year just simply cannot afford to come up with the \$600 needed to joint the plans, "prepaid plan or HMO."

With incomes in excess of \$3,700, these families don't qualify for title XIX, but they don't have enough uncommitted money to buy into the group practice program. Yes, gentlemen, these American families need a boost from you. So the grant has been turned over out there to another body for another demographic study of patient flow. The doctors knew the problem and the answers, but the results were

sought by HEW. The doctors will not, and should not, merchandise and sell prepaid service, nor would the drawing area of 36,000 sign up.

But those doctors up there at Marshfield also told you that those families with more than \$7,000 a year had no problem buying into the plan.

And that's the point I'm trying to make American families in an income range of around \$10,000 a year and up don't need health care insurance assistance, except for catastrophic illness. This large group of middle income. Americans under no stretch of the imagination qualify for any top priority in improving our health care system. This Government, gentlemen, is strapped for spendable tax dollars. Those Americans who don't need help, shouldn't be given help, at least by tube feeding or any type of per-oral infusion.

Ladies and gentlemen, I hope you won't accuse me of oversimplification. What I am doing is pleading with you to set up priorities, and then start doing first things first.

I certainly hope I have been constructive. That was my intent. And I hope my remarks may be of some assistance to you in your deliberations on this important subject. I am available and anxious to help.

I am open for any questions that I might have the expertise to answer.

Mr. ULLMAN. Dr. Hall, you are always constructive and we appreciate your testimony. I hope that when we get further along in the writing of the bill that we can count on your continued advice. I would hope, if you haven't done so to date because it has not been published and you couldn't be here, that at some point you will study the record, particularly areas where I think these long hearings have been very constructive; and I hope that you will give me and the rest of the committee your advice on a number of matters that I think are going to be very important in the writing of a bill.

I wouldn't attempt to enumerate them all, but I mean, for instance, the field of preventive medicine. I think we have had excellent testimony on a variety of approaches toward getting to the very fundamental problem of making available, from childhood on, the kind of checkup diagnosis that modern medicine certainly can make available to all Americans.

Then there is the computerized recordkeeping which has been demonstrated in a number of communities as an extremely valuable tool in assuring the flow of the right kind of medicine to Americans.

Third, there is the medical foundation approach to medicine which in parts of California, and even in my own district in Oregon, and now in Phoenix, is offering, I think, some rather exciting new alternatives to the implementation of the HMO concept that do not violate the existing system of services but do face up to that problem.

Peer review, of course, has been talked about a great deal, and is being implemented in part, but if you have any ideas on how that could be beefed up, that would be helpful. All of these things would be extremely helpful to us if you would comment on them at some future time.

Mr. HALL. Mr. Chairman, I will be glad to study the record and comment in detail. Indeed, Chairman Mills has, as have you, asked

that I do the same thing along with our colleague from Wisconsin, Mr. Byrnes.

As I said in my signoff, I am available and anxious to help in any way that I can.

Taking the last and the first of your suggested comments just for off-the-cuff comment today and realizing that you want a study and a detailed analysis and comment later on, only last Friday I suggested to the Missouri Academy of Family Practice meeting in its annual clinical and legislative session that perhaps the name of Health Maintenance Organizations should be changed to "Preventive Health Organization," preventing trouble rather than trying to maintain something forever in what the good Lord has decreed must eventually become a deteriorating mechanism.

No one expects to maintain health indefinitely albeit desirable as far as a striving approach is concerned. But we might very well emphasize, and I think the committee's wisdom is already evident in trying to emphasize preventive medicine.

I will certainly be glad to comment further on HMO's and computerized adaptations to informational immediate retrieval and interpretation for the benefit of quality care to all patients through their doctors. It just so happens that I believe the first regional medical program of America was started out of our hometown and through the University of Missouri.

It has been adapted in many other places since that time with the use of computers and teledata retrieval and indeed one of the popular magazines recently had a story which I am sure you have all had exposed to you. It was from our colleague Richard Eckhardt's district in Salem, Mo., and was about one man who is adapting this program in eight out of the 14 areas in which it is immediately available.

Having come from a group practice myself for over 26 years and having stepped down as chief of staff in this group type of practice, and having come from Missouri where there have been health maintenance organizations in being for over 50 years, I believe we can be of help to you and the committee when you are ready as far as the proposal for health maintenance organizations is concerned and whether or not they are feasible as an even long step toward the solution of delivering quality health care.

Mr. ULLMAN. Thank you, Dr. Hall.

We will look forward to your further communication.

Mr. Byrnes?

Mr. BYRNES. Doctor, I want to express my appreciation to you for your presence here and your helpfulness in this matter.

Thank you very much.

Mr. ULLMAN. Mr. Schneebeli?

Mr. SCHNEEBELI. I have just one question.

Dr. Hall, we are always glad to have you as a constructive witness.

You mentioned about the HMO's that you have had in Missouri for the last 50 years. Are they of any consequence or are they more or less pilot projects? Do these constitute a large proportion of your medical profession or how much impact do they have in the State?

Dr. HALL. In the two metropolitan areas of Missouri they have had a very large impact and they are in no sense pilot or demonstration

or experimental programs. These have mostly been brought about, gentlemen, as a result of labor organizational activities.

I would cite, for example, the one arranged by the butchers, the one arranged by the mineworkers, the one arranged by the St. Louis-San Francisco Railroad system, and even the Missouri Pacific system. I have been the company surgeon for those last two, in addition to practicing in a group practice myself.

My group never did do prepaid health maintenance type of work. We were a group of specialists that were simply banded together for the facility and ease of group practice. But in these other areas in the St. Louis area, they have been tried and tested and actually have reached a summit of providing services; and for many reasons, which we can discuss at length later or I will provide to you in writing, are actually dwindling off.

Mr. SCHNEEBELI. With your personal involvement, however, you have much to offer from experience. How long have you personally been involved with these HMO's?

Mr. HALL. Oh, probably since 1947 or 1949. After I left the Army and went back home, I became intimately involved with them.

Mr. SCHNEEBELI. I didn't want to get too personal and reveal your age by this question?

Mr. HALL. That is pretty well known.

Mr. SCHNEEBELI. Thank you very much.

Mr. HALL. Thank you.

Mr. ULLMAN. Mr. Collier?

Mr. COLLIER. I want to take just a moment to compliment you on what I think is a very excellent diagnostic statement on the national health care problem in its proper perspective.

I am particularly impressed with your proposal's goal to provide a program so that there would be equal medical benefits to individuals regardless of the State in which they live.

I think this was very vividly pointed out by the experience we had shortly after we amended title XIX, when former Under Secretary Wilbur Cohen came before our committee in support of that proposal, and there were many of us, including myself at that time, who took issue with many, particularly in the estimates that he made of what the costs of the program would be.

Subsequently, as you know, the proposal of the State of New York actually ran in cost about half of what the estimate that he made was of what the national program would cost, and, of course, there was the fact that many States were either very slow in implementing the program and so on.

But I will make this one observation and invite your comment. With the number of health proposals, some of which are so very broad in scope, many of which have a certain amount of temporary political sex appeal which might soon turn into disillusionment, if you attempted to put these programs into effect.

How do you feel with regard to the ability today of the medical profession to deliver this health care? What would be the result in terms of quality of this health care if we adopted some of the very broad programs, and I will be specific: the so-called Kennedy proposal, for example?

Mr. HALL. Well, as I tried to say in what I believe in my statement was the fifth priority, in the first place, I just don't think we can afford that at this time and place, unless more means are found.

Perhaps that priority is in the wrong place as far as my statement is concerned. But, as I interpret your observation and question, it is much broader than just the question of financing it. I realize that those who believe we should dedicate quality health care a very high priority as far as our gross national product and other income and/or indebtedness is concerned, would stop at no sacrifice in order to accomplish it.

As far as the capability of the profession to deliver is concerned, again I would point out that I think it can be done if arranged by professionals.

I think maybe those who would grab a headline or those who would indulge in political intrigue or those who would not be realistic who necessarily in their hearts want everything good for every one, have unnecessarily promulgated the idea that this cannot be accomplished under our present system.

Actually, we have improved on the ratio of physicians to patients in this country since 1949.

I followed this very carefully all during World War II because that was a responsibility of mine. Since that time, by Government help in the Higher Professions Act, and with the capitation to medical schools that is now coming on, and what private industry and foundations themselves have done for medicine, to say nothing of an on-coming accelerated program to turn out graduates, I think we can meet any requirement. To do this, we must always bear in mind that, because of worldwide experience of individuals, because of regimentation, because of conscription, because of perhaps too many wars, wars that none of us ever liked but in which we have had to engage, there has been a totality of exposure to quality medical care to the point where people are demanding more and more services whether it is of the hospitals or the physicians or the nurses or pharmacists or what not.

This is what keeps us from crossing the curve of requirement of physicians to patients even though the ratio is better.

I think we can and could provide that quality but I think we must establish these priorities and do first things first, and, as the gentleman, my colleague from Illinois, has so wisely pointed out, the first priority must be to correct by amendment and perfection title XIX with equality among the States, so that all people can have an equal shot at this care.

Thank you.

Mr. ULLMAN. Thank you, Doctor. Mr. Pettis?

Mr. PETTIS. Thank you, Mr. Chairman.

I, too, am delighted to have our colleague, Dr. Hall, here. I want to join you in saying that I am looking forward to his further involvement with us in considering some of the testimony we have received and helping us develop something that is workable. But I would like to have one idea commented on which may be rather unique.

The reason I suggest this to you is because you serve on the Armed Services Committee. I am just wondering what your reaction would

be to our considering the use of military hospitals and veterans hospitals for enriching and maybe expanding internships and fellowships which are now closed out as far as those kinds of institutions are concerned.

The VA has recently, I think, adopted some new policies which would help in some measure to alleviate some of these problems. For example, I think they are building all of their new VA hospitals very close to a teaching institution.

However, here in Washington, I don't think a civilian intern or resident can get inside Bethesda or Walter Reed. Maybe that is good. I don't know. What I am really trying to get at is, without spending any more money than we are now spending, are there ways of, say, using some of these military medical facilities to help solve some of these problems?

I don't expect an answer today unless you want to just give us an off-the-cuff answer.

Mr. HALL. I just happen to have the answer I think. The gentleman is 100 percent right. I think all of these great institutions should be used in a training capacity. We did at the wind down of World War II establish what we called the dean's committees of the U.S. Veterans' hospitals.

That was worked out with the old personnel department of the Office of the Surgeon and the Veterans' hospital in the transfer of many of the then existing Army general and station hospitals to the Veterans and specifically in transferring Dr. Arden Freer, a colonel of the Regular Army, to operate this in the Veterans' Administration immediately after World War II under General Howley when he was the administrator.

That has worked to the point that you now suggest where the new hospitals are being built in juxtaposition to the medical schools almost as a requirement but even more they are being opened up.

Second, I will say to the gentleman as a result of his very excellent question that of course this is just exactly what we are accomplishing under H.R. 2, the Armed Services School of Medicine so-to-speak wherein 20 percent of the graduates will be assigned back to civilian areas and where we will utilize for the first time not only these great hospitals for training institutions but such things as the Armed Forces Radiological Research Institute, the Armed Forces Institute of Pathology, the National Library of Medicine which used to be the old Army Medical Library for which I had the privilege of appointing the director for two terms.

They must be used in expanding our effort to expand training and quality of people.

Mr. ULLMAN. Mr. Duncan?

Mr. DUNCAN. I too, Dr. Hall, would like to compliment you upon your great contribution to these hearings. The hearings we have had so far have pointed out that there is an apparent shortage of allied medical personnel.

Do you have any idea as to how we might train more people. Do you think the medical schools could do a better job in that field or expand their facilities for that purpose?

Mr. HALL. Yes, exactly. Again if I can refer to H.R. 2, this will be an institution for training not only through scholarships in existing

institutions but through the Armed Forces Academy of Medicine so-to-speak all-allied health professionals.

It is envisaged that that will include dentists and of course we already have the Delano School of Nurse Training which has recently been reinstated as I think a suggestion of this committee along with the Committee on Armed Services out on the Army Medical Center grounds. That will be enlarged.

In addition to that, I think we have just recently graduated the first 200 medical assistants. My son-in-law, who happens to be an orthopedic surgeon in Oregon by the way, is using one of the first medical assistants and it is a most satisfactory relationship all the way around.

I think we have much to do in this area from returning veterans who have been in the medical or Hospital Corps, the medical department, who are technicians in every sense of the word continuing and having their training expanded so that they can be medical assistants upon return not only spreading the influence of a capable physician, whether he be a general practitioner or family practitioner or the highest specialist, to cover more people and actually it enhances the quality of care given.

Mr. DUNCAN. Dr. Hall, what do you estimate your proposal would cost in dollars?

Mr. HALL. My proposal?

Mr. DUNCAN. Yes, sir.

Mr. HALL. \$4.6 billion annually using social security statistics and embracing both programs, the catastrophic care and the changes to medicaid wherein the Federal Government would assume 85 percent of the burden.

Mr. DUNCAN. Thank you, sir.

Mr. HALL. Thank you.

Mr. ULLMAN. Mr. Burke?

Mr. BURKE. Dr. Hall, we appreciate your appearance here this morning because you are eminently qualified to testify on this subject. I was wondering if you would want to make any observations on the recommendations of some officials to close eight public health hospitals around the Nation.

What effect would that have on the health services, health care of the people?

Mr. HALL. Mr. Chairman, I feel very strongly about this.

Some of you have heard me express myself on the floor about it. I think it is absolutely unconscionable at a time when we are developing other Health Corps for care of people in underprivileged sections to close existing working operating public health hospitals or research centers with their proud tradition and ability to serve across State lines and do anything else in an emergency or a pinch. I also think it is almost unconscionable to degenerate the Surgeon General of the United States, who by statute is the Surgeon General of the U.S. Public Health Service, and the corps of commissioned officers who are trained in international relations, quarantine, medical diplomacy as another form of M.D. around the world by absorption in any department of Government or subjugating them to others than the direct responsibility that Congress originally conceived was theirs in reporting directly to the President.

Mr. BURKE. I want to thank you.

I knew that you would give us a good frank honest answer. I appreciate that answer.

That is all, Mr. Chairman.

Mr. ULLMAN. Mr. Brotzman?

Mr. BROTZMAN. Thank you, Mr. Chairman. This is not really a question, Doctor, but just to express my gratitude for you taking your time to come over here to give us the benefit of your expertise.

I wanted to agree with the tenor of your remarks as they reflect what I have learned in my district, that the greatest need that I hear expressed is in the area of catastrophic illnesses.

This is almost a unanimous request. I think a lot of the people, because we are just having the hearings now, haven't evaluated the impact of all the various programs. They have not had an opportunity. They are not talking about programs as much as a need and certainly I think the testimony before our committee has been quite strong in that regard too.

So I merely wanted to agree with your observation and to restate what others have said that we do appreciate your testimony.

Mr. HALL. Mr. Chairman, if I may just make a one-sentence remark in answer to that or in corroboration of that, it has been most interesting since we first broached the idea to see the others fall in line and adopt this compassionate quality of relatively rare cases but of very decimating cases that families should be insured and insured against.

Mr. BYRNES. Mr. Chairman.

I am prompted to ask one question in view of the colloquy that you had with Mr. Collier. That is about the increase in the number of physicians in proportion to the population, which is a salutary thing of course.

But I must express a concern, and I wonder if you share it, over the reduction in the number of primary care physicians in proportion to the population.

The information we have is that there were about 94 per 100,000 population in 1931, whereas today there is a ratio of 73 per 100,000. I find this somewhat disturbing, because it seems to me that this concerns some of the basic care needed in many ghetto and rural areas, which show a need for more medical care than they are presently receiving.

I wonder whether you have some idea of how we can get doctors, or students who are thinking of medicine as a career, to move away from the more refined specialties and into the primary care area.

Mr. HALL. I think the gentleman makes an excellent point, Mr. Chairman, and as a matter of fact, I agree with him wholeheartedly.

As probably one of the most overtrained and highly trained specialists that there could be in my own right, I would be the first to agree that as a result of the pendulum swinging too far after World War II the profession itself has become overspecialized.

The Congress in its wisdom is doing much about this. As you know in the Higher Health Professions Act which came out of another committee credit and low interest pay back or relative deferment is granted for those who do go to these needy or disadvantaged areas.

As you probably know, the profession itself has recently formed an Academy of Family Practice and they give credits and allow specialization and indeed have established in approved hospitals residence

training in the type of thing you are talking about which we prefer now to call family practice.

Mr. BYRNES. It has a long way to go in many of your clinics or hospitals.

Mr. HALL. Yes, it does; but when it is made a factor of capitation and/or grants for higher professional training I think you can be assured that the pendulum has stopped its swing and they will swing back in that area.

Indeed, this is exactly why I addressed the Missouri Academy of Family Practice which saw fit in the past to give me their distinguished service award. It was because I believe so wholeheartedly in what they are doing and what you are doing.

Mr. BYRNES. Thank you.

Mr. ULLMAN. If there are no further questions, again you have been very helpful, very constructive. We appreciate your testimony.

Mr. HALL. Thank you, Mr. Chairman.

I hope there was no conspiracy to keep me off of the floor. [Laughter.]

Mr. ULLMAN. We talked about it, Doc. It is my understanding that two of our very distinguished colleagues from the other side are over here and, recognizing their time situation on voting, is Senator McIntyre here?

Senator, we would be very happy to hear you at this time. You have been very active in the field. We appreciate your coming across the Hill to our side to give us the benefit of your thinking. You are recognized, sir.

STATEMENT OF HON. THOMAS J. MCINTYRE, A U.S. SENATOR FROM THE STATE OF NEW HAMPSHIRE

Senator MCINTYRE. Thank you, Mr. Chairman. Thank you for the opportunity of appearing before this distinguished committee.

I have a full statement that I trust will be made part of the record. In the interest of time I have attempted to summarize that.

Mr. ULLMAN. Without objection it will be in the record in full.

(The statement referred to follows:)

STATEMENT OF HON. THOMAS J. MCINTYRE, A U.S. SENATOR FROM THE STATE OF NEW HAMPSHIRE

Mr. Chairman, I am here to make a statement in support of The National Healthcare Act of 1971, a measure introduced in the House as H.R. 4349 by the Honorable Omar Burleson, a distinguished member of this Committee, and which I introduced in the Senate as S. 1490.

This is a measure, Mr. Chairman, which seeks to provide a national health care system offering equal access to quality health care for all citizens, regardless of income.

Most of us, I am sure, agree that we have a crisis in both the delivery and cost of adequate health care in this country today.

We know that delivery of care is frequently uneven and fragmented.

And we know that the cost of that care is rising by the day.

We also know that while our resources are great, they are not unlimited. Were health care our only challenge, perhaps there would be no problem. But we face many other crises as well, and our ability to pay for corrective programs to resolve all of them is therefore circumscribed by reality.

This is why I have said that while we strongly need health care reform, while we are obligated to provide quality care for the poor and the near-poor, we

cannot afford to squander tax dollars, we cannot afford to impose a crushing burden on the middle-class taxpayer, and we must not promise more than can be delivered.

In the case of health care, I believe that tax dollars should be used to buy such care for those who cannot buy it on their own. I do not believe tax dollars should be used to buy health care for those who can afford it.

Indeed, Mr. Chairman, it makes sense to me that the tax dollars saved by adhering to such a principle could be put to effective use in resolving other crises which have a direct bearing on health—pollution problems, for instance, or housing problems, nutrition problems, yes, and traffic and transportation problems.

There is more to preventive care than Vitamin C or the vaccination needle.

I cannot help but wonder how many hospital beds we could make available, how many doctor hours we could suddenly salvage if we could end the air pollution that triggers respiratory and cardiac attacks, if we could drastically reduce the traffic accidents that kill 50,000 of us and injure millions more each year, if we could get rid of disease-infested substandard housing and wipe out malnutrition.

So this bill, Mr. Chairman, responds to the need to allocate limited tax dollars to the most appropriate priorities.

It saves tax dollars for that purpose by preserving and building upon a system of private health care insurance which already covers 90 percent of the population under 65 (a total of 164 million Americans). More than 60 percent of our people under 65 are covered under employer group health insurance programs.

Why should we scrap this system and start over?

Why—in this era of inflation and unemployment—should we pump billions and billions of Federal tax dollars into a government directed and financed health care system?

And what would we do with the 350,000 employees of private health insurance companies who would be thrown out of work? Put them all on the Department of Health, Education, and Welfare payroll?

No, Mr. Chairman, what we propose in this measure is a substantial, but at the same time non-radical, reform of our health services, utilizing and improving upon some of our existing systems by adding—whenever needed—the resources of government. It is the next logical step in the evolution of a better way.

Thus the plan would provide government financial help to get more students through medical school and into medically deprived areas; government financial help for medical schools to meet the need for new skills; government financial help to build more ambulatory care centers to provide quality health care at lower costs.

This proposal would set Federal minimum standards for health care insurance policies and provide tax incentives for meeting those standards.

It would require cost control in health care institutions and peer review of doctor care and fees.

And it would provide for comprehensive health care planning in order to mobilize our great, but nevertheless limited, resources to maximum positive effect.

As I see it, Mr. Chairman, there are four primary reasons why the existing system fails to meet our needs and must have government support in order to meet them.

First of all, there is a bad distribution of health manpower.

To begin with, there is an acute shortage of such manpower. We need at least 48,000 more doctors, at least 18,000 more dentists, and at least 50,000 more nurses.

And what limited health manpower we have is poorly distributed geographically and poorly distributed in terms of type of practice. We are all familiar with the inability of rural areas and urban ghettos to get competent medical personnel and the difficulty so many communities have in obtaining certain medical specialists.

The new medical manpower bill just passed by the Congress will make a significant contribution to this problem. But we must not stop there.

Second, we have poor allocation of health facilities and not enough diversification. Hospital bed shortages contribute to the spiraling cost of institutional care. So does a surplus of beds, because of the economic necessity of keeping them filled.

Third, our country needs a rational National health policy.

Fourth, our entire system has been emphasizing treatment and care rather than prevention and rehabilitation.

Up until now, we have had little success in checking the rising cost of health care mainly because we have not had effective cost and utilization controls.

Our current problems with Medicare and Medicaid are caused in part by our having health primarily with the means of financing these programs, rather than with increasing the personnel and facilities needed to make the programs operate.

Further, while wages and salaries of medical personnel have properly gone up, there has not been a corresponding increase in productivity to offset the higher cost of services. What is to be done?

I believe we have three choices?

We can preserve the present system, largely operated by private enterprise, or we can discard the private sector and opt for a system largely dependent on government, or we can convert the existing system to one which is a more efficient blending of private enterprise and government services.

Mr. Chairman, the National Healthcare Act of 1971 takes the third course and does so through six action programs:

First, taking the problem of distribution of health manpower, my bill would lead to the coordination of all programs of financial aid and improve them to encourage training and placement of personnel where needed. It would provide student loans that would be forgiven for service in medically needy rural or inner city areas. It would provide grants to schools that train health personnel to provide ambulatory care. The bill would also provide for a five-year direct grant program to meet the immediate needs of rural and inner city areas and to attract health professionals.

Second, this bill proposes a redirection of health services to place less emphasis on costly hospitalization and institutional care and to provide improved health maintenance and disease prevention through ambulatory care. My bill proposes that Federal hospital financing be extended to encourage the construction and equipping of ambulatory care centers in areas of greatest need. The bill would subsidize administrative, operating and maintenance costs during the first three years.

If we could cut just one day from the average hospital confinement, we could save close to \$2 billion a year—and our people would be happier for it.

Third, this bill proposes a strengthening of comprehensive community health planning. This would avoid unnecessary duplication of facilities and would assist in cost control.

Fourth, this bill seeks to regulate the quality and uniformity of health care. It would require certification of essential need by an appropriate health planning agency before any health facility could qualify for Federal financing. It would involve the planning agency and health facility in planning capital expenditures, developing of administrative systems and encouraging combined purchasing and/or cooperative equipment use with other institutions. It would require effective review of services and charges by health care institutions. It would set guidelines for such services and charges. Before any institution qualifies for payment under any Federally-supported program, it must agree to abide by a controlled charges system, i.e. its budget and charges must be reviewed and approved in advance by a State Healthcare Institutions Cost Commission.

Fifth, this bill creates a National Council of Health Policy Advisors which would function in a manner similar to the Council of Economic Advisors. This advisory board would keep the President and the Nation informed on all matters relating to health and recommend on priorities and needs. The President would also utilize this body in making a mandatory annual health report to the Nation.

Sixth, and finally, this bill provides access to quality health care for all persons regardless of income.

Most Americans, 90% of those under 65, are already covered by health insurance. Most of those—60 percent—are covered by employer group health insurance programs. But some are better than others, so I propose the setting of Federal minimum standards for health insurance. If an employer's plan measures up he gets a full tax deduction for his expenses of the plan. If not, he only gets half. The minimum standards would apply to both benefits and coverage.

These standards would also apply to individual health plans. Premiums paid by individuals covered by qualified plans would be 100% deductible on their Federal income tax return instead of being only partly deductible, as under present law.

But what of those who cannot buy insurance themselves, because of poor health or lack of money?

The poor, the near-poor and those previously uninsurable would be eligible for coverage under a State plan in which all insurers in the State would be required to participate.

The poor would pay nothing, the near-poor would pay a partial premium, and the solvent but uninsurable would pay a full reasonable premium.

However, there would be no second-class care or second-class plan. The State plan would have to meet the same Federal standards as other plans. In fact, the initial benefit standards would be even higher for the State plans.

This bill proposes that these minimum benefit standards be phased in on a three-stage basis. The gradual phase-in seeks to avoid a repetition of the mistake of imposing additional financing before health delivery is improved.

We have a responsibility not to raise expectations beyond our capacity to delivery. By phasing in benefits as our delivery capacity increases, my bill attempts to bridge the gap between promise and performance.

Between now and mid-1975, this measure would authorize nearly 2½ billion dollars for specific improvements in our capability to deliver health care.

At the same time, the Federal minimum standards for health insurance will be steadily raised over the next decade as our delivery capability increases.

The first stage would be effective by 1973, the second by 1976 and the third by 1979. No individual would go without the opportunity to benefit.

Initially, more extensive benefits would be required for those people covered under the state pool plans, because they generally have less resources and need more care. In fact they would get benefits under the bill in 1973 which would not be required for the remainder of the public until phase II went into effect in 1976. In 1976 these individuals would begin receiving benefits not required for the general public until 1979. These benefits would increase again in 1976, at which time group and individual coverage would also advance to the level previously accorded to the pool plan.

By 1979 however, groups, individuals and pool plans would all share comprehensive coverage that would include ambulatory care coverage of diagnosis and lab exams, surgery and radiation therapy, visits to physicians, well baby care, dental care for children, prescription drugs, maternity care and family planning and 300 days in a general or psychiatric hospital, 180 days in a skilled nursing home and 270 days under an approved home health care program.

Mr. Chairman, the National Healthcare Act meets another deep concern of every thinking American—the fear of financial ruin should he or a member of his family be struck down with a catastrophic illness or injury.

Under the benefits proposed under the bill, catastrophic illness claims of \$50,000 or more could be made by those who are covered.

I might point out that this coverage is more than that provided for Federal employees, a plan familiar to the members of this Committee. Surely every American citizen deserves protection against a blow that could bankrupt the average man.

Let me briefly summarize, then, Mr. Chairman:

The National Healthcare Act of 1971 would build upon a private health insurance system which already serves millions and millions of citizens.

Because it is primarily based upon the free enterprise system, it would encourage healthy competition to make health care more efficient and less costly.

Monopoly, Mr. Chairman, whether it be in private or in public enterprise, stifles dynamic growth. It does not make sense to me, for example, to move the postal service out of government and move health care into it.

At the same time, however, the nature of the health care crisis, and its awesome proportions, make it naive to believe that the private sector can resolve it without government help.

The feasible option, I am convinced, is to harness private and public resources into that working partnership which throughout our history has been so effective in resolving crises that defy the individual efforts of either sector.

This is a combination which can, indeed, offer quality health care to all—at a cost all can afford.

This combination, functioning under the provisions of S. 1490, would bring these benefits to the average Americans:

Make qualified health insurance costs 100% tax deductible.

Cover catastrophic illness claims of \$50,000 or more.

Establish Federal minimum standards to make sure his insurance policy measures up and provides the maximum benefits the economy can sustain and the system can deliver.

Help develop lower-cost ambulatory care centers to take the place of some higher-cost hospital care.

Provide incentives for hospitals to give better care at lower costs.

Insist upon a controlled charge system for all health institutions by withholding Federal support from those which do not comply.

Require cost and quality review of his health care.

Provide more medical personnel for areas that need them by giving financial help to students who agree to practice there upon graduation.

Encourage development of health care teams to multiply a doctor's productivity and efficiency.

Give financial help to medical schools to develop the new skills needed in the 1970's.

Require planning and coordination to avoid costly duplication of medical facilities—such as cobalt cancer treatment units—in one community, while another community goes without.

For the poor, this bill would establish a government-subsidized insurance pool in every state to make quality care insurance available at no cost and to the near-poor at a cost they can afford.

For the previously uninsurable, this bill provides that the same state insurance pools would make quality care insurance available at a reasonable cost.

Finally, Mr. Chairman, this proposal will not impose a crushing burden on the average taxpayer.

I estimate that the operation of this program would increase governmental expenditures by \$4.2 billion in 1974. Costs ultimately would reach \$7 billion in 1979 as more and more benefits are phased in.

This is not an insignificant amount, I realize. But if we concede that the only way we can protect those who simply cannot afford health insurance is through government subsidy—if we agree that the only way to develop a health care delivery system that will match performance to promise is to draw upon the resources of government—and if we contrast that \$4.2 billion with the \$70 billion in tax dollars that a full Federal health care plan would cost, then I respectfully suggest that the price of the National Healthcare Act of 1971 in terms of tax dollars spent is a modest price, indeed.

Mr. Chairman, opponents of the National Healthcare Act argue that it doesn't go far enough.

Opponents of the Kennedy healthcare proposal, on the other hand, argue that that plan goes too far.

But while we argue about the relative merits of the various proposals, the American people are going without even the basic health care reforms that most of us are agreed upon.

So I make this appeal, Mr. Chairman:

Instead of continuing an argument over how far we must ultimately go, an argument that conceivably could go on for years, why not move now to make those very basic reforms that most of us can agree are needed now?

I contend that my proposal is a logical *first* step, a natural progression in evolving a new approach to health care.

It is an approach that neither traduces the past nor subverts the future. It would move fast enough, hard enough to accomplish basic reforms within a traditionally acceptable framework and, at the same time, lay a firm foundation for whatever further perfecting is needed in time to come.

Most important, Mr. Chairman, by moving and moving *now* along the lines set forth in my proposal we can assure the American people of health care reform that they need *today* . . . not some distant tomorrow when delay will have made the problems all the more difficult and costly to resolve.

Senator McINTYRE. This morning, however, I would like permission to proceed with that summary and to clarify the record in a little fashion.

Before I begin my prepared testimony, Mr. Chairman, I would like to comment briefly on an article which appears in the November 15

issue of "Monday," a newsletter published by the Republican National Committee.

This article quotes criticism I have made of the health care proposal advanced by the distinguished Senator from Massachusetts, Hon. Edward M. Kennedy.

The quotations are accurate, Mr. Chairman, but because they have been lifted out of context the impression left is misleading.

The article does not report that those criticisms were made only to contrast Senator Kennedy's proposal with the health care plan I have introduced in the Senate. Indeed, the article makes no mention of the fact that I have introduced such a measure.

Second, the article conveniently ignores the fact that I have consistently emphasized that my differences with Senator Kennedy in the matter of health care reform have been differences over methods—not ends.

Every time I have discussed health care, I have pointedly remarked that I admire Senator Kennedy's humanitarian concern and his determination to make quality health care available to every American.

This, after all, is the real challenge in health care reform to provide equal opportunity for better quality protection.

And this fact, Mr. Chairman, points up the major reason why I am disturbed by the one-sided impression left by the article in "Monday."

For this article also fails to report that I have taken strong issue with the Nixon administration health care proposal on those very grounds.

As I interpret the administration proposal, Mr. Chairman, it offers a double standard of benefits, a standard that treats poor people as something less than first-class citizens.

In contrast, Senator Kennedy's proposal treats all citizens alike.

My proposal does the same.

I want to make it clear this morning that, while I may criticize the Kennedy proposal on economic and procedural grounds, I criticize the discriminatory features of the administration proposal on moral grounds.

I thank you, Mr. Chairman, for giving me an opportunity to set the record straight at this time.

Mr. ULLMAN. Senator, we appreciate your coming over here to do so.

Are there any questions?

Senator McINTYRE. I would like an opportunity now to give a brief statement.

Mr. ULLMAN. If you would proceed with your testimony we would be happy to hear you.

Senator McINTYRE. Mr. Chairman, as I said, in the interest of saving time I shall read only a summary of the full statement I am submitting for the committee record.

I am here in support of the National Health Care Act of 1971, a measure introduced in the House as H.R. 4349 by Hon. Omar Burlison, a distinguished member of this committee, and which I introduced in the Senate as S. 1490.

This is a measure which seeks to provide a national health care system offering equal access of quality health care for all citizens, regardless of income.

Most of us, I am sure, agree that we have a crisis in both the delivery and cost of adequate health care in this country today.

We know that delivery of care is frequently uneven and fragmented.

We know that the cost of that care is rising by the day. We also know that while our resources are great, they are not unlimited. Were health care our only challenge, perhaps there would be no problem. But we face many other crises as well, and our ability to pay for corrective programs to resolve all of them is therefore circumscribed by reality.

This is why I have said that while we strongly need health care reform, while we are obligated to provide quality care for the poor and the near-poor, we cannot afford to squander tax dollars, we cannot afford to impose a crushing burden on the middle-class taxpayer, and we must not promise more than can be delivered.

The National Health Care Act of 1971 would meet the challenge and avoid the pitfalls by building upon a private health insurance system which already serves millions and millions of citizens.

Because it is primarily based upon the free enterprise system, it would encourage healthy competition to make health care more efficient and less costly.

Monopoly, Mr. Chairman, whether it be in private or in public enterprise, stifles dynamic growth. It does not make sense to me, for example, to move the Postal Service out of Government and move health care into it.

At the same time, however, the nature of the health care crisis, and its awesome proportions, make it naive to believe that the private sector can resolve it without Government help.

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For the poor, this bill would establish a Government-subsidized insurance pool in every State to make quality care insurance available at no cost and to the near-poor at a cost they can afford.

For the previously uninsurable, this bill provides that the same State insurance pools would make quality care insurance available at a reasonable cost.

Finally, Mr. Chairman, this proposal will not impose a crushing burden on the average taxpayer.

I estimate that the operation of this program would increase governmental expenditures by \$4.2 billion in 1974. Costs ultimately would reach \$7 billion in 1979 as more and more benefits are phased in.

This is not an insignificant amount, I realize. But if we concede that the only way we can protect those who simply cannot afford health insurance is through Government subsidy—if we agree that the only way to develop a health care delivery system that will match performance to promise to draw upon the resources of Government—and if we contrast that \$4.2 billion with the \$70 billion in tax dollars that a full Federal health care plan might cost, then I respectfully suggest that the price of the National Health Care Act of 1971 in terms of tax dollars spent is a modest price, indeed.

Mr. Chairman, opponents of the National Health Care Act argue that it doesn't go far enough. Opponents of the Kennedy health care proposal, on the other hand, argue that that plan goes too far.

But while we argue about the relative merits of the various proposals, the American people are going without even the basic health care reforms that most of us are agreed upon.

So I make this appeal, Mr. Chairman:

Instead of continuing an argument over how far we must ultimately go, an argument that conceivably could go on for years, why not move now to make those very basic reforms that most of us can agree are needed now?

I contend that the proposal made by Congressman Burleson and I is a logical first step, a natural progression in evolving a new approach to health care.

It is an approach that neither traduces the past nor subverts the future. It would move fast enough, hard enough to accomplish basic reforms within a traditionally acceptable framework, and, at the same time, lay a firm foundation for whatever further perfecting is needed in time to come.

Most important, Mr. Chairman, by moving and moving now along the lines set forth in my proposal we can assure the American people of health care reform that they need today—not some distant tomorrow when delay will have made the problems all the more difficult and costly to resolve.

Mr. ULLMAN. Thank you, Senator.

Your statement will appear in the record in full.

Are there questions?

Mr. Burke?

Mr. BURKE. Senator, I wish to commend you for your statement. I would like to ask you does your plan envision covering every indi-

vidual who applies for health insurance? Suppose an individual is restricted.

Senator McINTYRE. No; it would envision covering every one who wants to have a plan. The uninsurable, the one who is in such a difficult situation that normally today we wouldn't insure him, would go into the State pool and would pay the same premium, the normal reasonable premium that the healthy man would pay. It is a voluntary plan, Congressman.

Mr. BURKE. In other words, everyone would be covered whether the insurance companies wanted to cover them or not?

Senator McINTYRE. If they want insurance; yes.

Mr. ULLMAN. Are there further questions?

Mr. Burleson?

Mr. BURLESON. Mr. Chairman, may I thank the Senator for coming over to give his testimony. We are, of course, inclined to think that the individual who agrees with us is correct in his position, and I think you are.

Senator McINTYRE. Well, thank you very much.

Mr. ULLMAN. We appreciate very much your being here.

Are there further questions?

If not, Senator, thank you very much.

Senator McINTYRE. Thank you.

Mr. ULLMAN. I see another colleague from the other side in the room, Senator Hansen.

Senator, we would be very pleased to hear you now.

STATEMENT OF HON. CLIFFORD P. HANSEN, A U.S. SENATOR FROM THE STATE OF WYOMING

Senator HANSEN. Thank you, Mr. Chairman.

Mr. ULLMAN. Senator, we know how active you have been in this field. We appreciate you coming here to give us the benefit of your views.

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

As was the case with my distinguished predecessor, I too would like to summarize my statement if I may and ask your permission and consent that the entire statement as furnished earlier could be included in the record.

Mr. ULLMAN. Without objection it will be in the record in its entirety. (The statement referred to follows:)

STATEMENT OF CLIFFORD P. HANSEN, A U.S. SENATOR FROM THE STATE OF WYOMING

Mr. Chairman and Members of the Committee, as you near the close of these landmark hearings on health insurance, I envy you the knowledge you have gained and the understanding of how difficult it will be to solve the problems we face in health care.

While I know that some have suggested doing nothing, and others have suggested doing everything, a more moderate and sensible course will prevail. As a member of the Senate Finance Committee I expect that I will hear in detail many of the problems presented to you and the many different suggestions for their solution. I look forward to such hearings before our Committee.

Even without the experience of the weeks of testimony presented to you, I know from several days of testimony we did hear that the problems are thorny

Indeed, I know, as you do, that we must not jump into a Medicare situation with costs running far ahead of revenues. To those who believe that the Ways and Means Committee or the Finance Committee will find a quick, easy answer, I am reminded of a recent statement it saw attributed to H. L. Mencken: "For every human problem, there is a solution which is simple, neat and wrong."

Certainly this applies to the problem of supplying and financing medical care for the American people, a problem tied in with our accident rate and lifestyle, our vast rural open spaces and teeming slums, differences in our ethnic backgrounds and even the tremendous advances made since World War II in medical training, drugs and techniques.

In looking at these problems—separate and yet intertwined—we must assess what can be done by government now, what must be postponed, and what needs must be met by the people without real government impact.

Certainly we all recognize that the problems fall into such areas as the individual's ability to afford medical care, the availability of medical services, the quality and cost of services and the overall cost to the taxpayers. To some extent, these are the concerns of the Congress. We may well have a responsibility to take action in these fields and there is a likelihood that *proper* action will help relieve the problem.

Other problems probably lie generally outside the authority of Congress, or at least beyond the area where we can really be effective. Our lifestyle which causes so many automobile accidents and heart attacks cannot—unfortunately—be legislated very effectively to make significant improvements. Despite several decades of massive federal spending, many question whether the welfare program, public housing, food stamps, federal aid for sewage treatment facilities and a host of other programs have improved the lifestyle of the poor so that their health is on a par with the non-poor.

But the problem today—in this committee and in mine—is to tackle those things which we have direct jurisdiction over; those problems where our actions can make a real difference.

I believe the Congress can make a difference in the financing of health care for those Americans who now cannot receive adequate medical care because of costs. I believe that the American people will support such a program based on the principle of giving the most help to those who need the most help and gradually reducing the amount of federal assistance as an individual or family moves up the economic ladder.

Such a principle is basic to the Health Care Insurance Act of 1971 which I have sponsored in the Senate, and which a number of members of this committee have also sponsored, led by Mr. Fulton and Mr. Broyhill. This is the bill termed "Medicredit." Let me emphasize that while there does not seem to be any clear call for vast new federal health programs by the American people, a recent survey showed strongest support for a program which would help the poor.

On the other hand, the survey showed only one in six Americans favored a federalized health system such as some have suggested. With your permission, Mr. Chairman, I shall include that survey for the record.

Medicredit is possible, workable and basic to any federal role. It was first introduced in the 91st Congress. Upon its introduction, those of us who were the sponsors suggested changes and improvements. I am pleased to say that this bill this year is an improved model. It does three things:

1. It pays for medical care for the poor.
2. It helps all Americans provide health insurance for themselves and their families.
3. It protects everyone against major medical expenses of catastrophic size.

These things should be done. They can be done. They can be done through Medicredit at a cost which the American taxpayer can afford.

It may be that some further modifications in this approach are desirable. For instance, I have also sponsored the Nixon Administration bill which mandates employers to provide health insurance for all employees. I believe that this is a valuable contribution, and it builds on the present system in which many employers already provide such insurance. That is another principle in which I believe strongly—use the present system and improve it. Don't destroy it.

Use of group policies and pools for high-risk individuals, the self-employed and others outside employer groups would also be desirable. It would provide the maximum coverage for the minimum cost to employer, employee and taxpayer.

In brief, a few other principles which I believe are very important in this discussion and consideration:

First, benefits must be comprehensive and stress coverage for outpatient and ambulatory care. Mediredit does this. It also stresses keeping well by paying for annual physical examinations, inoculations and well-baby care.

Second, coverage for everyone must include catastrophic illness protection. Mediredit does this on a sliding scale based on family income.

Third, use of deductibles or coinsurance is necessary for all but the truly indigent. Mediredit's deductibles are small compared to the benefits, but they are important to keep the cost within reason. The taxpayers must not be expected to pay everything. They cannot.

Fourth, review of the appropriateness of treatment and charges should be carried out by the peers of the providers on an organized basis. While last year's Mediredit contained such a provision in the same bill, this year it is a separate companion measure, S. 1898.

The other basic principles I have already mentioned :

The most help for those who need help the most ; build on the best of the present system ; encourage group coverage and pools.

This—in summary—is Mediredit. I was pleased to be the principal sponsor of the bill in the last Congress. I am even more pleased with the improved bill in this Congress.

The principles on which Mediredit is based have widespread support in the Congress. Mediredit has more sponsors than any other bill by far. These men and women have said—in effect—that this is a bill which will work, a bill which makes sense, and an approach which the American people will support and can afford.

Like the physicians whose ideas became Mediredit, we all want to be part of a realistic and effective solution to these health problems. I am pleased that the physicians of the country through the American Medical Association have sponsored a meaningful contribution to this debate. I think the bill which has resulted is based on the soundest of principles and commend it to you.

Thank you.

Senator HANSEN. Mr. Chairman and members of the committee, as you near the close of these landmark hearings on health insurance, I envy you the knowledge you have gained and the understanding of how difficult it will be to solve the problems we face in health care.

While I know that some have suggested doing nothing, and others have suggested doing everything, a more moderate and sensible course will prevail. As a member of the Senate Finance Committee, I expect that I will hear in detail many of the problems presented to you and the many different suggestions for their solution. I look forward to such hearings before our committee.

Even without the experience of the weeks of testimony presented to you, I know from several days of testimony we did hear that the problems are thorny, indeed. I know, as you do, that we must not jump into a medicare situation with costs running far ahead of revenues. To those who believe that the Ways and Means Committee or the Finance Committee will find a quick, easy answer, I am reminded of a recent statement I saw attributed to H. L. Mencken :

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Certainly we all recognize that the problems fall into such areas as the individual stability to afford medical care, the availability of medical services, the quality and cost of services and the overall cost to the taxpayers. To some extent, these are the concerns of the Congress. We may well have a responsibility to take action in these fields and there is a likelihood that proper action will help relieve the problem.

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Such a principle is basic to the Health Care Insurance Act of 1971 which I have sponsored in the Senate, and which a number of members of this committee have also sponsored, led by Mr. Fulton and Mr. Broyhill. This is the bill termed "medicredit." Let me emphasize that while there does not seem to be any clear call for vast new Federal health programs by the American people, a recent survey showed strongest support for a program which would help the poor.

I would like to ask unanimous consent, Mr. Chairman, that it might be included.

Mr. ULLMAN. Without objection, it will be a part of the record, sir. (The survey follows.)

ORC

Report to Management

Mid May, 1971

Consumer Well-Being: What Type Of Federal Health Insurance Do Americans Really Want?

Public support is growing for Federal health insurance.

Americans are almost evenly divided over their preference for Federal hospital & medical insurance versus private plans. In 1955, they preferred private plans by a margin of two-to-one.

People think that Federal aid is badly needed for our creaking health-care system.

One question still at issue is, what forms should Federal assistance take?

Something less than Senator Kennedy's proposed "Human Security Program" seems desirable to the public.

Only 17% of Americans favor paying for "all medical expenses of every resident of the United States." Public support is approximately twice as great for each of three elements in Nixon's proposed "National Health Insurance Partnership":

- (1) Increasing the supply of doctors
- (2) Insuring everyone against the effects of catastrophic illness
- (3) Assisting in the formation of health maintenance organizations.

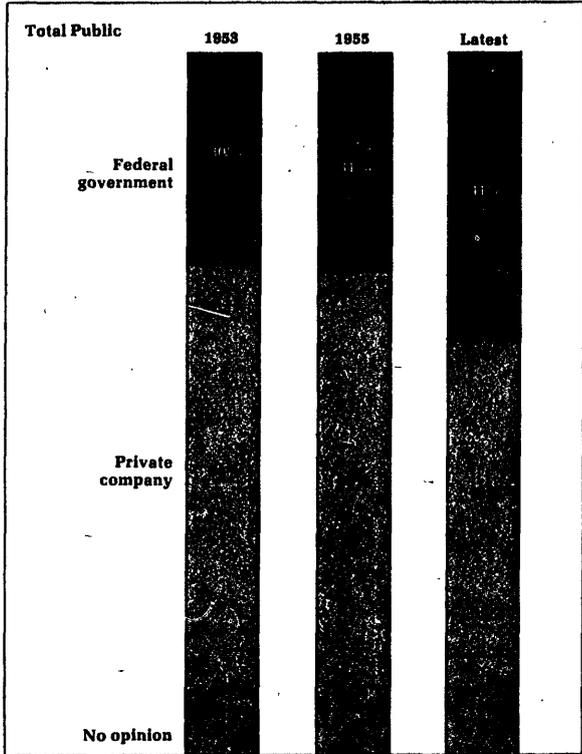
Many people today would prefer to obtain hospital and medical insurance from Uncle Sam.

President Nixon and Senator Edward Kennedy have each prescribed new Federal medicine for America's ailing health-care system. Nixon describes his program as a "National Health Insurance Partnership," while Kennedy seeks to create a new Federal agency with broad taxing powers (similar to Social Security) called the "Health Security Board."

The nations health bill for 1970 was \$71 billion, an increase of \$44 billion over 1960. Costs have far outpaced the funds available—the Health Insurance Institute estimates that private plans lost \$600 million last year.

Preferred Source Of Hospital & Medical Insurance

"If you could get hospital and medical insurance from either a private insurance company or from the Federal government, which would you prefer?"



Note: Question wording was revised in both 1955 and 1971.

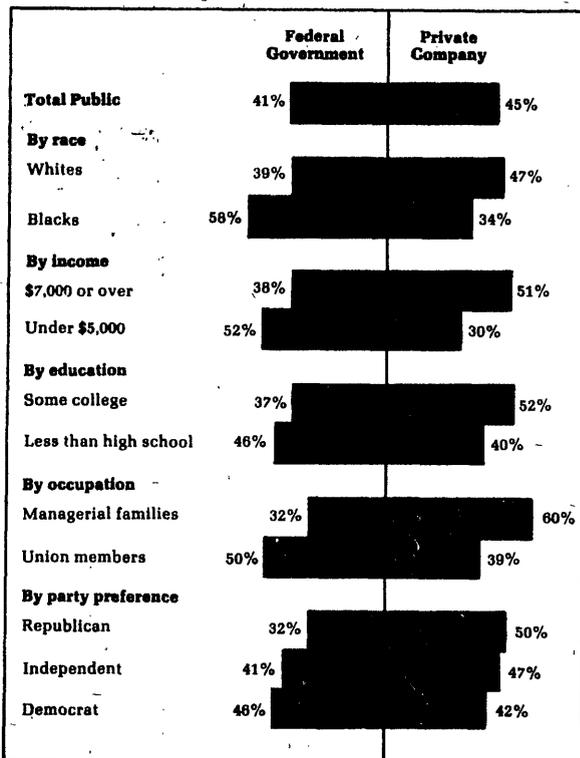
Most low-income families and blacks express a preference for government health insurance.

Under Nixon's proposed program, employers would be required to offer basic and major medical coverage to all their employees and would wind up paying 75% of the premiums. For people not covered by this program, such as poor families with children, the government would finance and administer a new family health-insurance plan.

Kennedy's proposed program would cover everyone, regardless of income, and be financed half by a new payroll tax (3.5%) and half by general government revenues. Private plans would probably go out of existence under the Kennedy program.

"If you could get hospital and medical insurance from either a private insurance company or from the Federal government, which would you prefer?"

Preferred Source Of Hospital & Medical Insurance



"No opinion" omitted

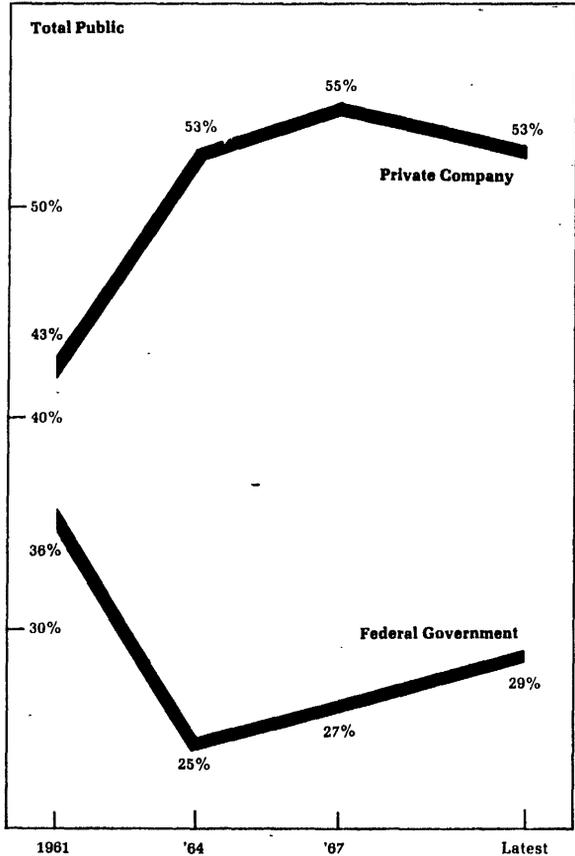
Americans prefer to do business with private companies for their home and auto insurance needs.

Despite a lot of publicity recently about policy cancellations and hefty rate increases in home and auto insurance, people still prefer to insure with private companies, rather than with the Federal government, by a ratio of almost two-to-one.

Index Attitude Trend Data show slightly increasing preference for government insurance, but public favor is at a lower level today than it was ten years ago.

"If you could get home and automobile insurance from either a private company or from the Federal government, which would you prefer?"

Preferred Source Of Home & Automobile Insurance



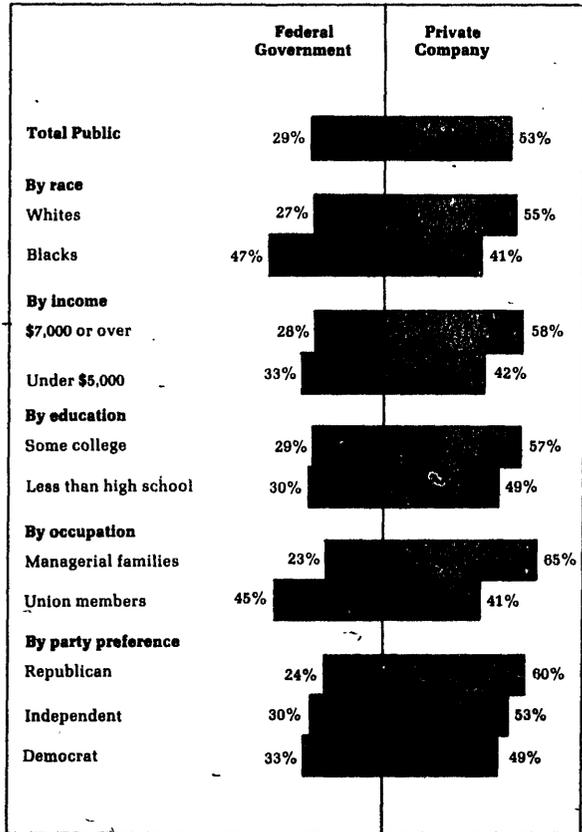
Union members and blacks would like Washington to offer home and auto insurance.

In contrast to most subgroups of the population, union members and blacks tend to prefer Federal rather than private insurance for their homes and automobiles.

People in managerial households, Republicans, and families earning \$7,000 or more would much rather deal with private insurance companies than with the Federal government.

Preferred Source Of Home & Automobile Insurance

"If you could get home and automobile insurance from either a private company or from the Federal government, which would you prefer?"



"No opinion" omitted

The public is calling for some type of new Federal health insurance program.

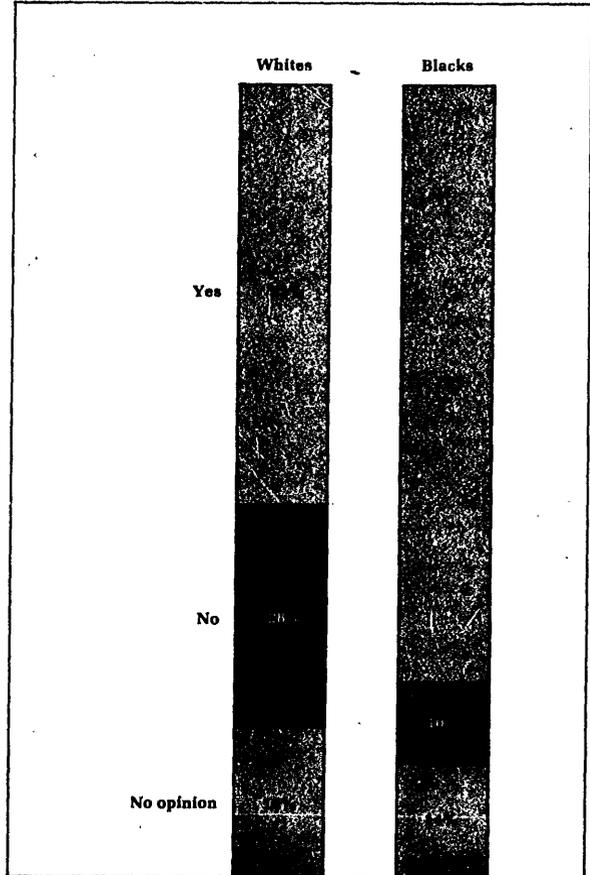
There can be no doubt that Americans want Federal help for the nation's badly-strained health-care system . . . the only question is, what form should it take?

Many different proposals have been offered, along with a variety of revenue-raising methods to cover the anticipated annual costs (which range from an estimated \$5 billion for the Nixon proposals to more than \$50 billion* for the Kennedy proposals.) The more important of these proposals, as evaluated by the public, are discussed on the next two pages.

*Of which perhaps half might be diverted from private plans.

"Do you feel that we need a new nationwide Federal health insurance program?"

Need For New Federal Health Insurance Program



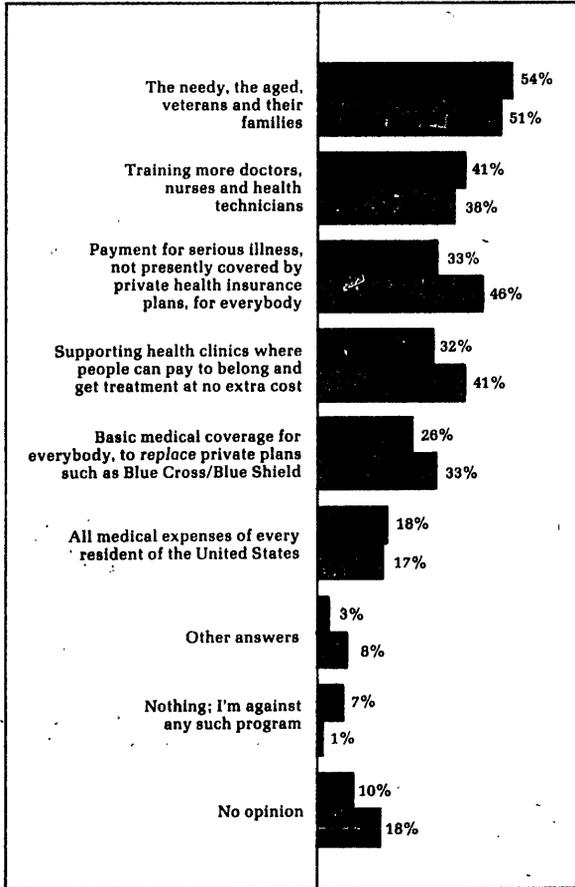
The American people do not want fully socialized medicine at the present time.

The all-inclusive health insurance program sponsored by Senator Kennedy appeals to only about one out of six Americans (17% of the total public.) In contrast, a majority (54%) support Federal coverage for the needy, the aged, veterans and their families.

President Nixon's proposals to: (1) increase the supply of doctors, (2) insure against the effects of catastrophic illness, and (3) assist in the formation of health maintenance organizations, all receive fairly widespread public support.

What Federal Health Insurance Program Should Cover

"What (as shown on this list) do you think a nationwide Federal health insurance program should cover?"



Whites
Blacks

Multiple mentions

There is surprising agreement among Democrats, Republicans and Independents about various Federal health insurance proposals.

The first three proposals listed in the chart below are supported at equivalent levels, regardless of party preference.

Republicans tend to be somewhat less enthusiastic about the following three proposals, however.

Voter Preferences For Federal Health Insurance Proposals

"What (as shown on this list) do you think a nationwide Federal health insurance program should cover?"

Federal health insurance program should cover . . .	Democrat	Republican	Independent
The needy, aged, & veterans	55%	54%	50%
Training of doctors, nurses, etc.	43%	40%	44%
Catastrophic illness	38%	33%	35%
Health maintenance organizations	35%	25%	38%
Replacing private plans	33%	19%	28%
Full coverage for everyone	21%	13%	17%
Other answers	5%	1%	5%
Nothing; complete opposition	5%	10%	7%
No opinion	8%	13%	9%

Categories rephrased from original question wording.

ABOUT THIS STUDY: Results in this report are based on a nationwide probability sample of the United States public 18 years of age and over. Interviews with 900 whites and 114 non-whites were conducted in the homes of respondents by ORC Caravan Surveys from March 21 to April 9, 1971. Index Attitude Trend Data draw on previous nationwide samples of the adult general public.

The ORC Public Opinion Index is directed by John S. Schafer.

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Senator HANSEN. Thank you.

On the other hand, the survey showed only one in six Americans favored a federalized health system such as some suggested.

Medicredit is possible, workable and basic to any Federal role. It was first introduced in the 91st Congress. Upon its introduction, those of us who were the sponsors suggested changes and improvements. I am pleased to say that this bill this year is an improved model. It does three things:

(1) It pays for medical care for the poor. (2) It helps all Americans provide health insurance for themselves and their families, and (3) it protects everyone against major medical expenses of catastrophic size.

These things should be done. They can be done. They can be done through medicredit at a cost which the American taxpayer can afford.

It may be that some further modifications in this approach are desirable. For instance, I have also sponsored the Nixon administration bill which mandates employers to provide health insurance for all employees. I believe that this is a valuable contribution, and it builds on the present system in which many employers already provide such insurance. That is another principle in which I strongly believe: Use the present system and improve it. Don't destroy it.

Use of group policies and pools for high-risk individuals, the self-employed and others outside employer groups would also be desirable. It would provide the maximum coverage for the minimum cost to employer, employee and taxpayer.

In brief, a few other principles which I believe are very important in this discussion and consideration are:

First, benefits must be comprehensive and stress coverage for outpatient and ambulatory care. Medicredit does this. It also stresses keeping well by paying for annual physical examinations, inoculations, and well-baby care.

Second, coverage for everyone must include catastrophic illness protection. Medicredit does this on a sliding scale based on family income.

Third, use of deductibles or coinsurance is necessary for all but the truly indigent. Medicredit's deductibles are small compared to the benefits, but they are important to keep the cost within reason. The taxpayers must not be expected to pay everything. They cannot.

Fourth, review of the appropriateness of treatment and charges should be carried out by the peers of the providers on an organized basis. While last year's medicredit contained such a provision in the same bill, this year it is a separate companion measure, S. 1898.

The other basic principles I have already mentioned: The most help for those who need the most: Build on the best of the present system; encourage group coverage and pools.

This, in summary, is medicredit. I was pleased to be the principal sponsor of the bill in the last Congress. I am even more pleased with the improved bill in this Congress.

The principles on which medicredit is based have wide-spread support in the Congress. Medicredit has more sponsors than any other bill by far. These men and women have said, in effect, that this is a bill which will work, a bill which makes sense, and an approach which the American people will support and can afford.

Like the physicians whose ideas become medicredit, we all want to be part of a realistic and effective solution to these health problems. I am pleased that the physicians of the country through the American Medical Association have sponsored a meaningful contribution to this debate. I think the bill which has resulted is based on the soundest of principles and I commend it to you.

I thank you, Mr. Chairman.

Mr. ULLMAN. Thank you, Senator Hansen.

Are there questions?

Mr. Brotzman?

Mr. BROTZMAN. I wish merely to say, Mr. Chairman, that I would like to welcome the Senator from a neighboring State of mine and thank him for a very valuable contribution.

Mr. ULLMAN. I would just add to that that we have just gone through, Senator, some very extensive hearings here.

As a member of the Finance Committee you will no doubt go through the same process at some future time. This is a broad extensive field and as you said, there are no easy answers.

Thank you very much for coming over here.

Senator HANSEN. Mr. Chairman, thank you.

If I could be permitted just one further personal observation, those of us on the Finance Committee recognize the expertise and in-depth understanding that you gentlemen have on this side of the Capitol and we certainly recognize generally that you, because of your intense concentration on problems coming before the Ways and Means Committee, I am sure gain an expertise that exceeds that that we have on our side.

Mr. BYRNES. Mr. Chairman. I want to say that I am pleased that the Senator has seen fit to come here and I do appreciate his testimony before the committee.

Mr. ULLMAN. You have been very helpful to us, sir.

Thank you a lot.

Senator HANSEN. Thank you.

Mr. ULLMAN. I would advise the members that are here that there are other members on the way back and, if you would like to stay here, as soon as the members get back from the quorum call, we will hear you.

I see Mr. Koch in the room.

You will be the next witness.

With that the committee will stand in recess.

(Recess taken.)

Mr. BURLESON (presiding). The committee will come to order.

The next witness is our colleague from New York, Mr. Koch.

Come around, Mr. Koch.

STATEMENT OF HON. EDWARD I. KOCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. KOCH. Thank you, Mr. Chairman.

Mr. BURLESON. We are pleased to have you. Our colleagues in the House understand these interruptions and absences. We hope others will be back after they answer to their names.

You may proceed, sir.

Mr. KOCH. Mr. Chairman, I want to thank the committee for permitting me to attend its meeting this morning to speak on behalf of three bills.

I am actually going to have my remarks respond really to two of those bills in which I am intimately involved.

The third bill while it is extremely important is one on which you will receive an enormous amount of testimony. That is H.R. 22, the National Health Security Act of 1971.

So that with respect to that I would prefer merely to rely on the formal remarks.

I would like to have permission to file my formal statement and simply comment orally on the other two bills which I will mention in a moment.

Mr. BURLISON. Without objection your full statement will be included in the record.

(The statement referred to follows:)

STATEMENT OF HON. EDWARD I. KOCH, A REPRESENTATIVE IN CONGRESS FROM THE
'STATE OF NEW YORK

Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before you today to speak about three bills I have sponsored: H.R. 8799 to extend for five years the federal funding for the Children and Youth and Maternal and Infant Care projects authorized under Title V of the Social Security Act; H.R. 22, the National Health Security Act of 1971; and H.R. 853 to provide a \$25 tax deduction for blood donations.

H.R. 8799 TO EXTEND FOR 5 YEARS THE FEDERAL FUNDING FOR THE CHILDREN AND YOUTH AND MATERNAL AND INFANT CARE PROJECTS AUTHORIZED UNDER TITLE V OF THE SOCIAL SECURITY ACT

I would like to speak to you concerning an extraordinarily successful program which is scheduled to terminate on June 30, 1972 after 5 years of existence—the special project grants under Title V of the Social Security Act. I have introduced legislation to extend the federal funding for these Children and Youth and Maternal and Infant Care projects for an additional five years at a funding level of \$630,000,000. This bill, H.R. 8799 is cosponsored by 86 Members of the House and has been introduced in the Senate by Senators Gaylord Nelson and Edward Kennedy with 15 other sponsors.

There are at present 68 regional Children and Youth programs with additional satellite and 56 Maternal and Infant Care programs in existence delivering comprehensive health care to ½ million children and youth of lower socioeconomic levels in central cities and rural areas. Although it was the intent of Congress that these existing projects should continue with State support, that now seems highly unlikely given the budgetary strain on all of the states, as, for example, New York which has 9 C&Y and 4 MIC projects.

These projects render quality medical care at low cost to mothers and children in low income families within medically deprived communities. Medical services provided include hospital services, family planning, dental care, nursing and social services, speech and hearing therapy, nutritional services, psychological services, physical and occupational therapy, health education, transportation and follow-through on patients.

We all know from experience, and from scientific data, the serious consequences emanating from a lack of medical care during pregnancy and in childhood and adolescence—lead poisoning which undetected leads to brain damage, lack of proper nutritional care causing mental retardation, unwanted children resulting from a lack of birth control guidance and infant deaths and birth defects caused by poor prenatal care. The economic and social as well as medical benefits reaped from quality comprehensive health care are considerable.

The national coverage health care cost per year per man, woman and child is \$350. The cost for care under these C&Y and MIC projects as of June 30, 1971

was \$129.81 per patient. In spite of inflation, the estimated cost by June 30, 1972 will have *decreased* to \$126. And even with this reduced cost there has been an *increase* in the quality of care. The statistics are impressive. Hospitalization is less for indigent children in C&Y projects than for indigent children not enrolled, and their average hospital stay is shorter. The underprivileged families keep appointments and follow the therapies prescribed more than does the general public. In one area of New York City, the MIC project is responsible for a 50% drop in the infant mortality rate.

H.R. 8799 provides for the funding level for Title V to be increased to \$630,000,000. There are 11 million underprivileged children in this country. The C&Y and MIC projects serve ½ million children. Only ¼ of indigent obstetric patients are covered by MIC or similar projects. These programs are operating with only modest funding and could serve a much greater population if provided with a modest increase in funds.

Continued federal funding for these special projects has the endorsement among others of the American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists and the National Association for Retarded Children. These projects constitute an existing delivery system of comprehensive health care serving those persons who would be among the first beneficiaries of a national health insurance program. They must soon receive the assurance from the Congress that continued funding will be forthcoming so that personnel will continue to serve, rather than look elsewhere for new positions fearing the program's termination date.

We must provide medical care for our nation's poor—especially the children of our deprived citizens who suffer in so many ways. The men and women involved in these projects are dedicated persons who have been giving the highest quality of medical care at the lowest cost to these underprivileged mothers, infants, children and adolescents for the past 5 years. In some very unique way they have given more than physical health to their patients. They have eradicated a sense of helplessness for those they serve.

We are also considering here today H.R. 22, The National Health Security Act, of which I am a co-sponsor.

I don't think there is anyone in this room now who can deny that American health care standards do not measure up to what this country could and should be providing for its citizens. Our doctors and scientists have consistently over the years been developing new medical techniques and methods of diagnosis and treatment, and to the few who can afford it, research and specialization among doctors in this country has made possible the most advanced health care available anywhere in the world. Yet there has been comparatively little progress in delivering these achievements to all of the American people.

How has it happened that the U.S., which spends more on health care services than any other country in the world, now ranks 13th in infant mortality, 7th in maternal mortality, 11th in life expectancy for women, and 18th in life expectancy for men among the industrialized nations? I know these figures have probably been repeated to you several times during these hearings, but I repeat them again here because they are so staggering and indicate the seriousness of the present crisis in our health care programs.

There has been a lot of talk in the past few months about the need to curb inflation, to free Americans from the fear of rising consumer prices; and the Nixon Administration has taken some decisive steps to confront this problem. Now here in this committee we have an opportunity to adopt a program which would eliminate the prospect so frightening to most Americans of facing catastrophic illness in the family and having their savings and assets wiped out defraying medical expenses. Not only are medical costs already exorbitant and impossible for the average American to finance with dignity, but they are growing at twice the rate of other consumer costs. Many Americans are so afraid of being financially destroyed by those medical costs that they do not go to doctors for the preventive care and diagnosis which would save them further and more drastic future expenses. We must adopt a program which provides real "health" care, not simply "sick" care. And I believe that one of the best aspects of the proposed National Health Security Act is that it will provide not only for the payment of the cost of illness but will also emphasize preventive care. It is, after all, much less costly to prevent illness than to treat it.

The health care Americans have been receiving has clearly been inadequate, and the present health insurance programs have done little to encourage im-

proved health care or even to allay people's fears about the expense of medical care. Americans have been paying high premiums for insurance that covers only a meager percentage of health costs. 16% of those under 65 have no health insurance at all, and those who do have only spotty coverage often not covering all or part of hospitalization, surgical costs, doctor visits in the hospital and home, or x-ray and laboratory costs. Hundreds of insurance companies, each having its own forms, methods of payment, and fine print qualifications have led to and indeed can only continue the chaos in health care. On the other hand, National Health Security would create one financing system and guarantee at least a minimum of medical benefits for all Americans, and one source of payment to providers of health care. The result would be the most efficient system of health care—where the providers of services are compensated in full and the individuals receive the quality care every American deserves and indeed has a right to—regardless of his or her ability to pay.

Opponents of a comprehensive national health program will argue that it will cost too much. But when analyzed, we find that in fact it will cost no more than what we are paying now for inadequate care and over the long run it will cut costs because of increased productivity of a healthier public. Actually we would only be rechanneling money that is now being spent inefficiently by government agencies, insurance companies, and individuals.

One of the most important aspects of this bill is its provision for the adequate supply and efficient use of medical facilities and trained personnel. No health security program can be effective in extending quality care to all Americans unless we provide incentives for the expansion of our medical resources. A percentage of the Health Security Trust Fund proposed in this bill would be earmarked for the recruitment and training of providers of medical services and for the enlargement and improvement of the institutions furnishing health care services.

Let me remind you that every major industrialized nation except for the U.S. now has a national health care program. For two years the Committee for National Health Insurance, initiated by the late Walter Reuther, worked with consumers, providers of health services, and authorities in the economics of health care to develop a sound program for reorganizing the health care system and financing health care by a means which would make medical services available to all Americans at a reasonable cost. One of the Committee's three vice-chairmen, Mrs. Albert D. Lasker, is an outstanding national leader in health care matters. The product of their efforts is embodied in H.R. 22.

Surely, we are all in agreement that the opportunity for adequate health care must be available to all Americans, and I support the National Health Security Act because I believe it to be the very best vehicle to do that.

H.R. 853, A BILL TO PROVIDE A \$25 TAX DEDUCTION FOR BLOOD DONATIONS

At least 150,000 people will contract hepatitis this year, the majority of them by the means of blood transfusions. Approximately 3,000 of these people will die. This is a tragic loss, particularly when it is one that can be averted.

I have introduced H.R. 853 providing that blood donations be considered a charitable contribution deductible from a taxpayer's gross income. The bill allows a \$25 deduction for each pint of blood donated to a non-profit blood collecting agency, setting a \$125 annual limitation for each donor. The purpose of this bill is to provide incentives for "voluntary" blood donating, thereby increasing the number of voluntary donations and eliminating the demand for commercially collected blood.

Most of the hepatitis ridden blood comes from commercial blood banks. The dangers of contracting hepatitis are 10 to 12 times greater from a commercial pint of blood than a donated pint. This is because commercial blood banks maintain poor health standards, and many of their suppliers are addicts, derelicts, and winos. Many of these donors are unhealthy, and many sell their blood more frequently than they should—some as often as one a week.

Only 3% of the potential donor population now gives blood. More than half of these donors are middle income taxpayers. My bill would provide an incentive for the middle income wage earner to give blood, and to give blood regularly. If we can just increase the percentage of blood donors by one or two percentage points, we will be able to eliminate the demand for commercial blood.

Most important, the nature of a tax deduction is such that it would provide the voluntary donor an incentive to give blood, but it would not be attractive to the

dope addict or derelict who is only interested in the immediate on-the-spot cash offered by the commercial blood banks.

The opponents of my bill have suggested that providing a tax deduction would encourage people to falsify their medical histories, and give blood when they shouldn't. I don't think this would happen. The monetary rewards would come at the end of the taxable year, not immediately. While the tax deduction would provide an incentive sufficient to encourage people to develop regular blood donating habits, it would not be so great to be worth falsifying one's medical record.

Most people in this country think of blood donations as a charitable contribution. But, because the Internal Revenue Service regards blood donations as donations of "service" rather than of property," a tax deduction for a blood donation is not allowed. It is ironic that while someone can take a tax deduction for a \$25 monetary contribution to the American Red Cross—perhaps the money gained from selling a pint of blood to a commercial blood bank—a deduction for the pint of blood given to the American Red Cross is not allowed. But what greater personal property can a person give than his blood to save another person's life. For someone who is sick or dying, a pint of blood is much more important than \$25 in cash donated to the American Red Cross.

The pivotal facts in this matter are: blood cannot be synthetically reproduced, it must be obtained from human donors; hepatitis cannot be accurately detected nor eliminated from bottled blood; blood usually is given to our hospitals' sickest patients—patients that can ill afford to be struck by hepatitis; and the demand for transfusable whole blood and blood components is growing.

Your Committee is now considering legislation to provide a national health insurance program. The victims of hepatitis contaminated blood transfusions will be an expense to this program. As I have indicated, at least 150,000 people will contract hepatitis this year, the majority of them through blood transfusions. And, there is every reason to believe that the number of these victims will increase in future years, particularly since the number of drug addicts in this country is still growing. Would it not be better in economic terms, say nothing of the human terms, to spend some money on an incentive program to provide the needed number of healthy donors?

Furthermore, the enactment of H.R. 853 would mean an acknowledgement by the federal government of the importance of voluntary blood giving. It would establish a national policy, which we now do not have, that blood giving is a practice to be encouraged. In this country we expend great sums of federal money to maintain resources for the purpose of national security. Shouldn't we do the same, at a comparatively small cost, for the health security of our people?

While the Treasury Department has yet to submit to the Committee its report on this bill, it would appear that the costs of H.R. 853 are calculable and modest. The National Institute of Health estimates that approximately 6.6 million units of blood were collected in 1969. This includes commercial blood (approximately 50% of the 6.6 million) collections. With the \$25 tax deduction actually costing the federal government an average \$5, the cost of this incentive program provided by H.R. 853 would be approximately \$33 million.

Is it not worth \$33 million a year to save the lives of 3,000 people and prevent the illness of over 100,000 more costing millions of dollars in hospital care?

I might note that the federal government purchases a large percentage of blood used by patients. In 1970, the government paid for 1 million pints of blood under medicare at a cost of \$26 million. Thus, the government does have an immediate interest in the quality of this "medicine" it is purchasing. And while H.R. 853 would not totally eliminate the costs of blood to medicare patients, it would greatly reduce it by allowing them to draw on donated blood.

I urge this Committee's favorable consideration of this bill. I would add in conclusion that earlier this year, the National Research Council Panel of Consultants on Transfusion Hepatitis (a component of the National Academy of Sciences which is part of the President's advisory Office of Science and Technology) indicated in a report on transfusion hepatitis that the basic need is to encourage a wider base of voluntary donors. The Panel indicated that H.R. 853 would be helpful in achieving this objective. Thank you.

I should like to append to my statement an excellent article that appeared in the August 1, 1971, issue of the Washington Post by Nobel Prize winner, Joshua Lederberg, entitled "The Dilemma of Tainted Blood." I am also including an expose that appeared in the Chicago Tribune on the men who sell their blood to buy wine. A Tribune task force spent weeks investigating the crisis of the qual-

ity of blood being used in Chicago and the nation, and their report presents an alarming description of the treacherous practice of some of our commercial blood banks. Finally, I would appreciate having the Washington Post editorial of July 28, 1971, endorsing H.R. 853, included in the printed record.

[From the Washington Post, Aug. 1, 1971]

THE DILEMMA OF TAINTED BLOOD

(By Joshua Lederberg, A Nobel Prize winner, Lederberg is professor of genetics at the Stanford University School of Medicine)

"Giving blood saves lives" was one of the last commemorative appeals of the old U.S. Post Office Department. Its purpose was to encourage more generosity from 100 million potential donors of blood who contribute to an already deteriorating and disorganized system of collection of staying home.

We cannot easily tell whether such an appeal has had any effect, for lack of comprehensive national statistics. Richard M. Titmuss, in "The Gift Relationship," guesses that about 8 million pints are collected yearly, and some 2 million of these are unaccounted for. How many of these were wasted, how many were utilized in unreported transfusions is not known. As every potential donor is a potential donee, we all have a stake in the integrity and efficiency of the system. Transfusions of blood undoubtedly save hundreds of thousands of lives each year; and no reliable substitute is known for many of its uses.

But blood is sometimes a treacherous gift, for at least 3,000 patients die each year, not from their primary disease or injury, but from hepatitis derived by transfusion of infected blood. According to J. G. Allen, professor of surgery at Stanford, transfusion hepatitis is grossly underreported and the hazard may be much greater. Generally about 1 per cent of patients who have received blood transfusions undergo a risk of jaundice and liver disease which may not appear until several months later. Dr. Allen has argued for many years that the main burden of this risk stems from the use of "commercial blood," as opposed to that from voluntary donors. In recent years these claims have been substantiated on the basis of new knowledge of the hepatitis virus.

THE AUSTRALIA ANTIGEN

It is hard to imagine a more esoteric, seemingly more useless line of research than the study of new blood factors in Australian aboriginals and Peruvian Indians. This sort of game might inspire congressmen and presidents to demand that scientists stop playing in the laboratory—or field-tripping around the world—and get down to the real business of delivering results, quickly, for the health of the multitude. Geneticist Baruch S. Blumberg, of Philadelphia's Institute of Cancer Research, could not have known that his studies of blood factor genetics among tropical peoples would soon illuminate a vital problem affecting many lives and exposing many dilemmas of ethics and policy.

In 1964 Dr. Blumberg described what appeared to be another genetic marker, analogous to the familiar blood types. However, this one, the Australia antigen, was a characteristic of the blood serum, rather than of the red cells, of a small proportion of the people tested. Its first detection depended on the serendipitous discovery of an antibody reacting with the Australia antigen in one particular serum. This was in a patient who had received repeated transfusions as a treatment for hemophilia.

In further studies Blumberg found that this new factor occurred quite rarely (less than 1 per cent) in most populations throughout the world. Australian aboriginals and inhabitants of the South Sea Islands all ran around 5 per cent. The factor reached a level of 9.5 per cent in Ghana, 13 per cent among Taiwanese—and 20 per cent among an isolated tribe of Cashinahua Indians in Peru.

Family studies in areas where the Australia antigen was prevalent indicated that the factor was inherited in simple genetic fashion. Unlike most blood factors, however, it was found only in individuals who received the gene from both parents.

Eventually the antigen was also found in Europeans and Americans, but only very rarely, and then often in association with leukemia, or with the chromosome-anomaly disease, Down's syndrome. This bewildering set of correlations made little scientific sense until Blumberg and a number of other investigators

finally verified that the Australia antigen was frequently associated with a history of hepatitis.

A DISEASE OF CIVILIZATION

At the present time most workers believe that the Australia antigen—or HAA as it is now called, for hepatitis-associated-antigen—consists of actual virus particles and their skins. These particles have not yet been firmly identified as a virus, for we lack a reliable laboratory animal or cell culture systems in which to cultivate them or demonstrate their infectivity. However, the particles have already been reported to contain an enzyme similar to the RNA-DNA system which was one of last year's most exciting discoveries in the field of virus biochemistry.

How does HAA, presumably a virus, relate to the genetic factor originally postulated by Blumberg? We cannot close our minds to the idea that a gene may be liberated and behave like a virus, or vice versa. However, the most likely explanation is that this particular gene marks those individuals who are most susceptible to this virus and who, once infected, retain it in their blood for a long time. In tropical environments the virus is assumed to be so prevalent that everyone will be exposed to it. As with many other viruses, children infected with it may show little disease, but they would acquire a life-long immunity. And some of them may also be long-term carriers.

Elsewhere, improved hygiene makes the disease much rarer; but when it does occur in adults it may have much more severe consequences. In this sense, lethal hepatitis, like polio and smallpox, is another disease of civilization. Other studies support the view that high levels of HAA in the blood are correlated with very mild, even imperceptible, disease, and vice versa.

This may be a sufficient explanation for the lethal risk associated with commercial blood. People who earn a living by selling their blood are likely to have grown up in less hygienic environments and to be asymptomatic carriers of the virus. They have, furthermore, a financial incentive to deny a history of hepatitis, even if they were aware of it, that would disqualify them as a donor.

Hepatitis is also transmitted by infected needles shared among drug addicts. Commercial donors who sell blood to finance a drug habit may then also add to the risk of undetected hepatitis. We can only speculate about the relative importance of these and other factors. At any rate, several studies with the now more powerful tool afforded by the test for HAA have shown that commercial donors are at least 10 times more likely to transmit hepatitis than volunteers.

TESTS LACK PRECISION

A simple solution to the problem might be to test every blood sample for HAA before transfusion. Unfortunately, in its present state of development, the test will detect only about one-third of the samples of contaminated blood. This is already a good enough reason to institute the use of HAA testing on a wide scale but obviously it only begins to solve the problem. Many blood samples, although still quite infectious, may simply contain too little of the virus to be detected by present techniques.

Furthermore, other forms of hepatitis, including the so-called "infectious hepatitis" that might be derived from contaminated seafood or water supplies, are due to a different agent than HAA. But they may still play an important role in disease after transfusion. No biological test, other than transmission to human volunteers, is known for this other agent at this time.

We surely must still try to save another 2,000 lives a year and debilitating illness for 20,000 more. But we must then rely on rather imprecise criteria for disqualifying blood from high-risk donors.

Very thorough medical examination of prospective donors, and their formal registration, would be one, prospective avenue. This is precarious, for it might dry up an already inadequate supply by making the process of donation more cumbersome than many people would tolerate. The flat prohibition of cash payment for blood used for transfusion has similar perils unless we can motivate a near-doubling of voluntary donations to make up the difference. And it might force the desperate resort to a gray market that would be even more hazardous than the present one.

Our dilemmas are worsened to the extent that the donor's class background is as relevant to the risk of transmitting hepatitis as any test we can ask of

the individual. But until we have better tests for contamination, we can do little better than encourage the rich to donate their blood more freely than the poor, for the benefit of all.

TAX INCENTIVE FOR DONORS

Needless to say, the most elementary respect for social equality must make that blood equally available to all. Blood-sharing cooperatives are a partial answer to motivating donors to give low-risk blood. But can we exclude any hospitalized patient from the common supply? Will we relegate a stranger to sources that are bound to carry inherently higher risks? In the face of this overt ethical confrontation, the cooperatives will somehow have to solve the problem for the entire community, or share the remaining risks with it.

The basic problem is to encourage a wider base of voluntary donations, to undercut the treacherous commercial market in blood, and to evade the social and ethical dilemmas of allocating this particular resource, if the supply is so limited that "bad" blood must be used to fill out the need.

We have here some rationale for the proposal, supported by the National Research Council Panel of Consultants on transfusion hepatitis, and now sponsored by a group of congressmen, for a bill to allow income tax deductions for "voluntary" blood donations. This incentive will be relatively unattractive to the traditional type of commercial blood donor, both because he is likely to pay very little income tax anyhow and because the benefit may be deferred for many months. One can raise theoretical objections to this scheme as one can for almost any other attempt to use the income tax for purposes other than revenue. Should we not compensate the donor of a kidney or a heart (for the benefit of his estate) many times more? Indeed, the taxpayer who wishes to donate, but is rejected for having faithfully reported a history of disqualifying diseases, should get a double indemnity.

This proposal, nevertheless, has much pragmatic and even more symbolic utility. The proposal may be attacked for opening the door to a formal system of social accountability of each individual, in addition to the annual tax return. This is precisely what is being demanded today of corporations and other institutions.

Few people today have recourse to an organized framework for the invigoration of conscience. The blood sacrifice may yet return as a manifestation of the brotherhood of man. It is not alone among the religious impulses that are vital to the objective survival of the human species.

[From the Chicago Tribune, Sept. 13, 1971]

MEET THE MEN SELLING BLOOD TO BUY WINE—THE SKID ROW DERELICT: CHANCES ARE HIS BLOOD JUST MIGHT KILL YOU

There is a crisis in the quality of blood being used in Chicago and the nation and The Tribune Task Force spent weeks investigating the problem. This second part in a series deals with those who sell their blood and was prepared by William Jones, Task Force director; and reporters Philip Caputo, William Currie and Pamela Zekman.

Philip D. Testard is a peddler and his product is his blood.

He makes his sales calls at any one of several Chicago commercial blood banks and the \$5 he receives in exchange for each pint is enough to keep him in cheap wine for a week. When times are hard, he drinks canned heat by cutting it with water and soft drinks.

"I'm on the wine now and I'll be on the wine till I die," said the 41-year-old Testard, an unshaven, toothless ex-convict.

Testard lives in the city's sink—Skid Row. His home is the street, and he sleeps on benches and in abandoned buildings. His diet consists of food scraps filched from garbage. Mostly, tho, he subsists on wine, going on drinking binges that last as long as five days.

He is one of the thousands of derelicts, drug addicts and alcoholics in Chicago who regularly peddle their blood for a few dollars to spend on the binge or the next supply of drugs. Their product carries no guarantee, no warning that it might be poison, even tho it is 10 times more likely to be teeming with potentially lethal hepatitis virus than the blood from a volunteer, an unpaid donor.

CITES HEPATITIS ODDS

Some day, blood from men like Testard may be in your veins. It is being used right now and is causing medical nightmares for surgeons and public health officials alike.

As much as 60 per cent of the 250,000 pints of blood needed in Chicago every year is drawn from the paid professional donor. Hospital blood bank directors report that 1 out of every 20 patients who receive this blood will contract hepatitis, but only 1 out of every 200 recipients who are given volunteer blood will be infected with the disease.

The possibility that their product might kill or debilitate someone does not concern the blood peddlers. Most are so desperate for money to support their habits that they endanger their own health by selling blood—two, three and as many as four times a month.

Some peddlers, like Testard, do not even know what hepatitis is, altho they must profess they never had the disease to be allowed to trade a pint for a few dollars. And the only medical test ever devised to spot hepatitis in a potential donor is effective in only one out of four cases according to medical experts.

BLOOD HIS LIVELIHOOD

"What is hepatitis, anyway?" Testard asked a reporter as he waited to donate at the Beverly Blood Center, 4420 N. Broadway. He had just been told to return later because the center did not immediately need his blood type. The wait relieved Testard because it would give him time to have a few more drinks to compose himself before donating.

Testard said he was worried about being turned down because a rejection would mean the loss of his only source of income. He employs a number of tricks of the blood peddlers' trade to avoid being turned away.

One of the rules of the blood buying business limits donations to once every two months. Nevertheless, Testard is able to donate every two weeks—largely because there is virtually no communication between the various blood centers and hospitals that draw blood.

"Sure I give blood every two weeks," Testard said. "It takes five days to a week to get rid of that needle mark and then I'm good for another blood bank."

Occasionally, Testard sells blood twice within two weeks at the same donor station, skirting the rule by using false identification, he said.

Testard said he maintains his strength thru his grueling schedule by eating garbage.

"You heard of the National Tea, you heard of the A & P, you heard of the Jewel?" Testard asked. "Well, that's how I eat. They throw out-of-date food into the garbage cans in back of the stores and I pick it up. It's tough, tougher than working, but the food isn't bad. I eat the pies and the cakes and the cold cuts. The meat that needs to be cooked I sell to the pizza joints up here (in Uptown) for a few bucks."

RECALLS PAYOFFS

Such eating habits account for the most common hurdle faced by Testard and most other professional donors. Their diet causes them to suffer from a low blood iron level. To qualify for a donation, the donor's iron count must be 41, but many blood peddlers register counts as low as 35.

Testard also knows his commercial blood banks. Some have tough rules while others will overlook a low iron count, especially if they are behind in their monthly quota. He claims that some technicians will pass a donor with low iron in exchange for a cut of his fee.

"There used to be a nurse over there at (a commercial blood firm) who'd pass you if you gave her a buck," Testard said. "What you'd do is tell her that you needed the money real bad and that you'd give her a buck for passing you. She'd pass you and then you'd take your voucher and cash it at the currency exchange. Then you'd go back to the blood bank and drop the dollar in a wastebasket next to her desk."

When bribes fail, the donor simply barter his blood at a station where the rules aren't strictly enforced.

Ray Armour has been a blood peddler for 30 of his 50 years and claims he is frequently rejected for a low iron count. Armour describes himself as a vagabond and drunk. On the day he was interviewed, Armour had just been turned

down at the Chicago Blood Donor Center, 2320 N. Clark St., but was not discouraged. He said he planned to make the rounds that day and was certain he would find a station that would buy his blood.

"LIKE BUTCHER SHOPS"

"Some of 'em are like butcher shops," Armour said. "They don't care, just as long as you walk in breathing."

A companion of Armour, who identified himself only as John, said it is possible to sell blood twice in one day, simply by offering your other arm for the second sale. John has sold blood so many times that scar tissue has formed on both arms. Like Testard, Armour and John make their homes in flophouses and under viaducts, using phony addresses on their donor cards.

The practice of using false identification and addresses makes it virtually impossible to track down paid donors who are hepatitis carriers.

Task Force reporters made this discovery when they attempted to find 10 professional donors whose blood was found to be infected with the disease. None were found and their addresses turned out to be vacant lots, park benches, abandoned buildings and warehouses.

Perhaps one or more of them was the peddler whose blood infected Richard S. with hepatitis. A hemophiliac, he asked that his real name not be used because he feared he would lose his job if his employers knew of his condition.

To stay alive, a person suffering from hemophilia often must take numerous transfusions each month of blood products drawn from the blood of several donors.

RISK IS ASTRONOMICAL

Considering that the ordinary patient has an 11 to 1 chance of contracting hepatitis from a paid donor, the chances of the disease's striking a hemophiliac are astronomical.

In October, 1970, it struck Richard S., who has to transfuse blood products from seven different pints every three weeks.

"It was a real blow to me," he recalled. The doctor said it might take me the rest of my life to recover, Hepatitis on top of hemophilia was almost too much. Two chronic illnesses—it just didn't seem fair."

He has words for Phillip Testards and Ray Armours and the other blood peddlers whom he believes to be imperiling his life for a bottle of wine.

"I'd think that people who sell blood should think about it a little more and realize what might happen if they lie about their condition. It doesn't seem at all fair. Why can't they take someone else into consideration instead of that lousy money? I'll give them the money if they need it, but don't put my life on the line for it."

[From the Chicago Tribune, Sept. 14, 1971]

BLOOD BANKS: PAY STATIONS OF WINOS, ADDICTS

The young man was unshaven and dirty, his breath reeked of cheap liquor and there was a needle mark on his left arm.

In the opinion of many medical authorities and blood experts he was a classic example of a walking health hazard. Living from drink to drink, he pays for his binges by peddling his blood as often as he can.

On the surface it appears to be a harmless transaction. But if his blood is crawling with hepatitis—and there is no sure way of telling for certain—another bottle of poison will be on its way to a hospital operating room where it may ruin or destroy another life.

2D DAY OF GIVING BLOOD

On this morning the scruffy blood peddler is preparing to do business in the Interstate Blood Center, 2543 W. North Av. Less than 24 hours earlier he had sold a pint of blood at a North Side commercial blood bank and under the rules of giving blood should have waited at least another eight weeks before selling another pint.

He is the kind of donor that is giving the nation's medical community nightmares. The blood of these donors is 11 times more likely to be infected with

hepatitis, a disease that attacks the liver, than the blood of the unpaid donor. The transaction at Interstate was not unusual. What was unusual is that the donor was Philip Caputo, a Task Force reporter, and his report of the incident underscores the laxity in some of Chicago's commercial blood banks:

STOPS ASKING QUESTIONS

"The technician took down my phony name and address, then he started going down the list of illnesses. After I had replied 'no' to the first half dozen diseases, he stopped asking questions and just marked 'no' down the rest of the list. That done, he sent me into the back of the building, where a female technician tested my blood pressure, pulse, blood type, etc."

This exchange followed:

"Is that a needle mark?" the employee asked.

"Yeah, I had a blood test yesterday when I was looking for a job," Caputo replied.

CAUTIONS THE RESPONSE

"You know you're not supposed to give blood more than every eight weeks," she cautioned, apparently suspicious of the response. "A lot of people try to do that."

Caputo protested that he had not given blood recently, and the employee then told him to lie down on a couch so the blood could be drawn. As they prepared to take the blood, he was forced to make an excuse to leave in order to avoid giving blood twice in 48 hours.

A blood bank technician who worked closely with Task Force reporters said he learned on his first day at work how easily some unqualified derelicts can sell their blood.

CLIENTELE OF WINOS, ADDICTS

The Scientific Blood Donor station is located at 573 W. Ogden Av., and almost all of its clientele are the drifters, winos, and drug addicts who live in the flophouses along West Madison Street.

"The very first day I worked there some guy came in whose iron count tested at 38. My supervisor told me to write in phony numbers. He told me to go ahead and pass him and put down a 41 [acceptable iron count for donors] on the card," the technician recalled.

He said he quickly learned that falsifying records and passing unfit donors was a regular practice at Scientific. He said the practice extended from prospective blood sellers with low iron counts to those with high blood pressure.

"One guy came in. Everything else was all right with him, but his blood pressure was 196 over 152 [normal is 120 over 80], but my supervisor passed him," he said.

The technician said he suspected that the pressures of filling a daily quota forced employees to ease up on screening donors.

"But I wouldn't accept any of them," he said. "I would reject everybody, with all their drinking and wrecking themselves with malnutrition."

But even basic standards of cleanliness are sometimes laid aside, according to the technician. He said he became aware of this one day when he accidentally dropped a needle on the floor as he was attempting to correct its position in the arm of a paid donor.

TAKES NEEDLE FROM FLOOR

As blood spurted from the arm of the donor, his supervisor picked the needle up and prepared to reinsert it because the blood bag was only three quarters full.

"That's a dirty needle," the technician said he warned the supervisor. But he said the supervisor reinserted the needle.

"What he should have done was paid the donor and scratched the blood sample since it wasn't a full pint," the technician said.

Brig. Roland W. Quinn, officer in charge of the Salvation Army's Harbor Light Center, 654 W. Madison St., accused commercial blood banks of "exploiting" men in search of liquor.

LIE TO GET MONEY

"The drive for the next drink is just so great that they will lie to get the money," said Quinn.

The Scientific Blood Bank makes it easy for donors to spend their fee on alcohol. Instead of cash or a check, donors are paid with a voucher that can be redeemed only at a nearby liquor store. The liquor store requires them to make a purchase. And if the donor makes a small purchase, he is charged a dime as a voucher cashing fee.

Robert Gallagher, president and owner of Scientific, explains the voucher system this way:

"There is a currency exchange three blocks away, but some of these guys [paid donors] would have a hard time finding it."

Scientific is one of 11 commercial blood drawing stations in Chicago. Five are located in Skid Row or low income neighborhoods. The 11 stations dominate the blood market in Chicago, supplying the city with 60 per cent of its blood needs every year.

HAVE NETWORK OF STATIONS

And two of the commercial operations—Scientific and Interstate—have a network of donor stations in slum and Skid Row neighborhoods in Washington, Cincinnati, Detroit and Milwaukee. Blood from these cities is frequently used in Chicago.

An officer of the Beverly Blood Center, Inc., 9944 S. Western Av., admitted that his company operates a donor station in Uptown because it puts them closer to their customers.

"At present? there simply aren't enough people volunteering blood, so you have to pick an area where low income people live," said Roger Sullivan, who manages Beverly's four drawing stations. "They use the money to buy a dress or augment their salaries. We hope it's not used to buy alcohol, but you can't control that."

Dr. J. Garrot Allen, an expert in blood research and professor of surgery at Stanford University, Palo Alto, Cal., takes a different view of the commercial donor. He contends that the fees paid for blood guarantee that more bad blood will enter the medical community.

"The pay scale [generally between \$5 and \$15 a pint] is all that is necessary to attract addicts and Skid Row people," said Allen. "It will not attract others."

The owners of some commercial blood banks dispute the statistics of people like Dr. Allen.

Dr. Coye C. Mason, owner of the Chicago Blood Donor Service, 2050 N. Clark St., labeled Allen's figures as "a lot of hogwash."

"Anyone who lies down to give his blood is a volunteer," said Dr. Mason. "We pay the donor for the time he takes to come and give his blood."

RESULT OF BAD BLOOD

Richard Frame, a 68-year-old engineer, doesn't care who wins the verbal battle. He received two units of blood during neck surgery in Wesley Memorial Hospital in April, 1969, and four months later he was back in the hospital with hepatitis.

Frame said his doctor told him the disease was a result of bad blood received during surgery. Frame has suffered 15 per cent permanent liver damage.

Frame is suing the hospital for \$100,000 and the hospital in turn has sued Chicago Blood Donor Service, alleging that it was the source of the blood.

Frame describes his experience this way:

"It's agony. Agony and a lot of turmoll. It was like the bottom had dropped out of everything."

[From the Washington Post, July 28, 1971]

BLOOD AND TAXES

Donated any blood lately? Probably not. Unless a relative or friend is on the operating table and needs a quick transfusion, or if an alert goes out that the neighborhood hospital is low on blood, most of us seldom roll up our sleeves to donate blood. Periodically in its 22 years of collecting blood, the American Red Cross has announced that it may run short. Although this matter is not among the major problems of the current American health crisis, it is one on which Rep. Edward I. Koch (D-N.Y.) has introduced legislation that might offer a solution.

His bill would give a \$25 tax reduction for blood donated to a nonprofit collecting organization. "Presently," says Rep. Koch, "only 3 per cent of the public donates blood through nonprofit organizations such as the Red Cross. If we can just increase this by 1 per cent, the blood shortage problem will be eliminated." The Koch bill, which has some two dozen co-sponsors from both parties, would allow up to \$125 in deductions annually per person, meaning a maximum of five donated pints. Besides this economic incentive that would increase the blood supply, the quality of blood might also be improved. Many commercial blood banks now offering cash to donors often attract people of questionable health. According to Rep. Koch, "today the chances of contracting hepatitis from a transfusion of commercial blood is 10 times that of donated blood."

The Internal Revenue Service, recognizing donated blood as a "service" which is not deductible rather than "property," which is, does not allow a tax benefit for donors. This is odd; a citizen can write a \$25 check to the Red Cross and take a deduction for that, but he cannot take off anything for the pint of blood he gives the same agency. Yet, when the blood supply is low, \$25 checks are nowhere near as valuable as a single pint of blood.

Changing the tax law—in this case, amending the Internal Revenue Code of 1954—is not an impossible goal, and can be accomplished by action in Congress. It would be pleasant if Americans gave blood out of only noble sentiments—as many do—but since most do not, why not provide a modest economic come-on? There is no substitute for that, and no substitute for blood, either.

Mr. KOCH. Thank you, Mr. Chairman. I am here, Mr. Chairman, in support of two bills. One is H.R. 8799 which would be a bill to extend for 5 years the Federal funding for the children and youth and maternal and infant care projects, which is authorized under title V of the Social Security Act. That would expire on June 30, 1972, unless further extended.

The second bill that I am here in support of is H.R. 853 which is a bill that I introduced, and which would provide a \$25 tax deduction for blood donations.

Let me first address myself to H.R. 8799 which is the extension provision to title V of the Social Security Act.

I know that yesterday you received testimony from four extraordinarily able doctors who are involved in these maternal and child welfare projects, and I am not going to dwell on the testimony or facts that they were far better able to present to you than I as a layman am.

They work with the program from day to day intimately, and I know, because members of my staff were present when they testified, that their testimony was superb, and as I understand from the members of my staff who were here, the committee was very impressed by their testimony, as I knew they would be.

These men came from all over the country to appear and give us the benefit of their experience.

Instead, I would like to tell you, Mr. Chairman, why it is that I am involved in this program. I am neither a doctor nor a parent, but I think that the children, particularly the deprived children, deserve at least in the area of medical care the best that this country can offer because they suffer in so many other ways, and, if there is one thing that the Government can do, should do, and in part through this program is doing, it is providing medical care for the indigent children.

This is not only helpful from the point of view of an individual child, but is surely helpful from the point of view of the Government, because if we are able to deal with problems as they commence or even

before they commence in these programs which include prenatal care until the child reaches 18, we are in a sense dealing also with preventive medicine, and that really reduces the ultimate costs to the Government.

If we are treating a child in a slum neighborhood, and we detect in these programs the onset of lead poisoning, and immediately are able to deal with that as opposed to having that child ultimately suffer brain damage—if a child suffers brain damage, it is estimated that if he is placed in the most minimum of institutions, it is never less than at a cost of \$10,000 a year to the Government, and with maybe a life-span of 25 years to such a brain-damaged child. Ultimately, that child will cost the Government \$250,000.

More important, of course, is that we have a child that has been removed from society whose life in a sense has been brought to an end. So that is why I think this particular program has more than shown its worth to the Government; and the cost of that program is, compared with other costs, very modest.

I know that the costs have been gone into with your committee by the members of that panel that came before you, and it was significant that they testified, and I understand it is quite accurate, that the cost per patient under these programs has in fact been reduced.

That is really unheard of in a Government program, that something costs less today than it cost yesterday. We know that that should only happen with our other programs, and we would all be delighted. But here we have a figure which shows that the costs for care under these children and youth programs, and these maternity and infant projects, as of June 30, 1971, was \$129.81 per patient, and, in spite of inflation, the estimated cost by June 30, 1972, will have actually decreased to \$126, and with the decrease, the quality of care will have in fact been improved.

Now, one very dramatic illustration of what this program means to an area and to children and to the mothers and parents of these children is that in one area of New York City the maternity and infant care project is responsible for a 50-percent drop in the infant mortality rate.

That is an impressive figure, Mr. Chairman. Fifty percent of the children who might have died had they not been in this program are alive and well and that is extremely indicative of the nature and quality of the program.

The program at the present time handles about 500,000 children. There are in fact, 11 million underprivileged children in the country and it would seem to me that it would be a step in the right direction to increase the program rather than to put it out.

What I find also very salutary is that these special projects have received the endorsement of the American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists and the National Association for Retarded Children.

In addition, to that, one of the President's own committees has endorsed this program and, when Secretary Elliot Richardson was here testifying on the first day, I asked him off the record in a sense what his position would be on the program and he indicated to me that he had a position which was favorable to its extension.

I don't know whether or not he has responded to the questions that were posed in that area by our colleague Mr. Carey, but my impression is that it is favorably received.

I certainly hope so for the benefit of these children.

Now, I also would like to mention at this point that when I became involved in this program it was as a result of the fact that there are a number of such programs in the city of New York.

One is at Beth Israel Hospital. It caters primarily, its catch basin is primarily involving Puerto Rican children in that particular area. There is another area involving Bellevue which has such a program and they are all around the city. They came to me because they said the project was now scheduled for termination. They were going to lose their directors and their physicians and as you know when a project is scheduled for termination people start looking for other jobs.

These people are wonderfully motivated. I spoke to doctors and others in the program and they are very desirous of continuing in the program.

What I suggested to them, Mr. Chairman, was that we form a coalition of all the groups—there were 68 children and youth programs and a lesser number, I think, of the infant and maternity care programs—and that we get together and put out a booklet which I would, after they had given me the material, put together myself, and I have done that and every Member in the House and every Member on the Senate side received this booklet entitled "The Nationwide Children and Youth Program," a comprehensive health care and delivery system.

It was delivered to the office of every Member in May. I recommend it to you because there is no rhetoric here. All that we have done in this booklet is to ask the director of every one of the 68 children and youth programs to—in two pages 8 by 10 double spaced—put in what that program has meant to his area.

I read this with fascination and also learned a great deal from it and I just urge the Members if they have not seen it to take a look at it.

Now I would like if I might to address myself to the second bill in which I have a great interest and that is the bill known as H.R. 853 which is a bill to provide a \$25 tax deduction for blood donations.

Mr. Chairman, in this country every year 150,000 people contract hepatitis. A majority of them contract it by way of blood transfusions; 3,000 of those people die each year. Hepatitis that comes from transfusions cannot be detected with certainty when they examine the blood specimen before it is used in a transfusion.

My recollection is that what is known as the Australian antigen form of hepatitis which represents only about a third or less of that which causes hepatitis is the only form of hepatitis detectable in tests today.

So that two-thirds of hepatitis found in blood is not detectable and some unsuspecting person receiving a transfusion may very well be receiving hepatitis-contaminated blood. Indeed the figures are that 150,000 such people receive that.

I know I have given blood in the past. Indeed a very close friend of mine had a mother suffering from open-heart surgery who required blood and the doctor said, "We may not take blood from the regular sources because we don't know whether or not it has contaminants in

it. You have to go out and bring in some of your friends and we will take them because we can talk to them and they will tell us the truth." And in fact, that is exactly what I did.

I came in with 10 other friends to give blood to the mother of a very dear friend of mine. It happens that my blood wasn't the correct type so that mine wasn't taken for her. That was the only way to protect her against the onset of hepatitis from which she in her then condition surely would have died as many others do.

So that the reason for this bill is this: At the present time a great deal of the blood, in fact, it is my understanding that 50 percent of the blood collected in this country is collected from commercial establishments.

What does that normally mean? It means that people on skid row, dope addicts, alcoholics, winos are the ones in desperate need of money, \$5, \$8, whatever those commercial places pay for blood, go to the blood banks, give their blood and get their \$8 or \$5 and that is the end of it.

The commercial center in many States is not registered at all, no regulation. In some States there is some and it is very modest regulation. It is not adequate so far as I know in any State. Fifty percent of the blood collected comes from that kind of an establishment.

Only 3 percent of the population now gives blood to the noncommercial collectors like the American Red Cross and other comparable groups, only 3 percent, and the estimate is that if we could encourage 1 percent more of our population to do that we would not have any blood deficiencies in terms of quantity.

That is to say there would be no problem in terms of the blood that would be readily available for the purposes needed in hospitals and elsewhere.

In order to encourage people to give blood, my thought was to use an idea which was not mine and I am sure has been around for a long time. It was proposed to me to advance and I was delighted to do it. That was to encourage that by providing for a \$25 tax deduction for each pint of blood that an individual gave with a maximum of 5 pints for such purposes or a maximum of \$125 a year for any one individual.

Obviously the purpose of this was to get the middle class which does most of the work in this country and is the backbone of this country come into an even greater degree than they are there now with this extra, so to speak, incentive of a tax deduction.

I was amazed, to tell you the truth, Mr. Chairman, that the American Red Cross did not support it. I tell you that frankly. I don't even know if they have come here before you to oppose it but I want the cards on the table because I have spoken with them and they are good friends and I know a number of their directors but I disagree with their position.

I want to tell you what their position is because I don't want you to buy a pig in a poke—not that you would. The position of the American Red Cross is the following: that there is something immoral about saying to someone, "If you give blood you can take a tax deduction."

When I said to the people with whom I discussed this:

Is there anything immoral about the fact that if I give \$25 to the American Red Cross and I can take a deduction? Why is it any more immoral if I give of my blood than if I give of my cash?

I have never heard a good response to that. I don't think that it will lessen the number of people who come in and give blood and I see no reason why those people who do ought not get the benefit of that \$25 deduction as they would if they gave it in cash. The fact is, I think that someone who gives it in blood as opposed to cash is giving a higher service than surely someone who gives a painting to a museum and gets a tax deduction. What is wrong with applying that principle?

Therefore, I say with respect to that single argument that it does not hold water. I am going to give you the second argument and here there is some credibility to the argument and I think there is a response to it.

The second argument has to do with the existing law, and I practiced law before I became a Member of Congress, although I stopped when I was elected and I recall these cases and there is some credibility to the comments which came from them which I will give you now.

Because blood is deemed a service and not a product if an individual in a hospital brings a law suit against the hospital for having placed tainted blood in that individual or a doctor may be sued for that purpose, under the existing law because it is a service you would have to show negligence vis-a-vis whoever it was who was responsible for having given you the blood.

That is a difficult problem because if you have done all that you should do based on the current state of the article there is no negligence even if in fact you become ill of hepatitis.

You would have to show they failed to exercise every reasonable medical precaution known under the present state of the article which most of them do I am sure.

Now, if you instead of deeming blood a service deem it a product which happens when you include it in the tax laws for this purpose, that is to say normally you can deduct for tax purposes products not services, then a different law applies in most of the States and that law is that there is a warranty, an implied warranty of fitness for use and the burden of proof shifts so that you would have to come in, you the doctor, you the hospital under the law that is applicable in most States and say that what you gave was in fact fit for the purposes intended and therefore the problem of negligence no longer exists and it is easier to collect on your law suits. It is true.

It is true. It is true but that is easily remedied in my judgment in one of two ways. If should this bill be adopted it would be deemed somewhere in our tax code, our tax law that for purposes solely of the tax laws blood not withstanding the fact it is continued to be considered a service is deductible as distinct from all other services that might be rendered that is one approach; or if the Congress says, no matter that we are permitting a deduction for tax purposes this is still a service and the ordinary law applies or alternatively either the States in their individual wisdom or the Congress collectively for all of us deem that the implied warranty of fitness for use shall not apply vis-a-vis blood but that the law of negligence should apply, if that is what the States decide they want to do.

What I am saying without trying to get into the legalism involved is that the two responses of the American Red Cross are not satisfactory to me and, while we have the same goal and I commend them

and I certainly recognize all the great work that they have done, in this area I think they have made a terrible error in resisting this tax change and I would just hope that the members of the committee would see it my way.

I thank you.

Mr. BURLERSON. Thank you very much, Mr. Koch.

We had testimony a few days ago, I think from the Hemophilia Association, to the effect that within a reasonable period of time, 2 years I think, they would be able to detect hepatitis to the extent of about 95 percent.

That is encouraging. I am sure that you would be interested in knowing that.

Mr. KOCH. Yes, of course.

Mr. BURLERSON. Mr. Schneebeli?

Mr. SCHNERERELI. Mr. Chairman.

I realize that other Members of Congress want to testify. I have just two comments.

On your first discussion about the C. and Y. program the doctors who were here were tremendous. They made a very favorable impression and quite an impact and all the members present indicated that they felt that the program should be encouraged and strengthened.

On your second thought regarding H.R. 853 there was an article in the Washington Star last night called, Giving Blood, Buying Booze.

The first paragraph says:

A Republican Congressman from California has discovered that a Northeast Washington branch of a Chicago-based commercial blood bank pays its donors with \$5 vouchers which can be redeemed only at a nearby liquor store.

I emphasize "only." And the article says that of the Nation's 7,000 blood banks which are used only 166 of them are supervised by the Federal Government. So that it substantiates much of what I have said.

I think probably you would be interested in including this article in the record.

I ask permission, Mr. Chairman, to include this article in the record because I think it is very pertinent to this testimony.

Mr. BURLERSON. Without objection the article will be included.

(The article referred to follows:)

[From the Washington Star, Nov. 17, 1971]

GIVING BLOOD, BUYING BOOZE

(By David Braaten)

A Republican congressman from California has discovered that a Northeast Washington branch of a Chicago-based commercial blood bank pays its donors with \$5 vouchers which can be redeemed only at a nearby liquor store.

Rep. Victor V. Veysey, a freshman from Southern California, made the disclosure as he called for federal supervision of the nation's 7,000 blood banks as a means of cutting down on the thousands of cases of hepatitis caused each year by impure blood transfusions. Only 166 blood banks are supervised by the federal government now.

The Congressman charged at a press conference that "ooze for booze," selling their blood to commercial blood banks for \$5 a pint, endanger the health of patients who may get the tainted blood in transfusions.

There are 2 million blood transfusions each year, Veysey said, and in the over-40 age group one out of every 150 recipients dies from serum hepatitis.

The unusual arrangement between Scientific Blood Bank, Inc. of 1007 H St. NE. and Moe's Twelfth & H Liquors two blocks away was confirmed by William Reiland, administrator of the blood bank.

Reached by telephone in Chicago, Reiland described the voucher system as a security measure. Keeping cash on hand "in that neighborhood" would be asking for trouble, Reiland said, and bank checks are easier to forge when stolen in a burglary. The solution, he said, was to work out an agreement with a neighborhood businessman to redeem the donor's voucher payments in cash.

Reiland called the choice of a liquor store "unfortunate" but said it really had nothing to do with the quality of the blood donation, since the donor goes there after he has sold his blood, not before.

Reiland said all donors must pass a physical examination before they are accepted, must wait eight weeks before selling blood again, and can sell only four pints a year. The impression that winos and derelicts can wander in off the street and sell blood without a screening is erroneous, Reiland said.

The blood bank's banker, Morris (Moe) Shulman, offered a more jaundiced view.

"I'll tell you, if I was sick, I wouldn't want to get blood from some of the ones who come in here," he said.

Shulman said there is no pressure on blood donors to make a purchase, and that those who do buy generally are good only for a bottle of wine or a pack of cigarettes. He charges Scientific 25 cents per voucher ("They wanted me to do it for 15 cents, but I said a quarter or nothing doing") and he complained that the blood bank often let \$300 or more in vouchers pile up before redeeming them by check.

Shulman estimated the daily traffic at around 20 donors, but said that "early in the month, when the welfare checks arrive," the blood business slacks off. "I wouldn't care if they never sent another one around," said Shulman. "It's a pain in the neck, if you want to know the truth."

He said that "about half" of the donors who come in, buy wine or liquor with the money. Others buy gum or cigarettes, he said.

Rep. Veysey's staff estimated commercial blood banks are a \$150 million-a-year industry and claimed that a profit of as much as \$50 a pint is possible.

Reiland rejected this figure as "way out of line." He said the usual sale price to hospitals is \$25 a unit, with the patient paying probably \$35 a pint.

"Reliable studies have repeatedly shown that the risk of contracting hepatitis from the blood of paid donors is from 11 to 70 times greater than the risk from voluntarily donated blood," Veysey said.

Reiland noted—as did Veysey—that Scientific Bloodbank, Inc., as an interstate shipper of blood, is one of the 165 bloodbanks in the country licensed and inspected by the Biological Standards Division of the National Institutes of Health.

Veysey said the Division of Biologics Standards "seems to have been 'captured' by the groups it is supposed to regulate." There appears to be a pattern of senior personnel in the division going to work for commercial blood banks, he said.

Veysey's bill would take the responsibility for blood bank supervision away from NIH.

His bill, which he said he would introduce today, also would require the source of the blood to be clearly stated on the labels.

Mr. KOCH. I would like to make two comments.

One is on the cost of this program. It is minimal. The cost of this program as a loss to the Government by way of this tax deduction is \$33 million. When you consider the fact that it will have a decided impact on 150,000 people who might otherwise get hepatitis through a bad blood transfusion and assuming for a moment that the gentlemen who appeared before your committee are correct and we will know the answer to hepatitis and be able to detect it in 2 years we are talking about 300,000 people who will have gotten hepatitis during that period and 6,000 people who will have died as a result of faulty blood transfusions.

Mr. SCHNEEBELI. The article is comprehensive. It says that the blood banks do about \$150 million a year business and claims that they make as much profit as \$50 a pint when they \$5 for it. I think the article in the record will substantiate your testimony.

Mr. KOCH. I am so pleased to hear that.

Mr. BURLESON. Thank you again, Mr. Koch, for your contribution.

Mr. KOCH. Thank you.

Mr. BURLESON. Mr. Vanik.

Mr. VANIK. Mr. Chairman, I ask unanimous consent that the statements which I received in Cleveland on Tuesday may be inserted in the record before it is closed.

Mr. BURLESON. Without objection, the request will be granted, and the referenced document included in the record.

(The statements referred follow:)

STATEMENTS ON NATIONAL HEALTH LEGISLATION SUBMITTED IN CLEVELAND, OHIO,
AT A REGIONAL HEARING HELD BY REPRESENTATIVE CHARLES A. VANIK

PREFACE

CLEVELAND HEIGHTS, OHIO.

MR. CHAIRMAN: My name is Morton B. Sutt, and I would like to preface the reading of my text and recommendations, by stating that I have been afflicted with Glaucoma for many years and in recent years have been served by Ophthalmologists, who invariably have the latest of Ophthalmoscopes, Tonograms and other sophisticated equipment. This and other specialized equipment used in serving Ophthalmology patients should be housed in Eye clinics or hospitals devoted to such care—thus affording continuous use of equipment.

WAYS TO CURB SPIRALING MEDICAL COSTS AND PROVIDE MORE EFFICIENT MEDICAL SERVICE

I am in accord with Dr. Burkons, who in a Cleveland Press article of March twenty sixth of this year, contends that county hospitals are run inefficiently and indulge in duplicate and wasteful expenditures.

I herewith repeat some of the previous recommendations made to Congressman Vanik, on how to curb spiraling hospital and medicare costs.

The permissive purchase of sophisticated equipment (financed by excessive Blue Cross subscribers fees) by each hospital and used infrequently. This and the cost of training and employment of technicians or operators of such equipment, contribute to spiraling hospital costs. The purchase of such sophisticated equipment should be limited to specialized centers or hospitals, where it might be made available and probably continuously utilized by residents of the area.

The curbing of such purchases in infrequently used equipment, should not relate to the curtailing of other needed hospital services.

I also recommend guide lines be established on Surgical fees, for such minor operations as: Appendectomy-Hernia-Prostatis-Cystoscopy etc., and I refer you to Health and Accident policies designating reimbursements for such operations.

Now as to the Kennedy-Saxbe health security bill, I point out the inherent potential of an enlarged bureaucracy and possibility of executive conflict within HEW. There is also the danger that executive officers or board members might be tempted to favor Urban or Partisan localities, at the expense of others.

What I recommend is more stringent federal checks by HEW, on hospital expenditures and HEW directives, compelling each hospital to submit financial reports, detailing and itemizing: labor hours required per patient and its detailed cost—maintenance costs, including supplies and laundry costs—Food and Kitchen costs—Incidental Administrative costs—equipment and property depreciation and write offs.

Close examining and comparisons of operating costs should expose waste-duplications and padded charges, and keep hospitals in the spotlight.

Some of the blame for spiraling medicare costs can be attributed to excessive Doctors fees.

MORTON B. SUTT.

GARFIELD HEIGHTS, OHIO, November 23, 1971.

Congressman CHARLES A. VANIK.

SIR: Ours is an unusual circumstance. Tragic but not self inflicted. My husband is on disability 2 yrs. this month. Due to total blindness. He is only fifty-two yrs. old, diabetic and on insulin for thirty-one years. It was discovered during W.W. II and thus he was rejected.

He now needs my constant care, so I am unable to go to work. In this age bracket he does not get a pension from work (was there 13 yrs.) He does not qualify for Medicaid nor Medicare. We both feel that any disabled person should get as much help in health insurance as anyone else on Soc. Sec. or Welfare. I'm sure there are many more persons in this very same situation.

We have exorbitant Medical expenses and must have Blue Cross & B. Sh. Coverage. That alone takes $\frac{1}{2}$ of my husband's check (207.40). The Blue Cross & B.S. coverage is 63.36 per month. The latest large increase on property tax went up 156.38 more a year. Making our payment \$235.55 per half year, or 39.26 per month.

Just these 2 items are \$102.62 about half of our income (monthly). For example we spent twice as much for doctor fees, compared to the income, in 1970.

We are married 25 yrs. and managed to pay our home out & save some money. But we are not *that* well established in this short time.

Our savings is disappearing rapidly. We would not want to lose our home. The upkeep of our home, replacements, insurances, utilities, are also way out of line, same as for the people that work.

With this limited income, it's doubly hard for us to manage. We'd like medical assistance. I think my husband & others in this situation, merit that much from the Government. I understand that persons with a dope addiction problem (this is a self induced habit) get all kinds of help. I hardly think that's necessary.

Sincerely,

Mrs. STANLEY J. POTOCNIK.

Itemized monthly expenses:

Blue Cross and Blue Shield.....	\$63.36
Taxes on home.....	39.26
Illu	6.45
Phone	8.64
Water	5.50
Gas	15.00
Car Insurance.....	14.00
House Insurance.....	6.00
Groceries (at least).....	65.00
Approximate medication.....	40.00
Total	263.17

NOTE.—Monthly check, \$207.40; Social Security No. 295-03-6204.

COMMENTS OF EDWARD C. LECHNER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, MEDICAL MUTUAL OF CLEVELAND, INC., AND A MEMBER OF THE HEALTH PLANNING AND DEVELOPMENT COMMISSION OF THE WELFARE FEDERATION OF CLEVELAND

I. HISTORY

Medical Mutual of Cleveland, Inc. was formed in 1945 by a group of civic and business leaders to issue prepaid medical/surgical coverages for citizens of Northeast Ohio. Almost from the beginning, the Board of Trustees consisted of one-third physicians and two-thirds civic and business leaders. It is constituted today.

Today Medical Mutual covers approximately 1,380,000 residents (out of a population of approximately 2,000,000) in our five-county Northeast Ohio service area. Thus covering nearly 57 percent of the population. Its payments under a variety of coverages range from the *inadequate to paid-in-full for covered medical/surgical services*. Actually, one-third of our insured members' covered services are paid in full under our Usual, Customary and Reasonable Fee Program.

During 1970 Medical Mutual incurred benefit payments for its nearly million-and-a-half insured members in the amount of \$34,000,000 for their prepaid medical/surgical/dental services.

II. HEALTH CARE CRISIS (?)

Much has been said in the last year or two about a health care crisis—a great deal of it emanating from Washington.

According to data from the Health Insurance Institute:

At the end of 1969, 85 percent of the civilian resident population was covered by some form of private health insurance.

Of the under-65-years-of-age population in 1969, 89 percent had hospital expense coverage.

Even with the presence of the Medicare program, 56 percent of the population 65 years old and over has supplementary private insurance coverage.

Payments of benefits by private health insurers totaled over \$14 billion in 1969.

While the high percentage of our population has some form of health coverage, it is apparent that the coverage in many cases is not adequate. It is also apparent that our health delivery system can and should be improved.

There is no more of a health care crisis in our nation than there is a crime crisis, a traffic accident crisis, a drug crisis, or in some areas, a housing crisis.

In these United States, we have the best medical care in the world.

There is, however, a health crisis for some 40 million people in our nation who do not have access to medical care—those who can't pay for it, and those in ghetto and rural areas where there are no providers.

Our nation's greatest asset is the good health of its people. I think it is generally accepted that good health care is a right. Reasonable access to medical care should be available to everyone. Impediments such as financial, sociological (geographic or depressed neighborhoods), or inadequate supply of providers should be removed.

III. MEDICAL/HOSPITAL CARE VS. HEALTH CARE

Basically, today our medical care involves primarily medical cure. *Health care* should go far beyond medical care. Involved in health care is good housing, adequate sanitation conditions, adequate diets, elimination of air pollution, water pollution and noise pollution. Health care should involve a massive education program to correct poor eating habits and lack of exercise.

While the medical profession and other providers of medical care are taking a buffet for the so-called "health care crisis," the items just mentioned are beyond the domain of these providers. Such items as safe streets, clean air, good housing, adequate diets are the responsibility of our civic and political leaders.

IV. COST AND ACCESSIBILITY OF MEDICAL AND HOSPITAL CARE

The "health care crisis" (if there is one) results (1) from economic factors and (2) from the sharply rising hospital costs, along with the lack of availability of medical and hospital services, both in urban and rural areas.

Doctors and High Costs

One of the least mentioned statistics, however, is that the Consumer Price Index shows between 1967 and 1970 hourly earnings of workers on non-agricultural payrolls and doctors' fees rose at almost exactly the same rate (21.4%).

During the same period, the average indexes for the CPI increased 12.9%; and for hospital daily service charges, 52.4%.

Health care expenditures in the United States reached approximately \$70 billion in fiscal year 1970—an increase of over \$7 billion from the previous year. During the fiscal year 1970, seven percent of the United States gross national product was spent for health care.

With respect to the increase in health care expenditures, it results basically from three factors: the first is the rise in population, the second is the increased price of medical services, and the third is the increased awareness and use of medical services and hospital facilities. In the last five or six years, there seems to be an insatiable demand for health care services. It is this demand, along with costly new sophisticated medical services, more than anything else, which have skyrocketed health care delivery costs. What we are really witnessing is the *high cost of maintaining good health and extending life.*

Cost Containment

Blue Shield has always had as one of its chief responsibilities the charge of cost containment.

In this area, Medical Mutual of Cleveland, Inc. has developed the following on an ongoing basis:

1. *Utilization Review*.—Medical Mutual presently has a computerized Utilization Review post-payment detection program which gives us information on patterns of care, total dollars charged, and average dollars charged per patient. This information, applied to a pre-payment professional review of individual claims for providers and consumers of health care services, is an effective method of detecting variance in utilization.

Of course, the biggest reward for Utilization Review will come from the *education and protection of all parties* involved by providing immediate access to statistical reviews of accumulated data.

Our new Electronic Data Processing system gives us a vehicle to so educate, detect and protect in combatting the rising cost of health care.

2. *Constant Claim Review* by a highly trained claim department and a Medical Review Board.

3. The Usual, Customary and Reasonable method of payment:

- a. Yearly calculation.
- b. 12-month notification waiting period.

V. PRESENT SYSTEM AN IMPERFECT SYSTEM

While our present system doesn't provide medical care for everyone, it does produce the highest quality medical care in the world.

This notwithstanding, admittedly, our present system is an imperfect one. It is essential that medical care be available to everyone. Recently Medical Mutual appointed a Health Delivery Systems Committee from members of its Board of Trustees. This Committee is studying the feasibility of Blue Shield offering to its members a *choice* of delivery systems such as *closed panel practice on a capitation basis* along with the traditional "fee for service" system. This, in essence, would qualify as a so-called Health Maintenance Organization. Most of the Bills in Congress now provide for some type of HMO.

Seemingly, this would be a panacea for all of the health delivery problems. A number of our senators and congressmen seem to believe that, by the use of the practice of preventive medicine through HMOs, it would reduce hospital admissions and hospital lengths-of-stay, thereby reducing hospital costs. Basically, other than immunization, there in fact doesn't appear to be much in the way of *preventive medicine*. Probably what is really meant is "early diagnosis" or "early detection." The primary reason that the hospital admissions are less and lengths of stay reduced under group panel practice on a capitation basis—such as the Kaiser Foundation—is simply that the physicians in the group practice generally receive a bonus for keeping patients out of the hospital. This, of course, could lead to under-hospital utilization just as the present system on a fee-for-service basis probably leads to over-use of hospitals.

VI. NATIONAL HEALTH INSURANCE

There is no nation of our population size, with our borders thousands of miles distant from each other, which has an effective health delivery system which delivers *quality* health care to each citizen at reasonable cost. Since there is no system which we can copy, we should build upon the strengths of our present system.

A system of national health should be *pluralistic* rather than *monolithic*, so that we can ultimately choose the system or systems which best fit our needs.

A new system, therefore, should be *evolutionary* rather than *revolutionary*.

Freedom of Choice

There should be freedom of choice by the consumer in selecting the type of provider, and a choice by the provider as to what type of system he would like to provide service. A National Health Insurance plan should allow and make provisions for different methods of payment, such as fee-for-service, capitation and salaried practice.

Eligibility

Nearly all persons should be eligible for coverage under a National Health Insurance plan. Possible exclusions could be non-citizens residing in the United States, Americans abroad and military personnel.

Incentives

Any National Health Insurance plan should provide incentives to:

1. Improve the system of health delivery.
2. Encourage better use of present capability.
3. Better balance the provision of services.
4. Develop manpower with the encouragement of increased use of para-medical personnel.
5. Carry on research.

Acceptability

A system should be acceptable to both consumers and providers.

Flexibility

The system or systems should be flexible in order that it continue to be dynamic and ever-improving.

Financing

Financing of a National Health Insurance plan should come from three sources:

1. General revenues of the Federal Government (this is necessary to provide coverage for those unable to pay).
2. Employee-employer contribution through payroll tax.
3. Self-employment tax.

In order to involve the consumer at *all* levels of medical service, the individual should be expected, where able, to pay a part of his health care costs by direct payment; that is, through co-insurance and possibly deductibles.

Evaluation

There should be provision for an ongoing system of evaluation of both the delivery and financing of National Health Insurance.

VII. WHAT CONTRIBUTION FROM THE "BLUES" IN AN EVOLVING SYSTEM?

Currently, Blue Shield Plans cover nearly 66,000,000 people, or 32 percent of the population of the United States.

During 1970 Blue Shield Plans made benefit payments to or in behalf of insured members in the amount of \$2,176,000,000, representing 93.29 percent of subscriber income.

With respect to health care delivery and financing, Blue Cross/Blue Shield Plans have proven leadership, claims handling expertise, actuarial know-how, staff and financial resources.

We in the "Blues" are daily and intimately involved in the health care problems of approximately 75,000,000 human beings.

I respectfully submit that it is in the public interest and welfare that the leadership and resources of the "Blue Plans" be a deeply involved catalyst in evolving an effective and responsive health care delivery system for all the people.

HEALTH PLANNING AND DEVELOPMENT COMMISSION, THE WELFARE FEDERATION, CLEVELAND, OHIO

I am John E. Smeltz, Attorney, speaking on behalf of the Health Planning and Development Commission of the Welfare Federation. I have been asked to represent the Health Commission and the Federation because for the past eight months I have served as chairman of a special Health Issues Task Force appointed to study and advise the Commission about major health issues of the day, and initially and particularly about national health insurance.

As our Representative from the 22nd Congressional District well knows, The Welfare Federation has a long history of concern and action about the needs of people in this community. The Federation has expressed itself on problems of the aged, dependent-children, nursing homes, public welfare and a host of other concerns. Among our foremost concerns has been health—or rather the inadequacies in our health system.

It is not our purpose today to document the health needs of people. There is ample documentation already known to you, we are sure, (which we could provide for the record if that would be useful). Suffice it to say that many people, particu-

larly the near poor, are not getting the health care they need and seek. Part of the problem has been the lack of availability of the health services needed, and a major deterrent factor has been the inability of many to finance the high cost of care.

We interject the point here that financial underwriting to date, by both private insurance and the government, has been primarily for in-hospital acute care. This has resulted in high utilization of the most expensive facilities with attendant rising costs, and a neglect of prevention and early treatment. This has meant that too many people wait until they are acutely ill and need hospitalization before they are cared for.

We believe that some form of national health insurance is urgently needed and that this should be sufficiently broad in coverage so as not to perpetuate or further skew the system through an over emphasis on inpatient, acute or catastrophic care. Ambulatory care, home health care, and dental care are examples of services needing attention.

To return to the work of our Health Issues Task Force and the position we have taken with respect to national health insurance, first let me say that we started by looking at several of the major bills. But we found that arguing the merits and demerits of the bills as introduced seemed to get us no-where. We decided therefore to address ourselves to some of the issues and, more positively, to those criteria or principles that we believe should underlie any national health plan. We therefore prepared a guide for the assessment of national health plans which was presented to and approved by our Health Commission. You have already received a copy, and we have also submitted it directly to the House Ways and Means Committee for the record. In addition we are including it as part of this testimony.

Before highlighting this statement verbally let me emphasize that those who prepared it, as well as those on the larger Commission who approved it, represent a wide and varied spectrum of interests. We believe, therefore, that this can be viewed as a publicly acceptable position as well as a progressive one.

If you have questions after I review this you may address them to me or to Mrs. Frank M. Barry, Director of the Health Planning and Development Commission, who has accompanied me.

A GUIDE FOR ASSESSMENT OF NATIONAL HEALTH PLANS

I. Adequate health care should be available to all people. Health Care is a right.

II. The health care system in this country is imperfect. A substantial portion of the population has limited access to health care. The impediments are (a) financial; (b) logistical such as location and communication barriers; and (c) an inadequate supply of providers.

III. The health care delivery system should be pluralistic, not monolithic. A pluralistic system offers the advantages of choice and of competition. A monolithic system does not offer these advantages nor can it measure its own effectiveness. A pluralistic system in the delivery of health care recognizes and adapts to the differing requirements of groups—both consumers and providers; it encourages change and the need to adapt to new needs and styles while at the same time realizing that change takes time and that existing strengths should be preserved; it allows for and encourages health services to be distributed more rationally and with more social consciousness and awareness of changing conditions than can be expected under a monolithic system.

IV. There should be freedom of choice by consumers in selection of providers. The principle of consumer free choice of delivery of health care (providing there are quality controls) should prevail, and provision made for at least two informed options as to type or system of delivery. No one, including the poor, should be required to be locked into districts or a single source of primary care.

V. This nation needs a national health insurance system that is applied nationwide and that covers all people. This should be a national goal. The principle of universal coverage should apply. Adequate health care should be made available whether the recipient can pay or not.

Practically this goal will be more likely to be achieved in a series of steps. If a complete program cannot be financed, a greater portion of the cost may need to come through payment by the patient (such as through deductibles and co-insurance), through cost ceilings and other controls, through limitations in services

that are less costly and less essential to maintenance of health. Only very limited restrictions on eligibility should be applied.

VI. The financing of a national health insurance plan should come from all three of the following sources:

- General revenues—Federal Government
- Employer-employee contributions through payroll tax
- Self employment tax

The individual should be expected to pay part of his health care costs by direct patient payment, through co-insurance, possibly through deductibles, and out-of-pocket for desired but not required treatment such as cosmetic surgery and for small drug charges.

VII. A central federal agency provides a feasible means of collecting the tax revenues and of insuring coverage of all or the major portion of the population of the country, and on a uniform and equitable basis.

Provision for a central federal agency need not and should not, however, destroy the private health insurance carrier or the Blues any more than Social Security has infringed upon private insurance and retirement plans. The role of the private health insurance carrier and the Blues may well be (a) for additional or supplemental coverage, and (b) as intermediaries.

VIII. A national health plan should allow and make provision for different methods of payment, such as fee for service, capitation (prepayment), and salaried practice. Payments limited to fee for service are not in harmony with today's basic organizational trends.

IX. All persons should be eligible for coverage under a national health insurance plan, including, but not limited to, those in the following categories.

- (a) Low income-poverty level
- (b) Medically indigent level
- (c) Employed (through payroll tax or self employment tax)
- (d) Unemployed
- (e) Persons over 65
- (f) Disabled
- (g) Dependent children
- (h) Dependent and institutionalized (any age)

A possible exception to the above, namely categories of persons who might be excluded, or included on a restricted basis, are:

- (i) Non citizens residing in U.S.
- (j) Americans abroad
- (k) Military personnel

X. National health insurance should insure that persons receive the services they need, not be a device for rationing of services inadequate in supply. The concept of comprehensive benefits should apply. There should be a better balance between inpatient and ambulatory care. Health services which should be covered under a national health insurance program, whether or not fully covered, by type of provider and type of service, are:

By type of provider:

- (a) Professional services
- (b) Hospital in-patient services
- (c) Hospital OPD and FW services
- (d) Extended care facilities
- (e) Nursing home care
- (f) Home health services
- (g) Ambulatory care centers

By type or degree of service needed:

- (a) Preventive care
- (b) Treatment: acute, emergency, etc.
- (c) Treatment, not acute but professionally recommended (subject to limitations)
- (d) Rehabilitative—restorative (medical)
- (e) Rehabilitative—restorative (non-medical)
- (f) Drugs—prescribed
- (g) Prosthetics and other appliances—prescribed
- (h) Dental services
- (i) Mental health services

Excluded should be patient desired but not required services such as cosmetic surgery.

XI. Expenditures for health care have been rising and will continue to rise in absolute dollars and as a percent of GNP. Both government and taxpayers seek controls on expenditures and incentives for efficiency and economy while maintaining effectiveness. Open-ended individual cost reimbursement for hospitals and other institutions and providers is a disincentive for efficiency. Americans will tolerate some waste and duplication in return for greater freedom, but they recognize that over-generous funding leads to inflation and can adversely affect cost. They seek a balanced system whereby quality care is provided at reasonable cost. This requires controls.

Acceptable methods of controls include:

- Cost control mechanism
- Quality control mechanism
- Other federally required standards such as licensing, accreditation, audit
- Medical review audit—peer review
- Fee guidelines and reimbursement plans (acceptable, equitable and uniformly applied)

Some provision for direct payment by the consumer

XII. The nation needs a national health plan that extends beyond just the financing of health care through national health insurance. Added components should encourage and provide incentives for the following, but not at the expense of providing health services:

- New systems of delivery
- Better use of present capabilities
- Better balance in the provision of services
- Development of manpower and facilities as needed for balanced and effective expansion

Research and development

XIII. There are some general principles which should apply to the development, administration and financing of any national health program.

1. Acceptability to the majority of consumers and providers. If unacceptable to providers the results are lack of cooperation and an inadequate long-run supply of doctors and other providers. To be acceptable to consumers, programs must be seen by them as administratively equitable and consistent with the cultural norms of the community.

2. Flexibility in the face of changing supply and demand factors. Health care is dynamic, always changing. Any financing system totally in harmony with today's underlying delivery system will be outdated tomorrow. Provision for periodic revision should be built into the program, not requiring a return to Congress except for major change. This means administrative discretion and the need for channels for ideas and innovations to and from grass roots and leadership.

3. Opportunities should be provided for the consumer as taxpayer and patient to play a significant role in policy formulation and administration of the health system. It is appropriate for the consumer to be concerned and have a voice in, for example: how his money is spent, the efficiency of administration, the manner in which he is treated, the determination of priorities.

Professional responsibilities such as diagnosis and treatment of disease or disability are not appropriately carried by consumers.

4. Health personnel should be assured reasonable compensation, opportunities for professional practice, advancement, and the exercise of humanitarian and social responsibility. Components in a national health program should be designed to foster highest quality of health care with individual and group responsibility. There should be adequate and stable income for providers.

5. Public and private interface is desired. There are philosophic reasons, such as this country's historic and traditional commitment to public and private partnership in the provision of health and other social services. There are practical reasons, too, for public and private partnership. The size and diversity of the undertaking—of any national health plan—require use of the expertise of human and institutional resources in both the public and private sectors.

6. Assuming a federal program, eligibility for service should be determined by federal rules to assure due process and equal treatment to every individual.

7. As part of a national program, but not as a part of a national health insurance act, there should be encouragement and acceleration of plans for more balanced and effective expansion of health personnel. Stable financial support should be provided for expanding training and use of more physicians, nurses, dentists, other allied health personnel such as assistants, aides and technicians, blacks and other minorities, women.

8. A national health program—whether a national health insurance program, a broader more inclusive health program, or a more limited categorical program—should provide stability in governmental appropriations sufficient to insure the development and operation of effective, sustained and viable programs. Vagaries in governmental appropriations tend to discourage planned long range developments, may seriously impair programs initially financed and of proven value, and can result in further fragmentation, disorganization and imbalance of the health system.

9. There should be an on-going system of evaluating both delivery and financing.

STATEMENT OF VERNON R. BURT, PRESIDENT OF BLUE CROSS OF NORTHEAST OHIO

I am Vernon R. Burt, President of Blue Cross of Northeast Ohio, one of the 74 Blue Cross Plans in the United States which in toto serves 74 million people, and as an intermediary for certain Federal Government programs acts in behalf of some 24 million additional persons. In our service area consisting of 12 counties in Northeast Ohio, over 1 million, 700 thousand persons have their health protection through Blue Cross which is substantially in excess of 50% of the total population. In Cuyahoga County over 65% of the total population is enrolled.

At the outset, may I express our appreciation of the thoughtfulness of the Congressman in holding this hearing in the local community. It is firmly felt that the issues of health and health protection are so broad and so important that no decision by Congress should be made until not only national leadership has been fully heard, but in addition Congress has heard from those at home and in the trenches so to speak. May we congratulate you for this effort today.

Before any review is made of any particular legislation now or hereafter brought before the Congress regarding national health insurance, we believe it is essential to establish and recognize a few basic principles and premises.

One of the first of these premises is that every American should have access to adequate health care, and that no person should suffer an undue hardship because of illness.

A second premise is that the health system and its financing is a vital and viable system with notable underlying strengths but with some significant weaknesses, such as the poorer health record of the low income groups, the spiralling increase in health care costs, and soft spots in efficiency and effectiveness.

These lead us then to the challenge that must be met—how to improve access and how to improve productivity within the system while strengthening rather than weakening its fundamental vitality.

We believe that Medicare has taught us a lesson that you cannot accomplish the goals we have mentioned merely by pumping more money into it. This has led to inflation. As you increase demand that can pay, the cost of the supply which is short will inevitably rise.

Any national health program is bound to give rise to increased expectations. The American public does not want to be disappointed in its hopes. We must build our change slowly and from a base that is known to be solid and expand it as we increase our capability of delivery.

We must recognize that some of the major detriments of health lie outside the broad boundaries of the health system such as adequate welfare support, better housing, a more balanced nutrition, improved sanitation, elimination of pollution and better education. These problems also need everyone's attention if we are to improve the nation's health. All of them call for the expenditure of huge sums of money—much of it from the Federal Government. This money is limited and therefore must be wisely spent—as well as wisely managed as it is spent. We must, therefore, establish priorities in the efforts of solution and utilize fully alternatives that have capacity for success with reduced Federal monetary contributions.

We suggest, however, that the best engineering of money will not solve the problem unless at the same time we improve the delivery system itself. In the

main we see recognition of this in most of the bills now pending before you. However, as far as current bills are concerned we feel there is much to be done by the Congress before it finally acts.

Any proposal that relies heavily on tax and other incentives to encourage people to purchase health insurance would only magnify the problem for those who because of their income level do not pay a tax. These proposals underestimate the need for change in the health delivery system itself. The Federal Government must be heavily involved in its regulation which is a premise ignored in this legislation.

Another major proposal calls for a unitary federal financing program operated out of Washington, D.C. It provides for universal coverage and elaborate controls. In the process it creates an extensive federal bureaucracy which would spend some \$70 billion for 200 million people with one national board reviewing and approving budgets of the myriad of providers as the only basis of payment. This national board would have authority to make judgments regarding quality of care and effectiveness, direct providers to discontinue services or initiate services, cutback sharply on reimbursement when funds are short and to detail procedures. It would discard the existing structure and thereby lose its strength for a monolithic, rigid, untried structure in the hands of persons untrained and unfamiliar with the health delivery and health financing system.

The Administration's proposal does try to capitalize upon the good in both the public and the private sector through extension of Medicare, the institution of a Family Health Insurance Plan and the institution of a mandated coverage for employees. It also has its shortcomings. It does not achieve universal coverage. The number of deductibles and co-payments would impose heavy burdens on particularly the near poor as well as a burden on its comprehension and expense factor in its administration.

To turn then from criticism to the positive we believe it is possible for the Congress to fashion a bill between the two unworkable extremes of a simple tax incentive bill on one hand and a largely federally financed system on the other.

Any such legislation must make it possible for all citizens to get health care coverage—broad comprehensive protection is required.

It should utilize a stronger department of Health, Education, and Welfare to do that which government does best—that is establish national goals, monitor and regulate performance, establish priorities, encourage innovation and experimentation, provide resources and demand performance that results in social justice.

It should call upon the private sector for its vital and unique ability to perform in the area of actual delivery using managerial expertise, diversity, the capacity to innovate and change. We have become cumbersome and ineffective, not more efficient.

It should call upon government to assist in the development of alternative methods of health delivery and of financing, giving opportunity of choice to our citizens in how they want their health problems solved.

There should be several sources of income to guard against the specter of underfinancing.

There should be, by intent, room for the various systems to play against one another in regard to both delivery and financing.

The focus should be on results and not be too preoccupied with the method of getting there.

It should demand better planning for the improvement and expansion of the health care system.

It should permit some flexibilities in the pattern of benefits through the use of broad minimums. We have worries about too heavy a reliance on a catastrophic program unless it is a supplement to a strong basic program.

It should provide for federal regulation of the carriers that provide the mandated coverage to the extent there is inadequate or absence of regulation at the state level.

It should provide for long term care and provide in the mandated program protection for the use of alternate facilities or programs as a substitute for acute in-hospital stays.

It should contemplate greater use of consumers but at the same time authorize programs of education of the public to the end that they will show them where and when to go and not to abuse it.

These are specifications not easily met but we suggest they are minimal if the goals we have expressed are to be realized. National Health Insurance is a very large and complex public issue.

Blue Cross pledges to you, Mr. Congressman, and to the Congress its cooperation and dedication to help you in making the decisions that are required in the next few months or years that lie ahead. May I thank you for the privilege of appearing before you.

Gentlemen: Mr. Bernstein, Mr. James and I, Ruth Saylor, represent the local Chapter of the National Hemophilia Foundation.

The National Hemophilia Foundation and this local Northern Ohio Chapter believe a national health bill must aid hemophiliacs, whether the sufferer is an out-patient, an in-patient, or on a home care program.

While our Foundation is particularly interested in having coverage for hemophilia, it asks that other chronic blood diseases such as leukemia, sickle cell anemia, Cooley's anemia, and others to be included, although we cannot speak directly for other representative health agencies. The hemophiliac, though, is the prototype of the chronic blood user and as such he has his own peculiar problems.

As you know, hemophilia is a genetic disorder of the blood in which the clotting factor is either partially or completely missing. Hemophilia is widely known as the bleeder's disease.

Hemophiliacs are unique among chronic disease victims because they are not born crippled and can be cured if financial conditions continually allow them to purchase the missing clotting factor. Without this ongoing treatment, the hemophiliac becomes an unnecessary burden to himself, his family, and eventually to society.

The sufferer is subject to hemorrhaging—both internally and externally, and in severe cases, internal bleeding will start spontaneously—that is, with no apparent cause. A procedure as routine as a tooth extraction, for example, could become a major crisis for a hemophiliac, requiring countless transfusions and a hospital stay. With the repetition of bleeding episodes, the hemophiliac becomes crippled by his own blood.

But beyond the physical crisis, the hemophiliac is constantly threatened with uncertainty since a bleeding episode may occur without warning. Consequently, there is a tendency among family members to curb day-to-day activities for the sake of the sufferer. The psychological toll is incalculable, and in some cases devastating.

Even with optimal genetic counseling, hemophilia has an extraordinarily high rate of occurrence, it is safe to say it cannot be eradicated. The disease occurs spontaneously, without any previous family history, and as such, hemophilia has the highest rate of mutation of any genetic disease.

Medical advancements are providing us with materials capable of correcting the missing clotting factor. Bleeding can usually be checked with transfusions of fresh whole blood, plasma, or clotting concentrates. This procedure is known as replacement therapy; and from 10 to 15 thousand patients are severely enough involved to require continuous replacement therapy from birth to death.

The hemophiliac poses specific medical and financial problems. (1) Replacement material is extremely costly, running from \$5 to \$95 a unit, depending on the locality where it is administered. It is not uncommon for a single hemophiliac to use 100 to 150 units a year. (2) Replacement therapy is generally carried out in an out-patient emergency room where "third party" coverage is often *unavailable*. (3) Reconstructive surgery for correcting crippled joints is both time-consuming and extraordinarily expensive, and the cost of replacing products alone, without doctors' fees or hospital costs, can be as much as \$15,000. Again, this is rarely covered by "third party" payments. (4) Maintaining an out-patient clinic offering comprehensive care beyond replacement therapy—with a social worker, psychiatric, dental, and vocational assistance, is a necessary but overwhelming financial burden. (5) In addition, all replacement therapy, either in the form of direct transfusion of blood or one of its components, makes a major impact on the blood banking industry in the United States. It is estimated that 27 percent of all the blood units collected is used by the 10 to 15 thousand severely involved hemophiliacs. This blood need to combat hemophilic bleeding was the

initiating force behind the creation of the National Hemophilia Foundation, which has dedicated its efforts to recruit donors.

A hemophiliac *can* live a useful life as long as replacement therapy is readily available. Hemophiliacs, whether they are students or employed, show a positive attendance record with continuous treatment. But the cost of replacement therapy is prohibitive for most patients. Blue Cross and private insurance carriers will only cover out-patient care if an accident is involved. Many insurance companies will not even insure a hemophiliac. We have members in our organization who have hospital bills for in-patient and out-patient care that are beyond belief. One family owes \$46,000, another \$21,000, another \$11,100. These families owe this because they wanted their hemophiliac to live.

To have not incurred these debts would have meant death for a loved one. Only the very wealthy can afford to pay for the treatment of a bleeder. Can you imagine how it feels to be dunned constantly to pay a debt of this magnitude when you know you cannot possibly repay \$46,000 on an \$8,000 a year salary and when you know the debt will increase because your hemophiliac son will continue to bleed.

Many areas of the country have successfully started a program of "home therapy." At the onset of bleeding, the patient himself or his parents may give an infusion of the necessary blood component, which will control both pain and bleeding. This is being carried out at home, at work and at school in many metropolitan areas. However, this has not been started in Cleveland. Home therapy greatly reduces the cost of controlling bleeders—but the cost still remains expensive.

It is possible that a child born today and diagnosed as a severe hemophiliac will live a normal life without any crippling results from his disease if he is continuously treated. A National health insurance program is the only way all hemophiliacs can be continuously treated. It is unfortunate that the majority of our adult patients were not born in an era when modern therapy existed. It is vital that the out-patient and home care program be covered in national legislation along with in-hospital care, so that already crippled patients and the newly-diagnosed child can be salvaged.

With the advent of component therapy, we are utilizing our blood resources more effectively and reducing the burden for local blood banks. As home therapy techniques become more widespread, the hemophiliac will evolve from a hospital-dependent to an independent individual. The costs of out-patient replacement therapy are still beyond the normal financial capacity of the average family, and many families become medically indigent as a result—even with assistance from the Crippled Children's Service and Medicaid programs. This is why coverage of replacement product costs is so desperately needed by hemophiliacs.

It is important to realize that even though the initial cost of providing such coverage for out-patient replacement therapy may increase the public burden for the moment, the long-range expense to the taxpayer will be lessened as more and more hemophiliacs are able to maintain their health, become educated, work without great absenteeism, and eliminate the need for public assistance.

Again, we emphasize that hemophiliacs can become functioning, productive members of our society if they are able to obtain adequate therapy and financially cover costs. By a continuous replacement of the missing clotting factor, they are able to become the living dividends of the very investment I am requesting here today.

We will endorse a health insurance program that will shoulder the costs of in-patient, out-patient and home therapy as well as the costs of blood replacement products. Without this care program, the cost to patient, family, and public service agencies will be even higher. We are confident that if such a program were established, hemophiliacs would further their efforts in blood recruitment.

The National Hemophilia Foundation proposes, then, that a national health bill include the following provisions:

- (1) Medical coverage will be provided for hemophiliacs and other persons with chronic blood disorders, whether they are in-patients, out-patients, or on medically approved home care programs.
- (2) Persons for whom the maintenance of life and health requires periodic or systematic transfusions of blood or blood derivatives will be covered for the cost of their blood product, its preparation, and its administration.
- (3) And thirdly, that payments regarding blood and blood derivatives should apply to the use of in-patient or out-patient hospital facilities and under medically approved home care programs.

STATEMENT OF SIDNEY LEWINE, PRESIDENT, GREATER CLEVELAND HOSPITAL ASSOCIATION

I am Sidney Lewine, Director of the Mt. Sinal Hospital of Cleveland, and President of the Greater Cleveland Hospital Association which represents fifty-nine health care institutions in Cuyahoga County and nearby counties.

The hospitals in this area consonant with the position of hospitals nationally, are not coming out in favor of any given National Health Insurance bill over any other. We stand ready to provide whatever services are dictated by law, and are required by the sick in the professional judgment of physicians.

We ask, however, that when you tell us by law to provide certain health services under government auspices, that you are prepared by law to pay for them at reasonable cost. All too often we have seen insufficient funds made available to pay for services, either by reason of inadequate appropriations or faulty law. We are then left with the choice of two alternatives; either cutting back on services, or overcharging patients who are not on government programs to make up the government program deficit.

A case in point is found in H.R. 1 as passed by the House Ways and Means Committee earlier this year. The Social Security Act now provides that payment for hospitalization of Medicaid patients shall be at reasonable cost. Section 232 of H.R. 1 as passed by your committee and the House amends the Act to authorize the states to develop their own methods for determining the reasonable cost of inpatient hospital care for Medicaid patients. We can tell you from bitter experience in Ohio what that can mean. Under law, our State now is permitted to set standards for payment of outpatient services to Medicaid patients. Payments to hospitals in this area for such services have been at less than half the cost. We have been forced to load this deficit on the paying patient. This is obviously an unfair way of financing this service. In addition, I should point out that the deficit in payment for outpatient services to the indigent has brought the large voluntary hospitals in this area close to insolvency.

We assume that H.R. 1 will be passed in somewhat different form by the Senate. When it returns to Joint Conference Committee we trust that this dangerous section will be deleted.

On the broader issue of national health insurance legislation I can only repeat the plea: When you pass legislation to provide services, be sure to provide the funding mechanism that will pay for the services at reasonable cost.

STATEMENT ON NATIONAL HEALTH INSURANCE BY AMASA B. FORD, M.D.

Mr. Vanik, Mr. Betts, Ladies and Gentlemen: My work is that of teaching community health to medical students. My definition of the subject matter of community health is that it consists of the answers to two deceptively simple questions: first, who gets sick? and, second, what are we doing about it?

Who gets sick? The answer, of course is that we all do: we are mortal, and we all suffer the ills that flesh is heir to. But that is not the whole answer. Some of us are more likely to get sick—and to die young—than are others. In Cleveland, as elsewhere in this nation, poor people living in the center of the city experience higher rates of sickness and death than do the affluent residents of the suburbs. Some census tracts in inner Cleveland have infant mortality rates more than twice the national average, while the outer suburban communities all have below average rates. Tuberculosis, venereal disease, lead poisoning, and many other diseases occur at higher rates among the poor. The leading causes of death in the United States today, cancer, and heart disease, kill at progressively higher rates as you approach the inner city, in part because of increasing exposure to industrial pollution.

Poor people have more disease and die earlier than affluent people. Why is this so? I would give two answers: first, because the vicious cycle of poverty arises out of illness and disability and also perpetuates them. Poor education, unemployment, a childhood spent in an urban ghetto or on a marginal farm—these experiences expose a person to great dangers and many diseases and fail to teach him how to provide for his own health. The second answer is that poor people do not have equal access to health care. In spite of the fact that they

experience more disease and disability and therefore need more care, the inner city and rural poor, compared with well-to-do suburban residents, see doctors less frequently, get to hospitals later and with much greater difficulty, and are more likely to be admitted to state mental hospitals and other large and inadequately funded institutions than they are to be cared for at home or in the doctor's office.

The poor do not have equal access to our health care system largely because access to the system, in this country more than in any other industrialized western nation, is based on money. Very simply, if you can't afford a doctor's fee or the twenty-five dollars or more it now costs to go to an emergency room, or if you don't have expensive private insurance to cover the costs of hospital care, now \$100 a day or more in many hospitals, you don't go, or you delay until your problem is more severe—and more difficult and more expensive to treat.

I am not an expert in medical economics, and I will not attempt a critique of the bills that have been submitted to Congress. But I would like to conclude this brief statement by putting before you four principles which, on the basis of my own experience and research, I believe are essential components of any health insurance system if it is to meet human needs.

First, the law must aim at greatly improved and increased primary health care. By this term I mean ambulatory care for every-day health problems, conveniently located, available at appropriate hours, and connected efficiently with hospitals and all other kinds of health service. The greatest deficiency of our health care system is that we have failed to develop primary health care while investing heavily in specialized hospital care. Family physicians are abandoning the inner city, and hospital out-patient clinics and emergency wards are badly designed and completely inadequately supported to provide primary care.

Second, in order to achieve this kind of service, the law will have to provide incentives for new and improved ways of delivering care. Money is not enough. We have learned from Medicare that money alone merely inflates prices without delivering more care. Even in a state like New York, which matched Medicaid funds far more generously than did Ohio, the poor relieved of a cost, and grateful for that, but they did not see more doctors or get more preventive health care. We must establish hundreds more health centers where they are needed: in center cities and in rural areas, and doctors will not undertake to do this in any numbers unless they have good facilities and a good professional environment to work in. Incentives for group practice, federal support for the development of existing local health services, and for the training and use of non-physician health workers, are examples of ways in which federal legislation can stimulate progress without taking over all health services.

Third, the law must provide for quality control. We are all keenly aware of dramatic increases in the cost of medical care, and it is evident that the most effective way of controlling costs is to reduce the most expensive item: hospital care. I favor this, where hospitalization can be shown by such methods as peer record review to be unnecessary. But quality control is not the same as cost control. Quality control must also deal with ambulatory care and with such questions as whether patients fail to obtain hospital care and consultation when they need it, resulting in greater ultimate costs for treatment and rehabilitation. The consumer also has a contribution to make to defining the quality of health care, while, on the other hand, controls will not work unless the providers are also included in the process in a way that makes sense to them.

Finally, I believe that the law must clearly express a social consensus which has been growing in this country for the past 50 years. It can be simply stated. Good health care is the right of every citizen, and it is the responsibility of a democratically elected government to assure that every citizen has equal access to such care. There are two equally important corollaries to this principle. One is that we must move from the present two-class system of care to one in which access to care is based entirely on need and not on ability to pay. The other is that we must make an identifiable government agency accountable for access to health care, in place of the present total lack of clarity about who is responsible.

Once the principle of the right to health care is clearly stated and accepted, we will be able to set about the difficult task of putting it into practice. Until then, we are confined by the accidental restrictions of history and will continue to be unable to cope with the shameful fact of persisting medical indigency in the wealthiest large nation on earth.

STATEMENT ON NATIONAL HEALTH INSURANCE

Prepared for Congress by Walter Ermer, Executive Director, International Health Council, 15328 Edolyn Avenue, Cleveland, Ohio, 44111, phone 216-671-6638. We now have about 3,500 worker-members, including over 50 professionals of various types. Our particular interests are in legislation affecting degenerative diseases and we do act as a clearing house for information that doesn't appear in the usual publications. This is a nonprofit organization and expenses are covered by donations.

In the preparation of this statement, I canvassed many people in the health movement, the church, young people who will have to pay the bill and others. In addition I reviewed a summary of the major proposals that have been introduced in Congress. I gained very little in this review because most of that which was offered is too shallow and many future problems are left unanswered. Frankly, this is a project requiring creativity and not a re-shuffling of old "stuff". This project must cover the entire field of health and disease, not just how to pay the bill national insurance or otherwise. Possibly what I have to offer is so drastic it may not come in our lifetime but it will come eventually and I hope Congress will see fit to take a creative point of view for the benefit of future generations.

The ancient Chinese were steeped in wisdom which they preserved from the original civilization that existed before the dawn of recorded history. The ancient Chinese paid their doctor when they were well and the doctor paid the patient when he was sick. Now how can we turn this ancient wisdom into a practical modern application?

Free Enterprise in America is a desirable state and part of our tradition. The American Medical Association in apparent conspiracy with other vested interests have violated the American Free Enterprise System with a monopoly and conspiracy against the health of the American people.

Attached is a copy of The Fitzgerald Report, to be considered a part of this statement, that lends credence to the allegation that a monopoly and conspiracy does exist. Benedict Fitzgerald was a Department of Justice investigator borrowed by Congress who dared tell the truth about the AMA and was fired for his honesty. Other documentation confirming the monopoly is available from many sources. To name a few: A Doctor is Born by Dr. W. D. Chesney MD, The Dictocrats by Omar Garrison, The Right To Live by Rev. R. D. Damerow, Brief filed in U.S. District Court at Columbus, Ohio by some 700 patients and chiropractors against AMA, Ohio State Medical Board, Ohio State Medical Association, Civil Action #71-90. AMA and other vested interests have a long history of fighting every measure by the government or other concerned agency aimed at improving the health of the American people. Even the President bows down to the will of the monopoly when appointing high health officials. Doctor's fees are rising twice as fast as other prices, hospital costs increase about 15% every year, our total medical bill in 1975 is expected to be twice what it was in 1968. Witness the high cost of disease today, the lack of medical care in some areas, the fabulous incomes of some of the "disease merchants" using production line techniques, the ridiculous time spent in medical school, the shortage of doctors, the lack of training in prevention and Natural (drugless) Therapy, the suppression of many useful remedies, the fantastic number of malpractice suits, iatrogenic or doctor caused diseases—the third largest cause of death in this country. Let's face it, these problems are caused by the monopoly which few people have the courage to talk about because of their power and influence.

To establish a sound financial program through National Health Insurance or any other means, efficiency must be established by breaking this power structure. Those profiting on disease have brought us to the brink of disaster and in so doing have forfeited all rights to our Free Enterprise System. Therefore, if our nation is to survive, we must nationalize everything connected with disease. Most unfortunate but this is the only way, and anything less is merely patching a rapidly sinking ship.

A Department of Health covering everything connected with health and disease must be separated from the Department of Health Education and Welfare. Administration of this program could be handled as a government agency or a separate corporation like the present postal setup.

Health Care Centers including hospital, nursing home, eye care, dentistry, in fact all health care, would be owned and operated by the government and strategically located to serve a definite fixed area.

Physicians, both allopathic and non-allopathic, and supporting staff would be hired by the government owned facility on a salary commensurate with their qualifications in the same manner as other civil service employees. A group bonus would be paid, based on low per capita costs of health care services in the district served by the Health Care Center. This would encourage better low cost service because the lower the cost the more money the physicians and others would earn. This incentive is commonly used in industry management to promote internal efficiency. Patients would be free to select any doctor on the staff of their Center as their personal physician. Anyone not covered by national insurance such as visitors from foreign countries would pay cash. Those traveling could be covered by a billing between Centers. Physicians and private facilities would be permitted to function independently if they wish but without help from National Health Insurance.

Medical schools must include natural or drugless healing of all types including prevention. They must be a part of the national system. An effort must be made to graduate more physicians and total school time can be shortened. Funding would be mainly tuition with very little help from the taxpayer.

Funding of this entire program should be handled as additional social security taxes and handled by the present agency. Patients would be required to pay all diagnostic costs including diagnostic hospital costs and must pay at least 10% of all treatment costs. This is to discourage the hypochondriacs and others now insisting on costly checkups just to get their money's worth from Blue Cross, Medicare, etc. Other than the above, all treatment costs would be covered.

The lack of knowledge among our young people regarding anatomy, prevention and home treatment of disease is terrible. For long range cost control, this should be included in public school curriculum from the first grade through college at government expense.

All boards, committees, panels, etc., concerned with health and disease must have a voting majority of citizens without vested interest. Right now health decisions affecting the taxpayer's pocketbook and well being are being made by those making money on disease and is a big factor in our present high costs. This principle must be applied to both national and local situations.

I fully realize this is a shocking but realistic approach to the National Health Insurance problem. I am sure you will agree that more than just funding is involved. I am sure you will agree that efficiency must be a part of funding if we and future generations are to survive. I am sure Congress will have the foresight and fortitude to do a complete job and will not take the easy way out by "patching the old ship" with more money.

STATEMENT BY MR. GERALD STRUCKHOFF

ADMINISTRATOR OF EUCLID PARK NURSING CENTER AND EVERGREEN MANOR
NURSING HOME, EUCLID, OHIO

The information below comes from a nursing home administrator. The perspective, however, comes from many dealing and conversations with both patients and relatives of patients.

(1) THE "AVERAGE CARE" RATE OF WELFARE PAYMENTS

Euclid Park Nursing Center is an Extended Care Facility. Mrs. F. L. and Mrs. E. K. have been with the nursing center for some time, each paying the current rates obtaining. (Which currently happen to be \$450.00 per month or \$15.00 per day.) For a year now Mrs. F. L. has been receiving Aid for the Aged (Welfare—known as AFA). If she had been approved for "maximum care", she (or we, the Nursing Center) would receive \$14.00 per day. But, because her physical condition does warrant it, she has been approved for "average care," or \$9.00 per day (\$270.00 per month.) No Welfare social worker will be able to find a "home" for Mrs. L. at that rate. Since she was with us since November, 1960 we can not just ask her to leave. Where would she go? Mrs. E. K. just recently had to go on AFA. She was approved for "average care" only. We decided to geign "hard-boiled-tality" and asked her to leave. We were informed that we have to keep her (at \$180.00 loss per month) until the AFA office can find somewhere that she can stay. When will that be? Your guess is as good as mine?

The dilemma—What should we do. Simply toss out such “unfortunate” elderly (i.e. those who have health good enough to warrant merely “average care”? Or do we absorb a loss of income? Or is there a compromise area whereby the rate for average care in an Extended Care Facility is perhaps 90% that of “maximum care?” Since the state seems to be having difficulty in maintaining the present rates, perhaps a Federal Aid Program could help out the State in this area.

An aside—this “average care” rate can apply, for example, to another resident of our Nursing center who has physical health (warranting \$9.00 per day) but is a severe custodial problem. There is not a nursing home in Ohio, I would venture, that would accept Mrs. P at the “average care” rate. What do we (and her family) do?

(2) In Ohio, to receive Welfare, two of the conditions are: resources or savings must be less than \$300.00, and the client's monthly income must be no greater than \$230.00 per month. It is the second condition that I would like to challenge. Take your hypothetical “Uncle Harry.” He never worked a day in his life. At the age of 65—in poor physical condition—the relatives finally unloaded Uncle Harry onto the State. He is approved for “maximum care”—thus a nursing home is paid \$14.00 per day for his care—and he ends up with \$8.00 per month for spending money. Your other uncle, Uncle Pete, worked hard, saved his money, and looked forward to a fairly comfortable old age. At 65 he has used up most of his savings. His monthly social security check is \$130.00 and he has a pension of \$120.00 per month. There he is—getting \$250.00 per month—a nice sum???? He applies for AFA—and is refused. Refused—penalized—“condemned”—discriminated against—because he was productive and saving during his earlier years. Yes, Uncle Pete can not get ONE CENT from welfare because of his colossal income for \$250.00. This example has occurred with two of our residents recently. One gets about \$250.00 per month (her husband left a trust fund years ago stipulating \$200.00 per month). Her small social security check is just enough to deprive her of AFA. Another gentleman received \$182.00 in workman's compensation and \$139.00 in Social Security. This \$319.00 leaves him with not even \$8.00 spending money (as Uncle Harry would get) and the nursing home is short \$101.00

Perhaps some kind of Federal subsidy in such cases could be worked out. The present practice is patently unfair. Or should we begin to encourage renouncing social security benefits or workmen's comp benefits? It would help the residents and the nursing homes more.

STATEMENT OF MR. MURRAY OAKES, PRESIDENT OF HUMANISTS ASSOCIATION

Position Paper of Humanist Association of Cleveland-East On National Health Insurance Plans

“We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.—That to secure these rights, Governments are instituted among Men.”

These are the ringing words from our Declaration of Independence that have been, and must continue to be a beacon in charting the development of our country. Implicit in the Right to Life, is the Right to the preservation of that Life. We believe that this is a clear mandate to provide proper Health Care and the conditions to make Health Care readily available to all of the people.

We believe that it is contradictory to the spirit and meaning of the Rights which are guaranteed to the people in this country by the Declaration of Independence and the Constitution to permit the exploitation of sickness and infirmity in the interests of building vast empires and industries fattening on excessive profits by supplying prescription drugs and other supplies to treat disease for our Health Delivery facilities and services. We must take profit out of sickness and the misfortune of ill health!

It is in keeping with the times and the changing attitudes of people in the United States that programs dealing with the health and welfare of people be determined and administered by and with the close involvement of the consuming public.

Of all the Health Insurance bills before Congress at this time, the Griffiths-Corman bill HR 22, co-sponsored by Congressman Charles Vanik appears to

approach some of the problems that need to be dealt with to insure Health Care for the American public.

Vital factors in the Health Care field have not been dealt with in the proposed legislation, and others have only been addressed on a basis that will not deal with the abuses present today in this field. Portions of this bill, as summarized, would, in effect, underwrite at public expense, some of the exploitative and self-serving situations existing at present. There are no standards or controls provided by the bill as outlined to insure maximum service at the lowest cost. Government administration without adequate guidelines and controls would ensure nothing in the Health field but comparable situations to the TFX fiasco, the Lockheed bailout, and many others.

Too large a burden for financing this bill would fall on the lower income taxpayer who can least afford it. A large number of self-employed individuals fall into moderate to low income brackets, but would be taxed at a rate of 2.5%. Earnings and income are only taxed up to the first \$15,000 leaving the large unearned incomes virtually free of any burden. A total cost of provided services has not been projected in the summary of the bill.

Therefore, The Humanist Association of Cleveland-East proposes the following to be incorporated into a comprehensive Health Care Bill needed by this country.

1. Broad benefits with no cost sharing, and limitations of benefits to be determined by the requirements of full treatment for individuals. Benefits to include Hospital, Nursing Home, Physicians, Dentists, and other health professionals, laboratory, X-Ray, medical appliances, eyeglasses, and prescription drugs. Benefits for preventive Health Care to comply with National standards to be established by a commission under the Department of Health, Education, and Welfare. Such commission to be made up of $\frac{1}{3}$ broad consumer representatives, $\frac{1}{3}$ professional representatives, and $\frac{1}{3}$ representatives designated by DHEW.

2. The administration of a Health Care program to be under the DHEW through regional and local offices with the broad consumer community represented at all policy and administrative levels.

3. Profits on the manufacture and delivery of all prescription drugs, medical appliances, eyeglasses, and supplies for facilities providing Health Care to be limited, with overhead costs and advertising costs all limited by Federal law. In the event that private industry cannot or will not supply the Health Care field under these conditions, such producing industries should be nationalized, and operated within the set guidelines.

4. The Health Care programs shall be financed by general tax revenues and taxing the employers on the basis of their payroll. Employers with 10 or less employees and a profit of \$15,000 to \$20,000—1% of their payroll; under 10 employees with profits over \$20,000—2.5%; Employers with 11 to 50 employees—3.5% of payroll; Employers with over 50 employees—5% of their payroll. All unearned income up to \$15,000 taxed at 3.5%; All unearned income over \$15,000 taxed at 5%. Self-employed with incomes of \$10,000 to \$15,000—1%; Self-employed with incomes \$16,000 to \$25,000—3.5%; Self-employed with incomes over \$25,000—5%; All industries with defense contracts comprising 25% or more of production with profits over \$25,000 to be taxed at 10%.

5. All Health Care planning programs, all institutional providers of Health Care services shall have consumer representation on their boards of no less than $\frac{1}{3}$ of the board. All construction of Health Care facilities to be planned, and approved by regional co-ordinating and planning boards, also to have consumer membership of $\frac{1}{3}$.

6. Grants to medical schools and other training facilities of medical and paramedical personnel to be made on an incentive basis related to high quality training and increased numbers of personnel trained.

7. A commission to be established to outline Health Care services that paramedical personnel can take over from medical personnel, and to set standards for the qualification of such personnel.

8. Medical evaluation boards to be established regionally and locally to evaluate the work of physicians and other professional providers of Health services and to maintain medical standards. Such boards shall be composed of 50% professional representatives of the medical professions, 25% non-medical professional representation, and 25% consumer representatives.

Implementation of a program as outlined above will, in the opinion of the Humanist Association of Cleveland-East, soon establish the United States as a world leader as a provider of Health Care for its people.

OHIO REGIONAL HEARINGS ON A NATIONAL HEALTH INSURANCE PLAN

We come before you with our concern for the health needs of our elderly poor and ethnic peoples. My name is Mary Vadas, Project Director of the Buckeye-Woodhill Multi-Service Center for Older Adults. We are in the heart of a heavy concentration of Hungarian, Slovak, and Italian-speaking elderly. Because they are old and do not communicate in English, they suffer gaps in health care.

Consider the true life story of Peter and his wife, both in their mid 70's. Between them they spoke six languages, but English imperfectly. They lived in an inner city tenement where rent was \$60. Peter fell ill and attempted calling his doctor who spoke his language. The doctor had died. Peter phoned other doctors, and one agreed to make a house call. When given the address, he refused to enter that part of the city. Defeated, Peter gave up and took to his couch. For six months, his over-burdened wife, who spoke no English, nursed him, bathed him, tried to keep him eating, and watched him die. Both despaired of any help of anyone being interested in an old couple. Peter did die, the morning a city health nurse was coming to investigate. Ironically, Peter was a few blocks from an excellent neighborhood medical facility.

Why did Peter die? A learned man in his native Russia, who spoke Russian, Ukrainian, Hungarian, and several other languages fluently, spoke English too poorly to summon help. Elderly, foreign-speaking people, often isolated from children and family, cannot *communicate*. They do not know *resources*; nor *how to use them*. Doctors *refuse to make home calls* especially in the inner city. The neighborhood medical center did not sufficiently reach ethnic-speaking elderly pocketed in the area. One might also suspect that an *elderly* patient, fumbling in English, is not eagerly sought as a *new* patient. Peter was rebuffed because he was old and did not speak English.

The elderly face an attitudinal problem—one that treats aging itself as a disease, and chronic illness as unworthy of much attention. The elderly continually complain that the doctor is "too busy to listen", "doesn't care", "just tells me to take these pills . . .". We propose *medical personnel receive training in understanding geriatric patients*. I have talked with elderly persons who appear seriously depressed, even suicidal, who the doctor is dismissing with a prescription and a laugh to "take these, don't worry. It's just old age . . .".

In our area, the elderly had their doctors concentrated in a building familiar and fairly accessible. Now the doctors have fanned out to newer medical buildings in suburban areas. One couple may have 4 or 5 doctors, all in different scattered locations. If their children or neighbors can provide transportation, they continue care. If not, they may give up and go without attention. One lady on a small pension had to pay \$9.00 cab-fare plus the \$10.00 doctor's fee. She could not keep appointments twice a month.

We propose geriatric medical centers one place where all medical specialties internal medicine, podiatry, dentistry, ophthalmology, are available and medical people are sensitive to the needs of the elderly. The elderly's fear of a new doctor would be lessened if he felt assurance of acceptance and concern for his special problems.

One center would simplify struggling through a maze of phone numbers, names, for distance locations in a city they cannot traverse.

The elderly ethnic population are easily identified in urban areas. We propose that where such concentrations of people exist, medical facilities adapt their approaches accordingly and provide some outreach efforts at—communicating on the consumer's level—provide multi-lingual personnel familiar with the ethnic culture.

Medicare forms pose a most horrendous problem to someone alone and unable to read or to understand English. I have consoled a lady in tears, trembling over a medicare statement clearly marked "This is not a bill". How frequently do the elderly, anxious to pay on time, and with failing eyesight, pay that "This is not a bill". Some system of standardizing reporting is needed at the doctor's level. Record-keeping may range from non-existent to copies in triplicate. The elderly patient hears the doctor's wrath and difficulty in obtaining those statements. We encounter people who do not claim benefits because the system is too complicated and too threatening for them to deal with. Many elderly fear making a mistake when it involves the Federal Government.

One final consideration—There is a desperate need for discharge planning from hospitals that extends to after-care and follow-up. Old people are sent

home requiring specialized, alert attention, and the caretaker may be confused and incapacitated. Many are discharged with the assumption neighbors will look in on them. Frequently these cases only end up as re-admissions in emergency a day or two later, adding unnecessarily to hospital costs. Sometimes, the ill patient simply expires—and is found days or weeks later. Procedures in hospital, social service departments, vary so widely that the elderly often come to no one's attention. Adult children presumably alert and not ill, may not even be aware of the services available to the geriatric patient. We propose that Social Service Departments be especially aware of the elderly admission and make efforts to reach him.

The effectiveness of good after-care depends upon a strong home health care program. About 95% of our elderly reside in the community, and they prefer to remain in their own homes. Home care services to meet their increasing dependency would reduce institutional and hospital costs.

We would point out a necessary distinction between home health care and home services related to the *normal* process of aging. We would find it tragic to see *all* kinds of home services to the elderly moving under medical supervision. We are desperately in need of increased funding for both programs. But let us not assume again that normal aging is synonymous with ill health.

In summary, we re-state our proposals:

1. Medical personnel receive training in understanding geriatric patients.
2. Geriatric medical centers be established where all health specialties are concentrated in one accessible location, and the elderly know they are welcomed.
3. Multi-lingual personnel and persons sensitive to a particular ethnic culture be used in areas where there is a heavy concentration of ethnic elderly.
4. Medicare forms be simplified for elderly usage.
5. Discharge planning from hospitals needs to extend to after-care and follow-up.
6. A solid home health care program makes discharge planning effective. But home health care and home services related to normal aging need to be thought of as separate programs.

MARY VADAS, *Director.*

STATEMENT OF GERMAN THOMPSON, VISTA WORKER, GLENVILLE
NEIGHBORHOOD OPPORTUNITY CENTER, CLEVELAND, OHIO

Everyone talks nowadays about how life expectancies are rising. But how many of you know that the average life expectancy of black people is 10 years shorter than that of white people? Experts relate this to poorer health and poorer health care during younger years, which lead to more chronic conditions and worsening health in later years.

In Ohio, we were told by Mr. John Hansan, director of the department of public welfare, only \$8.00 of every \$100 of personal income tax returns to Ohio in the form of welfare funds for the aged. Good health care costs money. The poor, both young and old, are forced to use clinics, where they encounter long waits and are shuffled around from long line to long line. They are expected to be grateful for this meager care. They are taught to make no criticism. If they criticize, they might be turned away, and they can't afford anything else. So they wait.

It's no surprise that there is inadequate preventive care—with treatment like this, who wants to go to a doctor except in an emergency? As you get older, you pay less attention to the need for regular physical examinations. Add that to poor nutritional backgrounds and you find people dying of heart disease, cancer, diabetes complications and strokes. All of these could be lessened by an emphasis on prevention.

Many elderly poor qualify for medicaid, which covers glasses, drugs, the \$50 deductible on medicare, dentures and the many inadequacies of medicare. But there are countless elderly poor who miss these benefits because they make even \$1 too much to qualify for aid for the aged. Being elderly and poor means: (1) We can't pay for special care; (2) we have trouble getting to health services; (3) we often can't get home health care services after an illness; (4) we don't always get good explanations of what is being done to us; (5) prescription directions are given rapidly and not explained well.

Many of today's elderly poor are not well educated. That does not mean we give up control of our lives. We want to be in control of our lives just as you are.

STATEMENT OF MRS. LOUISE KADLECK, PERSONAL ASSISTANCE AIDE, WEST SIDE
NEIGHBORHOOD OPPORTUNITY CENTER, CLEVELAND, OHIO

I have a few things I'd like to say today about elderly health care as it relates to medicare.

When most people think of "elderly" they think of sick. That's not really fair. Sure, most of us have some condition or another, but only 14% of those 65 are unable to function.

The only problem is that those conditions we do have are pretty likely to be chronic conditions. These cost far more in terms of both medical attention and drugs, which is why the elderly spend three times as much as the non-elderly population on health bills and drugs. Almost half the elderly population spends between \$50 and \$250 on drugs, according to H.E.W. projections; yet, medicare allows nothing for drug expenses. And medicare still covers less than half of the elderly's medical expenses.

Other financial inadequacies of medicare include lack of coverage of the many chronic ailments which plague the elderly—dental problems, foot conditions, which require the attention of a podiatrist, eye glasses, which are vital after a cataract operation or hearing aids. There is also that first \$50 a year for medical bills, which places a great burden on those who have minimal social security benefits but who just barely miss qualifying for medicaid.

Then there's all that red tape. Many doctors refuse to file the forms themselves, so you must pay him and file for your own return on forms which are far too complicated to fill out. Then comes waiting for the refund—which can take as long as two years. Waiting that long for a \$10 refund is somewhat ridiculous, so what too many elderly do instead, is go to already over-crowded hospital clinics. The clinics provide minimal care at best and usually involve long hours of waiting.

When doctors do consent to fill out the forms for you, even they don't always check to make sure that all the details are filled in correctly. When it comes to filling out forms, three different social security staff members will give you three different answers. Of all people, they are supposed to know what's going on! Senator Eagleton, from Missouri, Special Subcommittee on Aging of the Senate, states that it is estimated that in 1971, only 37% of our bills will be paid by medicare.

Medicare at this point, does not include the wife of a retired man on medicare unless she, too, is 65. Yet on a retirement income, he cannot afford hospitalization insurance; and if she were to become ill, he would be financially wiped out.

One more point. Medicare covers only illness. It makes no consideration for preventive care, regular physical examinations, flu shots—anything that might help us prevent getting any sicker or avoid crisis situations. We want medical coverage that will help us get well—but we also want coverage that will help us stay well!

TESTIMONY ON NATIONAL HEALTH CARE BY MISS MOLLY BRUDNICK,
GRADUATE STUDENT IN SOCIAL WORK, CLEVELAND, OHIO

I have come here today in appreciation of both Congressman Vanik's invitation and our shared concern for the health needs of all people. The following testimony gives evidence of my recognition of the need for a Comprehensive National Health Care Plan. My experience in working as a social worker has illuminated the crisis in health care today.

My background includes 2½ years as a social worker in public assistance in California, 8 months as a medical social worker at Hadassah Medical Center—Jerusalem, one semester's student experience as a youth counselor with Ohio Youth Commission, and from January, 1971, to the present, working 3 days a week at Cleveland hospitals in Social Service.

My focus of concern today is the chronically ill person, many of whom would not be chronically ill had there been adequate preventive services to diagnose and prevent their current disability. I believe that a National Health Care Program should provide, in addition to preventive care, comprehensive treatment, rehabilitation services, and social services, no matter what the person's financial status, race, and religion. Access to such care is the right and responsibility of every human being and should be available wherever and whenever needed.

One of the major barriers to adequate care is the residence requirement. For example, you may have read in the local papers recently about a 22 year old

woman, paralyzed from the waist down who came to Cleveland from Akron in 1969. This woman was denied admission for many months to a long-term care facility in Cuyahoga County for much needed rehabilitative services to restore maximum physical functioning. The reason for denial was that she had not lived in the County for a year without public assistance. It was only after Legal Aid attorneys informed the Hospital that this requirement was unconstitutional was she admitted. I advocate a National Health Care Plan which would eliminate such local and regional restrictions.

However, the loss a person suffers in being chronically ill cannot be measured only as a matter of physical impairment; it must also be seen as a psychological loss to the patient and his family, as well as a loss to the community of the patient's productivity. Therefore, another point of greatest importance is that a National Health Care Plan must be a coordinated multi-disciplinary approach to both the planning and provision of adequate care for the individual patient.

An example of the needless frustration a person suffers due to the lack of such a comprehensive plan is the situation of Mr. F., a man in his late thirties who is disabled due to a severe disc problem. He has a wife and five children and they live on ADC and what his wife can earn in a part-time job. In looking at the services to which Mr. F. is entitled and which he needs to maximize both his physical and mental health, his social worker found many gaps.

Mr. F. is not receiving Workmen's Compensation because his physician plans to hospitalize him in the near future, for traction and treatment; the doctor is waiting to hear from the Workmen's Compensation authorities as to when the man will be covered by them for the hospitalization. It will take 3 months of processing before Mr. F. receives Social Security Disability payments. The State of Ohio Bureau of Vocational Rehabilitation said that, due to a shortage of staff, it will take 5 months before Mr. F. can begin an educational or retraining program through them.

A National Health Care Plan must provide for new approaches to delivery and financing of health care and not just extension of present programs which purport to meet the needs of low-income, poverty level and medically indigent persons, such as the Medicaid and Medicare programs do. These programs are most inadequate. They admit to eligibility only a small proportion of the population they set out to serve and they do not cover all of the medical needs of people who are considered eligible. Fragmentation of services is exemplified by Home Health Care in relation to Medicare subscribers, less than 3% of whom are reimbursed. Also, Medicare does not cover the age-ineligible spouse of a subscriber to that program; this means that the couple's retirement income must be used to meet the medical expense of the uncovered spouse. The tremendous drain that uncovered medical expenses can be on any income is illustrated by a Cuyahoga County long-term care facility's all-inclusive care rate of \$100 per day or a Cleveland private hospital's rate of \$90 per day excluding laboratory work or doctors' fees.

The question is not whether we can afford a comprehensive National Health Care Program. We cannot afford not to have one. Anyone can become chronically ill—including you and me. This would be devastating to our families, both emotionally and financially with the present health care "non-system".

Take the example of the 45 year old auto plant foreman whose story was in the New York Times earlier this year. He has a wife and two children. Due to an accident he requires kidney dialysis at a hospital 3 days a week, at \$1300. per month, for life. Though his wife is working, they certainly cannot afford his \$15,000. a year medical bill and his insurance only covers up to \$50,000. for catastrophic illness. So, he plans to move to Canada in time to pave the way for his receiving services under the Canadian government's program when his insurance runs out.

We, as the people, have a common cause to see that our tax money goes to the common good. Opponents of a Comprehensive National Health Care Program say that we cannot afford it, yet at the same time it is well-known that multiples of the legal \$55,000. in farm subsidies are paid to people such as a well-known movie star and a Senator who know how to finesse the system. We must set priorities in determining the use of our tax funds and I believe that we must make a Comprehensive National Health Care Program our top priority.

This testimony points to the need for a National Health Care plan—and of course everyone realizes we need a vast change in our present system. The basic unanswered question here is, how we will raise the 63 to 70 billion dollars, it will cost in the first year alone. There are many things people need—better housing, cleaner cities, better health care. The question is, how do we get them?

STATEMENT OF MAUREEN DEBENEK, SENIOR NURSING STUDENT, ST. JOHN'S
COLLEGE, CLEVELAND

As a senior nursing student I have become acutely aware of the shortcomings in the present health care delivery system. There exists a need for comprehensive health care services of the quality that this country is capable of providing but up until now has been unable to render.

In reviewing the current proposals that have been introduced either in the House of Representatives or the Senate I find only one that comes close to meeting the needs of the people and that is the bill introduced by Senator Edward Kennedy. This bill is the most comprehensive, providing all citizens complete coverage of the majority of their health needs. It eliminates out-of-pocket expenses and encourages group practice in an effort to minimize fragmentation.

However, there are some disadvantages and these include: 1) financing—which still places the brunt of the payments (60%) on the working class people; 2) control of the system is given to the government rather than to the consumers and provides jointly; 3) other limitations on dental care, mental health coverage, and prescription drugs; 4) and lastly it does not specifically affirm that health care is a right and not a privilege enjoyed by a select few.

In order to consider any proposal seriously, it must be founded on the idea that health care is a right and not a privilege. This means that health care cannot be bought and sold as a commodity. Health care must be established as a service and not as a profit making enterprise.

I feel an urgent need to revamp the existing health care delivery system which does not meet the needs of the people it serves. The system is inadequate because it essentially remains disease-oriented with little emphasis on prevention, and preventative medicine. Health insurance is actually hospital insurance—you must be sick in order to collect.

All the health insurance proposals had various limitations on the type of coverage or the people eligible to receive the services. If quality health care is recognized as a right, limitations have no place in a program dedicated to the promotion of health and welfare of all citizens.

Small but courageous attempts have been made to provide personalized, community-controlled care that is easily accessible and available to all. These are the free clinics that have developed in all major cities from coast to coast. They have in no way solved the problem but serve as examples for what can be possible on a much larger scale.

Unfortunately I have no statistics to illustrate the inadequacies and inequalities inherent in the present health care system, but I am not so sure that what I have seen and experienced can be neatly compiled into columns and rows of figures of statistical data.

I have worked in hospitals where the ratio of nursing personnel to patients was such that I could only give the basic essentials of nursing care involving personal hygiene and prescribed treatments. There was no time to sit and talk with the patient as a person or do any health teaching.

I am presently taking my public health experience in nursing where only the student nurses make home visits. Due to the cutback in funds the nursing personnel had to be reduced to such a degree that they could only cover the health of the community by using the telephone as a means to promote good health practices. You will find no statistical data on the number of people in a certain community of lower socio-economic status whose faces reflect the apathy and resignation to their state in life.

The state mental hospitals are worse. They have become the dumping ground for alcoholics, drug abusers, and overflow psychiatric patients from other mental institutions. In some of the wards the doctor/patient ratio was approximately 1:200, and many of these doctors were medical doctors and not qualified psychiatrists. In these large institutions the individual patient loses his sense of worth and when he did exhibit signs of ego strength by getting angry an injection of Thorazine is quickly administered.

The struggle within the professional bureaucracy itself has contributed to the fragmentation of patient care. Redefining the role of the professional nurse in relation to the doctor has become a controversial subject. Each is striving for autonomy while in the meantime the patient suffers.

The present health care system has not met the needs the needs of patients which include reduction of cost, accessibility, personalized, total patient care, some voice and control of the institutions that provide health services.

In conclusion I would like to say that we definitely must change the existing health care delivery system to one that is responsive to the previously mentioned needs of the health consumer. The only bill I see as significantly meeting these requirements is the Kennedy bill.

BASIS FOR A PROPOSAL FOR AN ADEQUATE HEALTH CARE SYSTEM

(Jerome Lieberman, M.D.—University Hospital and Medical Committee for Human Rights)

In 1971 it is finally becoming clear to most everyone that our system of health care in the United States is inadequate. Though obviously some will deny this statement, there are others who will state that the word "inadequate" itself is unsatisfactory to describe the remarkable inefficiencies and inequities.

In the United States we have the highest per capita expenditure for health care in the world, yet if we compare mortality rates with those of other developed countries, we do not score well. This parameter of poor care holds for the affluent as well as the poor, which is not to say that there isn't a remarkable difference between the two. It has been estimated that as much as one-third of our population, mainly urban ghetto and rural, gets crisis care at best. Infant mortality, always a sensitive indicator, has in the past decade become even more remarkably higher in the poor than among the affluent. A recent estimate of the increase in the difference was 90%; and despite all this, and despite the fact that no one would dare today make a statement such that medical care is a privilege and not a right, there are some who implore that we cannot *afford* to have adequate care for all.

It is well known that the official AMA positions in health care have traditionally tended to favor the rights of the physician rather than the patient. But this has not always been the case, for an AMA legislative body in 1919 passed a resolution favoring the development of a national health care system for all. Obviously the traditional attitudes are not universal to all physicians nor for all official health worker organizations. The Physicians Forum, a scholarly, liberal, nonactivist group has been in operation since the 1930's, while the "Physicians for Social Responsibility" and the most activist "Medical Committee for Human Rights" have been in operation in the 1960's.

The federal government has been officially involved with health care only since 1935, when attempts to provide some services as part of the Social Security Act were ineffective. The well known Wagner Murray Dingle bill of 1948 was a national health insurance plan, but it never made it out of committee. At that time there was no administration support, but in 1948, despite President Truman's desires, the bill failed once again. The Hill-Burton act of 1946 has provided 11 billion dollars in matching funds to help 3700 communities build hospitals and other health facilities. Finally, in 1965, after a tremendous battle with the American Medical Association, Title XVIII, the Medicare Bill, became law. But coverage was limited to the elderly and it is a health insurance plan administered by private insurance companies. It has filled a great need, but it has been inefficient (to be admitted to a nursing home, the patient must first spend time in a regular hospital) and it is mainly for inpatient care. Title XIX, the Medicaid Bill, was poorly conceived, designed to give certain types of care only to certain types of indigent groups (the care to be comprehensive by 1975), involved means tests, and was left up to the individual states to run. The expense for those states, such as New York which has tried to do the job right as part of today's health care system, has been fantastic. Other states, such as Ohio, merely used the money to run already existing limited programs so that the State saved money.

The Finch-Eggeberg report of 1969 stated "What is ultimately at stake is the pluralistic independent voluntary nature of our health care system. We will lose it to pressures for monolithic government-dominated medical care unless we can make that system work for everyone in this nation." On March 25, 1970, Mr. Finch said that H.E.W. proposes to amend Title XVIII so that Medicare beneficiaries may select comprehensive health care through a prepaid group practice. But since then all we have heard from the administration is the Nixon-AMA plan called Mediredit wherein federal income tax credits would be awarded to those individuals and families who voluntarily purchased health coverage from approved private insurance companies. More recently, there has also been a non-specific urging of development of group practice plans presumably with some

financial help in getting started. Clearly, the 1969 Finch-Egeberg statement above will be the administration's guide in the coming battle.

The problems of some of the major National Health Insurance plans so far proposed have been incisively discussed in an article, "National Health Insurance—American Dream or Scheme", written by Dr. Oliver Fein in the January, 1970 Health-Pac Bulletin. The plans were summarized by Dr. Fein as reproduced below :

	AMA plan	Rockefeller plan	Reuther plan
Reorganization of health care delivery system.	None.....	None.....	Pushes reorganization but allows physician to choose reimbursement mechanism (fee-for-service).
Use of private insurance companies.	Rely entirely on Blue Cross and the commercial companies;	Rely entirely on Blue Cross and the commercial companies.	Probably will rely on Blue Cross and/or commercial for administration.
Cost control mechanisms.	None.....	Might institute some cost controls but little discussion of mechanisms to prevent hospital workers' wages from being frozen and to hold down profits of hospital supply and equipment industries.	Might institute some cost controls but little discussion of mechanisms to prevent hospital workers' wages from being frozen and to hold down profits of hospital supply and equipment industries.
Taxation base.....	Progressively based income tax credits.	Regressively based employer-employee taxes with supplemental support from general sources.	Regressively based employer-employee taxes with supplemental support from general sources.
Community/consumer participation.	None.....	None.....	Token National Advisory Board.
Changes in existing programs.	Medicare and probably Medicaid unchanged.	Medicare unchanged; Medicaid eliminated.	Medicare and Medicaid absorbed into NHI without loss of benefits.
Universal coverage.....	Only taxpayers.....	All citizens.....	All residents living in US, including Mexican migrant workers, etc.
Comprehensive coverage.	Unclear. Probably minimal coverage of hospital and doctor services.	Unclear. Probably minimal coverage of hospital and doctor services	Advocates inclusion of prescription drugs and dental care, but undecided about introducing these all at once or in stages.

At this point it is pertinent to discuss aspects of eight features to help us decide whether a national health insurance program is good or bad. Some of these features are being considered by the Medical Committee for Human Rights in developing their own health care program proposal.

I. Financing.—The health care plan must be paid for using a progressive graduated tax structure so that the wealthy pay more than the poor. There must not be a regressive tax structure which puts a tremendous burden on the poor and lower middle economic classes.

II. Health Benefits covered.—Total care must be provided, including dental care. The number of hospital days must not be limited.

III. Out of Pocket Expenses.—The concept of deductibles is unfair to the poor, who may not be able to pay the first \$50 or \$100. The concept of co-insurance is also unacceptable, wherein the patient pays 20% of all expenses. In each case, the patient who is well off is happy not to have a large expense, but the poor cannot afford any expense.

IV. Cost Control.—Medicare has been partially responsible for the tremendous recent medical care inflation. Some drug houses and nursing homes have apparently been realizing tremendous profits. Making profit out of others' misfortune has been condoned for too long. Third party payers (commercial insurance companies and Blue Cross) add tremendously to the cost. Involvement of consumers would help, but this is a complex issue.

V. Quality Control.—There is no inherent control of the quality of medical care. There is no mechanism for peer review of physicians, dentists and other health workers. A plan involving trained consumers in each locality guided by clearly defined standards might be very helpful. This is another very complex and even more difficult issue.

VI. Health Manpower.—The health worker shortage is tremendous, made more so because the majority of physicians work alone. At the present time, complete

comprehensive health care is, therefore, not yet possible. On the other hand, even now we could do a great deal better if the distribution of health workers was more acceptable. There are over 20 counties in Georgia, for example, without a physician.

VII. Organization of Health Care.—At the present there is essentially no organization of health care. There are large numbers of fine physicians, but they are rarely where the poor are. There are also large numbers of fine hospital centers. Sometimes the fine hospitals are a few blocks from each other. Clearly, some sort of regional system must be devised with neighborhood health facilities (primary care centers) linked to hospitals. The regional system must be organized not according to geography but according to population, so that each population group has the same facilities.

VIII. Control of the Health Care System.—At present control is solely in the hands of the providers of health care. Therefore, though it is not solely conscious, their own needs may be prime, while the patients' needs may be secondary. Obviously, the federal government is going to have to be involved, but this should be as little as possible. A coalition of the consumers and the providers should have the most say in the operations of the system.

The two most discussed proposals are the AMA-Medicredit Plan, backed by President Nixon, and the Reuther Plan, the basis of the Kennedy Bill.

AMA-Nixon Plan.—The one promising aspect of it is that the method of payment, involving tax credits, is progressive, but this, as well as other related conservative proposals, provide lower income groups with help in purchasing entirely inadequate and inflationary commercial insurance coverage, so that they can obtain medical care through the same fragmented and inaccessible system. Let us consider the eight points made above:

- I. The middle income groups bear the brunt of the tax burden.
- II. The insurance covers 60 days of hospitalization, limited outpatient and nursing home care, no dental services, and no medication.
- III. The patient must pay \$50 of each hospital stay and 20% of the first \$500. The poor lose out.
- IV. There is no cost control.
- V. Quality is monitored only by a board of physicians.
- VI. There are no provisions for increasing health manpower.
- VII. There is no change in the organization of services.
- VIII. Control of the health system remains entirely in the hands of the health providers.

For those who pay no income taxes, Medicaid would have to be retained. In some states, Ohio, for example, where Medicaid provides very little, care for certain poor will necessarily remain meager.

THE REUTHER-KENNEDY PLAN (THE HEALTH SECURITY PROGRAM)

This is the most satisfactory of the plans brought forward, but even though it is greatly improved over the original Reuther plan as summarized above by Dr. Fein, there are still grave deficiencies.

All residents would be enrolled and care would be without cost, and without deductibles. Dental care, however, would be paid only for children, only certain drugs would be free, only five days of psychiatric hospital treatment would be allowed, and only 120 days of nursing home care would be allowed. The financing would be very complicated with 50% of the funds coming from general Federal revenues, 36% from an employer payroll tax of 3.5%, 12% from a 1% employee payroll tax based on the first \$15,000 of income, and the remainder from a 2.5% tax of the self-employed. Costs and policy would be under the control of a Health Security Board with regional branches. A fund would also be created to encourage group practice and to help train family physicians. The commercial health insurers, including Medicaid and Medicare, would be eliminated.

Let us consider the eight points once again:

- I. The financing system is regressive with a social security type of mechanism for collecting much of the revenue, meaning that lower income workers pay a higher percentage of their income. Someone earning \$30,000, for example, pays no more than a worker earning \$15,000.
- II. There is no dental care for adults, there are limitations in drugs, and psychiatric care is inadequate. Otherwise, the health benefits are quite comprehensive.

III. There are no out of pocket expenses. Excellent.

IV. The Health Security Board controls the cost, presumably by budgeting fixed amounts to regional areas. The providers do not have any say about the costs, but neither do the consumers. The combination of lobbying by the drug industry and a lack of appreciation for needs to particular geographical areas could mean underfinancing by the congressionally influenced board to certain areas while the drug industry continues to make its profits.

V. *Quality Control.* Once again, as with cost control, the Health Security Board with its regional offices can provide a good start, but once again where are the consumers?

VI. *Health Manpower Needs.* The funds and the specific plans for training additional health manpower are not truly in the bill.

VII. The urgency of the development of group practice and other health care reorganizations is very nonspecific.

VIII. Control of the system is in the federal government, not the providers. Consumers are only minimally part of the Health Security Board as advisers. Thus, though this is an improvement over the control being in the hands of the providers, to have purely federal control is obviously also undesirable.

An Adequate Proposal.—A change in the health care system must be gradual, but it must begin almost immediately. The stress must also be that the poor must get exactly the same care as the affluent.

I. *Financing.* A graduated, loophole-free income tax separate from general revenues with the funds purely for health is essential. The greater the income, the more you must pay and if your income is minimal, there must be no cost.

II. Health benefits must be comprehensive.

III. There must be no out of pocket expenses.

IV-VIII. The system of health care must not be fragmented. Furthermore, we must not lose sight of the needs for teaching and research. The system must, therefore, coordinate patient care, teaching and research. The control of the system must be from a mixture of health workers and health administrators to provide expertise plus consumers. A National Health Service should be organized. There should then be regional services based not on geography or the states per se, but on population units. There should then be a division into a series of smaller population units within each region and, finally, into the smallest community population units where primary care is given. In Montana, the area would be large, but in New York City, it would be small. All care would be given in groups. The primary care centers would be where the people are, but they would really be part of a medical center complex. Since the centers for teaching not only physicians, dentists and nurses, but all health workers would be part of the medical center complexes and since the primary care centers and the community hospitals would also be part of the medical center complexes, then patient care and teaching would be integrated. Since research activities of all types would also be part of the medical center complexes, it could be organized such that all three activities are integrated. Research could still be esoteric, but it would mainly be relevant and related to the problems of health care. A transportation network must be linked to the health care system so that a poor dirt farmer in Mississippi, for example, could be taken where he needs to (perhaps by helicopter) as readily as a wealthy businessman living in New York City.

Each health unit, from the primary care center up to the largest national unit in Washington, must be in the hands of a board of control, that includes a well thought out mixture of health workers, administrators and consumers.

All health care students must get their education without cost and each regional population unit must have the same number of medical centers and teaching units. Therefore, since most people will get their education near where they live, there is a much greater chance that the health workers, on completing their education will work where they live. Gradually, an even distribution of health care will then be possible.

One final principle must be reiterated. Health care is different in this country for the affluent and the poor. No plans for an adequate health care system can be meaningful unless everything possible is done so that all care for everyone everywhere is the same. Therefore, it is likely that such elements of our economy as a health unit of the transportation system, the pharmaceutical industry, and hospital supply companies will have to be nationalized and included in the health care system.

STATEMENT OF OHIO OCCUPATIONAL THERAPY ASSOCIATION, INC.: CLEVELAND DISTRICT TO PUBLIC HEARINGS ON PROPOSED HEALTH INSURANCE LEGISLATION

Congressman Vanik: The Cleveland District of the Ohio Occupational Therapy Association, Inc. welcomes and appreciates the opportunity to voice its comments on the pressing current issue of national health insurance, prior to congressional consideration of the various proposed pieces of legislation before the Ways and Means Committee of the House of Representatives.

My name is Marlene Sulteanu, and as Legislation Chairman of the Cleveland District, I have been asked to be its voice. We are an affiliate of the American Occupational Therapy Association, which has submitted written testimony into the record of the Ways and Means Committee. Since that testimony is available to you, and since it details many excellent, thorough, and all-encompassing observations and suggestions, we do not intend to reiterate its points. Instead, in full support of that testimony, we have chosen to try to help you read between its lines with *our* interpretation of its underlying rationale, directed by our experiences in this community. We assume and hope that those experiences and resultant viewpoints will be helpful to you.

To begin such setting of a stage, we offer a terribly unofficial, yet a tested and proven definition of our profession. Occupational therapy is a treatment, a service to persons of all ages whose life style has been or may be influenced by disability. When we say life style influenced by disability, we refer to the highly individualized and varying effects of almost any identifiable medical condition on the equally individualized patterns of their victims' daily living situations. That is, occupational therapy concerns itself with how a client or patient views the effects of his or her problems on his or her own particular life style.

To exemplify how O.T. concerns itself with the influence of disability on life styles, here are some common situations. Occupational therapy does not ask only, "Will this woman survive her stroke?" but rather, "What techniques can we teach her so that she can take care of herself, her family, and her household—despite whatever disability may remain when this life-threatening crisis is passed?" Another example might be, occupational therapy does not ask only, "Is this young man's addiction under control?" but rather, "Can we evaluate his vocational and social skills sufficiently to provide him with the ability to cope with those stresses which might cause his return to drugs?" Or, occupational therapy does not ask only, "Will this businessman survive another heart attack?" but rather, "How can we help him find satisfaction in more sedentary activities, to prevent another heart attack?" Or, occupational therapy does not ask only, "How will this child's learning disability affect his academic success?" but also, "How can we help him and his family structure daily situations to avoid failure experiences?" Or, occupational therapy does not say, "Poor old lady will probably have to end her days in a nursing home," but rather, "Let us show the old lady that she can maintain interest in and continue to contribute to the society in which she lives."

We could ramble on and on with such examples. They are used only to serve a purpose. This definition and its brief examples are intended to demonstrate that throughout its more than fifty years, the profession of occupational therapy has directed itself to giving meaning to the mere fact of living, has stressed meaningful productivity, with health concurrently both its goal and its prerequisite. Occupational therapy's unique contribution in the health care system has been viewed by some as a luxury treatment, a service beyond traditional medical concerns, when health has been defined as the state of being alive, when the health care system concerned itself only with the maintenance of the ability to breathe or only with the value of "normalcy". It is time that those who control the purse strings of the health care system recognize that society has long since outgrown that stage of medicine. It is time to acknowledge that human worth rests not in one's ability to look and act like everyone else, and certainly does not rest in surviving a blow to one's physical normalcy, only to remain dependent on family and/or society as a whole. It is time to put a value on human worth that gives depth and breadth to the rhetoric about "quality of life". It is time to reorder our priorities so that quality is the value; time to view health in its broad definitions—beyond mere physical well-being; to include emotional, social, and economic well-being—and time to consider such health as an inalienable human right.

Then, when *quality of life* is the reordered priority, when *human worth* is the concern of the delivery of health services, occupational therapy, as we have defined it for you, becomes not a superfluous luxury but a vital necessity in the attainment of the goal of each client's or patient's physical, emotional, social, and economic health.

Then, when quality of life and human dignity are the values dictating where money is spent, it becomes incumbent on any health insurance system to assure that anyone whose physical, emotional, social and/or economic health is threatened can face that threat with security. Then, further, when health is seen as an inalienable human right, it follows that a federally-sponsored health insurance system must assure uniform, comprehensive coverage, with standards of care established for all, equally, throughout the country.

This brings us to the chicken-and-egg-type question so often recurrent in discussions of providing for "inalienable human rights". Can government legislate to morality or ethics or values? We have said here that society has already surpassed legislation in giving high priority to quality of life and to the value of human worth and dignity. Whether or not you agree with that contention, it seems fair to conclude that the time is ripe for legislation that will put credibility into the popular rhetoric that claims to value quality of life. It seems fair to assume that it is now safe to try to give to health its due position of priority— as prerequisite to any other rights' being met satisfactorily.

Thus, we see this as the unique responsibility before the Ways and Means Committee of the House of Representatives. And we see the proposed legislation, and these times, as providing the unique opportunity for fulfilling that responsibility. We charge you with putting depth and breadth into the phrase "quality of life" and with making it a realistic value rather than merely convenient rhetoric. If quality rather than the mere fact of life is built into the health insurance legislation that comes out of your committee, it follows that, as detailed in the testimony submitted by the American Occupational Therapy Association,

a. there will be uniform coverage and standards of care for comprehensive services, oriented to the total human being rather than to his or her diagnosed ailment;

b. the likelihood of health professionals feeling frustrated by legislative limits will be decreased (for example, coverage of transportation costs and home health care would assure access to indicated services and/or facilities);

c. there would be a marked decrease in the incidence of abuses, since utilization review mechanisms would feel no need to cheat in order to obtain payment for services felt vital but not covered; and

d. we would see less dependency on family and on society following catastrophic illness or following the onset of chronic illness, with corresponding increase in productive, self-sufficient contributors to society.

We feel confident that your committee will accept our charge to responsibility for such legislation not as a challenge, but as a just, appropriate and timely opportunity to assure health as an inalienable human right, to reorder priorities so that health is a *primary* value in modern American society.

Thanking you for allowing us to express these views.

STATEMENT FOR HEARINGS ON NATIONAL HEALTH INSURANCE PROPOSALS

THE CLEVELAND SOCIETY FOR THE BLIND,
Cleveland, Ohio.

The Prevention of Blindness Services, The Cleveland Society for the Blind, encourages that any final bill adopted include provision for existing prevention agencies to continue and expand their screening and education programs.

The current Medicare coverage, from the point of preventing blindness, does not cover routine checkups. Recent figures show sixty new blind every day, half of which is preventable.

People experienced in delivery of medical services readily acknowledge that even the most modest National Health Insurance Proposal will, if adopted, place a fearsome burden on an already over-worked and under-staffed medical community. We cite the ophthalmologists in our area, with bookings three to four months ahead common among the more experienced doctors.

We point with pride to more than 1,800 volunteers trained in a preschool vision screening program by the Prevention of Blindness staff, The Cleveland Society for the Blind, who last year screened 18,282 youngsters. 307 of these children were referred for professional evaluation and care. 85% of those referred have had eye examinations to date and 180 of this number have eye problems requiring treatment or observation.

In the prevention of blindness we believe that screening serves two purposes:

1. Education for better eye health and safety on a personal and community level.

2. Service to the individual referred for evaluation and/or care.

Please remember that every volunteer who participated in the six-hour training to do this important community service knows a good bit more about eye health and care for herself and her family. Every adult who brought one of those 18,282 youngsters for screening had just a little of that same information in the screening routine. Day Care Center personnel, Headstart Mothers, mothers of retarded children, PTA volunteers, Delta Gamma Alumni are all represented in the volunteer-learning-participation group. Any long term health care bill needs education for personal motivation to the wise use of medical service.

This program is supervised by the Prevention of Blindness Committee, The Cleveland Society for the Blind, chaired by Mrs. Clark E. Bruner, with Dr. Webb P. Chamberlain, co-chairman, and membership of local professionals and lay people truly interested in children's vision.

The adult screening program under the auspices of this same group has screened more than 5,000 persons this year for glaucoma. Rightly called the sneak thief of sight, this sight destroying disease moves slowly in its chronic form to cause blindness if unchecked.

Because there are few early symptoms to hurry a person off to the eye doctor simple screening is an effective way to get those persons with a high tension or suspicious reading to the medical eye doctor.

More than 180 people have been referred for evaluation and care. 43 new glaucomas and suspicious have been sent to doctors. 7 other problems from refractive errors to cataracts and diabetic retinopathy have been diagnosed. Truly this is a prevention of blindness. Education is important here too—especially in the over 35 group. Extensive public education has preceded each screening in such diverse setting as Golden Age Housing Metropolitan General Hospital employees, City Hall employees, parents of junior and senior high school children in North Olmstead, Richmond Heights and tonight, Maple Heights.

Because tonometry is a doctor supervised and professionally administered tests fewer volunteers are needed. However, setting the programs up in community, industry or special places, involves a good many people in the "what and who" of glaucoma.

Isn't the voluntary agency, working to educate and eliminate handicapping and killing disease important to our way of life?

Any national health insurance should support and encourage screening and prevention services.

STATEMENT BY ROZELLA M. SCHLOTFELDT, PH. D., R.N. DEAN, SCHOOL OF NURSING, CASE WESTERN RESERVE UNIVERSITY

Congressman Vanik and Congressman Betts: I am Rozella Schlotfeldt, a nurse educator and Dean of Case Western Reserve University's School of Nursing. I appreciate having this opportunity to have input into deliberations of the House Ways and Means Committee as they relate to National Health Care Proposals. I wish to enunciate some general observations and principles, rather than to speak specifically to the content of any of the several bills now before the Committee.

Firstly, it is regrettable, but true, that people generally do not seek health; instead people generally seek relief from their ills. I say that this is regrettable because it reinforces the tendency of legislative endeavors to encourage massive and increasing expenditures for sickness care and for support of heroic efforts to seek cures for ills while there are limited efforts and expenditures on a system of care that holds promise of keeping people healthy. I note that the several pieces of legislation now before the Committee are concerned primarily with guarantee of sickness care through various schemes of providing financial subsidy for such care. There is a tendency to equate the terms Health Care and

Medical Care, when the latter term means primarily treatment for people who are ill or injured. The two terms are, of course, not synonymous. Our people need health care as well as sickness care. In my view nurses and physicians must be colleagues in providing such care, with nurses utilizing their talents primarily in helping people to attain, retain, or regain maximum health and function while doctors utilize their talents primarily in seeking to diagnose and cure illness. Wise use of the competencies of both will assure an efficient and effective system of comprehensive care.

Secondly, I wish to endorse a pluralistic approach to providing programs of health and sickness care for our very diverse population. In our great democracy there must always be opportunities for citizens to choose from among several payment plans. The fundamental criterion to be fulfilled is that *access* to health and sickness care must be provided for all citizens regardless of their social or economic circumstances.

Thirdly, the nature of health and sickness care henceforth to be made available must be of uniformly high quality, regardless of the diversity of payment plans through which it is provided.

Fourthly, if universal entitlement for health and sickness care is henceforth to be assured then there must be adequate and prior attention to legislation that will assure adequate manpower and womanpower to deliver such care. We must not be in a position of promising that which cannot be delivered. Reasonable subsidy of educational programs that prepare key health professionals and their technical assistants must be assured. Success can be had in planning and executing a program that emphasizes high quality health and sickness care with all people valuing and having ready access to both and with options of varying approaches to paying for such services. The *sine qua non* is, of course, assuring that there are well trained, competent, concerned dentists, physicians and nurses and allied personnel in sufficient numbers to provide those services. Reasonable subsidy of educational programs as well as adequate financial support for students must be provided through legislation in our national congress inasmuch as a healthy population is indeed one of our greatest national assets.

Thank you for this opportunity to speak to these very vital issues. It is here that I add my very grave concern about news that was released last night at the 75th Anniversary dinner celebration of the American Nurses' Association. Congressman Rogers released to the group assembled that the Nurse Training Act of 1971, just passed in the Federal Congress to authorize capitation grants was "Slapped" in the Office of Management and Budget and that we in Nursing could anticipate no support for appropriations to fund that portion of the legislation. If irked Congressman Rogers is correct, then our own School—a leadership school in this State and Nation, faces a bleak future—and so does the Nation anticipating health care that cannot be delivered without nurses.

STATEMENT OF JOHN DEVITO, CHAIRMAN, RETIRED WORKERS' CHAPTER OF LOCAL 45, UAW

My name is John DeVito. I am Chairman of the Retired Workers' Chapter of Local 45, UAW and also Vice President of the International Advisory Council of the UAW representing 250 thousand UAW Retirees in 472 chapters that work with our Union, the UAW, in collective-bargaining, on the picket line, in the halls of Congress, and at the ballot box.

We are also affiliated with the National Council of Senior Citizens, three million strong, and we identify ourselves with the 20 million senior citizens in America who are receiving Social Security and are in Medicare.

Health care is the hottest issue in the country today. Out of the 20 million on Social Security, 17 million of our Senior Citizens today live on a Social Security check only averaging \$120 a month, and five million of this figure live below the poverty level with this number raising 200 thousand every year.

With millions of Senior Citizens on a fixed income, it is obvious they are on a treadmill of frustration, confusion, and despair, trying to make both ends meet and pay medical bills that keep going up and up and up. It is like trying to hold back the ocean with their bare hands.

We in the UAW are backing the late Walter Reuther's program of National Health Security which was set up with a committee of 100 prominent people across the country, including 25 doctors and dentists, who studied health care

from every different facet for two years, Leonard Woodcock is the chairman of this committee now.

The National Health Security program was introduced in the Senate by Senator Edward Kennedy as Senate Bill #8 is cosponsored by 25 Senators, Democrat and Republican. It was introduced in the House of Representatives by Martha Griffiths as House Bill #22 and #23 and is cosponsored by 75 Representatives, Democrat and Republican.

We spent \$70 billion in health care last year and still 30 million people in America were not covered at all. With the National Health Security program #8 and #22, we could have covered every man, woman, and child in America for \$47 billion because our plan would be more efficient. Preventive health care would reduce hospital care, and unnecessary operations. Checkups, flu shots, Pap tests, X-ray, blood tests, etc. would keep Americans healthy before they become seriously ill.

We in the UAW have had the best Blue Cross coverage in the last 20 years and still find it inadequate. Twenty years ago we paid 5¢ an hour for health care in our contract. Today health care costs 30¢ an hour and we are still paying bills, because Blue Cross does not give full coverage like a Health Security program would.

General Motors in its booklets shows Blue Cross and Blue Shield is not the great protector of health that it claims to be. G.M. protects its salaried employes with three layers of health care, Blue Cross and Blue Shield, Health Service, Inc., and Connecticut General Insurance.

A Michigan employee's wife in the hospital for an abdominal operation has a bill of \$1,270.00. Blue Cross pays \$856.00 of this bill for both the salaried and hourly rated worker. Health Service pays \$80.00 and Connecticut General pays \$363.00 for the salaried worker and he pays \$152.00 under the \$100 deductible plan. The hourly rated worker with Blue Cross coverage only pays \$428.00 or three times as much.

In Delaware a patient with a heart condition who is in the hospital for 31 days with no surgery would receive a bill of \$1,688.00. Blue Cross would pay \$1,086.00 of this bill for both the salaried and hourly rated worker. The salaried worker would also have \$602.00 of the bill paid by his other coverage. He would pay \$190.00 while the hourly rated worker would pay \$602.00, three times more.

In Michigan an employee being treated for a liver infection over a period of two years with hospitalization and surgery not required would have physician's bill and drug charges of \$1,374.00. Blue Cross, of course, would pay nothing but the salaried worker's other coverage would pay \$939.20 and the salaried worker would pay \$434.80. The hourly rated employee would pay the entire \$1,374.00. As you can see Blue Cross coverage alone does not hold up here.

As reported in the Wall Street Journal, April 8, 1970, Mrs. Henry Nelson of Milwaukee (77 years old) had a stroke and spent 31 days in the hospital. Medicare paid the full bill for this. She then was sent to a nursing home for 60 days. Under Medicare the first 20 days were free and the next 40 days called for \$6.50 a day or \$260.00. Her husband received a bill for \$1,616.75 because the Social Security Administration said it should have been custodial care. Her husband was receiving \$130.00 a month from Social Security which then deducted \$50.00 a month from his check and he will continue to receive \$80.00 a month for 32 months until this bill is paid. This is outrageous. This is President Nixon's tighten up program. Rejections have jumped from 2% in 1968 to 7.2% in 1969 and will be higher in 1970 and 1971. The doctor and nursing home made the arrangements for Mrs. Nelson and told her she was protected and yet Mr. Nelson is paying \$1,616.75 at \$50.00 a month.

With Medicare costs going up and up and up on the one hand and benefits being denied on the other hand, the Senior Citizen is in a terrible mess.

Many of us in the UAW in Cleveland belong to the Kaiser Community Health Foundation which operates in the preventive health care area and we don't pay any bills.

Mrs. Josephine Krajec was in St. Vincent's Charity Hospital for three open heart operations. She was in the hospital for over six weeks and had three plastic valves inserted at \$250.00 each. Under Blue Cross she would have paid a few thousand dollars. It didn't cost her one cent.

My wife, Mrs. John DeVito, was in the hospital for three weeks for an operation on a tubercular knee. There were no bills. She didn't have to pay one cent.

John Baines, Virginia Beach, Virginia, has a daughter who was stung by a bee. He had \$10,000 coverage under Blue Cross and in one year and four days, he paid \$57,704.00 and he is still not through. If he was in K.C.H.F., it wouldn't have cost him one cent other than the payment of his premiums.

We are the only large industrial nation in the world without a national health program. We put Germany and Japan flat on their backs in World War II and today they have better health programs than we do.

We think that the time has come when all Americans will fight for and support a national health program and we recommend Senate Bill No. 3 and House Bill No. 22.

The Kaiser plan in 40 years has proven that preventive care is workable and that the National Health Security program which would be financed by the employee, the employer and in the case of the self-employed, 50% by the government, would be a real national health program for all Americans.

In conclusion, we believe that the Senior Citizen in the last 55 years has paid his dues to America by fighting in two World Wars, living through a great depression, building his home, paying taxes, educating his children, sacrificing, and struggling to make America the greatest nation in the world. We Senior Citizens have planted the tree of greatness in America and have the right to pick and eat the fruit in dignity and decency in the twilight of our lives and this can only be true with a National Health Security program for all Americans.

STATEMENT BY REV. MGR. C. S. COLEK, DIRECTOR OF CATHOLIC CHARITIES

As the Director of Catholic Charities of the Diocese of Cleveland, I wish to compliment Congressman Vanik and Congressman Betts for coming to Cleveland in order to hear a cross section of views and opinions in regard to National Health Insurance. I feel quite certain that they will receive frank and honest opinions concerning this all important subject. It is only through such meetings as this that a broad representation of the community has the opportunity of expressing itself.

I do not intend at this particular time to give any particular opinions concerning the proposals that have been brought forth by different groups in respect to national health insurance. I feel quite certain that all of these proposals are based on valid assumptions and observations. The overall position of these proposals is that the present system of meeting the health needs of our citizens is inadequate. Of course, there are many factors which explain, at least partially, the reasons why such a large segment of our population is unable to receive adequate medical attention.

I would only like to point out that it seems most appropriate that serious consideration be given to the establishment of area-wide health planning groups, or organizations, which would have the support and backing of not only local and state governmental units, but also the federal government. A central overall planning group should necessarily be composed of all areas of concern in this total problem of bringing comprehensive medical attention to all the citizens. This means that not only professionals, but also lay men and lay women should be a part of the total planning effort. A very important member of this planning group should be the recipient, or client of service.

There is also the need on the part of this broad planning group to recognize a responsibility of educating the total population as to what a national health insurance plan means and encompasses. One of the greatest difficulties encountered by service agencies in the field of medicare and medicaid has been the inability of groups to understand and appreciate what the programs intended and could do. This thrust in the area of education should not limit itself just to the area of rendering service to people who are acutely ill, but also it should embrace an effort on the part of all concerned to initiate programs of preventive health measures.

A third point, which I believe should be considered with great diligence, is the delivery of service. We are all conscious of the fact that present hospital facilities are overtaxed and understaffed. It is therefore, of paramount importance that there be determined efforts on the part of professional schools of medicine and nursing to develop new educational programs to meet the needs. I believe that the medical profession, as well as the nursing profession, should be complimented on their efforts to develop programs whereby paraprofessionals are

being trained to assume many of the responsibilities formerly done by physicians and nurses. I think it is extremely important that the dental profession is not overlooked in this overall program. It would be somewhat hazardous to concentrate merely on providing medical assistance without providing needed dental services. I sincerely hope that all of us, professional as well as nonprofessional, make every effort to design a program which will take into consideration the needs of all our citizens. But in our haste to develop this program, let us not create a bureaucratic monstrosity that will invalidate the purposes for which such an insurance plan is developed.

OLMSTED FALLS, OHIO.

WHY WE NEED A NAT'L HEALTH PLAN

We are continually told we have the best medical care in the world.

We are continually told Americans are the healthiest people in the world.

But like the song in Porgy and Bess that says "It taint necessarily so".

Let's look at the facts; there are 17 countries now who keep there men alive longer than we do. They all have a national health plan. We don't.

There are 18 countries that have less babies die the first year than we do. They all have a national health plan. We don't.

More American's die during their most productive years than any country in western Europe. For every 100 Americans age 40 only 94 reach age 50. This is double the Swedish death rate and at least 20% higher than a dozen other countries including our Canadian neighbor.

Our women do a little better. They live 7 years longer than their husbands. But in 10 other countries the fair sex lives longer than they do here.

It is estimated by the U.S. Health Dept. 1 million Americans are walking around with syphilis and completely unaware they have it. We now have the highest V.D. rate in the industrial world. Most of the world has a national health plan. We still don't have one.

Today some groups are running around the country screaming a national health plan is socialized medicine. They don't know the difference between socialism and rheumatism. Remember when workmens' comp., unemployment insurance, the T.V.A., social security, unions, and the guaranteed annual wage were all Communist plots and the country was going to hell in a hand basket.

With this kind of poor medical care we would think medical costs should be dropping—but just the opposite is the case.

Our total Medical Bill was \$42.5 Billion in 1966, in '67 it went to 47.8 Bil. and jumped to 53 Bil in 1968 and in '70. it Reached 69 Billion and the Costs are still Rising.

There are hundreds of towns and villages across this land without a doctor in them.

Twenty Years ago a Presidential Commission on the nation's health needs reported a shortage of Doctors which would grow more acute as the Pop. increased. They Recommended Expansion of Medical Schools with Federal Funds. The A.M.A. denied the shortage and Blocked every attempt to Build new schools. The A.M.A. Claimed this would Lead to Government Control. In 1967 the A.M.A. Finally Gave In.

A Study Conducted By the U.S. Senate indicated America should have 600,000 Doctors. We have less than half that many. In many Communities a Doctor is not available at any time. The Wall St Journal Reports that Patients in some localities must Plead up to 1/2 Dozen Doctors Before one will treat them. The Governor of Texas Reports 15 Counties in his state have no Doctor at all.

Today's So Called Health Insurance Puts a Premium on Sickness Rather Than Health, and on Being "Horizontal" Rather than a vertical Patient. This is not Health Insurance. It is sick insurance. That's all most of us have.

The system of prepaid Comprehensive Group Practice Programs is what is needed to fight escalating costs and Deliver Good Medical Care. The Only System that can Supply this is National Health Insurance.

Despite Pressures of the A.M.A. Group Practice is growing About 28 Multiple Specialty and General Practice Groups have been formed Comprising 20,000 Doctors Some in Big cities Some in Remote Towns.

One of the most famous is the Mayo Brothers Clinic in Minnesota the Kaiser Plan on the West Coast and Cleveland Area. The Health Institute Plan in New

York the Miners Plan in Pennsylvania, Kentucky, and West Virginia. These Plans operate on the thesis of keeping People Healthy Not Waiting Till The Patient Is $\frac{1}{2}$ Dead Before Giving Care.

Sweden, Norway, Denmark, Holland, England, France, Germany and many others all have had National Health Plans for many years. These Plans Cover Health, Dental Care Glasses, Crutches Therapy and Mental Care. At a Cost That is Far Less than ours. We are Far Wealthier than these Countries yet our health Standards For all our People is Far Below Theirs. Whats our Excuse.

WILLIAM RAMELT,
Retired UAW Auto Worker.

RELEASE

The attached position paper on health care for deprived areas represents a commitment of the Hough Area Development Corporation. It was prepared by our Health Planning Section, and endorsed by the Board of Trustees of the Hough Area Development Corporation.

NEW HEALTH CARE SYSTEMS FOR CLEVELAND

There are many crises in our city. None is more painful to bear and inhuman to tolerate than the crisis in health care.

Cleveland is the city of early pioneering in heart surgery and the home of one of the world's great research and training centers in the health science. We have hospitals and medical practice groups which are serving the nation and sick visitors from far flung lands but do not serve their own neighborhoods. Our medical skills, techniques and equipment have reached incredible levels of competence and sophistication but many of our citizens are priced out or kept out of the medical market.

Although health care is an American right, like free speech, press and assembly, those who cannot afford the dollar charges—and that number is growing constantly—are flooding the clinics and emergency rooms of their community's hospitals and waiting 3, 4 and 5 hours or more to be seen and cared for. Care, when it finally arrives is often callous, cursory and condescending.

Hospitals and other health installations are built and run with the use of community money. Direct donations, tax funds for construction, tax funds for operation and tax exemptions on their land holdings subsidize these institutions. A study published by Fortune in January, 1970 showed that we were paying more for health care but getting less.

The stress of higher and higher costs has driven home the need for a more economical system. The loss of health insurance benefits through unemployment has forced Cleveland citizens to further strain hospital emergency rooms and clinics. Private hospitals are threatening and preparing to close their doors to those who cannot pay because federal, state and county welfare medical programs don't pay the hospitals enough.

If the hospital doors close to the poor the crisis will deepen and the consequences are frightening to contemplate.

The dilemmas are staggering; we have paid for a medical scientific revolution and we threaten to bypass those who can most benefit from it; health care costs have escalated 600% in 20 years and now rise about 15% a year and many of our city's residents have 4 to 8 times the illness rate as suburbanians and 3 to 4 times the infant death rate; health care is paid for by taxes but bought and sold like any other item without accountability to the public; our people need more health care but our city is forced to reduce services and lay off health department personnel.

National Health Insurance Plans are piled high on the desk of the secretary of H.E.W. Senators Kennedy and Javits offer solutions. President Nixon has a plan. The A.M.A. and the American Hospital Association offer complex system cures. The Insurance Industry is looking toward feathering its nest. When the smoke clears, we may all be gone from advanced age or systematic neglect. We can't wait much longer. The crisis is now. We must end the dilemmas now!

Baltimore, Denver, St. Louis and other cities of our size range have the same problems we have but are trying interesting new solutions. They have developed community health partnerships between citizens and institutions to stimulate, control, encourage and support the development of an efficient and effective health care system.

We must develop similar partnership corporations which would plan to:

- (1) Select a target population for complete, comprehensive and preventive health care.
- (2) Establish a community-owned, prepaid, group medical practice health center financed through voluntary memberships and current city, state, county and federal funds.
- (3) Develop areas of care such as preventive, diagnostic, treatment, dental, rehabilitation, drug and alcohol addiction, mental health, eye examinations and follow-up services.

Such a community health partnership corporation would have specific program objectives:

- (1) Developing a comprehensive health care system that is economical and effective;
- (2) Developing a partnership with existing hospitals and medical care providers;
- (3) Developing a working partnership with a school for training in the large range of medical care jobs needed;
- (4) Monitoring costs and developing incentives for efficiency; evaluating effectiveness; and
- (5) Negotiating a prepayment pool from State, Federal, other government resources and other health care funding agencies (TB, VD, OEO, HUD, etc.) on a per capita basis for each neighborhood resident covered by the plan. Services to be delivered by the prepayment plan corporation would be:

- (1) Ambulatory care:
 - (a) Health assessments, prenatal care, well baby preventive services;
 - (b) Diagnostic laboratory and X-ray services;
 - (c) Eye examinations;
 - (d) Minor surgery;
 - (e) Family Planning;
 - (f) Physical therapy treatment and supplies;
 - (g) Dental care;
 - (h) Psychiatric diagnosis;
 - (i) Prescription drugs;
 - (j) Treatment for addiction and habituation; and
 - (k) Emergency services and transportation.

(2) Hospital Care:

- (a) Semi-private acute, including childbirth and acute psychiatric care for a time span established with a third-party contract;
- (b) Drugs, appliances, and supplies as prescribed and supervised by physicians;
- (c) Special laboratory, X-ray and all other diagnostic services;
- (d) Physician care, consultations and professional supervision in nursing homes; and
- (e) Ambulance services.

(3) Exclusions of certain services may be necessary to avoid financial insolvency. These are:

- (a) Extended care facilities;
- (b) Nursing and rest homes;
- (c) Home physician services;
- (d) Chronic care in psychiatric, TB, VA hospitals or other government institutions;
- (e) Workmen's compensation;
- (f) Eye glasses; and
- (g) Dentures.

What would be the cost of systematic, comprehensive health care? Communities are now delivering total care by generalists and specialists, complete with drugs, hospitalization, X-ray and laboratory services for \$700 per year for a family of four persons. This includes the cost of buildings and their maintenance. Medicare and other inefficient systems cost more now.

As an example, if 5000 people were cared for and each one had 5 doctor visits and 1.25 hospitalization days per year (this is considered average) the cost would be about \$875,000, plus approximately \$35,000 for rent and depreciation or about \$910,000 per year. If \$80 per family per year is added for dentistry, or a total of \$100,000 for 1250 families, the total health care cost for 5000 people would be about \$1,100,000.

Where would the money come from? There would be more than enough to cover the cost from present funding programs. An analysis of such potential income reveals that about \$1,850,000 can be anticipated from current sources presently in operation. Detailed income analyses and estimates are attached.

Let this plan be thought to be a pious dream, it should be known that such community corporations and such medical care delivery systems at such funding levels exist and operate in several U.S. cities today.

In Cleveland, the time for health care system change is already late. We must adopt a new type of health corporation and a prepaid health system that satisfies needs, cares for people because it's their right, protects the professional integrity and the quality of services delivered by the providers, is affordable by the people and their government and accountable to them and operates as a partnership between communities and their health institutions. Nobody denies that we are in crisis. Nobody argues against quality health care for all. The controversy has revolved about how to do the job. We now have the opportunity to learn from the successes and failures of other cities. We know what works and what good health care costs. We have the will, the people and the resources. Let's get on with it!

FRANKLIN R. ANDERSON,
Executive Director.

MENORAH PARK JEWISH HOME FOR AGED,
Beachwood, Ohio, December 2, 1971.

HON. CHARLES VANIK,
*House of Representatives,
Washington, D.C.*

DEAR SIR: Thank you very much for letting me testify before your Ohio Regional Hearing on National Health Insurance Proposals. I left a copy of my remarks with your aide. These had been prepared in haste, as the decision that I testify was made at the last moment. I would therefore appreciate if you would use the enclosed statement, which is better worded, in record of the proceedings of the November 23rd hearing, and discard the earlier statement which I had left with you.

Thank you again for taking so much of your valuable time to hear the people whom you serve on this vital issue. I am

Cordially,

HOWARD B. BRAM,
Executive Director.

Enclosure:

OHIO REGIONAL HEARING ON NATIONAL HEALTH INSURANCE PROPOSALS'

Congressman Vanik, ladies and gentlemen. My name is Howard Bram. I am administrator of a long-term, highly skilled geriatric facility for the care of the aged, known as Menorah Park in Beachwood, Ohio; 265 beds plus an extensive day care program. I also am Vice President of the Association of Ohio Philanthropic Homes for the Aging, and further, am treasurer and a member of the Executive Committee of the American Association of Homes for the Aging. I therefore am representing that part of the health care community involved in non-profit institutional care of the aged. First, let me state that we favor a form of Comprehensive Health Insurance for all Americans as their inherent right. We believe that Health Insurance is around the corner, and from all indications, we will undoubtedly see parts of health insurance programs enacted, Congress by Congress, within the next several years. One characteristic of all Health Insurance Programs now being considered is the total absence of provision for the long-term care of the aged and chronically ill, and this we believe, is a serious omission. Presently, we have a Medicare law in operation, and a Medicaid law, the latter being more deeply responsive to long-term care than the former. We fear that because Health Insurance is now in the exploratory stage before the Congress, that the Congress might be deterred from much needed improvement of existing programs for the aging.

It is our recommendation that all federal programs for the aging be merged under one program, federally financed and federally administered, both for institutional and non-institutional health care services, and that Medicaid be

totally financed on the Federal level. We suggest that health care of the aged individuals in the general hospital and non-institutional services such as physicians' fees, lab, X-ray, appliances, and so forth, continue to be paid through the existing system of the Social Security Trust Funds. We have found however, that Extended Care under the Medicaid program within long-term care institutions has not worked, is not feasible, and should no longer be considered as a viable part of the Social Security Trust System. We believe that the whole concept of the "spell of illness" to qualify for extended care, the concept of "distinct part" within a long-term care institution and the definition of "Skilled care" make the programs too limiting and ineffective and it's better that we do without. Instead, we suggest that extended care and long-term care come under the auspices of the general revenue system. By bringing non-hospital institutional services, such as those provided in the nursing home and the home for the aged under the general revenue system, federally financed and administered, it would eliminate the negatives of the present system; namely the great burdens on the states, the fifty different programs all with distinct qualifications and payments plans, and the resulting inequality from state to state that now exists under Medicaid. The federal government is now financing 76% of nursing home care through matching title XIX programs. The other 24% of financing could certainly be picked up as the federal government's method of relieving some of the financial burdens now carried by the states.

We further believe that all persons who are over 65 should be entitled to total health care as a right, and as such, there should be no Means Test to qualify for long-term care within properly certified institutions, properly administered and with proper accountability. Once the admission for service has taken place, the individual elderly person should then pay part of his cost of care according to his own ability. The poor would pay nothing; those who are wealthy would pay most. This approach would assure equality of care and immediate and high-quality care to all citizens.

We believe that such a program, under federal administration and federal financing, would enhance the philosophy of "one buyer of service" concept. Under this system, the administration of the program would be one of simplicity and would reimburse the institutions for the care provided on an average per diem basis. This would call for uniform cost reporting and uniform accounting, and success to the records of the institutions by federal government. The reimbursement could be based upon the actual cost of the care and services, plus a rental factor for utilization of the land, plant, and equipment of the institution involved.

This, gentlemen, we contend *is* the only equitable and sound approach to financing the long-term care of the aged, and we believe that this *is* essential for the people of the United States now, and cannot and should not wait for a National Health Program which, may, through several Congresses eventually merge with the Medicare and Medicaid Programs.

In closing, we believe that the United States of America has the ability to provide adequately for old age, and for care of the long-term sick. We recommend that this ability be translated into action as soon as is possible, for *it is* a national responsibility to secure old age in every way possible.

Thank you.

Mr. BURLESON. Our next witness is my colleague from Texas, Mr. Eckhardt.

Mr. Eckhardt, we are delighted, of course, to have you come before the committee. I personally welcome you. I know that my colleagues join me. We will be glad to hear you.

STATEMENT OF HON. BOB ECKHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. ECKHARDT. Thank you, Mr. Chairman.

I always feel personally guilty for holding captive an audience of my peers, no matter how small.

I shall, if the committee will permit me to do so, present my written statement for the record and summarize orally.

Mr. BURLISON. Without objection, your complete statement will appear in the record.

(The statement referred to follows:)

STATEMENT OF HON. BOB ECKHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Though I am a co-sponsor of the Health Security Act, I should not presume to take the time of this distinguished committee to discuss generally a subject which is so much within the command of this committee and particularly of the able member from Michigan who is the principal author and to whom we all owe so much for her diligent and effective work in behalf of its progress. Rather, I should like to address a special facet of the topic of health insurance which I do not believe has been the subject of discussion here. That is: How this bill ties in with other legislation prominently before Congress at this time.

Specifically, my concern is the interdependence between national health insurance and the reform of the automobile insurance system. I am a member of the Subcommittee on Commerce and Finance of the House Interstate and Foreign Commerce Committee which this year, under the chairmanship of our colleague John Moss, conducted several weeks of hearings on the adoption of a system of no-fault automobile insurance. As a result of those hearings Chairman Moss, subcommittee member Charles Carney, and I introduced H.R. 10808 the National No-Fault Motor Vehicle Insurance Act.

According to the Report to the Congress and the President issued by the Secretary of Transportation in March of this year, entitled *Motor Vehicle Crash Losses and Their Compensation in the United States*, more than 50,000 people in 1967 sustained motor vehicle accident-related injuries which ultimately resulted in or contributed to their death. Another 450,000 persons were seriously injured while an additional 3¼ million suffered less serious injuries. Medical expenses totaled more than \$1 billion while net reparations from various insurance sources were several hundred million dollars less. Clearly, then, injuries resulting from automobile accidents must be one of the major focal points of any system of national health insurance.

RELATION BETWEEN AUTO INSURANCE AND HEALTH INSURANCE

The major issue we must face in this area is how the automobile insurance and health insurance coverages mesh. Under H.R. 10808, the national health insurance coverage would be an important and primary basis or source of recovery. The term "net economic loss" is defined, for the purpose of insurance coverage under that bill, as economic loss reduced . . . by the amount of any benefit or payment received (or legally entitled to be received and actually available to the claimant) for losses resulting from such injury or death from any of the following sources:

- (a) Any public health insurance or plan;
- (b) Any private insurance or plan containing explicit provisions making its benefits primary to any benefits under a qualifying no-fault policy."

National health insurance, as proposed in the Health Security Act, would, with the exception of workmen's compensation, be the primary source of benefits. Of course, there are certain limitations of coverage in the Health Security Act—especially under Section 24, Institutional Services—that would have to be covered under the no-fault policy in order not to leave any gaps in coverage. Thus, the no-fault policy would provide excess coverage.

There are two major reasons why I believe that national health insurance should be thus available and become the primary source of benefits. One is philosophical and the other is practical. Both have a common denominator: money.

Owning an automobile is no longer a luxury. With few exceptions, getting to and from work in any way other than by car is a major inconvenience, if not an impossibility, for workers throughout the United States. Almost 90 million passenger cars were registered in the United States in 1970 and the number has been increasing by about 3 million a year. Until a national commitment and massive effort is made to construct intra and inter-city public transportation systems commensurate with need we will have to live with and accommodate the automobile.

Aside from the initial cost and depreciation of the automobile the next largest cost associated with it is insurance. In 1970 Americans paid out \$14.6 billion in automobile insurance premiums, of which \$6.6 billion was for personal injury coverage. After insurance company operating costs, profits, claim adjusting, defense lawyers, trial lawyers and other litigation expenses only \$2.8 billion in benefits was left to be paid against a total medical, wage and future income loss of \$6.8 billion. Thus, in addition to being expensive and often unobtainable, automobile insurance is generally inadequate.

PRESENT AUTO INSURANCE PREMIUMS APPROXIMATE A REGRESSIVE TAX

If owning an automobile is a necessity, then automobile insurance can be viewed as a tax and a very regressive one at that. Even if people at all income levels paid the same for insurance this tax would be regressive but since the poor are likely to be charged the most for insurance the regression is enhanced. Lower income people are considered greater risks and must pay higher premiums. These are the people, however, who are most dependent on their cars. The following table shows the percentage of low income families owning automobiles:

Percentage of low income families owning automobiles, 1970

Annual Family Income:	Percent
Under \$1,000 -----	25
\$1,000-\$1,999 -----	41
\$2,000-\$2,999 -----	50
\$3,000-\$3,999 -----	60
\$4,000-\$4,999 -----	70
\$5,000-\$5,999 -----	75
\$6,000-\$7,499 -----	86

Source: The University of Michigan, Survey Research Center, *Survey of Consumer Finances*.

Now, national health insurance as set out in the Health Security Act would be financed partially out of general federal revenues and partially out of taxes related to wages and salaries. In general, these taxes would be progressive since general federal revenues are raised through the use of the progressive federal income tax.

In 1969 there were approximately 108.3 million licensed drivers in the United States, over $\frac{3}{4}$ of the population aged 16 and over. Most of these drivers presently are paying for automobile insurance. If we were to adopt a system of national health insurance, financed largely by progressive taxes, which would eliminate the burden of hospital and medical costs from the automobile insurance premium, we would have, at once, greatly reduced the very heavy financial load inequitably shouldered by lower income drivers. Since the vast majority of the American people do drive and do carry automobile insurance, there can be little criticism that all the people must pay the bill for a few. All we would be doing is to put medical insurance on its proper basis: ability-to-pay.

REPLACEMENT OF TORT LIABILITY INVOLVES EQUITABLE CONSIDERATIONS

The major reason I would urge the committee to make national health insurance primary to any no-fault automobile insurance to drive down the cost of automobile insurance for all drivers. There is a compelling equitable reason why the total burden of no-fault insurance coverage should not be upon the purchaser of insurance. It is inequitable to give a member of society who is injured—against whom a tort has been committed—only the relief which he has pre-purchased by payment of insurance.

Such class of persons under a no-fault concept include those who were not negligent and who would have been entitled to recover damages even had they not paid a dime in insurance. All persons would be included in the proposed no-fault reparation system because—

- (1) Such a system would be easier and cheaper to administer and
- (2) Because there is a compelling social interest in rehabilitating and re-compensing those who suffer auto accident disability.

If such a system is to be a fair substitute for the rights injured persons enjoyed under a tort system, there must be a public monetary contribution to the

system to make up for a right which could have been exercised by an injured person who was not negligent.

Then, too, as a practical matter, it may not be possible to pay full compensation for injury to a broader base of claimants—both those with and without fault—without increasing already excessive insurance premium costs.

I have pointed out in hearings on no-fault insurance that it is not an acceptable exchange for the tort system to reduce premiums on the basis of curtailed measurement of damages that does not do justice, and I shall not discuss that point here. But in order to afford an adequate money base to establish a fair and efficient automobile reparation system, I think it is essential to pump in some public monetary contribution. The only alternative is to curtail for certain classes of innocent victims of auto injuries their measure of recovery.

There are, of course, other ways to relieve inordinate pressures on the auto reparation system. I have discussed assembling revenue to pay for the outflow. The other approach—which should be made simultaneously—is to reduce the outflow. One way to do that would be to make cars safer and less costly to repair. H.R. 11627, the Motor Vehicle Information and Cost Savings Act, of which I am a cosponsor, would do just that. Hearings on this bill and several closely related ones will conclude tomorrow in the Subcommittee on Commerce and Finance. This is the other side of the coin from my proposal here: to relieve automobile insurance of the burden of paying for medical and hospitalization costs.

INCREASED EFFICIENCIES OF A SINGLE HEALTH REPARATION SYSTEM

Thus, enacting the Health Security Act and making its coverage primary to no-fault automobile insurance would accomplish two things. It would make automobile insurance less costly and would put the financing of health insurance on a relatively progressive tax basis. But more basically, the Health Security Act would establish a rational and economical system of paying for and delivering health services to the American people.

If we left coverage for medical and hospitalization expenses incurred in automobile accidents under a separate automobile insurance system, there would be unavoidable duplication of coverage and double payment of premiums. Would one's payroll deduction for national health insurance and one's federal personal income taxes be reduced by the amount one paid for automobile insurance? Of course not.

I think that I can say with a very high degree of confidence that under a system that makes national health insurance primary to automobile insurance the total amount of premiums that an individual would have to pay for the excess automobile insurance and the national health insurance would be less than the total premiums under a system making automobile insurance primary. This is because a single insurance system paying for all health needs is far more efficient than two separate systems. For one thing, the single system virtually eliminates insurance acquisition costs for the medical and hospital coverage portion. Acquisition cost of auto insurance now constitutes at least 15% of the whole premium cost.

There is the additional danger that a system making automobile insurance coverage primary could lead to duplication in benefits. A person could collect from his own automobile insurance company under his no-fault policy and then from his health insurance policy. This could only lead to higher costs and unnecessary over-coverage.

It is important to keep in mind that no-fault insurance does not mean that a driver's own insurance company will automatically pay off the driver's medical bills resulting from an accident, like a slot machine. There will clearly be cases where there will be controversy over the amount and cause of the damages which could lead to delays in payment and to court suits. I want to make insurance payment of medical bills as automatic as possible, and only a system of national health insurance can accomplish that without regard to cause of injury or such questions as percentage of injury related to the accident.

Mr. Chairman, our constituents are demanding many things from their government, but two of the most insistent are demands for:

(1) Improvement in our automobile insurance system and a lowering of its cost, and

(2) A revolution in our health insurance and health care delivery systems. These problems are related. Between our two committees, we have an opportunity to meet both of these demands. As you know, the committees on which

we serve, Ways and Means and Interstate and Foreign Commerce, have a long, cordial experience of cooperation with each other, and it is in that spirit that I appear before your great committee today.

Mr. ECKHARDT. Mr. Chairman, I should not presume to say to this distinguished committee that I could bring much additional knowledge with respect to the general subject matter that you have before you, but with respect to a relationship between this bill and several bills on the committee on which I serve, the Committee on Interstate and Foreign Commerce, I think I may be able to contribute somewhat.

As you know, the House Interstate and Foreign Commerce Committee's Subcommittee on Commerce and Finance, is considering a no-fault insurance bill, H.R. 10808, and, of course, the question of insurance respecting automobile accidents and the question of medical care for persons who are injured in those accidents have a close relationship, our bill bearing on the first point, and the bills before this committee bearing on the second.

There were some 50,000 people in 1967 who sustained motor vehicle accidents ultimately resulting in their deaths, and about 450,000 persons in the same period of time were seriously injured. An additional 3.75 million received some type of injuries. Medical expenses totaled more than \$1 billion, while net reparations from various insurance sources were several hundred million dollars less.

Certainly, then, injuries resulting from automobile accidents must be one of the major focal points of any system of national health insurance.

The major issue we must face in this area is how the automobile insurance and health insurance coverages mesh. Under H.R. 10808, the no-fault bill which has been most recently introduced by Chairman Moss of the subcommittee and myself and Mr. Carney, the national health insurance coverage would be an important and primary basis or source of recovery.

The term "net economic loss" is defined, for the purpose of insurance coverage under that bill, as "economic loss reduced * * * by the amount of any benefit or payment received (or legally entitled to be received and actually available to the claimant) for losses resulting from such injury or death from any of the following sources:

- (A) Any public health insurance or plan;

Which, of course, would be embraced within this plan.

- (B) Any private insurance or plan containing explicit provisions making its benefits primary to any benefits under a qualifying no-fault policy.

National health insurance, as proposed in the Health Security Act, would, with the exception of workmen's compensation, be the primary source of benefits. Of course, there are certain limitations of coverage in the Health Security Act—especially under section 24, Institutional Services—that would have to be covered under the no-fault policy in order not to leave any gaps in coverage. Thus, the no-fault policy would provide excess coverage.

There are two major reasons, Mr. Chairman, why I believe that national health insurance should be thus available and become the primary source of benefits. One is philosophical, and the other is practical, but both have to do with money.

In the first place, today practically speaking every employed person that needs to be in the slightest degree mobile must own an automobile, and this has very little to do with the question of level of income.

I have inserted in my formal statement a table of the percentage of ownership of automobiles by persons in various brackets, and just as an example, in that table 70 percent of the persons with incomes from about \$4,000 to \$5,000, have an automobile. It goes up to 75 percent between \$5,000 and \$6,000, and 86 percent between \$6,000 and \$7,500.

So that practically speaking, the automobile is a necessity, and therefore when insurance is required as a condition for driving, or is practically required, the result is that insurance premiums are virtually a tax. One may not avoid them. And the tax is frequently levied at a higher rate for the poor than it is for those in middle- or high-income brackets because frequently they are driving in the central city where insurance rates are particularly high, thus the tax is regressive.

For that reason, it would appear that any no-fault reparation system should be at least in part paid on the basis of a public contribution.

Of course, that is what would happen if H.R. 22, as I understand it, is envisaged and the no-fault bill in the House were passed as they are today, because to a certain extent the burden on the insurance premium would be lightened by the national insurance program paying for hospitalization and medical expenses not only for persons injured in automobile accidents but across the board for other medical expenses.

As you all know, the present rates of premiums on insurance are becoming so inordinately high that the load is almost unbearable.

Now, the second reason why we should envisage a certain amount of the total cost of injury from automobile accidents falling upon a program like national health insurance is that any system that we may establish on a no-fault basis which affords reparation across the board to injured persons will replace not only an insurance system in the area of automobile accidents but will also replace a system of justice; that is, a tort system, and would broaden the base of recovery to include not only those who were not at fault but those who might be determined otherwise to be contributorily negligent.

The result of this is that certain persons who are not negligent at all and who without any insurance would be entitled to tort recovery are only getting what they pay for in insurance payments. For a right which they would get without purchasing it, they have traded a right which they would get for purchasing it.

So it seems to me that on any equitable basis such a broad based no-fault program should have pumped into it at least a portion of the cost of that program public funds and, of course, that is exactly what would happen if a bill like the Griffiths bill or like several other of the bills before this committee were put into effect and constituted the primary source for hospital and medical cost.

Such a class of persons under a no-fault concept include those who were not negligent, as I have said, and who would have been entitled to recover damages, even though they had not paid a dime in insurance.

All persons would be included in the proposed no-fault reparation system because, (1) such a system would be easier and cheaper to administer, and (2) because there is a compelling social interest in rehabilitating and recompensing those who suffer auto accident disability.

Then, too, as a practical matter, it may not be possible to pay full compensation for injury to a broader base of claimants, both those with and without fault, without increasing already excessive insurance premium costs.

So the passage of a national insurance plan is almost a necessity as a concomitant piece of legislation to a reparations system of the nature of no-fault.

I think it is essential to pump in some public monetary contribution. The only alternative is to curtail for certain classes of innocent victims of auto injuries their measure of recovery.

That is what has been done in some States. For instance, Massachusetts reduces insurance premium costs, but at the expense of reducing payout by limiting the measure of recovery.

There are, of course, other ways to relieve inordinate pressures on the auto reparations system. I have discussed assembling revenues to pay for the outflow. The other approach which should be made simultaneously is to reduce the outflow. One way to do that would be to make cars safer and less costly to repair.

H.R. 11627, which is now being heard in the subcommittee on which I sit, and of which I am a cosponsor, would do just that. However, the program that you have I think is an extremely important concomitant to the bills on our side.

I would just like to say, Mr. Chairman, in closing, that as you know, both the committees on which we serve, Ways and Means and Interstate and Foreign Commerce, have a long, cordial experience of cooperation with each other, and it is in that spirit that I appear before your great committee today.

Mr. BURLISON. Thank you very much, Mr. Eckhardt.

We do appreciate your coming. I had not really considered this matter in the light in which you have presented it.

I am sure that you would not expect a no-fault insurance bill probably to be produced in this session of the Congress, but more likely in the next session of the Congress.

Mr. ECKHARDT. Mr. Chairman, realistically, I think that is correct. I think that for that reason it becomes doubly important that something be done in this session of the Congress to somewhat pave the way for such an equitable approach and such a necessary approach to reducing the cost of insurance which is a necessary burden on driving automobiles.

I think that is another reason why the bills you have before you here are so important and should be passed in the present session.

Mr. BURLISON. We are not encouraged to believe that we will produce a bill out of this committee on national health insurance right away, at least in the next few days. But I would see reason why we should keep liaison between your efforts and the efforts of this committee.

I agree that if and when a no-fault insurance bill is produced, or when a national health insurance measure is produced, that consideration should be given to their relationship.

Mr. SCHNEEBELI.

Mr. SCHNEEBELI. Mr. Chairman.

Does no-fault insurance apply to trucks, or just passenger cars?

Mr. ECKHARDT. It would apply to all vehicles and all accidents except those very, very narrow categories where there is intentional injury or the like.

Mr. SCHNEEBELI. How about big fleet operations, et cetera in the trucking business? They would be covered, as well?

Mr. ECKHARDT. Yes, as envisaged, the bill would cover such.

Mr. SCHNEEBELI. How are premium payments made on this group where one company might own as many as 1,000 trucks? How do they participate in this arrangement?

Mr. ECKHARDT. Under the no-fault plan as presently introduced in both the House and Senate, all automobile injuries and certain property damages, that is all property damages recoverable under insurance—

Mr. SCHNEEBELI. Is that vehicle damage, too?

Mr. ECKHARDT. (continuing). That is right; would be on a first party basis, that is, would be paid by the first-party insurer.

In the case that you describe, a trucking company insured by its own insurance company would pay to those injured in the truck, and to the owners of the truck with respect to property damage losses, economic losses, and after a certain period of time a claim could also be made for additional losses other than economic losses, but would not be recoverable until economic losses had been recovered.

On the other side of the picture, that person who was involved in the accident with the truck would be insured by his own first-party insurer, who would pay his damages in such an accident.

Mr. SCHNEEBELI. Thank you very much, Mr. Chairman.

Mr. BURLESON. We want to again thank you very much, Mr. Eckhardt, for appearing before the committee.

Mr. ECKHARDT. Thank you, sir.

Mr. BURLESON. Our next witness is our colleague from Illinois, Mr. Philip Crane.

Mr. Crane, it is my privilege to welcome you before this committee, and you may proceed, sir.

STATEMENT OF HON. PHILIP M. CRANE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. CRANE. Thank you, Mr. Chairman.

I would like to thank you and the members of the Ways and Means Committee for giving me the opportunity to appear before you today, and, with your permission, I will read a summary statement, but I would like to ask that the complete text of my statement, together with some appendices, be included in the record of the hearing.

Mr. BURLESON. Your full statement will be included, and also the appendices.

You may proceed in your summary.

(The statement and appendices referred to follow:)

STATEMENT OF PHILIP M. CRANE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. Chairman, I certainly appreciate the opportunity to testify before the distinguished Committee this morning on one of the most important legislative proposals before the Congress.

Professor Robert Nisbet of the University of California, referring to those who see in all of our difficulties major "crises," and who see government intervention and the expenditure of huge sums of money as the only "answers," says of such critics and policy makers that, "As brilliance, rather than profundity of knowledge is the style of the intellectual, so a high sensitivity to the existence of 'crisis' is the hallmark of this thought. Among modern intellectuals, further, there is a frequently observed fondness for the uses of power, especially centralized, bureaucratized power in service to large-scale objectives."

Those who see all difficulties in terms of "crisis" rarely solve even the minor difficulties which do, in fact, exist. They seek, too often, to tear down the house rather than repair the roof, and they transform a minor problem into the major crisis which never existed until their own efforts came into play.

Much of this "crisis" mentality has gone into the current discussion of America's medical care system. Our medical system, we are told, is a failure, not nearly as successful as the socialized medical systems of, say, England or Sweden. We are low on all of the statistical charts, the critics state, and our costs have soared. Their prescription, of course, is government intervention, in one form or another. Some urge a totally nationalized system of medicine, others simply urge government subsidization and partial control.

These critics state that under their proposed plans the quality of medical care would be improved, the costs would be lowered, and the alleged "crisis" would be solved.

Despite the attempts to make it appear that the current cry for national health insurance is a spontaneous reaction to a current "crisis," the fact is that the campaign for national health insurance is really not new at all. National health insurance plans have been proposed in this country for nearly 60 years, and have been introduced in Congress for almost 30. But there is something different this time: a massive campaign to undermine confidence in private medical practice—a campaign of such proportions that even many doctors who themselves believe in the private practice of medicine have felt compelled to declare, "We have to do something about the health crisis."

A brief look at the facts, however, seems to show a situation far different than those who proclaim a "medical crisis" would lead their listeners to understand, and even a limited study of the socialized systems they hold out as models would indicate that far from being an improvement, the imposition of government into the medical field could lead in a far different direction.

Let us look at some of the signs of a "medical crisis." In 1900, the life expectancy of the average American, at birth, was 49.2 years; today life expectancy is more than 70 years and half of the babies born today can expect to live at least 74 years. One fourth of the babies born in 1850 died before the age of five. One fourth of the babies born as late as 1900 died before the age of 25. Three fourths of the babies born today can expect to live to at least 62.

Of every 1,000 infants born alive in 1900, approximately 125 would not survive one year. Today the annual infant mortality rate is approximately 21 per thousand—an improvement of 350 per cent. Tuberculosis and polio have been practically wiped out. Open heart surgery is almost commonplace. The death rate from cancer of the uterus has been cut in half in the last 30 years. Medicine, it seems, has been progressing steadily—and sometimes spectacularly.

But, rather than proclaiming "crisis" or simply engaging in emotional polemics, as has characterized much of the medical debate thus far, let us look briefly at the facts—at facts which anyone who takes the trouble to review our own medical system and those in socialized countries can easily discover.

Initially, we are told that a system of national health insurance would provide a more economical system of medical care. Would this, in fact, be the case?

For an indication of foreseeable costs, the sponsors of the Kennedy-Griffiths proposal estimate that in fiscal 1969 the federal government spent over \$9 billion for all personal health service programs. If their program had been in effect

then, they say, it would have disbursed most of that amount and would have required an additional \$8 billion from general tax revenues.

These are significant increases, and such before-the-fact estimates in this area are notoriously understated. Thus, an article in *The New Republic* by Washington health-affairs writer Mel Schechter states that Medicare alone, without any changes, needs more payroll taxes to meet a 25-year projected deficit of \$236 billion in hospital-related benefits an overrun of nearly 100 per cent.

The financial fate of France's system of partly socialized medicine provides an important case in point. The cradle-to-grave system of social security started in its present form in France just after World War II and has become one of the touchiest political issues in the country.

The system runs three funds, one to cover health costs, one for old age pensions, and one for family allowances.

The family allowance system, designed to combat a low birth rate by giving families money in direct proportion to their size, has the only fund showing a surplus. The health fund on the other hand, will run a deficit of \$165 million this year, which is expected to double next year and, according to experts of the Government Planning Commission, will rise to \$1.8 billion in 1975 if left unchecked.

According to *The New York Times*, "As a result of all of the advantages which the system accords, its officials have noted with rising alarm but general helplessness, there is an overwhelming eagerness among Frenchmen to take good care of themselves—The doctors, the medical laboratories and the pharmaceutical industry, both manufacturers and retailers, the prospering as the deficit grows."

Involving the federal government in control of medical care, either direct or indirect, would, according to Ralph R. Rooke of the National Association of Retail Druggists, "produce an administrative nightmare, with federal officials . . . working out contracts with 6,000 hospitals, 25,000 nursing homes, 700 visiting nurse groups and, later, with 208,000 doctors and 55,000 retail pharmacists." The paperwork involved in processing the millions of resulting claims "stagger the imagination. An extremely large force of government workers would undoubtedly be required to do the job."

And, in the end, would American health services be better than under the current system? The report concerning the British health system by Professor John Jewkes, who served on Britain's Royal Commission on Remuneration of Doctors and Dentists, concluded that "The average American now has more medical services than the average Briton" and "the gap between the two has been widening" since the inception of the National Health Service.

More and more Britons, according to the evidence presented by Jewkes, are seeking medical care outside the National Health Service. These people, the report notes, are "ready to make sacrifices in other directions in order to enjoy prompt hospital and specialist treatment, free choice of consultant and private accommodation." *The British Medical Journal* pointed out that Jewkes weighed in "with a quiet voice . . . to state some facts in this situation that could be read with benefit by medical men and medical politicians on both sides of the Atlantic."

The socialized medical system in England has been hailed by many as an example for Americans to follow. This example, however, appears to be something far different than its supporters in this country would lead us to believe. Let us look at some examples:

Due to the shortage of medical personnel in England, there are no nurses in the antenatal ward at Hemmel Hempstead Hospital after eight o'clock at night. A report recently appeared of the case of Mrs. E'len Foster. Her labor pains began after 8, so she had to climb three flights of stone stairs, in pain, by herself, to reach the labor ward. Within eighteen hours after she had her baby, she was discharged because the hospital was overcrowded and had to walk back down the three flights of stairs, carrying both her baby and her suitcase. This is, of course, a true story.

In addition, Mrs. Foster's experience is not unique. Health care facilities in European countries which have national health programs are far below the standards of the United States.

When Richard Crossman, the British Secretary of Social Services, visited a mental hospital in Warwickshire, he inspected wards so full that patients had to climb over one another's beds. His report said simply: "This hospital is over-

crowded to a hopeless extent—but it's no worse than many other hospitals I've been to."

This we must contrast with a report which appeared in *The New Times* of September 12, 1971, stating that in the United States "... on an average day last year, 818,000 hospital beds—one out of every five in the country—were empty."

Yet, while overcrowding obviously has a serious effect on patients in British hospitals, its effects are most deeply felt by those patients who cannot enter the hospitals at all. At the end of 1968 there were more than half a million patients awaiting admission to British hospitals—more than 70 per cent of them in need of surgery. Dr. Edward McNeill, a British physician who now practices in New York, wrote that there is a waiting list for many operations. "One to two years is not uncommon," he said. Joan Hobson, writing in *Private Practice* magazine, reported of a patient in the Birmingham area who applied for a prostatectomy operation in 1962 and was finally admitted to a hospital seven years later.

Dr. McNeill wrote of trying to supplement his meager income by working as a clinical assistant in London. "One of my duties," he said, "was to help re-evaluate those children on the waiting list to have their tonsils out . . . some had been on the list six years." He wrote that at the time he finally left England the waiting time for a tonsillectomy was ten years. Sign up an eight year old child today to have his tonsils removed and he'll have the operation when he is 18.

Marvin Edwards, the author of a forthcoming book concerning the question of national health insurance, writes this concerning the British experience:

"The British doctor's terms of service occupy a 50 page book of rules, regulations and restrictions. It is even worse in France where the rule-book has grown to 650 pages. So bad has the system been that when a British doctor I know recently checked a list of his medical school classmates, he found that more than half had either left England or quit the practice of medicine. But the most notable loss of freedom is for the patient. First, the patient will lose the right to choose his own physician. In Sweden, only 30 per cent of the citizens are still treated by their own private physicians, and a recent survey in England revealed that fewer than 50 per cent of National Health Service patients get to see the specialist of their choice."

Mr. Edwards concludes that "In their passion to convert to the non-system individual entrepreneur form of practice into a true 'system,' the planners will force the public into a new world of depersonalized mass treatment by doctors whose names they don't know."

Marvin Edwards, the author of a forthcoming book concerning the question of national health insurance, writes this concerning the British experience:

individual entrepreneur form of practice into a true 'system,' the planners It seems clear that medical care would be far more costly under a nationalized system than it is today. People would tend, if the experiences of England, France and Sweden are indicative, to overuse and overcrowd existing facilities. In addition, the cost of the bureaucratic administrative machinery that would accompany a National Health Insurance system would be staggering. The Swedish citizen, for example, pays 20 per cent of his taxes for health—the highest in the world.

It would be reminiscent of the Department of Agriculture, about which much concern has been expressed. We remember the bill which was proposed stating that at no time should there be more employees of the Department of Agriculture than there are farmers. Perhaps the administrators of a National Health Insurance system will one day outnumber the doctors, and the taxpayers will be obligated to pay the salaries of both.

Before returning to the question of cost, let us consider for a moment the question of whether or not government-controlled medicine would provide more efficient and higher-quality medical care.

Comparing our system of medical delivery with that of societies which have different forms of socialized medicine, and comparing the socialized medicine in these countries with the private medical practice which preceded it, leads to the conclusion that better health care is by no means the result of National Health Insurance.

While American patients stay in the hospital about six to eight days, on the average, in Germany, with a system of National Health Insurance, there is an average 24-day hospital stay. Although Germany has more hospital beds per

number of inhabitants than the United States, all hospitals are overcrowded throughout the year. Part of the reason is that there is a lack of interest by the patient in regaining health as soon as possible. In addition, doctors have no concrete feeling for the costs that could be avoided if the hospital stay were shortened.

A recent series of articles in the *Philadelphia Inquirer* compared American medical care to the European systems. The reporter, Donald C. Drake, made this point: "None of the European systems studied offered substantial incentives to doctors to do a superior job. In England, it is traditional for a British GP to swiftly send a patient off to the hospital if his care requires anything more than superficial treatment. In Sweden and Germany, patients are kept in expensive hospital beds for excessively long periods—more than twice the U.S. average—simply because there is no need to move them out and tradition says this is how it should be done. British hospital doctors are reluctant to discharge patients because they are afraid the overworked GP is not up to the task of handling post-hospital care."

Sweden provides another case in point. At the time nationalized medicine was initiated in Sweden, 70 per cent of the Swedish population was already covered by private insurance programs. In the name of equality, those 70 per cent were forced into a compulsory government-administered program in order to provide for the remaining 30 per cent of the population not privately insured.

Today there is hardly a single hospital in Sweden where there are not long waiting lists for all kinds of hospital care. It is estimated that in Stockholm alone there are more than 4,000 persons waiting to enter hospitals, 1,800 for operations. In some cases, waiting periods for minor operations may be more than a half year.

The same situation exists not only for surgery, but for internal medicine, outpatient clinics, neurological sections, and various specialization clinics. The situation is worse in state-administered mental hospitals, where there were 800 patients waiting for entrance in 1964, a situation which has since become even more critical. Extended-care hospitals, nursing homes and homes for the aged are desperately understaffed and overcrowded. In some cases there are waiting lists numbering 2,000 persons.

What has caused these conditions in a society which has the highest standard of living in Europe, which has no lack of educational facilities, and which has not suffered from war?

One of the chief problems is the tremendous increase in the use of hospital facilities at the inception of the medical program. Although the number of hospital beds increased by 25 per cent during a period when the population increased by only 10 per cent, there have never been enough hospital beds. Although the number of doctors has doubled since 1960, and the number of nurses has tripled in that time, there are still not enough to handle the demand.

Swedish writer Nils Eric Brodin explains: "The increase in utilization of existing facilities comes from those who demand 'Hospital vacations.' When the tensions of life or home get too intense, many will 'rest up' in a hospital. Often a patient stays in a hospital a week before he is diagnosed, and even then the diagnosis may be hasty and inadequate. 'I'm paying for it . . . I've got it coming' is the attitude."

Dr. Dag Knutsson, head of Sweden's medical association, estimated in the first years of the medical plan that half of the patients in Sweden's hospitals "need not be there."

A similar situation exists in Great Britain. The London *Economist* assessed national medical care this way: ". . . The British people soon found that as taxpayers they had to spend more money than they had done before as patients." In *The Genesis of the British National Health Service*, Oxford Professor John Jewkes and his wife, Sylvia, stated the system adopted in England may have "positively hindered the growth of the British medical services."

Recently the President of the American Medical Association, Dr. Wesley H. Hall, visited England. He reported that medical care under Britain's nationalized health system is so bad that Americans would not tolerate it. "The people over there don't know any better," he said. Dr. Hall based his views on a trip he took to attend a British Medical Association meeting. After the formal sessions he took a car into the countryside to see how the average resident of Britain receives medical care. I saw the type of medical care over there that you ladies and gentlemen would not tolerate over here," Dr. Hall told the National Press Club in Washington, D.C.

He said that he went on a house call in a little mining town in south Scotland with a specialist called as a consultant in a case. The specialist, Hall said, hardly spoke to the patient and didn't even carry a thermometer, stethoscope or blood pressure gauge. Hall said that he—not the British specialist—discovered that the patient's illness had started with a sore throat and had progressed to severe diarrhea. The British doctor, though, failed to prescribe any medicine.

Hospitals in Britain, the A.M.A. President said, are clean but antiquated. A new hospital going up in Scotland, he added, would never meet the standards of the Joint Commission on the Accreditation of Hospitals here.

Rather than providing more efficient health care, systems of national health insurance tend to do precisely the opposite.

The citizen no longer deals with his physician in the traditional doctor-patient relationship. Instead, he must deal with a bureaucratic government agency. The inefficiency of such agencies is no different in the field of medicine than in other areas. A heavy burden of proof, it would appear, rests with those who argue in behalf of a system of National Health Insurance, for they are arguing against most of the available evidence.

It is also important to consider the more general question, How does medical care in America compare with that of other countries?

The AFL-CIO, Senator Kennedy, even some Administration spokesmen and other critics of our private medical system advance the view that those countries which have socialized medicine are providing their citizens with better medical care than is available in the United States. Is there any truth to this charge?

A study issued by the Brookings Institution as long ago as 1948 entitled "The Issue of Compulsory Health Insurance," states that no great nation in the world has among its population better health than prevails in the United States. The report, prepared by George W. Bachman and Lewis Merriam, notes that "it is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. . . . There is every reason to believe that these trends will continue unabated under our present system of medical care."

The report states that "Compulsory health insurance would necessitate a high degree of government regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other large field previously entered by the government, and past experience with governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development."

Compulsory insurance, according to this view, would inject the government into the relationship between practitioner and patient. A real danger exists, in such a situation, "that government action would impair the relationship and hence the quality of medical care."

Rather than decreasing the cost of medical care, the report observes, a national insurance system would increase it because of (a) administrative expenses; (b) the tendency of insured persons to make unnecessary and often unreasonable demands upon the medical care services; and, (c) the tendency of some practitioners and agencies to use the system for their own financial advantage.

In the previously-cited series of articles concerning medical care in Europe and America, the *Philadelphia Inquirer* expressed the view that while "none of the systems, theoretically at least, dictate the way doctors should practice medicine," still, "in England the system is set up in such a way to hamper if not discourage initiative."

The *Inquirer* notes, for example, that American doctors are much more active in the new and promising field of preventive medicine; five times as many Americans as Germans seek preventive medical care; the average length of stay in American hospitals is many days shorter than in Sweden, Germany or England, countries that have centered their health systems in the most expensive units in the medical scheme; American doctors, on the average, spend more time with patients than European doctors do, even though they are less likely to make a house call.

The *Inquirer* expressed the fear that "The very real danger that exists at this time is that the reformers are ready to blindly throw away many of the advantages in the U.S. system for the sake of emulating the European plans. . . ."

Those critics who advance the view that American medical care is, in some sense, inferior to that of other countries use as their basis the comparison of infant mortality rates.

They charge that countries such as Sweden, the Netherlands, and Norway have lower infant mortality rates than our own. The statistics which are used as a basis for this charge come from the World Health Organization (WHO).

Upon careful examination it appears that this charge is inaccurate. Statistical methods of recording infant mortality are not uniform even within the United States. Each state has its own laws and requirements and reports are tabulated in the National Bureau of Vital Statistics and a national average is reported. In many countries the report is the responsibility of the parents and there is no compulsion for them to report. In the United States, on the other hand, the attending physician is responsible for certifying births and deaths.

In Sweden, which is close to the top of the WHO table, birth reports are not required until five years after the event. Many neonatal and prenatal deaths are surely unreported. In addition, the period of gestation, used as an important measurement of infant viability, has not been established by uniform standard. Thus, while one country would consider a seven-month old baby a "viable" infant and its death part of the infant mortality rate, another country would not. In addition, there are serious variations in the weight required for designation as a viable newborn, and such a difference clearly makes a significant alteration in the percentage of statistical arrivals.

In countries where the average individual stature is smaller than in the United States, the viable infant is likewise smaller. As a result, if United States weight requirements were applied to those countries, the infant mortality rates would naturally be lower than in the United States. In other words, those infants who die and are below a certain weight would be considered in the statistics of one country, and not of the other. It is, in effect, like comparing apples and oranges.

In addition, some countries do not even record births of children who do not live a designated length of time. And those countries which have legalized abortions in cases where birth may be harmful to mother and child would, of course, have lower infant mortality rates than in a society such as our own which has generally, until very recent days, made abortion illegal. It is clear that such a comparison of infant mortality rates has little to do with the relative merits of a country's health-care delivery system.

There are many other considerations. In the United States, if a child breathes or has a heartbeat for even a short period after delivery, then died, it is usually considered a neonatal death and classified as infant mortality. In many other countries this is not so.

Discussing the statistical comparisons which are frequently made between American medicine and the medical systems in other countries, New York Times correspondent Harry Schwartz wrote the following in his article concerning American medicine in the *Saturday Review* of August 14, 1971. He wrote:

"A staple argument advanced by those who profess to see a health care crisis is that the nation's health is well below what it might be because of the inadequacies of the present medical mechanism. To buttress this argument, the critics virtually always trot out international statistics purporting to show that the United States is way down on the list of the world's nations ranked by such indicators as infant mortality and expectancy.

"In part, this argument is based upon simple naivete in statistical matters. It assumes that it is meaningful to compare small, homogeneous nations concentrated on relatively tiny territories—Sweden and Holland, for example, with the United States, whose population is roughly twenty times as large, incredibly heterogeneous, and spread across a whole continent. Moreover, those who triumphantly cite these statistics usually ignore the problems of statistical definition that make such comparisons even more suspect. As they almost never point out that if comparisons are made between the two most nearly comparable large countries for which data are available—the Soviet Union and the United States—the Soviet Union turns out to have a much higher infant mortality rate than the United States and approximately the same life expectancy. Why doesn't anyone talk about a Soviet health care crisis?"

Mr. Schwartz continues to make an important point which is often overlooked by those who have seen fit to comment upon the state of America's health and health care. He notes that "... this argument has an even more fundamental fallacy, which is the assumption that in a highly developed, modern urban society medical care is somehow the decisive element in such matters as infant mortality, and life expectancy. This, of course, ignores all the complex

social forces at work. Whatever its sins, the American medical establishment is not responsible for hunger in this country, for the automobiles that kill 50,000 or more people here annually, for the drug overdoses that claim thousands of young lives, or for the millions of Americans who court heart disease and lung cancer by overeating, exercising little or not at all, and smoking a pack or more of cigarettes daily. If a person chooses to eat or smoke his way to death despite his doctor's warning, why blame the doctor?"

Those who engage in a discussion of statistics often forget to report the dramatic decline in American infant mortality in recent years—a drop of more than 20 per cent just between 1965 and 1970. Last year, for the first time in American history, the infant mortality rate went below twenty deaths per thousand live births. In addition, when allowance is made for the changing age distribution of the population, the death rate in this country has been dropping significantly. In 1967, the last year for which data are available, the age-adjusted death rate was 7.3 per thousand population. Twenty years earlier, the corresponding figure, 9.0 per thousand, was almost 25 per cent higher.

The fact is that American medical care, as the Brookings Institution report states, equals that of any nation in the world, and is far superior to most. It is particularly superior to those in which government has involved itself in the delivery of medical care.

Those who support government involvement in medicine argue that such intervention is necessary because we have a doctor shortage, and somehow government control of medicine will ease this shortage.

We must ask this question: Is there a doctor shortage and would a program of National Health Insurance in any way alleviate it?

In the United States today there are 318,000 medical doctors. With a national population of roughly 200 million, that is an average of one doctor for every 640 persons. No other major nation in the world enjoys anything close to this ratio.

Of these doctors, 169,656 are engaged in full-time private practice, and 19,586 are engaged in part-time practice. The remainder are engaged as follows: 28,105 in government service, 17,725 on full-time hospital staffs, 10,452 in full-time medical faculties, 33,247 in resident training, 9,102 in internship, 4,919 in preventive medicine, and 2,653 in administrative medicine. The remainder are retired or in some type of work other than the practice of medicine.

The problem, it seems clear, is not that there are not enough graduating doctors, but that too few are in direct patient care. In fact, it is government involvement in the field of medicine which is, in large measure, responsible for this situation.

Discussing this point, Dr. Walter C. Bornemeler, president of the American Medical Association, stated: "A little over 10 years ago, our Congress . . . appropriated substantially more than was requested for research. In order to use this money, it was necessary to train a great many research people. Once more hundreds of our best young men, just finished their specialty training and ready to go into practice, were persuaded to accept a research traineeship which was a training program of several years' duration.

"In order to accommodate this influx of research money, it became necessary for medical schools to provide housing for this activity, so great research laboratories were built. The school hoped to benefit from the teaching that would be provided by research physicians. But as it developed, the research grants that became available carried with them rigid restrictions on time spent on unrelated activities. So, instead of a plum, the medical school may have picked a fruit of a different color."

Would there be more doctors and would those doctors who are practicing be more productive were we to have a system of National Health Insurance? The evidence seems to indicate that under a system of government-controlled medicine the situation would be far worse.

Discussing the British National Health Service, Dr. John R. Seale, writing in *Northwest Medicine*, noted: "The state has . . . used its immense power over physicians, nurses and other health professionals to obtain their services inexpensively. Those professionals are particularly vulnerable when faced with a monopoly employer because they will not harm their patients by striking against their employer."

According to the English economist, D. S. Lees, in his book, *Health Through Choice*, "the real incomes of general medical practitioners fell by one-fifth between 1950 and 1959, while those of the general community went up by about as

much. Even with the much-publicized increase in physicians' pay in 1960, they were no better off than they had been 10 years before. This can be said of few other sections of the British working community and contrasts strongly with the trend of medical incomes in most other countries of the Western world."

Britain, as a result, is rapidly losing its doctors. In the 10 years of the 1930s, before nationalization, an annual average of 27 doctors with British degrees registered for practice in Australia. But since the early 1960s the annual rate has been more than 225. In one year, 1960, more doctors (162) trained in England and Ireland passed their State Board Examinations in the United States than in the whole 10 years of the 1930s.

The reason for their departure, according to Dr. Seale, is that "... In Australia and North America the professional freedom of doctors is greater, and the opportunity to practice medicine well, particularly in general practice, is greater, and the financial rewards are more appropriate to the years of study, the long hours of work and the heavy responsibility involved."

The situation is similar in Sweden. The Swedish government is placing pressures on private physicians in many ways. They may not treat private patients in hospitals and only a few of the doctors in hospitals may have private patients. All private and semi-private care is being gradually eliminated as something "anti-egalitarian." There are very few private (and no denominational) hospitals and private nursing homes are being forced out because of excessive taxation.

The number of private physicians is diminishing. Of the 8,500 doctors remaining in Sweden, there are only 1,200 private physicians, one-fourth of whom are over 70 years old. Only 30 percent of Swedish patients are treated by private physicians and because of heavy taxation private physicians do not work more than six to eight months a year.

The Swedish government, in order to relieve the shortage of doctors, has shortened medical studies by two years, filled many positions with interns and medical students, and imported a large number of foreign doctors. Sweden today has fewer physicians per citizen than the United States, West Germany—even Austria and Italy.

How many young Americans would want to enter the medical profession if it became similar to that in Great Britain and in Sweden, as many advocate? It would appear that such a system, rather than alleviating any doctor shortage, would compound it and drive young men and women into other fields and professions.

Let us turn our attention once again to the question of costs. Initially, the advocates of increased government involvement ignore the fact that our medical costs have risen not because of a selfish interest on the part of doctors, but for the very reasons that the cost of everything in our inflation-ridden society has increased. It would be unusual indeed if medical costs remained stable while all other costs skyrocketed.

Hospital workers have now become unionized and are demanding wage increases. Construction workers are among the most highly paid in the nation, and the sophisticated new equipment used in modern hospitals is expensive, even in non-inflationary periods. Nurses are demanding better pay and better working conditions, and the demand upon hospitals has increased notably because of government programs such as Medicare and Medicaid. All of this has driven medical costs up.

The question we must ask ourselves is what would a government health program cost, how would it lower such costs, or would it, in fact, increase them?

Harvard Professor Rashi Fein believes that "at least 10 per cent of the \$63 billion we spend on medicare care is wasted." Howard Ennes of Equitable Life guesses that "We're losing 40 per cent of what we're putting in."

One benchmark of what good care ought to cost is provided by the program of the Kaiser Foundation, a private group health program. The services provided currently cost about \$120 per year per person, counting the nominal fees paid by members when they receive treatment. Making allowance for services not provided, the Kaiser experience indicates that a good job could be done for the non-aged, non-poor population for about \$175 per capita—or about one-third what this group currently spends.

What would a government plan cost—given the \$175 figure as one which is now being used by the private practitioners of the Kaiser Plan? Discussing the real projected costs for the proposal introduced by Senator Edward Kennedy, Robert J. Myers, professor of Actuarial Science at Temple University and for-

merly chief actuary of the Social Security Administration for 28 years, wrote in *Private Practice* magazine: "For calendar year 1974, the first full calendar year of operation, I estimate that income to the system will amount to about \$57 billion (from the specified taxes and government subsidy). The Social Security Administration has estimated that the total cost under the proposal for calendar year 1974, for both the benefits provided and the administrative expenses involved, would be about \$77 billion if the reimbursements were made under the standards of reasonable costs and charges of Medicare.

"What this means," notes Professor Myers, "is that the program's income would likely be somewhat insufficient to pay off the costs for hospitals and GPs, and there would be nothing left over for fee-for-service physicians."

What would the tax burden of \$57 billion mean to an individual? Professor Myers points out that "First, we should recognize that the government subsidy of two-thirds of the direct taxes must be paid by the taxpayers. It just does not represent money that comes down from Heaven or from Santa Claus. The \$57 billion represents an average payment of about \$265 per year from each person in the United States. It can be expressed as an average annual payment of about \$680 from each worker in the population."

Thus, even working for the figures set forth by the advocates of a national health program, we see that the cost would be approximately \$265 per person per year, as opposed to the \$120 to \$175 figure now in force by such private plans as that of the Kaiser Program. The fact is, however, that estimated costs by sponsors of government programs are notoriously low, as such scandals as that surrounding the TFX airplane show so clearly, and as the original estimates for the Medicare and Medicaid program themselves, which were previously mentioned, verify for us.

When the initial estimates for the cost of a government program by its own sponsors are so outrageously high, the public can expect overruns of at least the 100 per cent experienced by Medicare. Thus, the cost per individual would be far more than \$265, and plans such as the Kaiser Program would effectively be put out of business. Why, for example, would anyone voluntarily pay \$120 to Kaiser if the government is taxing him \$265 or more on a compulsory basis anyway? It seems clear that medical costs, rather than declining, will rise dramatically.

Overuse of facilities which are paid for in advance through compulsory taxation also increases the cost. A German physician, Dr. Klaus Rentzsch of Hamburg, who has compared the medical care systems in his own country and in the United States discussed the differences in these terms: "Under Germany's form of health insurance, every employee and industrial worker is obliged to contribute about 10 per cent of his income, with half of the contribution paid by the worker and the other half by the employer. The insurance covers payment for all medical care. The employer is also required to pay full wages for the first six weeks of sickness. . . . The insured gets exactly the same money when he is sick as when he is at work. All medical care is provided by the government without any direct payment by the patient himself. Nobody can say how many millions of dollars are wasted in this way every year."

Dr. Rentzsch points out that there are those patients who take their sickness every year exactly for those six weeks during which the full payment is guaranteed. But, he notes, the greater loss comes from those who are sick for some time. "According to our social insurance statistics, tonsillitis caused the average patient to be laid up for 21 days in 1927—and in 1967. In those 40 years therapy developed from aspirin to sulfonamides to penicillin and other antibiotics. Every medical process shortened the process of tonsillitis. But not one day was cut off the time the average patient was out of work. This may show what happens when all the risk of a sickness, including the income loss, is completely covered. The will of the patient to take up his work as soon as possible is paralyzed. . . . The situation is comparable in every country with a total medical program such as ours."

Thus, a national health system such as the one which now operates in Germany and which is being proposed for our own country has not seen an improvement in medical care or a decrease in costs. Instead, medical care has remained stagnant and costs have risen as facilities have been unable to accommodate the thousands who sought to use them, primarily because of the fact that they were available and were "free."

In proclaiming an alleged "crisis" in American medicine, critics overlook the fact that most Americans under the age of 65 are already covered by private insurance plans which are far cheaper than the projected government plans.

As of the end of 1969, the Health Insurance Institute estimates 164 million persons under 65—80 per cent of the total—had some form of private protection against medical costs. About 140 million Americans, it is estimated, have some protection well above the minimum. They have Blue Cross extended coverage or private major medical insurance offering some help in the area of medical costs dealt with recently by the proposal for catastrophic health aid by the Senate Finance Committee.

If a national health system were to become law, the government program would replace all of these private plans—at a much higher cost. Since 80 per cent of the group in whose behalf such socialized medical plans are being supported and advocated are already covered, the advocates of such plans have not met the burden of proving a "need" for the program at all.

There are, of course, other health plans being considered which do not support the concept of totally socialized medicine. They seem, however, to accept the first premise that there is a "crisis" in health care and that massive government intervention is, as a result, necessary.

The health plan proposed by the Administration is less costly than that of the proposals being supported by organized labor and the advocates of total nationalization. It is also less far-reaching. Mr. Nixon put the cost of his program at \$2.95 billion, largely to fall directly on employers. Since these premium costs will be taken as tax deductible expenses by businessmen, however, the general taxpayer will also be footing a large part of the bill. In addition, to finance proposed changes in Medicare, the Administration has recommended larger Social Security payments.

One recent estimate of what the Nixon Plan would cost employers is at least \$3 billion a year. In addition, medical costs are rising at about 15 per cent a year, so that large increases in future premium costs might be expected. Only by solving our general economic problem of inflation can we solve the problem of increased medical costs—for one is only part of the other.

The Administration program also calls for the subsidization of group health practices. While it has not spelled its plans out in precise terms, Lewis Butler, Assistant Secretary of Health, Education and Welfare, proclaimed that "Our aim is to try to have 90 per cent of the population enrolled in HMOS (Health Maintenance Organizations) by 1980." This sounds like something other than government neutrality with regard to the specifics of the health care delivery system.

Discussing the relative merits of private solo-practice as opposed to group practice, Dr. Russell B. Roth of Erie, Pennsylvania, recently testified that "Actually physicians in private, fee-for-service solo practice and those in prepaid comprehensive groups practice essentially alike—and interchangeably. The urologist with Kaiser has no magic that I do not have—or vice versa. In consequence, the notion that preventive medicine could be significantly advanced by reorganizing me, and those like me, into another kind of a group, differently financed, is a will-'o-the-wisp."

In a free society, all individuals who want to provide medical care for themselves and their families through such groups do have, and should have, the opportunity to do so. But why the government should subsidize this form of medical practice or any other form, is unclear.

The New York Times and others who generally advocate increased government involvement in society believe that subsidization for Health Maintenance Organizations is something for which need and demand have yet to be proved. The Times commented editorially: "Both the Nixon and the Kennedy proposals rely in differing degrees upon the assumption that increased use of prepaid group practice systems can simultaneously lower costs and improve care. Unfortunately, this assumption requires more proof than is yet available and there are some students of medical economics who challenge this claim vigorously. Moreover, some existing system of prepaid group practice—such as the Kaiser-Permanente groups—have found that they tend to be inundated by clients whose troubles are more emotional than organic, thus hindering patients with serious organic illness from gaining timely access to proper care. More study and experimentation are needed."

The program described by the President, as well as an alternative program presented by the insurance industry itself, also envisions increasing control

of the health industry. To meet the law's standards, for example, the government will set forth exactly what a health insurance policy must include. "Healthcare" is the proposal of the Health Insurance Association representing 808 member firms, which account for 80 per cent of the health insurance written by the nation's insurance companies.

This plan retains existing voluntary insurance plans but proposes changes in the delivery system to cut costs.

It calls for improving student loans and providing federal grants to medical schools to increase health manpower and, to reduce costly hospital use, recommends federal support for comprehensive health care centers.

Under this bill state pools of private health insurers would be established to provide standard benefits for the poor and other low-income persons, with the benefits being subsidized by state and federal money.

Like the AMA plan, this one appears designed primarily to benefit the insurance companies which have developed it. While the AMA plan calls for government funds but no government control over the health care delivery system, the Health Insurance Association plan calls for major government-induced changes in the private system of medical care with insurance companies receiving the major benefits of government subsidization.

Neither the doctors nor the insurers should suspect that government involvement in their fields will not lead to increasing government controls. It is inevitable that those who pay the bills will seek to make the major decisions and those who would substitute freedom for subsidization should at least do so with their eyes open and without any illusion about maintaining their own independence.

The American Medical Association has introduced its "Medicredit" bill which essentially calls for tax credits for those who purchase private insurance plans and does not call for the government controls included in the Kennedy Plan, the Nixon Plan, and the Health Insurance Industry plan.

Yet, the AMA has generally reacted favorably to the Nixon proposals. The AMA President, Dr. Walter C. Bornemeier, said that "I think the Nixon Administration is to be congratulated on their health proposals. They have given this very complex subject a lot of attention and study.

"We think they have gone about it in the right way. They have consulted with all of the various people who are, of necessity, involved in health care programs and they've consulted with the AMA as representing most of the medical profession. We think they have come up essentially with statesmanlike, forward-looking proposals."

The AMA president called the proposal for compulsory health insurance purchased by employers "an intriguing one," and expressed possible disagreement only with regard to subsidization of Health Maintenance Organizations. On this subject, he said, "We are going to have to take a more detailed look at the proposals on health maintenance organizations."

Comparing the Nixon proposals with the AMA's own Medicredit proposal, Dr. Bornemeier said that "It differs from the Nixon Plan, of course, but in over-all philosophy and approach I think you will find a great deal of common ground between what we think will serve the American people best and what President Nixon thinks will serve the American people best."

Many non-doctors viewing the current AMA position feel that it is not only a rejection of that group's previous criticism of government involvement in medicine but is a case of wanting to have your cake and eat it too.

Thus, the AMA supports all aspects of the Nixon Plan which involve coercion of others, such as employers, but reject that portion which might lead to coercion of doctors themselves, as is stimulating them away from private practice and into group practices. Such doctors seem to want government money but reject government controls.

A position such as this, one which does seek a government subsidy but opposes the controls which inevitably accompany such a subsidy, is unrealistic but opposes the controls which inevitably accompany such a subsidy, is unrealistic, for whenever government enters an area financially it also enters it in other ways.

Federal aid to education, it must be remembered, is leading to increasing federal controls. The same is true for welfare, housing, agriculture and all other areas entered by government. Why the AMA thinks medicine would be an exception is difficult to tell. If men such as Dr. Bornemeier persist in supporting such government involvement it should at least be done with a clear view of

what lies ahead, namely government control. It is also highly inconsistent for a Republican Administration to propose the use of the federal government to coerce private employers into participating in particular insurance plans for their employees. Such questions should remain in the realm of collective bargaining, and do not in any sense constitute a government question or concern.

During the past several months I have been in touch with many doctors in my district. I have had the opportunity to study and consider their views with regard to the question of national health insurance, and I would like to share with my colleagues at least a sampling of such views:

Dr. Frank B. Kelly, Jr. of Chicago expressed this view concerning those governmentally controlled medical programs we have had experience with thus far: "As a private practitioner I have seen both benefit and abuse of the present Medicare system. For those elderly people with limited resources we are thankful that there is a method where they can receive medical care and not leave them destitute. However, all of us can easily fall into the limbo of disregarding costs as long as the other fellow (the government) is footing the bill. The same attitude holds for other insurance carries such as Blue Cross etc. Patients frequently are anxious to be hospitalized for diagnostic studies and those hospitalized are reluctant to leave till fully recovered as long as the other person is picking up the expense tab. What I have noticed is a disregard of personal responsibility for expenses incurred, a trend that is dangerous and if it continued can only lead to total government control."

In another communication, Dr. Wallace D. MacKenzie of Evanston, Illinois wrote the following: "Since socialized medicine has been instituted in Germany and Sweden and England, very little in the way of original work towards the advancement of the science of medicine has come out of those countries. Prior to socialized medicine, many of the great advances were attributed to Germans and Britishers. Now most of the advances are made in the countries whose medicine is not socialized, most of them in the United States."

Discussing the effects of the Medicare program, which would be magnified many times over were we to enter into a system of national health insurance, Dr. W. G. Bagnuolo of Mount Prospect writes that "In the short time that we have had Medicare, we are at the present time feeling pressure by hospital administrators, the Medicare offices, and excessive paper work not remotely connected to the true care of patients. If this continues, we will have less and less time to pursue our vocation of treating ill patients."

These comments are representative of the views of the doctors in my district, and my understanding is that they are representative of the views of individual private practitioners throughout the country, the men who are in the best position to tell us what current government programs have meant for the quality of health care, and what future government programs might mean.

Yet, we must return to our starting point, Professor Nisbet's observation that somehow in 1971, America no longer has "problems" in the fields of education, welfare, the status of women, agriculture etc. All problems have automatically become "crises" and no one understands why.

Our medical system is, by any standard, the best in the world. In 1968, over \$58 billion was spent on health services. Approximately two thirds came from the private sector, well in excess of private expenditure in other countries even on a relative scale.

Health facility construction now amounts to \$2 billion a year. Research expenditures are now approximately \$1.6 billion a year. Both figures represent a significant increase over a five year span.

In the important area of mental health, we now have 428 community mental health centers established. In 1965 there was none as such. Between 1964 and 1968, 12 new medical schools were opened, three times the number opened between 1954 and 1963.

Planning of health facilities and programs has improved markedly in recent years. In 1979 there will be 45 regional medical programs relating medical schools more effectively to their trading areas. In 1968 there was none.

Between 1963 and 1970, there were significant declines in infant mortality, diseases of early infancy, maternal mortality, tuberculosis, and hypertensive heart disease, for example. There has been a decline in the number of mental hospital patients. By 1976, it is expected that the old and new medical schools will effect a 45 per cent increase in the number of graduates over 1963. Only two small countries in the world have a higher ratio of physicians per unit of population.

Many critics argue that something must be wrong with our medical system because our mortality rates in different areas are higher than certain other societies. Testifying before a congressional committee, Dr. Max Parrott recently noted that "Many of our health problems . . . are more factors of our society and economy than the absence of medical treatment . . . one of the most damaging blows to our health statistics comes from the very affluence of our society . . . the truth is our fat standard of living does create health problems. We ride in cars when we should be on bicycle or on foot. We overeat. We overdrink. We smoke cigarettes."

The doctor also pointed out that poverty affects our health statistics. Infant mortality, for example, ties in with nutrition, it relates to the age of the mother. Ill-fed, ill-housed teenage girls are simply not strong enough, quite often, to support a healthy fetus. The real problem is our urban areas themselves "and if we try a medical program alone, without attacking all the other problems of the ghetto, we may be in for a sharp disappointment . . . Our nation did not attack malaria by doubling the number of hospital beds or tripling the number of doctors. It conquered malaria by draining the swamps."

Yet, more and more, we continue to hear the simple answers: spend more money, have more government controls, compel employers to pay the bills and, somehow, all of our medical problems will be solved.

Such a mentality totally overlooks what is right with American medicine, and blames American medicine for social ills which are completely outside of its province.

To reorganize what is probably the most effective and efficient medical system in the world makes little sense. What we have are "problems" and not "crises." A small percentage of the population is not covered by insurance, doctors are often scarce in the inner city and in rural areas. Surely we can approach these problem areas without coercing employers, subsidizing a particular form of health care delivery, or engaging in the kind of "crisis" rhetoric which leads many Americans to the conclusion that their medical system is, in fact, to be condemned as a failure. Out of the current debate it is hoped that this common sense will finally emerge.

I would like to include in the appendix to these committee hearings several articles which I believe highlight many of the questions we are discussing at this time, and request the permission of the committee to submit these for publication in the final record of these hearings.

[From the New York Times, Mon., Oct. 18, 1971]

WHAT HEALTH CRISIS?

(By Harry Schwartz)

Chairman Wilbur Mills of the House Ways and Means Committee will open hearings tomorrow on the many and varied plans on Capitol Hill for modifying or revolutionizing this country's medical care system. Mr. Mills' power is such that his conclusions could greatly influence the future of American medicine.

By coincidence, shortly before Representative Mills announced his hearings, the Department of Health, Education and Welfare issued what is in effect the closest thing this country has to an annual report on the health of the American people. The data in this document should help ease the fears of those who believe the United States is in a "health care crisis" requiring radical remedies.

These statistics suggest that the American people as a whole may well have enjoyed the best health in their history last year. And preliminary data now available for the first seven months of this year indicate that the picture in 1971 may be even better.

The key barometer Washington has just published is the average life expectancy of an infant born in 1970. That was 70.8 years, the highest such figure ever registered in this country. And last year's record wasn't merely a flash in the pan. Just since 1963, the trend toward greater life expectancy for Americans has added almost an entire year to the life span a newborn American baby can expect.

The life-expectancy measure takes into account the increasing years of life becoming available to Americans at all age brackets. But the news is particularly good for the very youngest Americans, because the nation's infant mortality rate has recently been in an extremely sharp downtrend. Thousands of Ameri-

can babies—both white and non-white—survived last year who would have died without this progress. And the indication is that an even better infant survival record is being rolled up this year.

It is remarkable that so little attention has been paid to the extraordinary medical success story represented by the plunge in this country's infant mortality rate since 1965. Relatively more progress has been made in this area since 1965 than in the previous fifteen years.

In 1950, 29.2 American babies out of every 1,000 born died before reaching the age of one year. Until 1965, progress in this area was made at a snail's pace, and the 1965 rate, 24.7 deaths per thousand live births, was only 15 per cent less than the 1950 figure. Then came the amazing improvement in the late 1960's which brought the 1970 infant mortality rate down to below 20 deaths per thousand births for the first time in American history, a more than 20 per cent drop in a half decade.

We need to know more than is now known about how this astonishing feat was accomplished. And we need to know more, as well, about the reasons for the gross discrepancies among different states in this country. Why, for example, did North Dakota lose only 14.1 babies out of every thousand born last year while the figure for Mississippi was exactly twice as great? One can guess, perhaps, at some of the factors in Mississippi's poor record, but one would hardly have expected rural North Dakota to be leading the nation.

There are, of course, political overtones in these not-so-dry statistics. The present conventional wisdom in Washington—shared by personalities as different as President Nixon and Senator Edward Kennedy—holds that this nation is now undergoing a major crisis which requires drastic action to shake up and revise the country's entire medical system.

The latest statistics obviously challenge this conclusion. If Americans are living longer than ever, if fewer babies are dying than ever before, then is there really imperative reason to go in for revolutionary, quick changes? Perhaps there are strengths as well as weaknesses in the existing structure, and caution is advisable lest the existing strength be damaged in any sudden and far-reaching changes which would bring at least short-run confusion and chaos.

Unfortunately, this kind of thinking does not appeal to ambitious politicians anxious to win votes. They know that the way to make headlines and to win popularity is to paint matters in stark black and white, and to claim that one has magic answers that will produce miraculous results.

One may suspect, therefore, that the latest statistics showing consistent and important gains in the nation's health are likely to be greeted with less than maximum enthusiasm by some politicians who have claimed to be most concerned with the nation's physical well-being. What they need are statistics that show how terrible things are, not data that show reality to be better than ever.

But of course politicians in all countries know that statistics are flexible things. If the raw data are unsatisfactory, one can always find a statistician ingenious enough to put them through some kind of processing that will come up with figures that support whatever case one wants to make. Nevertheless, the raw data—the facts—remain, and they are stubborn. Those facts show that steady progress is being made in meeting the nation's health needs. Those facts imply there is time for evolutionary changes to meet existing problems, rather than an imperative need for hasty revolutionary change.

WHY I LEFT ENGLAND

I am often asked why I left England and the NHS to come to this country. There is no simple answer like "money," "opportunity," "politics," or "climate," but if I describe the conditions under which I found myself practising medicine in England, the reader may find his own answers.

When I qualified as a physician and surgeon, the NHS had been established for five years and there was virtually no private practice of medicine in England. The practice of medicine in war time did not offer any relevant basis for comparison with the system I found myself involved in; nor did the practice of medicine before 1839 as, in retrospect, that was another era about which the older practitioners were reluctant to talk. (I naturally suspected the old system of private practice wasn't good.)

My own knowledge of private practice in the USA was from a small number of patients and friends who had been there and reported that medical care was very expensive and that one had to establish credit at a hospital before being treated or admitted.

It was not until I had been in my own solo practice in Yonkers, New York, for about two years that I realized the tremendous advantages of the private practice system.

As a student I had always been more inclined towards the surgical disciplines, so my first "house job" was as House Surgeon in a London hospital with two surgical wards, 86 male beds and 86 female beds. There was also a smaller ward of about 10 beds which was used to isolate clean orthopaedic cases and serve as a spare ward for overflows of one or the other sex. There was rarely an empty bed and I had the unpleasant task of turning down at least two out of three requests by GPs for emergency admissions. Selective surgery cases had their admissions arranged through the waiting lists compiled by OPD clinics.

I later learned what it was like to be a GP trying to have a patient admitted for an emergency condition, telephoning five or six different hospitals without success, then, in frustration, sending the patient to the emergency department of a hospital that had already turned down a request for admission, and hoping for the best. In later years, London had what was called the Emergency Bed Service to which a GP could direct his requests for admission and they would call all the hospitals for him, then force the hospital they considered most able to adapt to an extra admission to take the patient. (This system was fine in theory, but in practice it would often take the EBS six to twelve hours to find a bed, and some patients could not wait that long.)

As the only house surgeon for at least 80 surgical patients, including some in the pediatric ward, I worked very hard but appreciated the technical experience which I crammed into six months. Within two months of qualifying I was performing laparotomies in the middle of the night, relying entirely on my own diagnostic abilities, relying on the house physician or obstetric house surgeon (also newly qualified) to give the anaesthetic, and relying on only one scrub nurse for my surgical assistance. (Before 5 p.m. I did have an Indian surgical registrar—a senior resident who was an excellent surgical tutor—to guide me, and the two attending surgeons did "rounds" every other day and a rushed "round" after their operating sessions.)

What humility I had as a "new boy" receded very quickly with the volume of experience, and I soon found myself agreeing with the other house staff that those doctors out there in GP land had minimal medical knowledge and no manners. Fancy an experienced GP sending a patient to the Casualty Department with a scribbled note saying "Please see and treat," with no history noted or any attempt at diagnosis; and such bad manners, when I had already told him on the telephone that I didn't have any empty beds and we had seven extra beds up in the corridors and down the middle of the ward!

Assisting the Chief and the Registrar at the surgical clinic also put me in the position of advising GPs with decades of experience about the diagnosis and management of their patients. The conceit of youth! At the clinics, the Chief would see the least number of patients and those most potentially interesting. The Registrar would share the remainder with the house surgeon. From the patients' point of view, it was pot luck whether they saw a real surgeon or me.

(Only a few years later I found myself as a GP referring cases to the clinic and waiting a few months for a letter from a newly qualified pipsqueak house surgeon telling me that the diagnosis had been considered to be "so and so," "such and such" had been done, and the patient was referred back to me on "such and such" medication.)

I quite naturally came to the opinion that a newly qualified physician was at the peak of medical knowledge and knowhow and thereafter it was a steady decline in his knowledge and ability. I took comfort in the excellence of my medical training but was repeatedly surprised at meeting situations I had not been taught about and finding patients didn't all respond to treatment as they should. Something seemed wrong with the system.

As previously mentioned, I was surgically inclined and considered I would eventually become a surgeon. A look at the prospects of surgical colleagues who were five or six years ahead of me in the race made me realize I might as well forget it. I knew many who had spent over five years in the specialty only to quit and go into general practice because the chances of becoming an attending sur-

geon (known as a Consultant) were so slim. A hospital of over 200 beds would only have one or two surgeons of consultant status and often the same surgeons would cover other hospitals as well. The only vacancies for consultancy occurred when a surgeon died or retired at the age of 65.

The situation in 1956 was that for every vacancy there would be about 70 applications for the post, each applicant having had considerable experience in surgery, holding an FRCS and many also having a Masters Degree in Surgery. Many of the vacancies would be in localities one wouldn't rationally choose as a place to live and bring up a family.

(I have heard that the situation has altered over the last few years and the competition for the posts is not as frustrating. This is because so many of the trained surgeons have emigrated. For many years, over 500 doctors were leaving the United Kingdom each year. Last year approximately 400 left.)

After my first surgical job, I became the house physician in the lovely Wiltshire market town of Salisbury near to Stone Henge. I enjoyed the experience and the six days off I received in the six months. One of the doctors in the hospital had just returned from a residency in the USA and from him I caught a glimmer that there were other ways to practice hospital medicine—and combine it with general practice.

However, my roots were in England and in its system, and one year of experience was not enough to say it didn't suit me. I entered general practice in a working class suburb of London in close proximity to where I had been the house surgeon. It did not take me long to question the attitudes and infallibility of the hospital-based doctors when I was wearing the GP's shoes. If I visited my patients who had been admitted to hospital on my old wards, I found I was less than welcome. Other GPs informed me that I would be considered to be interfering if I did visit them.

To supplement my income and get my foot in the door of a hospital, I obtained a post as clinical assistant in the OPD of the Royal National Throat, Nose and Ear Hospital in London. There, at least, I was able to order some followup studies and see some X-rays.

One of my duties in the ENT clinic was to help re-evaluate those children on the waiting lists to have their tonsils removed, to see if they should be moved up the list or onto the list with less priority. Some had been on the list six years! (At the time I left, the theoretical waiting time on the day the child's name went on the list was 10 years. This reckoning was with the assumption there would be no modification of priorities, no child would leave the area and no tonsils would recover without surgery.)

An ex-minister of health, The right honorable J. Enoch Powell, admitted in his book, "Medicine and Politics," that the only effective method for putting a brake on the unlimited demand for medical services was making patients wait for services. Many elective surgical procedures such as Cholecystectomy and Herniorrhaphy have a waiting list for admission. One to two years is not an uncommon time to wait for these procedures. The 'novel' method of using 'payment for services'—be it only a small price—has been little used as a brake on unlimited demand for services.

Some years ago, when prescription costs were soaring and the NHS was under a greater financial strain than usual, a token charge of approximately 25 cents was placed on each prescription instead of the medication being 'free.' During the six months following the initiation of this charge, the number of prescriptions decreased by almost 30 percent. With an election in the offing, the government in power at the time interpreted this decrease as meaning that 30 percent of the patients receiving a prescription from a doctor could not afford 25 cents (the cost of one-third of a packet of cigarettes)! The charge was then discontinued.

To return to the subject of my year in general practice, I was already used to working hard and long so the volume of patients seen in the office and on house calls didn't bother me too much until I realized that at least one-quarter of the patients needn't have come to see me at all on the occasion on which they did. The patient load fluctuated too closely with the mid-week soccer games being played at home and with the pre-holiday seasons.

Certificates for sickness absence (after the fact) were always tricky and frequent. If I hinted that I suspected some hanky-panky, the patient usually stuck to the story that he had come to my office but there were too many patients waiting and he felt too sick to sit there and wait. I usually handled the situation by giving the patient the certificate and saying, "Of course, I'm sure YOU were

sick but some people use my certificates improperly and they may get me into lots of trouble."

Not having any X-ray facilities in the office, less than meagre lab equipment, and little or no time for workup tests, any patient seen who needed those tests had to be referred to the hospital clinics. A very few simple tests could be referred directly to the hospital lab (mainly those concerned with the diagnosis and treatment of TB) but anything approaching a blood chemistry, an EKG or an X-ray could not be ordered by the GP directly, so the patient had to be referred to the appropriate clinic for those doctors running the clinic to decide on the tests and order them.

The result of this angle of the system, plus the difficulty of obtaining a hospital bed for acute conditions such as Myocardial infarction, Pneumonia and Stroke (especially Stroke), meant that a GP treated many of these conditions in the patient's home without any of the ancillary diagnostic aids which would be routine in a hospital. I recognised the satisfaction of 'curing' a condition with minimal help of diagnostic equipment and lab tests but there was always that sneaking suspicion at the back of my mind that the patient may not have had the condition I thought I had cured. Without this confirming knowledge, there was no testing of one's diagnostic and therapeutic ability and so improving one's effectiveness as a physician. With my present knowledge of cardiac arrhythmias which can be prevented or ameliorated by information only to be gained from ancillary equipment, I shudder at the risks the patients ran under my care.

Towards the end of my year in general practice it became clear to me that if I remained a GP under the NHS I would be practising medicine at an unsatisfactory level both from the point of view of my own lack of opportunities to improve my abilities, and from the point of view of my patients, as there seemed few ways of improving the quality of medical care being given. The urge to see the practice of medicine on the other side of the Atlantic increased so that when the sub-dean of my medical school asked me if I would be interested in a surgical residency in New York, I was on the boat in less than a month.

After a year in New York which opened my eyes to the tremendous opportunities here and the advantages of private practice, I returned to England for a time to clear up personal matters and to see if I had been mistaken about the NHS. I spent a year as Casualty Surgeon in a North Devon hospital in a charming small town from which part of the English fleet sailed to meet the Spanish Armada. My pay (\$45 a week) was three times as much as when I was a house surgeon and I was given a nicely furnished apartment, but the bureaucratic administration of the hospital was irksome and wasteful.

The GPs in the area had decided advantages over those in the metropolis and other big cities, insofar as they held appointments as surgeons, internists and anaesthetists on the hospital staff. However, as these men retired or died, their posts were filled with full-time specialists so the future as regards becoming an attending surgeon or a GP with hospital privileges was the same as elsewhere in the country.

Although the hospital was small (less than 200 beds) there was a veritable army of administrative assistants. Before nationalization, there had been a maintenance employee who looked after the heating system, lighting and mechanical appliances, with occasional help from outside private firms. At the time I was there, they had a chief plumber, electrician, heating engineer, and other specialists, all under a chief maintenance officer, all complete with offices, desks and secretaries, and inventory clerk. The hospital secretary also had a secretary. A few miles away was the governing hospital of the area, with a large administrative staff to pass on orders to the hospitals, in the group; and, of course, THEY were passing on orders from the Ministry of Health in London.

The town badly needed a new hospital with a modern building, and the chance of one being built was nil. Since the inception of the NHS in 1948, only three new hospitals have been completed in the whole country. I would be surprised if there were any counties in the USA that have not had at least one new hospital since 1948.

Within two years of returning to this country, I was in private practice and on the staff of three hospitals, and enjoying the immense amount of post-graduate education available in those hospitals. My office was equipped in a manner that would have been only a dream in England. The advantages of having a lab, X-ray equipment, physiotherapy equipment, an EKG machine and an examining table

that was designed to allow proper posturing of the patient, were great luxuries to me. They allowed me to offer services to my patients that to obtain under the NHS, they would have had to shuffle from clinic to clinic and hospital to hospital, hardly ever knowing who the doctor was who examined them.

I have been here permanently for 13 years now and I often wonder what sort of a physician I would be now if I had remained in England. A few years ago, my old medical school sent a list of all the old students. Reading down the list and noting their present addresses, I counted that more than half of those that graduated in my class had left England or the practice of medicine. Others must have thought as I did.

[From the Saturday Review, Aug. 14, 1971]

HEALTH CARE IN AMERICA: A HERETICAL DIAGNOSIS

"If the revolutionary proposals for transforming medicine are adopted, medical care in this country will cost more while providing less satisfaction and poorer treatment for millions."

(By Harry Schwartz)

The conventional practice of medicine and the physicians engaged in it are under attack in the United States as never before. Ranged behind a banner reading HEALTH CARE CRISIS, a large and vociferous group of critics claims that the nation's medical system is woefully deficient in so many major respects that it must be radically reorganized—and quickly. On this essential diagnosis and prescription, the Nixon administration stands shoulder to shoulder with Senators Edward Kennedy and Edmund Muskie, among others, as well as with numerous trade union leaders.

Many patients are vocally dissatisfied with the high cost of medical care and, increasingly, with the outcome—this latter fact attested to by an epidemic of malpractice suits. The past few years have seen a barrage of articles, books, television programs, and other investigations of the weaknesses and inadequacies of the medical system. "Don't get sick in America," the nation has been told, as though there were some place where it was good to have cancer or multiple sclerosis or schizophrenia. Alarmed by this atmosphere, the American Medical Association has begun to run scared, offering programs for improved financing and delivery of health care, and seeking to upgrade its public image by sponsoring advertisements to show that doctors do care about the health of their patients, the quality of the environment, and the like.

In their righteous wrath, many of today's critics seem to feel that limits of truth, balance, or plain good sense just don't apply to their holy cause. Thus, one national magazine recently blazoned its front cover with WHY YOU CAN'T GET A DOCTOR, though the editors surely know that every week millions of Americans see and are treated by physicians. And in another national magazine, a television critic who signs himself "Cyclops" assured his readers that Medicare has enriched the doctors in much the same fashion that the oil depletion allowances had served the oil industry. One wonders if in an earlier era Cyclops denounced "faceless and nameless accusers" who presented no evidence but simply accused broad categories of people. More generally, the critics have often focused on the worst areas in this field and trumpeted their findings as though they were typical. With that technique of course, every aspect of American life can be indicted since all—like medicine—have weaknesses and deficiencies.

Even unfair criticism can be useful in keeping an individual, an institution, or a section of society on its toes and helping prevent complacency. Vice President Agnew's attack on the media can be defended from this point of view. But in the case of medical care, many of the critics have "solutions" they want to offer. Having told us what incompetent, greedy monsters dominate the medical profession, the critics assure us that if we will only adopt their pet nostrum all will be well in the best of all medical worlds. The fact that for many years to come most of the physicians treating sick Americans will be the same men and women with M.D. degrees who are being denounced now doesn't seem to shake the faith of these true believers in simplistic solutions. Nor does it seem to occur to many of these would-be reformers that there could be heavy costs in the transition to some new health-care mechanism and there could even turn out to be serious new problems with the proposed "solutions." Such complications tend to

be ignored as the fighters against medical evil use the undoubted weaknesses of what now exists for their propaganda while assuming that their proposals would introduce a utopia. Only a few cynics seem to realize that all human arrangements have faults and that present difficulties need to be compared with probable future difficulties.

A staple argument advanced by those who profess to see a health care crisis is that the nation's health is well below what it might be because of the inadequacies of the present medical mechanism. To buttress this argument, the critics virtually always trot out international statistics purporting to show that the United States is way down on the list of the world's nations ranked by such indicators as infant mortality and expectancy.

In part, this argument is based upon simple naiveté in statistical matters. It assumes that it is meaningful to compare small, homogeneous nations concentrated on relatively tiny territories—Sweden and Holland, for example—with the United States, whose population is roughly twenty times as large, incredibly heterogeneous, and spread across a whole continent. Moreover, those who triumphantly cite these statistics usually ignore the problems of statistical definition that make such comparisons even more suspect. And they almost never point out that if comparisons are made between the two most nearly comparable large countries for which data are available—the Soviet Union and the United States—the Soviet Union turns out to have a much higher infant mortality rate than the United States and approximately the same life expectancy level. Why doesn't anyone talk about a Soviet health care crisis?

But this argument has an even more fundamental fallacy, which is the assumption that in a highly developed, modern urban society medical care is somehow the decisive element in such matters as infant mortality and life expectancy. This, of course, ignores all the complex social forces at work. Whatever its sins, the American medical establishment is not responsible for hunger in this country, for the automobiles that kill 50,000 or more people here annually, for the drug overdoses that claim thousands of young lives, or for the millions of Americans who court heart disease and lung cancer by overeating, exercising little or not at all, and smoking a pack or more of cigarettes daily. If a person chooses to eat or smoke his way to death despite his doctor's warning, why blame the doctor?

Finally, it is curious that those who rush to use statistics to indict American medicine are so quiet about data that point in the opposite direction. Why is so little said, for example, about the dramatic decline in American infant mortality in recent years—a drop of more than 20 per cent just between 1965 and 1970? Last year, for the first time in American history, the infant mortality rate went below twenty deaths per thousand live births. Nor are we often reminded that, when allowance is made for the changing age distribution of the population, the death rate in this country has been dropping significantly. In 1967, the last year, for which data are available, the age-adjusted death rate in this country was 7.3 per thousand population. Twenty years earlier, the corresponding figure, 9.0 per thousand, was almost 25 per cent higher.

I do not mean to suggest that there is no room for further improvement. But if critics want to be honest with the American people, they ought to present the whole picture—including the undeniable evidence of substantial and continuing improvement, in some cases very rapid improvement—and not merely carefully selected international comparisons, the relevance or validity of which is dubious. It should be added, moreover, that the gains, i.e., the reductions, in American infant mortality and overall mortality rates have been shared by whites and non-whites of both sexes.

A second frequent complaint is about shortages of doctors, sometimes more generally of all health manpower and womanpower. Along with this grievance often goes the more or less explicit charge that the American Medical Association has been choking off the supply of doctors, presumably to increase its members' monopolistic power.

Nobody can deny that there are shortages of doctors in some places and that the worst problems are encountered in urban slums and remote rural communities. But the United States as a whole has one of the highest ratios of physicians to population in the entire world. Between 1950 and 1970 the number of M.D.s in this country increased almost 50 per cent, or substantially more than the roughly one-third population increase in the same period. Moreover, the country's rate of physician production is mounting rapidly as old medical schools expand enroll-

ments, new medical schools begin operating, and some medical schools cut the period for M.D. training from four to three, or even two, years. In September 1971, according to an estimate by the Association of American Medical Colleges, 12,500 new medical students will begin their studies, about 40 per cent more than the number of freshmen enrolled as recently as 1965.

The net increase of between 35,000 and 40,000 doctors in this country just since 1965 makes a mockery of the charge that the AMA or any other organization is attempting to preserve some sort of monopoly. The real problems are different, and they have at least three roots. One is the trend toward specialist care and away from general practice, a trend born both of the economic advantages of being a specialist and of the increasing volume and complexity of medical knowledge. A second factor is the understandable desire of many physicians to live and practice where it is most advantageous and pleasant for them to do so, rather than in surroundings of poverty or of professional isolation; physicians are abundant on Manhattan's fashionable East Side and in affluent Westchester County, but very scarce in Bedford-Stuyvesant and the East Bronx. Finally, there has been a tremendous upsurge in the demand for physicians' services born of the Medicare and Medicaid revolutions of the mid-1960s, which lowered the economic barriers to medical care for millions without immediately doing anything to compensate for the provision of this care.

Nevertheless, there can be little doubt that in recent years more Americans have been receiving more—and usually better—medical care than ever before in the nation's history. But this is hardly the situation that the term "health care crisis" brings to mind or is intended to bring to mind.

A third complaint is the rapid rise in the nation's total medical bill. Here is the way the Nixon administration's recent White Paper on medical care put the indictment:

In fiscal year 1970, the nation spent \$67-billion on health, nearly three-fifths again as much as had been spent only four years earlier. While undoubtedly there were improvements in the quality of care for at least some of the population, more than 75 per cent of the increase in expenditures for hospital care and nearly 70 per cent of the increase for physician services were the consequence of inflation.

Put this way, of course, there is a strong implication of gouging, of conscienceless profiteering at the expense of the sick. But every American knows that the last four or five years have been a period of rapid general inflation, of substantial rises in prices and wages throughout the economy. Between 1967 and 1970, for example, the consumer price index shows that physicians' fees rose an average of 21.4 per cent, or almost exactly the same percentage by which average hourly earnings of workers on private non-agricultural payrolls increased over the same period. Between 1967 and 1970, the consumer price index reports, the average price of a semi-private hospital room rose 45.4 per cent. Hospitals, of course, are very labor-intensive institutions, and before Medicare and Medicaid many of their personnel—interns, residents, and housekeeping workers, many of the last being from minority groups—received very low wages. These last mentioned groups have particularly benefited from above-average wage raises in recent years, a circumstance that hardly makes such formerly disadvantaged workers economic criminals.

There should be no illusions in this area. Proper care of the sick—particularly of the elderly, who make up such a disproportionately high percentage of the seriously ill—is and always will be a very expensive proposition. There are, of course, inefficiencies in the existing medical-care mechanism that add to costs, but it is a delusion to think that the physically ill or the emotionally disturbed can be handled satisfactorily and humanely in ways that will compare in efficiency and cost effectiveness with the assembly-line techniques Detroit uses to build automobiles. Certainly the nation does not want the high percentage of error and neglect in its health care that car buyers find in their new vehicles.

Yet, it is essentially assembly-line medicine provided by collectivized physicians that the critics suggest to meet the "health care crisis." The road to medical utopia, many voices now tell us, is to be found by general acceptance of prepaid group practice arrangements ("health maintenance organizations," in Nixon administration jargon) on the model of the Kaiser-Permanente groups along the West Coast. Such prescriptions are natural if one believes this country is now in a health care crisis, which derives from the clichés the critics em-

ploy to describe present American medicine. They hold that it is "a cottage industry" consisting of "solo practitioners" working on a "fee-for-service basis" in a "non-system." Simply inverting these terms produces the notion that what is needed is a mass-production medical industry staffed by teams of doctors working independently of payment in a highly organized system.

This description of the present situation is grossly oversimplified. American medicine today is highly pluralistic. Millions of Americans have completely socialized medicine; for example, those in the armed forces and in Veterans Administration hospitals. Several million others belong to prepaid group practice organizations, and additional millions look to hospital emergency rooms, outpatient clinics, and the like for their primary medical care. Medicare, Medicaid, and private medical insurance, including Blue Cross, have revolutionized the economics of medical care in recent years. In short, the stereotype of the sick American going to the isolated physician and digging into his pocket for the \$10 or \$15 fee covers only a portion of the reality. And, except in remote areas, no physician is really isolated since any good doctor is part of an informal system that includes him, the specialists he refers patients to when specialists are needed, and the hospital or hospitals he sends his patients to when necessary. And it is a strange cottage industry indeed that includes such institutions as New York City's Presbyterian Hospital, Boston's Massachusetts General Hospital, and similar large hospitals all over the country.

The existing pluralistic system provides choices for both physicians and patients. In such large communities as New York City, San Francisco, and Denver there is competition between private physicians and group practice organizations, as well as, of course, among the private physicians themselves. And where one uses private practitioners, the fact that the doctor collects a fee gives him an economic interest in satisfying the patient—not a bad motive however much the idealists might wish that doctors, unlike all other human beings, had no sense of self-interest. And the fee acts as a partial barrier to excessive calls on the doctor's service, a restraint against running for help for every vague pain. Moreover, a system in which the doctor's income is proportionate to how many patients he sees encourages physicians to work hard. Many doctors today work sixty or more hours weekly.

Of course, insofar as American medicine is still a cottage industry based on a one-to-one relation between a family doctor and a patient, it has much to recommend it. Since most ailments are self-limiting, they can be handled adequately even by a "solo practitioner," especially if, as is normal, he has access to laboratory and X-ray facilities. A family doctor—and there are still many of them around—gets to know his patients as human beings and is able to provide what is probably the most frequent positive outcome of the patient-physician encounter: reassurance and psychological support. A large fraction of people who go to doctors have no objectively detectable illness and really want psychiatric aid, which comes more effectively from a man or woman the patient knows than from some impersonal stranger. And for many frightened persons, reassurance is far more effective if it comes from a full-fledged M.D. than from a physician's assistant, a nurse, or some other person with less training than a physician has.

Private medicine also has flaws, of course, and is sometimes abused, as any human arrangement tends to be. Unscrupulous doctors can keep a patient coming back more times than necessary in order to collect more fees. But the fact that most doctors are busy probably minimizes this type of abuse. Some observers have charged that there is a fair amount of unnecessary surgery in some areas, a possibility that cannot be dismissed. Some surgeons have complained that general practitioners often perform surgery they are really not qualified to undertake, sometimes with terrible and even fatal results. A growing problem in private office and hospital practice is the plague of malpractice suits, which is adding substantially to the cost of medical care. Physicians, increasingly fearful they may be sued, are practicing "defensive medicine," prescribing more laboratory tests, more X-rays, and more specialist consultations than are often necessary in order to be sure they have an adequate defense if a disgruntled patient sues. But the same problem will exist with any type of medical system until the whole malpractice situation is radically changed.

There could be no quarrel with advocates of prepaid group practice systems if these advocates simply urged the elimination of existing legal barriers to such

arrangements and limited public subsidy to help meet initial costs of setting up such groups. Kaiser-Permanente and similar organizations have shown that group practice is one feasible way to organize medical care, with attractions for some physicians and for some consumers. Physicians get reasonable salaries, freedom from the entrepreneurial and other woes of private practice, regular hours, and the aid of other physicians and ancillary medical workers. Patients have a fixed or semi-fixed medical cost, for which they can budget in advance, and a source of medical care available at any hour and on any day. Competing with private physicians, group practices can put economic curbs on private doctors' fees and force the private practitioners to make their own informal or formal arrangements to ensure that patients can get a doctor at 3 a.m. on a Fourth of July and on other occasions when most people are sleeping or on holiday.

But the zealous advocates of revolutionary change in American medical care go far beyond such modest and realistic claims. They see group practice or health maintenance organizations as wonder-working systems that can provide better care for lower costs while simultaneously ensuring that the population enjoys better health than ever before. It is these expectations that explain the intensity of the more extreme propagandists for universal health insurance and compulsory group practice.

However, the evidence presented for these claims is very thin, particularly since group practice in the United States has historically been limited to special groups, while what is advocated by the extremists is extension of this mode of health care delivery to the entire population.

How, for example, can group practice improve the nation's health if medical science knows so little about the causes of the degenerative and hereditary diseases that cause so much illness? And what is there about group practice that will enable it to stop smoking, overeating, lack of exercise, reckless driving, heroin addiction, alcoholism, poverty, inheritance of genetic defects, and other individual or social causes of sickness and death?

Some people argue that the end of direct financial cost for medical care will encourage people to go to doctors earlier than they might otherwise and thus catch diseases at a stage where they can be dealt with more effectively. This may be true in some cases, but the change to prepaid medical care has more complex consequences.

The end of fee-for-service removes the individual physician's economic interest in his patient, while, for the group as a whole, it is economically advantageous to do as little as possible for the patient. For the subscriber to such a group, however, the removal of additional out-of-pocket cost for a visit to the doctor creates the temptation of overuse the group's resources. Thus, a tension is automatically set up between the group physicians and their patients.

One result of this situation has been well described by Dr. Sidney Garfield, the founder of the Kaiser-Permanente groups. Last year Dr. Garfield wrote in the *Scientific American*:

"Elimination of the fee has always been a must in our thinking, since it is a barrier to early entry into sick care. Early entry is essential for early treatment and for preventing serious illness and complications. Only after years of costly experience did we discover that the elimination of the fee is practically as much of a barrier to early sick care as the fee itself. The reason is that when we removed the fee, we removed the regulator of flow into the system and put nothing in its place. The result is an uncontrolled flood of well, worried-well, early-sick, and sick people into our point of entry—the doctor's appointment—on a first-come first-served basis that has little relation to priority of need. The impact of this demand overloads the system, and, since the well and worried-well people are a considerable proportion of our entry mix, the usurping of available doctors' time by the healthy people actually interferes with the care of the sick."

Dr. Garfield is attempting to meet this problem by experimenting with the use of computerized, automated, multiphasic screening techniques. A battery of tests—by machines and physician's assistants—is hardly the kind of warm, humane, intimate medical care most people want. On the contrary, the impersonality of such care, the lack of any long-term continued contact with one physician, is likely to repel many people. Moreover, the possibilities that a national system of prepaid group practice will turn into a bureaucratic monster are enormous.

It is strange that the enthusiasts for more "system" in medicine have not learned anything from the debacle of the nation's public school system. In every community, public school education is free to the recipients; yet, everywhere—or almost everywhere—there is bitter complaint of the failure of this system to teach effectively or to satisfy the psychological needs of our young people. Strikes by school teachers are now no longer novelties. Are there any guarantees that a national medical system will not follow the same path, and that someday we will not have strikes by doctors? Will some future Ivan Illich have to appear to demand the liberation of sick Americans from the medical bureaucrats as Mr. Illich now calls for the liberation of young Americans from the educational bureaucrats?

In an era when people are again referring respectfully to the one-room schoolhouse as a "daring experiment," should we lightly scrap the cottage industry aspects of medicine where they permit intimate, long-term, and humane contacts between physicians and patient? A human being is not a machine that can be fixed by any garage mechanic when something goes wrong. Yet, that philosophy is the implicit premise of much current discussion of medical reorganization.

The nation's real problems of medical care can best be met by measures that focus on particular trouble areas, rather than by a violent transformation of the entire complex medical system that would affect equally all parts, those working well and those working poorly.

Of course, the ghettos and small towns need more doctors and medical facilities. But the government already has authority to recruit physicians and other medical personnel to meet these needs. And if young physicians are idealistically anxious to go into these deficient areas, why shouldn't the state help them do so?

The family of moderate means struck by catastrophic illness can be bankrupted by heavy medical bills. That problem could be solved by government-organized, compulsory major medical insurance whose cost on a national per capita basis would be relatively small.

In the present period of galloping inflation, it is probably utopian to suppose that the inflation of medical costs can be curbed, short of a general wage-price freeze for the entire economy. But it is not unrealistic to suppose that the upward rocketing of hospital costs might be slowed down by a variety of measures. One important need is for revision of the formulas used to reimburse hospitals under Medicare, Medicaid, Blue Cross, and other insurance schemes. These formulas—which in the past have often stressed cost reimbursement without pressures for economy—need to be altered so that hospital administrators will be more economy-minded in the future than in the past. The needless proliferation of duplicative hospital facilities needs to be stopped and replaced by systems of hospital cooperation so that patients at several hospitals in a locality have shared access to a particularly scarce or expensive facility. The escalation of medical costs could also be usefully countered by effective action on the malpractice front so as to curb present excesses and abuses that add significantly to the costs patients, insurance firms, and the government must pay.

There are many other ways in which the present medical system can be intelligently and humanely improved. But these needed and useful improvements can be made within the context of a continued pluralistic system. Different people have different tastes and different needs. Those who want to use prepaid groups should be permitted to do so; those who want to go to a physician and pay him each time should be free to do so, too. The result may not seem to be as neat on an organization chart as a uniform national system, and it may have seeming inefficiencies and duplications. But the right of choice for doctors and patients alike is worth such costs—at least in a really humane society.

In an era of increasing and justified disenchantment with big government, it is astonishing that so many well-meaning and intelligent reformers essentially want to nationalize and bureaucratize American medicine, either explicitly as in Britain or implicitly as in some of the legislation before Congress. One would have thought that the postal and public school systems would have taught them long ago that nationalization does not mean efficiency, and that the telephone system would have taught them that even a private integrated system can develop serious flaws. Based on the record of the past, we have every reason to suspect that if the revolutionary proposals for transforming American medicine are adopted and implemented, medical care in this country will cost more while providing less satisfaction and poorer treatment for millions.

[From Private Practice, May 1971]

BRITISH HEALTH CENTRES: "I FEEL LIKE I'VE BEEN PROCESSED"

(By Joan Hobson)

The middle aged man I met coming out of a Nottinghamshire Health Centre was pale, unsteady and obviously in need of reassurance. His reaction to treatment in that recently completed, somewhat stark medical establishment indicated both dissatisfaction and disillusionment "I feel like I've been processed rather than healed," he said.

There are around 100 Health Centres now operating in Britain, buildings from which varied numbers of family doctors practice in combined operation. The local government provides the premises and GPs pay rental for accommodation and maintenance services. The Health Minister then reimburses that sum to the doctors (less a percentage to cover any use of the premises for treatment of private patients). Nursing, clerical and maintenance staff receive their salaries direct from the Local Authority.

The establishment of Health Centres throughout Britain was originally suggested in 1934. According to a 1944 survey 50 percent of the general practitioners were then in favour of such Centres—subject to the condition that doctors still work on a capitation fee basis and remain free to undertake private practice.

When the National Health Service was established in 1948, doctors counted on the Health Centres to revolutionize working conditions. By organizing duty periods and providing telephone cover, the Health Centre, it was thought, would relieve GPs of non-stop duty and the need to work from consulting rooms incorporated into their homes.

But the profession was in for a shock. First, the act of making health care free at the time of service increased work load beyond all expectations. Then, within six months, Parliament instructed local authorities to postpone provision of the promised Health Centres.

Only 20 Health Centres were built in the first 18 years of the NHS. After 1966 Health Centres were included in plans for numbers of new housing estates, resulting in the increase to 100.

Ironically, the government's delay in implementing the original promise has resulted in an about face by many of the doctors who initially voted for Health Centres. Armed now with knowledge that bureaucracy is constantly spreading its tentacles into all areas of medical practice, the profession has withdrawn its half-approval. A recent poll among doctors in one southern county revealed that 75 percent are now anti-Health Centre.

In view of the way in which the Centres have developed, many fear that working from Centres will further damage the doctor-patient relationship.

Every doctor likes to have his own consulting room, but local authorities say it is uneconomical for rooms to stand empty while the "owner" is making house calls, so there is sometimes insistence that the rooms be shared by other people. Four practitioners operating a Centre near London complain that a welfare clinic, a chiropody service for the aged and occasional blood donor sessions take over their personal offices during the afternoon. A Lanarkshire Centre now in the planning stage, has been designated on the premise that whenever any particular doctor is not there his room will be used by someone else. That Centre will house 18 doctors to cater for 50,000 patients.

Medical men have also come to realise that in providing premises the local authorities could also forbid doctor-tenants access to those premises if future disputes with the Ministry of Health drove the profession to undertake sanctions. How could its members take effective action knowing they would be left without practice premises were they to quit the NHS?

Some doctors have already found that they are locked out of their consulting rooms without prior notice. A Flintshire doctor arrived at the Centre he and five colleagues share with a local Antenatal Clinic to find a notice; "Surgery closed owing to infectious disease in the Clinic." The six doctors had to hastily arrange for accommodation in private houses nearby.

Many local authorities have publicly excused the prolonged delay in providing Centres by implying that their budgets have more deserving calls, but privately they are seriously concerned lest insufficient doctors come forward to

staff them. They fear having expensive "white elephant" Centres, unoccupied and unused.

In 1958, all eight family doctors of Clerkheaton in Yorkshire decided to form a Health Centre. They informed the government of their decision and asked for premises, but no progress was made until 1963. Only then, when the Divisional Medical Officer and the Public Health Department also asked for new headquarters, did building commence. For the past six years those departments, the doctors, a dental clinic, mothercraft classes, the Infant Welfare Department, an Antenatal Clinic and the town's Registrar of Births and Deaths have all been operating from the same premises.

Such centralisation has proved convenient in some respects, but patients who live on the outskirts of town must now travel considerable distances to reach a doctor.

At a six-doctor Centre which recently opened in Bedfordshire, a white-haired lady told me "Three miles is a long way to walk when you're not feeling well. The area is poorly served by public transport and even when I get here there's no guarantee I shall see my own doctor. I find the place very impersonal in comparison with the friendliness of the doctor's house. The carpetless floor and colour-washed walls give the place an institutional air."

Her neighbor whispered "It's the visiting arrangements that I object to. Previously I knew that my doctor would visit when I needed him, but now it could be any of the doctors who work here. In five consultations I haven't seen the same man twice. No doubt they all have access to my records but this constant change of medical adviser isn't very confidence-inspiring!"

Although patients at Health Centres still register with the doctor of their choice, each doctor in turn covers a different area for house-calls. There is no previous indication of which doctors are on duty during consulting hours and in some Centres the patient is not even told by whom he will be seen. "Wait outside door No. 4" could mean that it is a member of the practice on duty, a temporary assistant or even a locum.

In one Midland Centre I saw a determined-looking lady cause confusion in the appointment schedule by walking out when she caught a glimpse of the very young, shirt-sleeved doctor who would be treating her. Another woman nodded understandingly and said "I've often been too embarrassed to tell the reception clerk that I only care to see Dr. B., I take my turn but pretend I've only come about some trivial matter, then return in hopes of seeing Dr. B. a couple of days later. It was better when I could rely on seeing my own doctor every time."

A male patient in the same waiting room told me "I don't care for this method of working at all. If I get out of bed feeling unwell I want to see my doctor that morning. I was given this appointment two days ago."

A providential downpour allowed me to get some unexpectedly frank comments from patients at a Centre near Brighton. People who had been reticent in the waiting room talked more freely in the covered approach while we waited together for the rain to ease-off.

A bowler-hatted gentleman commented "I have to use this Centre because all the doctors in the area have now closed their home-based offices, but I'm very much aware that the personal relationship has been lost. I know that doctors are busy people and it is not likely that my doctor remembered me in great detail, but at least I knew him, and as each interview progressed the rapport we had earlier established was renewed and developed. Now it's often a fellow I've never previously met and unless I ask him directly, or can make out the signature on his prescription, I don't even get to know with whom I've been discussing intimate aspects of my life. I feel like a case history rather than an individual."

The wife of a newly-retired Army Colonel, who had been attended only by Army doctors for the past 25 years said she was shocked at the deterioration in medical care under the NHS. "We used to hold the family doctor in great respect and affection; so the impersonal medicine practiced here comes as an unpleasant surprise. I get the impression that doctors now only deal with actual sickness, they're no longer interested in their patients as people."

Doctors working in Health Centres find it necessary to meet for a daily discussion about patients and administration. This makes for smooth working but it is time consuming. At a medical conference held recently in Oxford Dr. Fairlea, senior member of a 16-man Health Centre, said that when he worked alone, with only his wife as aide, he was able to commence his house calls im-

mediately after the morning consulting session came to an end. Now he spends an hour conferring with other members of the practice and briefing the ancillary staff, which totals 17. Parkinson's law now operates fully at the Health Centre. The nurses think it beneath their dignity to make tea, so the juniors employed to do this and other small tasks swell the staff to a total which justifies a book-keeper and a personal secretary.

Maintenance of the Health Centre is a frequent bone of contention. A GP in Cheshire showed me examination cubicle curtains tattered and threadbare from use. He told me "We have twice gone through the procedure of submitting long requisition forms in triplicate to the local authorities but we are still awaiting the curtains. When I worked from my home my wife produced such things in a matter of hours."

Some doctors have come to feel that practicing medicine from a Health Centre is more like running a business than conducting a dedicated profession. They consider themselves entitled to observe office hours and at other times employ one of the several privately-run emergency services which have been set up in Britain (mainly staffed by junior hospital doctors using their off-duty time to augment income).

Undoubtedly Health Centres have lost the doctors working in them the image of family friend and advisor. Pooling resources enables doctors to afford better equipment and additional facilities, but do those things outweigh effects of the new type medicine being practiced from the Health Centres?

George Partridge, a recently retired Sussex GP described his first visit as a patient to the Health Centre which replaced the separate practices of himself and several other GPs. "I know that the furnishings alone cost rate-payers over \$48,000, and the place is certainly very spick and span. Each patient is received by one of several officious clerks. If he has no appointment with Dr. X he is told to sit on a red chair and wait; if his appointment is with Dr. Y he is directed to a green chair. If one of Dr. X's patients inadvertently sits on a green chair he is ticked off as if he were a naughty child and made to feel he has committed an unforgivable social faux-pas. When his turn comes, the patient's name is bawled out by a loudspeaker."

Dr. Partridge sounded bitter when he described the case of a local fisherman who cut his leg while mooring a boat. The man struggled five miles to the new Health Centre but was refused treatment because he hadn't made a previous appointment.

While on a walking holiday in Scotland I developed a painful heel and took the opportunity to visit a Health Centre as a temporary patient. To avoid confusion among patients of the 12 doctors, colour coding was also used there. I was instructed to pass down an orange-linoleumed corridor until I reached a mauve door. On the way I met a man who remarked "We're like a lot of ants following trails so that scientists can use us for study. They'll be putting us on conveyor belts next."

Doctors working from Health Centres are increasingly being called the "nine to fivers" by their patients, and many of them have become aware that true involvement in patient-care is impossible under the impersonal conditions such Centres impose.

Dr. Paul Sharpe showed me a report from the Mental Health Officer who occupies an office in the same Centre. It was headed "re Patient No. 4798" and at no point in the context did the person's name appear. Dr. Sharpe said "Patients are becoming mere cyphers. Registration numbers, identification digits and NHS numbers now figure so much in my work that I sometimes feel more like a mathematician than a physician."

Although it is now nearly 40 years since a British political party first talked about establishing Health Centres there still seems considerable doubt that they will ever come into countrywide operation.

At present Health Centres are still in the experimental stage, but there is no central agency for planning. No department of the Health Ministry has ever collected information about the Centres already built, let alone made any objective assessment of their performance. Until contra-indication is available the trend is towards ever-larger Centres. One now being built in Middlesbrough will house 21 GPs to take care of 62,000 patients. Several of the Centres planned for Glasgow will each be used by 25 practitioners and their patients.

Dr. Ditch of Wolverhampton wrote recently in a medical publication "While working on the Planning Committee 20 years ago I came to a lot of the view that

the Health Centre was to be the linchpin of future general practice, but the more I have seen since, the less I believe that family medicine can be satisfactorily carried on through Health Centres . . . sophisticated equipment and the ever-accumulating mass of data only form part, and possibly a minor part, of what is demanded in the care of the patient . . . this can be provided only by a medical attendant fully conversant . . . with all aspects of the patient's life and readily available in need. It is a hopeful sign . . . that so many general practitioners have preferred to continue in individual practice."

Evidently most of the 17 doctors who went into occupation of a Durham Centre a few years ago agree with Dr. Ditch. Only four of them remain and they now work there on a part-time basis.

A doctor in Newcastle expressed his antipathy to the Health Centre: "Personal relationship is an important aspect of doctor-patient communication. It is necessary not only to see the condition but to know all the background of the patients, their trepidations, their attitudes to life, their special fears. You cannot know this if the patient may be seen by any doctor in the Health Centre practice. A proper personal service just cannot be given in this way."

[From Private Practice, January 1971]

THE "CRISIS"

(By Marvin Henry Edwards)

One must use care in his choice of words, for words are meant to be precise.

The word "crisis" for example, has a specific meaning, and is not to be bandied about in any old fashion. Yet that is just what is being done today by those who, with great irresponsibility, speak of a health crisis in the United States.

According to the Webster's dictionary, "crisis" means either (a) the turning point in an acute disease or fever; (b) a paroxysmal attack of distress or disordered function; (c) a radical change or status; (d) a decisive moment, or (e) an unstable or crucial time.

Only from the standpoint of definition (d)—"a decisive moment"—can there be said to exist a "crisis." But that crisis is political, not medical, in nature.

In none of these regards can it be properly said that there exists a "crisis" in health care. Medical care in this country is suffering neither from illness nor disorder, nor has there been any radical change or instability. Instead it progresses at a wondrous rate, sometimes spectacularly, to provide better care for each succeeding generation.

One valid manner of measuring the progressive improvement in medical care is a comparison between life expectancies, past and present.

Much of the world's greatness has been snuffed out by early death: Robert Burns died at 37; Kafka at 41; Van Dyck at 42; Mozart at 35. Of the three famous Bronte sisters, only one lived beyond her 20s.

First, the old footman in Chekhov's "The Cherry Orchard," looked back at a life which, for all its years, had flown by too quickly, too lacking in purpose and accomplishment. "Life has gone by as though I had never lived," he mourned. And the man who wrote those words might well have said the same thing for, though Chekhov filled his life with achievement, becoming one of Russia's greatest writers, his life, too, flew by quickly. Chekhov was dead, of consumption, at the age of 44.

And how John Keats wanted to live to bare the beauty in his soul. "When I have fears that I may cease to be/Before my pen has gleaned my teeming brain . . ." he wrote. But consumption cut Keats down, too, at the age of 26.

Consumption—TB—has been practically wiped out as a potential killer. If Chekhov and Keats had lived today they might have looked forward to producing masterpieces for far more than a meager 44 or 26 years.

The tragic early deaths of Keats and Chekhov, of Mozart and Burns and the Brontes were typical of the age. Just 100 years ago the average American could expect to die before his 42nd birthday.

Dr. Wesley W. Hall, president-elect of the American Medical Association, recently wrote in this magazine "we can still do only one thing: exercise some influence upon the time and cause of death." By that standard, modern health care performs miracles unthought of when this century began.

Diseases which killed hundreds of thousands in the past have been virtually wiped out of existence. Tuberculosis and polio are prominent examples. Open heart surgery now saves many lives each year. The cancer survivorship rate continues to improve (for example, the death rate from uterine cancer has been cut in half in the last 30 years).

Life expectancy at birth has increased from 41 years in 1850, and only 49 years in 1900, to more than 70 years today. In 1850, a fourth of the newborn died before age five. In 1900, a fourth of the newborn died before age 25. But three-fourths of today's newborn can expect to reach their 62nd birthday and, according to the New York Times' Encyclopedic Almanac for 1970, half of today's newborn are likely to live at least 74 years. Nor is it only infant and child mortality which has been so drastically reduced; the diseases and illnesses which afflict all ages have been subdued, in part, by the advances of modern medical care. Americans at every age—even into their 70s—can expect still more life ahead of them than an American of the same age at the turn of the century.

Even more significant than the life expectancy rate is the great drop—at every age—in annual mortality rates. At the beginning of the 1900s, of every 1,000 babies born alive, 124.5 could be expected not to survive a year. Today the rate is approximately 21 per 1,000. The same is true at all ages: in 1900, of every 1,000 persons who reached age 35, nine would fail to survive to the age of 36. Today the mortality rate at age 85 is approximately two per 1,000.

Such is the nature of the current "crisis."

One might suspect that those who so blatantly cry of "crisis" do so deliberately—that they are purposely trying to deceive the public into believing that there is a medical "crisis" which would justify the drastic changes they propose.

Of course, there are imperfections in medical care, as there are in other things. America has more physicians per capita than any other major nation in the world—but obviously there is a capacity for more. Most Americans live in reasonably close proximity to excellent medical care—but there is great merit in seeking incentives to induce more doctors into areas of low physician concentration.

There is always room for improvement. But two things must be kept in mind: First, the existence of imperfections will not be erased by the establishment of government controls. Quite the contrary. In Britain, for example, there is an actual and desperate physician shortage; a shortage of hospital beds; a marked depersonalization of medical care; a multitude of waiting lists for hospital care. Such is the way government controls improve a nation's medical services.

Second, the continued existence of imperfection does not constitute a "crisis," and speakers and writers who use the word should be challenged promptly.

Medical care today is far better than it has ever been before. Further improvement is desirable, as it always has been always will be. *But there is no medical crisis.*

[From Human Events, Oct. 24, 1970]

THE CASE AGAINST NATIONAL HEALTH INSURANCE

(By Allan Brownfeld)

The question of national health insurance promises to become one of the political sizzlers of the 1970s. The opening shots were fired during the past few months, but they are only a bare indication of the rhetoric and political posturing which will follow.

In February, Rep. Martha Griffiths (D-Mich.) introduced an AFL-CIO-sponsored national health insurance bill. Sen. Edward M. Kennedy (D-Mass.) on August 27 led a bipartisan group of 15 senators in proposing to establish a Health Security Program, based on the recommendations of the Committee for National Health Insurance. The committee was formed in November 1968 by the late Walter P. Reuther, president of the United Automobile Workers.

The two bills are similar. They would provide health insurance for all Americans, financed largely through Social Security-type taxes on employers and employees and from general federal revenues. Coverage would include hospitalization, physician services, nursing home care, dental treatment and drugs.

The program, which would begin in mid-1978 if the congressional sponsors have their way, would cover all health services "required for personal health," with the exception of custodial, psychiatric and dental care, and some drugs and medical

appliances. Doctors and hospitals would be compensated for their services by the program—either on a fee-for-service or retainer basis. Employers and employees would be compelled to contribute to the plan whether they wanted to or not, and regardless of whether or not they were covered by private health insurance plans.

The cost for the program is estimated at \$40 billion.

The financing would be handled through a Health Security trust fund similar to the Social Security trust fund. A 3.5 per cent tax on employer payrolls would provide 35 per cent of the fund; a 2.1 per cent tax on individual income up to \$15,000 would add another 25 per cent; and federal general revenues would contribute the remaining 40 per cent of the fund.

A major emphasis in the bill is on reorganizing the delivery of health care services. A Resources Development Fund is proposed to increase manpower and resources and create new programs of organized health care. Up to 5 per cent of the total funds in the trust fund would go to the Resources Development Fund to be used on a grant basis to encourage improved health services, such as training of paraprofessionals and developing the use of helicopter health service for isolated areas.

The reason for the introduction of such bills for government involvement in and control of medicine at this time is that there has been much discussion of a doctor shortage, of increasing health costs and of the alleged "failure" of the American system of the private practice of medicine. A number of important questions must be asked, both about the medical delivery system as it now exists, and about the assumptions which seem to be the basis upon which Sen. Kennedy and his supporters seek to change our entire approach to medical and hospital care.

Initially, *would a system of national health insurance provide a more economical system of medical care?*

For an indication of foreseeable costs, the plan's sponsors figure that in fiscal 1969 the federal government spent over \$9 billion for all personal health service programs. If their program had been in effect then, they say, it would have disbursed most of that amount and would have required an additional \$6 billion from general tax revenues.

These are significant increases, and such before-the-fact estimates in this area are notoriously understated. Thus, an article in the *New Republic* by Washington health-affairs writer Mel Schechter states that Medicare alone, without any changes, needs more payroll taxes to meet a 25-year projected deficit of \$236 billion in hospital-related benefits, an overrun of nearly 100 per cent.

The financial fate of France's system of partly socialized medicine provides an important case in point. The cradle-to-grave system of social security started in its present form in France just after World War II and has become one of the touchiest political issues in the country.

The system runs three funds, one to cover health costs, one for old age pensions, and one for family allowances.

The family allowance system, designed to combat a low birth rate by giving families money in direct proportion to their size, has the only fund showing a surplus.

The health fund, on the other hand, will run a deficit of \$185 million this year, which is expected to double next year and, according to experts of the Government Planning Commission, will rise to \$1.8 billion in 1975 if left unchecked.

According to the *New York Times*, "As a result of all of the advantages which the system accords, its officials have noted with rising alarm but general helplessness, there is an overwhelming eagerness among Frenchmen to take good care of themselves. . . . The doctors, the medical laboratories and the pharmaceutical industry, both manufacturers and retailers, are prospering as the deficit grows."

Involving the federal government in direct control of medical care would, according to Ralph R. Rooke of the National Association of Retail Druggists, "produce an administrative nightmare, with federal officials . . . working out contracts with 6,000 hospitals, 25,000 nursing homes, 700 visiting nurse groups and, later, with 208,000 doctors and 55,000 retail pharmacists." The paper-work involved in processing the millions of resulting claims "stagger the imagination. An extremely large force of government workers would undoubtedly be required to do the job."

And, in the end, would American health services be better than under the current system? The report concerning the British health system by Prof. John Jewkes, who served on Britain's Royal Commission on Remuneration of Doctors and Dentists, concluded that "The average American now has more medical

services than the average Briton" and "the gap between the two has been widening" since the inception of the National Health Service.

More and more Britons, according to the evidence presented by Jewkes, are seeking medical care outside the National Health Service. These people, the report notes, are "ready to make sacrifices in other directions in order to enjoy prompt hospital and specialist treatment, free choice and consultant and private accommodation." The *British Medical Journal* pointed out that Jewkes weighed in "with a quiet voice . . . to state some facts in the situation that could be read with benefit by medical men and medical politicians on both sides of the Atlantic."

It seems clear that medical care would be far more costly under a nationalized system than it is today. People would tend, if the experiences of England, France and Sweden are indicative, to overuse and overcrowd existing facilities. In addition, the cost of the bureaucratic administrative machinery that would accompany a National Health Insurance system would be staggering. The Swedish citizen, for example, pays 20 per cent of his taxes for health—the highest in the world.

It would be reminiscent of the Department of Agriculture, about which one member of Congress expressed concern. He proposed a bill that at no time should there be more employes of the Department of Agriculture than there are farmers. Perhaps the administrators of a National Health Insurance system will one day outnumber the doctors, and the taxpayers will be obligated to pay the salaries of both.

A second question which present itself is: *Would National Health Insurance provide more efficient and higher-quality medical care?*

Comparing our own system of medical delivery with that of societies which have different forms of socialized medicine, and comparing the socialized medicine in these countries with the private medical practice which preceded it, leads to the conclusion that better health care is by no means the result of National Health Insurance.

While American patients stay in the hospital about six to eight days, on the average, in Germany, with a system of National Health Insurance, there is an average 24-day hospital stay. Although Germany has more hospital beds per number of inhabitants than the United States, all hospitals are overcrowded throughout the year. Part of the reason is that there is a lack of interest by the patient in regaining health as soon as possible. In addition, doctors have no concrete feeling for the costs that could be avoided if the hospital stay were shortened.

A recent series of articles in the *Philadelphia Inquirer* compared American medical care to the European systems. The reporter, Donald C. Drake, made this point: "None of the European systems studied offered substantial incentives to doctors to do a superior job. In England it is traditional for a British GP to swiftly send a patient off to the hospital if his care requires anything more than superficial treatment. In Sweden and Germany, patients are kept in expensive hospital beds for excessively long periods—more than twice the U.S. average—simply because there is no need to move them out and tradition says this is how it should be done. British hospital doctors are reluctant to discharge patients because they are afraid the overworked GP is not up to the task of handling post-hospital care."

Sweden provides another case in point. At the time nationalized medicine was initiated in Sweden, 70 per cent of the Swedish population was already covered by private insurance programs. In the name of equality, those 70 per cent were forced into a compulsory government-administered program in order to provide for the remaining 30 per cent of the population not privately insured.

Today there is hardly a single hospital in Sweden where there are not long waiting lists for all kinds of hospital care. It is estimated that in Stockholm alone there are more than 4,000 persons waiting to enter hospitals, 1,800 for operations. In some cases, waiting periods for minor operations may be more than half a year.

The same situation exists not only for surgery, but for internal medicine, outpatient clinics, neurological sections, and various specialization clinics. The situation is worse in state-administered mental hospitals, where there were 800 patients waiting for entrance in 1964, a situation which has since become even more critical. Extended-care hospitals, nursing homes and homes for the aged are desperately understaffed and overcrowded. In some cases there are waiting lists numbering 2,000 persons.

What has caused these conditions in a society which has the highest standard of living in Europe, which has no lack of educational facilities, and which has not suffered from war?

One of the chief problems is the tremendous increase in the use of hospital facilities at the inception of the medical program. Although the number of hospital beds increased by 5 per cent during a period when the population increased by only 10 per cent, there have never been enough hospital beds. Although the number of doctors has doubled since 1900, and the number of nurses has tripled in that time, there are still not enough to handle the demand.

Swedish writer Nils Eric Brodin explains: "The increase in utilization of existing facilities comes from those who demand 'hospital vacations.' When the tensions of life or home get too intense, many will 'rest up' in a hospital. Often a patient stays in a hospital a week before he is diagnosed, and even then the diagnosis may be hasty and inadequate. 'I'm paying for it . . . I've got it coming' is the attitude."

Dr. Dag Knutsson, head of Sweden's medical association, estimated in the first years of the medical plan that half of the patients in Sweden's hospitals "need not be there."

A similar situation exists in Great Britain. The *London Economist* assessed national medical care this way: ". . . The British people soon found that as taxpayers they had to spend more money than they had done before as patients." In *The Genesis of the British National Health Service*, Oxford Prof. John Jewkes and his wife, Sylvia, stated the system adopted in England may have "positively hindered the growth of the British medical services."

Rather than providing more efficient health care, systems of national health insurance tend to do precisely the opposite.

The citizen no longer deals with his physician in the traditional doctor-patient relationship. Instead, he must deal with a bureaucratic government agency. The inefficiency of such agencies is no different in the field of medicine than in other areas. A heavy burden of proof, it would appear, rests with those who argue in behalf of a system of National Health Insurance, for they are arguing against most of the available evidence.

It is also important to consider the more general question, *How does medical care in America compare with that of other countries?*

The AFI-CIO, Sen. Kennedy, and other critics of our private medical system advance the view that those countries which have socialized medicine are providing their citizens with better medical care than is available in the United States. Is there any truth to this charge?

A study issued by the Brookings Institution as long ago as 1948, entitled "The Issue of Compulsory Health Insurance," states that no great nation in the world has among its population better health than prevails in the United States. The report, prepared by George W. Bachman and Lewis Merriam, notes that "it is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country . . . There is every reason to believe that these trends will continue unabated under our present system of medical care."

The report states that "Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other large field previously entered by the government, and past experience with governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development."

Compulsory insurance, according to this view, would inject the government into the relationship between practitioner and patient. A real danger exists, in such a situation, "that government action would impair the relationship and hence the quality of medical care."

Rather than decreasing the cost of medical care, this report observes, a national insurance system would increase it because of (a) administrative expenses; (b) the tendency of insured persons to make unnecessary and often unreasonable demands upon the medical care services; (c) the tendency of some practitioners and agencies to use the system for their own financial advantage.

In an important series of articles concerning medical care in Europe and America, the *Philadelphia Inquirer* expressed the view that while "none of the systems, theoretically at least, dictate the way doctors should practice medi-

cin," still, "in England the system is set up in such a way to hamper if not discourage initiative."

The Inquirer notes, for example, that American doctors are much more active in the new and promising field of preventive medicine; five times as many Americans as Germans seek preventive medical care; the average length of stay in American hospitals is many days shorter than in Sweden, Germany or England, countries that have centered their health systems in the most expensive units in the medical scheme; American doctors, on the average, spend more time with patients than European doctors do, even though they are less likely to make a house call."

The Inquirer expressed the fear that "The very real danger that exists at this time is that the reformers are ready to blindly throw away many of the advantages in the U.S. system for the sake of emulating the European plans

Those critics who advance the view that American medical care is, in some sense, inferior to that of other countries use as their basis the comparison of infant mortality rates.

They charge that countries such as Sweden, the Netherlands and Norway have lower infant mortality rates than our own. The statistics which are used as a basis for this charge come from the World Health Organization (WHO).

Upon careful examination it appears that this charge is inaccurate. Statistical methods of recording infant mortality are not uniform even within the United States. Each state has its own laws and requirements and reports are tabulated in the National Bureau of Vital Statistics and a national average is reported. In many countries the report is the responsibility of the parents and there is no compulsion for them to report. In the United States, on the other hand, the attending physician is responsible for certifying births and deaths.

In Sweden, which is close to the top of the WHO table, birth reports are not required until five days after the event. Many neonatal and prenatal deaths are surely unreported. In addition, the period of gestation, used as an important measurement of infant viability, has not been established by uniform standard. Thus, while one country would consider a seven-month baby a "viable" infant and its death part of the infant mortality rate, another country would not. In addition, there are serious variations in the weight required for designation as a viable newborn, and such a difference clearly makes a significant variation in the percentage of statistical arrivals.

In countries where the average individual stature is smaller than in the United States, the viable infant is likewise smaller. As a result, if United States weight requirements were applied to those countries, the infant mortality rates would naturally be lower than in the United States. In other words, those infants who die and are below a certain weight would be considered in the statistics of one country, and not of the other. It is, in effect, like comparing apples and oranges.

In addition, some countries do not even record births of children who do not live a designated length of time. And those countries which have legalized abortions in cases where birth may be harmful to mother and child would, of course, have lower infant mortality rates than a society such as our own which has generally made abortion illegal. It is clear that such a comparison of infant mortality rates has little to do with the relative merits of a country's health-care delivery system.

There are many other considerations. In the United States, if a child breathes or has a heartbeat for even a short period, then dies, it is usually considered a neonatal death and classified as infant mortality. In many other countries this is not so.

The fact is that American medical care, as the Brookings Institution report states, equals that of any nation in the world, and is far superior to most. It is particularly superior to those in which government has involved itself in the delivery of medical care.

Sen. Kennedy and other supporters of his National Health Insurance plan argue that such a plan is necessary because we have a doctor shortage, and somehow government control of medicine will ease this shortage.

We must ask this question: *Is there a doctor shortage and would a program of National Health Insurance in any way alleviate it?*

In the United States today there are 318,000 medical doctors. With a national population of roughly 200 million, that is an average of one doctor for every

640 persons. No other nation in the world enjoys anything close to this ratio. Of these doctors, 169,656 are engaged in full-time private practice and 19,586 are engaged in part-time practice. The remainder are engaged as follows: 28,105 in government service, 17,725 on full-time hospital staffs, 10,452 in full-time medical faculties, 33,247 in resident training, 9,102 in internship, 4,919 in preventive medicine, and 2,653 in administrative medicine. The remainder are retired in some type of work other than the practice of medicine.

The problem, it seems clear, is not that there are not enough graduating doctors, but that too few are in direct patient care. In fact, it is government involvement in the field of medicine which is, in large measure, responsible for this situation.

Discussing his point, Dr. Walter C. Bornemeier, president of the American Medical Association, stated: "A little over 10 years ago, our Congress . . . appropriated substantially more than was requested for research. In order to use this money, it was necessary to train a great many research people. Once more hundreds of our best young men, just finished their specialty training and ready to go into practice, were persuaded to accept a research traineeship which was a training program of several years' duration.

"In order to accommodate this influx of research money, it became necessary for medical schools to provide housing for this activity, so great research laboratories were built. The school hoped to benefit from the teaching that would be provided by the research physicians. But as it developed, the research grants that became available carried with them rigid restrictions on time spent on unrelated activities. So, instead of a plum, the medical school may have picked a fruit of a different color."

Would there be more doctors and would those doctors who are practicing be more productive were we to have a system of National Health Insurance? The evidence seems to indicate that under a system of government-controlled medicine the situation would be far worse.

Discussing the British National Health Service, Dr. John R. Seale, writing in *Northwest Medicine*, noted: "The state has . . . used its immense power over physicians, nurses and other health professionals to obtain their services inexpensively. Those professionals are particularly vulnerable when faced with a monopoly employer because they will not harm their patients by striking against their employer."

According to the English economist, D. S. Lees, in his book, *Health Through Choice*, "the real incomes of general medical practitioners fell by one-fifth between 1950 and 1959, while those of the general community went up by about as much. Even with the much-publicized increase in physicians' pay in 1960, they were no better off than they had been 10 years before. This can be said of few other sections of the British working community and contrasts strongly with the trend of medical incomes in most other countries of the Western world."

Britain, as a result, is rapidly losing its doctors. In the 10 years of the 1930s, before nationalization, an annual average of 27 doctors with British degrees registered for practice in Australia. But since the early 1960s the annual rate has been more than 225. In one year, 1960, more doctors (162) trained in England and Ireland passed their State Board Examinations in the United States than in the whole 10 years of the 1930s.

The reason for their departure, according to Dr. Seale, is that ". . . In Australia and North America the professional freedom of doctors is greater, and the opportunity to practice medicine well, particularly in general practice, is greater, and the financial rewards are more appropriate to the years of study, the long hours of work and the heavy responsibility involved."

The situation is similar in Sweden. The Swedish government is placing pressures on private physicians in many ways. They may not treat private patients in hospitals and only a few of the doctors in hospitals may have private patients. All private and semi-private care is being gradually eliminated as something "anti-egalitarian." There are very few private (and no denominational) hospitals and private nursing homes are being forced out because of excessive taxation.

The number of private physicians is diminishing. Of the 8,500 doctors remaining in Sweden, there are only 1,200 private physicians, one-fourth of whom are over 70 years old. Only 30 per cent of Swedish patients are treated by private physicians and because of heavy taxation private physicians do not work more than six to eight months a year.

The Swedish government, in order to relieve the shortage of doctors, has shortened medical studies by two years, filled many positions with interns and medical students, and imported a large number of foreign doctors. *Sweden today has fewer physicians per citizen than the United States, West Germany—even Austria and Italy.*

How many young Americans would want to enter the medical profession if it became similar to that in Great Britain and in Sweden, as Sen. Kennedy and other advocates of National Health Insurance urge? It would appear that National Health Insurance, rather than alleviating any doctor shortage, would compound it and drive young men into other fields and professions.

Thus, it appears that whatever medical problems we may have would be compounded and not corrected by the program now being advanced in the Congress. During his 1968 presidential campaign, President Nixon opposed a compulsory national health insurance system, saying that new health programs should be directed only at the needy. During the first congressional hearing on this subject John G. Veneman, the under secretary of health, education, and welfare, estimated that the proposed insurance plan would cost \$77 billion in its first year of operation, fiscal 1974. For this and other reasons, Mr. Veneman said the proposal "is not a proper or workable approach to the solution of the health problems of the nation."

Whether National Health Insurance would cost \$77 billion a year, as the Administration contends, or \$40 billion a year, as Sen. Kennedy has estimated, it is clear that it would add billions of dollars to the cost of medical care at a time when the Nixon Administration is trying to cut down the duplication and feathering in its present health programs.

Beyond all of this, however, the evidence leads to the inescapable conclusion that the plan would compound our problems and not correct them. Hopefully, this will be made known as the hearings continue in January.

[From Health Care at Home]

FACT SHEET

Health Care At Home (HCH) is a not-for-profit, tax-exempt, home health care coordinating agency chartered by the State of Illinois in 1970. It was organized by the Heart Association of North Cook County (a division of the Chicago Heart Association) and the North suburban Association for health Resources, with the aid of a grant from the Illinois Regional Medical Program, to make readily available high quality health services in the home setting, so that home care is once again an integral part of the health delivery system. HCH will begin operating in January, 1972.

HCH will start in North Cook County, east of the Tri-State Tollway, but will extend its coverage to the entire area served by the North Suburban Association as rapidly as it can.

A single phone call to HCH (498-3710) will arrange for any or all of the following services in the home:

Nursing	Social Service	Laboratory Service
Physical Therapy	Nutritional Guidance	X-ray Service
Occupational Therapy	Homemaker/Health Aide	Pharmaceuticals
Speech Therapy	Delivered Meals	Dental Services
Inhalation Therapy	Equipment and Supplies	Other

These services will be provided by local VNAs, Health Departments, Home-maker/Health Aide Services and others. HCH will employ a Medical Social Worker on its staff and will contract with existing not-for-profit and commercial providers where appropriate. NSAHR hospitals may also have to provide certain services which are otherwise unavailable.

Services will be provided only on order of the *physician*. The physician will always control his patient's therapy. He will have the benefit of weekly progress reports, prepared jointly by providers under the guidance of HCH's Medical Director. He will be able to call upon skilled social workers and other specialized personnel. The physician will need deal with but one agency to adjust his orders whenever necessary. Much time-consuming paperwork will be prepared for the physician's signature or eliminated entirely.

The patient and his family will benefit by having but one agency to deal with. Problems can be solved by one call instead of many. The patient will receive an itemized and consolidated bill from a single source, which is advantageous for insurance, tax and budgeting purposes.

Provider agencies will benefit from efficient use of personnel, avoidance of duplication, reduced administrative tasks and costs, and from the "economies of scale" in purchasing and accounting, and in negotiating with third party payors.

HCH will serve patients regardless of their ability to pay. HCH will serve those who can be treated in the familiar surroundings of their own home and yet cannot be treated by office or outpatient visits alone.

HCH is governed by 24 directors representing hospitals, providers, physicians, consumers, insurers and others.

The administrative expenses of HCH are being defrayed by the Illinois Regional Medical Program and the Chicago Heart Association. Funds for the purchase of services are being supplied by Washington National Insurance Company, the American Cancer Society, the Field Foundation, the North Sub-Physician requests home health services for patient.

PROCEDURES

Physician requests home health services for patient.

Nurse evaluator visits patient.

Medical Social Worker visits patient's home to evaluate psycho-social situation.

Eligibility for coordinated home care program reviewed by HCH Patient Services Coordinator and Medical Director. (Eligibility, in general is based upon the assessment of the medical, nursing, social and environmental needs and resources within the individual patient-family situation. If the patient appears not to need the high degree of coordination of services which HCH provides, recommendations will be made for the level of care which appears to be appropriate for the patient's needs at that time.)

Note: HCH's program is available to all persons in the area served regardless of race, color, religion, sex or national origin and the ability to pay for services is not a requirement.

Upon acceptance to the HCH program, the physician is asked to submit written orders and fill out appropriate care plan forms.

Upon receipt of orders, services are scheduled.

Note: Arranging services depends on anticipated date of discharge, so physician must be accurate in estimate of situation.

There are weekly patient evaluation conferences with HCH Medical Director and providers of service. Reports of each conference are sent to physician.

HCH receives provider invoices, prepares statements and sends them to appropriate payment sources and then issues checks to providers of service.

Mr. CRANE. Thank you.

I realize you have had many witnesses testify on this subject, and I am sure the members of the committee rapidly are becoming experts in the area of national health care legislation.

In my brief summary, I would like to address myself to several points.

Foremost among these is the very basic question of whether or not there is a health care "crisis" facing our Nation, and if not, why must we consider such drastic changes in health care as have been proposed to this committee. If there is a "crisis," would a system of national health insurance provide a more economic system of medical care?

Despite the attempts to make it appear that the current cry for national health insurance is a spontaneous reaction to a current "crisis," the fact is that the campaign for national health insurance is really not new at all. National health insurance plans have been proposed in this country for nearly 60 years, and have been introduced in Congress for almost 30 years.

But there is something different this time: a massive campaign to undermine confidence in private medical practice—a campaign of such magnitude that even many doctors who themselves believe in the private practice of medicine have felt compelled to declare: “We have to do something about the health care crisis.”

Mr. Chairman, I am not convinced there is a crisis today, and I think a look at some of the facts and figures concerning health care in our Nation support this belief.

Let us look at some of the signs of a “medical crisis.” In 1900, the life expectancy of the average American, at birth, was 49.2 years. Today, life expectancy is more than 70 years, and half of the babies born today can expect to live at least 74 years.

One-fourth of the babies born in 1850 died before the age of 5. One-fourth of the babies born as late as 1900 died before the age of 25. Today, three-fourths of the babies born can expect to live to at least 62 years.

Of every 1,000 infants born alive in 1900, approximately 125 would not survive 1 year. Today, the annual infant mortality rate is about 21 per thousand, an improvement of 350 percent.

Tuberculosis and polio have been practically eliminated. Open-heart surgery is almost commonplace. The death rate from cancer of the uterus has been cut in half in the last 30 years.

Medicine, it seems, has been progressing steadily—and sometimes spectacularly.

Those who have criticized the quality of medical care, and who insist, despite the many facts to the contrary, that a crisis does exist, argue also that a system of national health insurance would provide a more economical system of medical care.

For an indication of foreseeable costs, the sponsors of the Kennedy-Griffiths proposal estimate that in fiscal 1969, the Federal Government spent over \$9 billion for all personal health service programs. If their program had been in effect then, they say, it would have disbursed most of that amount, and would have required an additional \$6 billion from general tax revenues.

These are significant increases, and, as you well know, such before-the-fact estimates in this area are notoriously understated. Thus, an article in the *New Republic* by Washington health affairs writer Mel Schechter states that medicare alone, without any changes, needs more payroll taxes to meet a 25-year projected deficit of \$126 billion in hospital-related benefits, an overrun of nearly 100 percent.

Even if we are to ignore the substantial increase in cost for medical care that would result from a national health insurance program, we can ask the question: “Would American health services be better than under the current system?”

The report concerning the British health system by Prof. John Jewkes, who served on Britain’s Royal Commission on Remuneration of Doctors and Dentists, concluded that, “The average American now has more medical services than the average Briton, and the gap between the two has been widening” since the inception of the National Health Service.

More and more Britons, according to the evidence presented by Jewkes, are seeking medical care outside the National Health Service. These people, the report notes, are “ready to make sacrifices in other

directions in order to enjoy prompt hospital and specialist treatment, free choice in consultant and private accommodation."

Yet advocates of a national health insurance system for our country tell us the British system is an example for us to follow.

This example, however, appears to be something far different than its supporters in this country would have us believe. Let us look at some examples:

Due to the shortage of medical personnel in England, there are no nurses in the antenatal ward at Hemmel Hempstead Hospital after 8 o'clock at night. A report recently appeared of the case of Mrs. Ellen Foster. Her labor pains began after 8, so she had to climb three flights of stone stairs, in pain, by herself, to reach the labor ward. Within 18 hours after she had her baby, she was discharged because the hospital was overcrowded, and had to walk back down the three flights of stairs, carrying both her baby and her suitcase. This is, of course, a true story.

In addition, Mrs. Foster's experience is not unique. Health care facilities in European countries which have national health programs are far below the standards of the United States.

When Richard Crossman, the British Secretary of Social Services, visited a mental hospital in Warwickshire, he inspected wards so full that patients had to climb over one another's beds. His report said simply:

This hospital is overcrowded to a hopeless extent—but it's no worse than many other hospitals I've been to.

This we must contrast with a report which appeared in the New York Times of September 12, 1971, stating that in the United States . . . on an average day last year, 318,000 hospital beds—one out of every five in the country—were empty.

Yet, while overcrowding obviously has a serious effect on patients in British hospitals, its effects are most deeply felt by those patients who cannot enter the hospitals at all. At the end of 1968, there were more than half a million patients awaiting admission to British hospitals—more than 70 percent of them in need of surgery.

Dr. Edward McNeil, a British physician who now practices in New York, wrote that there is a waiting list for many operations. "One to two years is not uncommon," he said. Joan Hobson, writing in *Private Practice* magazine, reported of a patient in the Birmingham area who applied for a prostatectomy operation in 1962 and was finally admitted to a hospital 7 years later.

Dr. McNeil wrote of trying to supplement his meager income by working as a clinical assistant in London. "One of my duties," he said, "was to help reevaluate those children on the waiting list to have their tonsils removed * * * some had been on the list 6 years." He wrote that at the time he finally left England, the waiting time for a tonsilectomy was 10 years. Sign up an 8-year-old child today to have his tonsils removed, and he will have the operation when he is 18.

Marvin Edwards, the author of a forthcoming book concerning the question of a national health insurance, writes this concerning the British experience:

The British doctor's terms of service occupy a 50 page book of rules, regulations and restrictions. It is even worse in France, where the rule-book has grown to 650

pages. So bad has the system been that when a British doctor I know recently checked a list of his medical school classmates, he found that more than half had either left England or quit the practice of medicine. But the most notable loss of freedom is for the patient. First, the patient will lose the right to choose his own physician. In Sweden, only 30 percent of the citizens are still treated by their own private physicians, and a recent survey in England revealed that fewer than 50 percent of National Health Service patients get to see the specialist of their choice.

Mr. Edwards concludes that:

In their passion to convert the non-system individual entrepreneur form of practice into a true "system," the planners will force the public into a new world of depersonalized mass treatment by doctors whose names they don't know.

We can use the British system as an example, but I think it is clear that the example set forth is one we very definitely should avoid.

Finally, Mr. Chairman, I would like to relate to the committee some of the comments from doctors in my own district with whom I have consulted on the question of national health insurance.

Dr. Frank B. Kelly, Jr., of Chicago, expressed this view concerning those governmentally controlled medical programs we have had experience with this far:

As a private practitioner, I have seen both benefit and abuse of the present Medicare system. For those elderly people with limited resources, we are thankful that there is a method where they can receive medical care and not leave them destitute. However, all of us can easily fall into the limbo of disregarding costs, as long as the other fellow (the Government) is footing the bill. The same attitude holds for other insurance carriers such as Blue Cross et cetera. Patients frequently are anxious to be hospitalized for diagnostic studies, and those hospitalized are reluctant to leave till fully recovered, as long as the other person is picking up the expense tab. What I have noticed is a disregard of personal responsibility for expense incurred, a trend that is dangerous, and if it continued can only lead to total Government control.

In another communication, Dr. Wallace D. MacKenzie, of Evanston, Ill., wrote the following:

Since socialized medicine has been instituted in Germany and Sweden and England, very little in the way of original work towards the advancement of the science of medicine has come out of those countries. Prior to socialized medicine, many of the great advances were attributed to Germans and Britishers. Now most of the advances are made in the countries whose medicine is not socialized, most of them in the United States.

Discussing the effects of the medicare program, which would be magnified many times over were we to enter into a system of national health insurance, Dr. W. G. Bagnuolo, of Mount Prospect, writes that:

In the short time that we have had Medicare, we are at the present time feeling pressure by hospital administrators, the Medicare offices, and excessive paper work not remotely connected to the true care of patients. If this continues, we will have less and less time to pursue our vocation of treating ill patients.

These comments are representative of the views of the doctors in my district, and my understanding is that they are representative of the views of individual private practitioners throughout the country, the men who are in the best position to tell us what current Government programs have meant for the quality of health care, and what future Government programs might mean.

Mr. Chairman, I welcome your comments and questions at this time.

Mr. BURLERSON, Mr. Crane, we are most appreciative of your appearing before the committee.

Your testimony is different from anything we have had in these discussions.

Mr. CRANE. I am sure, sir.

Mr. BURLISON. I must agree with you, that I prefer, as you said at the outset, we not describe our situation today as a "medical crisis." It is a matter of opinion, and degree, I suppose.

We have some inadequacies, I am sure that you agree, and that is what we are trying to reach and improve.

I am impressed by your description on that matter of crisis. It seems to be compelling and consuming for everybody and everything.

Mr. SCHNEEBELI, do you have a question?

Mr. SCHNEEBELI. I would just like to add further, Congressman, that we have had several very competent witnesses who raise the same issues and support your thesis of the question as to whether there is a medical crisis. There is a lot of validity to what you have said. It is a problem that has to be taken into consideration when we consider the problem as a whole.

Mr. BURLISON. Thank you for a very helpful statement.

Our next witness is our colleague from New York, Mr. William F. Ryan.

Mr. Ryan, we are pleased to have you before the committee, and we are glad to hear your testimony.

STATEMENT OF HON. WILLIAM F. RYAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. RYAN. Thank you very much, Mr. Chairman. It is always a pleasure to appear before you and the distinguished members of the very important Ways and Means Committee.

Today the committee is hearing testimony concerning national health care. I must say that I am convinced that the country is indeed in a crisis in health care.

I know that the chairman has expressed a contrary view a moment ago, but I think that what we face in America today is a critical inability on the part of our health delivery system to deliver adequate health services to all of our people.

Despite the fact that we spend more per capita on health care than does any other nation in the world, we do not compare well with other nations in basic health care indices. We are 12th among nations of the world in maternal mortality, 14th in infant mortality, and 18th in life expectancy for males at birth. Furthermore, the burden of inferior health care falls most heavily on the already disadvantaged. The maternal mortality rate for nonwhites is more than four times that for whites. The nonwhite infant mortality rate is twice that of whites. These grim statistics are not surprising when one considers the great gaps in our health insurance coverage.

For example, in 1968, of the 180 million Americans under 65:

20 percent, or 36 million, had no hospital insurance;

22 percent, or 39 million, had no surgical insurance;

34 percent, or 61 million, had no inpatient medical insurance;

50 percent, or 89 million, had no outpatient, X-ray, and laboratory insurance;

57 percent, or 102 million, had no insurance for doctors' office visits or home visits; and

61 percent, or 108 million, had no insurance for prescription drugs;

And these unfortunate gaps in health care coverage have been, and are now, accompanied by a dizzying rise in health care costs.

Between 1965 and 1969, medical care costs rose at an annual rate of 6 percent; hospital charges rose at an annual rate of nearly 13 percent. This compares with a 3-percent annual rise in the Consumer Price Index for the same period. In the 1970 fiscal year, overall health care expenditures increased 12.2 percent, to a total of \$67.2 billion. This total is 7 percent of the total gross national product of the United States.

When we consider the costs and the failure to adequately deliver, it seems fair to say that the private health insurance industry has not met the challenge of providing adequate health care for our Nation's people, either in terms of service, or in terms of cost. Hence, it is not surprising that a plethora of legislation has been introduced addressing—in one fashion or another—this crisis in our Nation's health care.

I have cosponsored the Health Security Act (H.R. 22 and H.R. 23) introduced by five distinguished members of this committee, Mrs. Griffiths, Mr. Corman, Mr. Burke, Mr. Vanik, and Mr. Green—the Senate version of this bill, S. 3, was introduced by Senator Kennedy.

H.R. 22 would provide a comprehensive system of national health insurance, making adequate health care a matter of right for all Americans.

Briefly stated, H.R. 22 establishes Government administration and financing of health services. Private practitioners, institutions, and other private providers of health care will be able to serve patients. The benefits encompass a wide range of health care services, including, and this is very important, the prevention and early detection of disease, the care and treatment of illness, and medical rehabilitation. The program provides full and complete coverage for physician's services, inpatient and outpatient hospital services, and home health services. It also provides full coverage for other professional and supporting services, such as optometry and podiatry. The bill does not require coinsurance, deductibles, waiting periods, or cutoff dates.

Financing the program would be national through a health security trust fund, similar to the social security trust fund. Income to the fund would derive from four sources:

Fifty percent from general Federal tax revenues;

Thirty-six percent from a tax of 3.5 percent on employers' payrolls;

Twelve percent from a tax of 1 percent on employees' wages and unearned income up to \$15,000 a year;

Two percent from a tax of 2.5 percent on self-employment income up to \$15,000 a year.

The Health Security Trust Fund would be administered by a Health Security Board, appointed by the President.

There would be three methods of payment to doctors for health services: Doctors could receive a fee-for-service payment in accord-

ance with established fee schedules, or doctors could choose payment on a capitation basis for the number of patients served, or doctors could join prepaid group practice plans, which would offer comprehensive health care for patients, and which would be paid on a capitation basis.

It should be noted that payment by capitation gives the doctor an incentive to practice preventive medicine and keep his patients well. Also, payment by capitation reduces paper work to a minimum—one form a year for each patient. But it should be emphasized that under H.R. 22, doctors are not forced into any particular payment plan. They may choose any of these methods of providing health care services.

None of the other bills before this committee provides the wide range of benefits that does H.R. 22. H.R. 22 seeks to meet the health insurance problems in this country by providing a broad range of benefits, by encouraging preventive medicine, and by providing incentives for efficient group medical practice.

That, I think, is what we must strive to achieve, and I urge the committee to report H.R. 22 out favorably so that the American public can begin to enjoy adequate health care service.

Mr. BURLISON. Mr. Ryan, we appreciate your appearance before this committee.

Mr. Schneebeli.

Mr. SCHNEEBELI. I would like to compliment the Congressman for his courage and foresight.

Mr. RYAN. Thank you very much.

Mr. BURLISON. Thank you, Mr. Ryan.

The committee will stand recessed until 2 o'clock.

(Whereupon, at 12:25 p.m., the committee recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

Mr. BURKE. The committee will be in order.

Our first witness is the distinguished member of the U.S. Senate, Hon. Edward M. Kennedy of Massachusetts.

On behalf of the committee, we wish to welcome you here and, of course, coming from Massachusetts myself I am very proud to have you here as a witness.

Of course, you have been in the vanguard, leading the fight to improve the health care of the Nation. You may proceed.

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

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

Mr. Chairman, I am very pleased to have the opportunity to appear before your committee today. I believe the subject under consideration, national health insurance, is one of the most important domestic issues before the Congress today. It is important not only because it deals with massive Federal expenditures—many other programs do that; not only because it is concerned with people's health—many other programs have impact, directly or indirectly, on people's health; and not only because over 7 percent of our gross national product is expended

on personal health services. We have other major national expenditures.

National health insurance, Mr. Chairman, is so important because it embodies in a concrete issue many of the social changes which are occurring in the United States. National health insurance tests our national mettle.

I have spent thousands of hours over the past year holding hearings, visiting facilities, and talking to providers and consumers concerning the health care crisis in this country. I have talked to many thousands of providers and consumers of health care during the course of my activities.

Mr. Chairman, a health care crisis exists in this country. But it is not a crisis created solely by the collapse of our health care system. It is a crisis created by an evolution of social principles which has taken place throughout the past 100 years in many of the European countries we visited, and which has rendered our way of providing personal health services obsolete. We are in the midst of a social revolution in the United States, and the debate over our methods of delivering health care services is one of the spearheads of that revolution.

The revolution is, in part, a revolution of rising expectations with respect to the delivery of quality health care for a society of more than 200 million persons. When an issue arises which affects so many people and cuts across all social, ethnic, economic, and geographic boundaries, it is time for the Government to act. Only the National Government can bring equity and greater rationality and economy to this Nation's health delivery system.

It has been said that it has been only in the last 50 years that a patient stood better than a 50-50 chance of benefiting from an encounter with a physician. I believe this to be the case. I believe the incredibly rapid advances which have been made in medical knowledge over the past half century have been largely responsible for the enormously increased expectations people have for medical services. Those expectations are not, as they have been in the past, confined to the wealthy or the well-educated middle class. Mobility within our society, immensely effective mass communication media, and rising levels of education of all people in America have contributed to the rise in demand for medical care.

Where a few years ago the delivery of very high quality care to a very few was acceptable, people now expect the same high quality care for all Americans, and they cannot and will not understand why the care they do receive costs so much.

Mr. Chairman, those rising expectations grow more profound each day. If Government is to meet its obligations to society, it must act soon. And act effectively.

All through America, people are frustrated, confused and angry at the way health services are delivered. They are angry at runaway costs and inaccessible services. They are frustrated by their inability to exercise control over the services they receive. They are confused by a health care system which each year consumes more of their income but does not provide greater service.

This sense of anger and frustration is not confined to the poor or the elderly. My committee has heard case after case of tragedy felt by

poor and middle-class working people alike, because of their inability to obtain medical services. Even the very wealthy are unable to obtain uniformly high quality care, or to gain assurances that the money they have spent for health care services has been spent wisely or appropriately.

For example, we have heard testimony from:

Mr. James Parson, a Nashville bridgeworker, whose employment-related insurance coverage lapsed when his employer went out of business at a time his wife was undergoing a series of hospitalizations for tubal pregnancies. The bills resulting from his wife's illness eventually drove him into bankruptcy. He now has trouble obtaining any care for himself or his family, and finds himself subjected to credit checks and payment in advance before he can even obtain routine health care.

Mr. Leonard Kunken, of Oceanside, N.Y., whose 20-year-old son, Kenneth was injured in a football game. The injury made Kenneth a quadriplegic. Mr. Kunken, an insurance company executive who carried the best policy his company had to offer, has exhausted his coverage, which was nearly equal to the "catastrophic" of the administration's bill. He estimates his ongoing expenses for his son's health care will be in the vicinity of \$75,000 per year. He has no further insurance coverage. He is considering releasing all of his property and giving up his income in order to qualify for medicaid.

Mrs. DeWitt, of Colorado, whose newborn infant had a birth defect costing \$5,000 to correct. It turned out the DeWitt's individual insurance policy, purchased at a cost of \$38 per month from an average income of \$600 excluded coverage of the infant during its first 15 days of life. Not only that, but the fixed sum it paid for maternity benefits covered little more than half the cost of delivery of the child.

Mr. Harry Steinberg of Los Angeles, who presented a 14-foot long computer printout of a hospital bill to the subcommittee. He documented his contention that Blue Cross in southern California paid many items on his bill without questioning them which were falsely or erroneously charged to him. These expenses, many of which were unjustified, were unquestioningly included in the following year's insurance premium increases.

Mr. Chairman, if you were to hold field hearings in cities and rural areas where health services are nonexistent or are so utterly disorganized as to be unavailable when most needed, you would hear the stories of mothers who are unable to get medical care for their sick children; you would listen to the people with serious illnesses that probably could have been prevented with proper health maintenance services; you would visit the families which are totally cut off from all health care because they lack the funds, the transportation or the strength to reach for it; you would talk with the elderly people and the chronically ill for whom, often, only the wrong kinds of expensive services are available because we have failed to develop a properly balanced health system. You would see for yourself the overcrowded and shuttered hospitals in Appalachia and rural communities; you would see the crowded docket of malpractice actions.

Make up your own mind as to the urgency of the health crisis. Make up your own mind about whether we can continue to tinker with the present system or whether we in the Congress must take the leadership in reforming it.

We in the United States have progressed far beyond the point where obtaining health services can be left as a matter of the survival of the fittest. Caveat emptor, a wise admonition in dealing with the practices of many health insurance companies, can no longer be tolerated as an operating principle in obtaining protection from illness.

Such a principle is not in the national interest.

We have, I believe, arrived at a point in the development of our Nation that we can now see the prevention and treatment of illness and injury as a responsibility and a benefit for all of us, not just the random victims of these conditions.

I do not believe the health care crisis has been created by misuse and collapse of a well-functioning system of medical care. No such system has ever existed in this country capable of filling our people's growing expectations and expanded vision. We must create that system now.

During our Senate Health Subcommittee's hearing into the health crisis, it has become clear that the providers of services are trapped just as deeply in the mire of our health care system as are those seeking services. We talked with many physicians who were overwhelmed with uncontrollable patient loads; whose judgment and effectiveness were clouded by fatigue and almost inhuman physical and psychological demands; whose frustration and anger were rapidly mounting because of their inability to bring the type of quality medicine they had been taught in medical school to their patients. We have talked to hospital administrators under constant pressure to fill hospital beds—pressure which, because of economic considerations, frequently induced them to interfere in judgments which should be purely medical. We have talked to people responsible for attempting to establish comprehensive health care programs who have been frustrated at every turn because of inadequate resources or fragmented sources of funding.

We have talked to municipal officials; terribly frustrated by their inability to stem either the escalation in costs of health care or the steady deterioration in quality which is occurring in virtually all municipal institutions.

We have talked with insurance company executives. Some have honestly attempted to control costs and provide decent coverage, but now recognize the impossibility of the task and are calling for increased Government regulation of the industry. There are also those who see a fast dollar to be made in health insurance, through misleading advertising, policy exclusions, experience rating, and cancellations.

The entire spectrum of rewards and incentives in the health care industry work to perpetuate the inequities and maldistributions which exist. Physicians are rewarded for performing unnecessary procedures because they are paid fee for service. They are rewarded for locating themselves in affluent communities because of a lack of uniformity in the distribution of health services purchasing power. Hospital administrators are rewarded for keeping hospital beds full because of the structure of insurance coverage and high-fixed institutional overhead. Academic centers are rewarded in prestige for opening new, expensive facilities, whether or not a need for them exists.

Calls for health care as a right remain empty rhetoric unless the need for completely redesigning our ideas and methods concerning

the organization and delivery of personal health services is recognized as the essential handmaiden of financing reforms. We will never be able to fulfill our promises of adequate health care for all Americans unless we are willing to face up to these difficult decisions which must be made. Of all the bills pending before your committee, only H.R. 22 squarely faces this challenge. Mr. Chairman, let's not repeat the errors of the past. Let us look into the eye of this hurricane and recognize it for what it really is.

If we do not harness the massive flow of public funding of medical care to the effort to refashion the delivery system, we will have abdicated our public responsibility. The generation and proper expenditure of funds for health services must satisfy two criteria if they are to enable the promise of uniform health care for all Americans to become reality. Only the Health Security Act satisfies both of these requirements. The first is that the cost for health services must be distributed equitably. Those better able to pay for health services, whether because of age, state of health, or income, must bear a proportionately greater share of the costs, so as to provide protection for those less well able to pay for themselves in less fortunate times. That is why the Health Security Act provides funding derived from all Americans based upon the ability to pay.

The second criterion is that benefits must be uniform and universal. Placing adequate and uniform purchasing power in the hands of the consumer of health services is the necessary first step in providing uniform health services to the people of this country.

A well-organized, efficient system of health care offering comprehensive services to all Americans is not possible as long as financing is fragmented and shot through with exclusions, qualifiers, and variation in benefits.

That is why all other proposals which rely upon the existing system of private health insurance are incompatible with the goal of a uniform standard of health care for all Americans.

The existence of over 1,400 individual health insurance companies, competing among themselves to "sell" the consumers insurance plans has served to further fragment the system of health care, to create tragic gaps in coverage, and to spread the costs of care inequitably—frequently placing the greatest burden on the poor; the competition, moreover, has made insurers so conscious of maintaining budgets and profits that they are unwilling or unable to put real pressure on the providers to control costs and improve services. Indeed, most insurers simply raise premiums to cover what the providers want and demand.

The Health Security Act has been accused of being monolithic. If by monolithic they mean that benefits are uniform and universal, cover all of the people of this country, and lack exclusions and fragmentation, then the method of financing health care under the Health Security Act is monolithic, as I think it must be if we are to reach our goals.

I am reminded of the monolithic health and assistance we give to the National Institutes of Health. Before the National Institutes of Health were ever established there were individual grants provided to research agencies.

Then the Federal Government underwrote fundamental and basic research programs under the National Institutes of Health.

As a result, there is no greater research facility in the world. The NIH is financed monolithically, and all the fears of the Federal Government reaching out and interfering with research have just never materialized.

The net result is 41 Nobel Prizes.

The Health Security Act is clearly not a monolith, however, when it comes to the organization and delivery of care. It offers providers more options and alternatives than they presently have. It even offers funds to help them get started in new or innovative ways of providing care.

The behavior of people is strongly influenced by the rewards they receive. During our investigation into the health crisis, it has become apparent that the method of financing health services is the most important single factor in determining the patterns of delivery which will develop. The two issues are inseparable. Of all the proposals before your committee at the present time, only the Health Security Act recognizes the fact that financing and patterns of delivery of services are two sides of the same coin. The Health Security Act proposes to use the enormous leverage generated by our Nation's billions of dollars of expenditures for personal health services to offer incentives rewards and controls to providers to reorganize health care and eliminate inefficiencies and enormously expensive practices in our present system of health care.

Only the Health Security Act provides this leverage, as well as an ongoing mechanism to evaluate, plan, and make decisions, coupled with the authority and the means to implement those decisions. Only the Health Security Act provides the means for channeling funds to where they are needed. Only the Health Security Act proposes an overall mechanism for controlling and preventing the type of inflation which was seen after the passage of medicare and medicaid.

For example, it is only the Health Security Act that has front-end budgeting.

Every other program that I have seen in the Senate provides open-ended budgeting. The more services you use, the more it costs. The Federal taxpayer one way or the other will have to pay more, either in terms of out-of-pocket expenses or in terms of the premiums paid under the programs.

I think one of the essential aspects of any act is that we are going to have some front-end limitations on the amount we are going to spend.

Otherwise, if we continue to try to use the present system we are just going to be providing additional resources in the same way in which they have been provided under medicare and medicaid. There will be no limitation in costs or inflation.

Only the Health Security Act would effectively redesign our incentives for the delivery of health care so as to reflect the desires of both the consumer and the provider.

Only the leverage generated by the Health Security Act would effectively move our fragmented, disorganized health care services into organized systems of health care, where rational evaluation, planning, and budgeting can occur.

Some argue that this leverage can and should be exercised by or through the insurance industry. I cannot close my statement without repeating my strong conviction that is a disastrous mistake.

I remind this committee, for example, that when the Secretary of HEW appeared before our subcommittee in February of this year, he indicated we not only had a health crisis, and indicated support for the administration's program but he also indicated he believed it was essential to have strong Federal regulations of the insurance industry.

That was really the only way we could expect the insurance industry to respond responsibly.

When he appeared before this committee, he talked about State regulation.

This is a basic part of the whole administration's program to keeping costs down. Now they say they will rely on what is going to happen in the States.

I think, as a result, you are going to have entirely different kinds of quality in different States. One State will provide a strong program and others will not.

That certainly has been the experience in areas which have been left to the States.

Both the history and current practices in this industry as well as the basic incentives and principles of operation of the industry show they cannot carry out this role.

They can only serve as high overhead salesmen and moneychangers with no effective leverage over the providers. Indeed, even worse, while taking their profits and overhead, they serve as a misplaced buffer between the providers and the people which prevents the provider from feeling the full force of the people's outrage.

I do not believe we can afford the health insurance industry in this country—nor do I believe we have any responsibility to maintain it at the public's expense now that its failure is apparent.

The administration's proposals have several major flaws. First of all, they rely heavily upon the private insurance industry. In so doing, they would freeze the existing system of health services in place. Second, they do not provide for universal, uniform coverage.

I am sure you are familiar with the examples. If you are unmarried and do not have children, you do not have coverage.

If you are unemployed and do not have children you are not covered or if you have been unemployed, married, and have children then you are covered.

You can spell out between four and five different kinds of programs that are suggested in the administration's program and I would suggest with these different kinds of programs you are going to get a variance by definition in quality all the way through.

They would perpetuate a multilevel system of health care, with special programs for the elderly and the unemployed. Third, they would continue the artificial separation of financing and delivery, which will continue to impede real reform in the health care system.

Catastrophic insurance would do nothing but cover a few admittedly tragic cases. It would have no effect in bringing about the basic reforms which are necessary.

Mr. Chairman, I have made these observations as a result of extensive investigations into the problems of our health care delivery system which are Senate subcommittee has conducted and will continue to conduct. The cry for adequate, accessible health services which prompted our investigations will continue and will grow louder,

Mr. Chairman; I am convinced these problems will never be solved until the measures proposed in the Health Security Act, or measures very similar to them, are implemented. Only then will we be able to move toward the goal we all support—uniform, comprehensive and equitable health services for all Americans.

The political realities of unburdening the American people of a \$70 billion cottage industry are difficult. But the question is whether we in the Congress will further contribute to the growing crisis of confidence in America's health care industry, or whether we will strive to cure it. I and my Subcommittee on Health stand ready to provide you and your committee with whatever assistance you may require, Mr. Chairman. I believe that it is essential that we here in the Congress take steps to bring into close harmony the activities of our respective committees. We must marry the interests of the health delivery system with the health financing system if we are to ever find our way out of this morass.

We must more clearly discern where we are going in health care. For if we do not, any road will take us there.

Thank you very much.

Mr. BURKE. Thank you, Senator Kennedy.

The committee appreciates your very fine statement.

In your trips around the country with your subcommittee, what were the conditions that you found in the rural areas and particularly in the urban ghetto areas as far as health care is concerned.

Senator KENNEDY. Obviously, these are two of the most critically underserved areas. They suffer from the common needs in underserved areas. One is the shortage of health manpower. Virtually little if any health care is being provided in too many areas. At best it is irregular. There is a shortage of facilities and of transportation.

I think the greatest challenge is how we are going to get adequate health care in the rural areas. Rural areas have acute problems. I think you can expect that people will go in urban centers and perhaps be willing to live or sleep some place else at night. This obviously is not the best of all arrangements, because you want to be able to have access to primary care physicians 24 hours a day, but you can conceive a situation like that.

In rural communities, health care is becoming increasingly inadequate. The AMA points to the 143 counties in the country that do not have any doctors. We have tried to insure in our "Emergency Health Manpower" legislation that the public health service could assign one health officer to every county in the country which didn't have a doctor.

What is always evident is the fact that a mother has to decide whether, for example, in some hollow in West Virginia her child has a \$35 or \$40 sickness, because that is what it costs to get a taxi to send them down to the hospital to check. When a child has a fever in the morning, they say:

Let's wait until tonight. If it is getting better fine, but if it is getting worse, let's make sure because we don't want to have to pay out of our limited resources to go to the hospital.

Mr. BURKE. Are there any questions?

Mr. Betts will inquire.

Mr. BETTS. I do not have a question. I just wanted the Senator to know that those of us who have introduced other bills appreciate his coming here. You have mentioned some of the shortcomings in ours and I am sure there are shortcomings in all of theirs, but possibly when we get into executive session, we can work them out in a harmonious fashion. I appreciate your coming over here.

Senator KENNEDY. That is very kind. I appreciate that.

Mr. GREEN. I want to take this opportunity to thank the Senator for contributing to our deliberations on this vital subject. Few people have shown the depth of concern about this problem that he has, and I commend him for his leadership in this area.

Mr. BURKE. Mr. Conable.

Mr. CONABLE. The administration's figures show what they call an \$8 billion induced-cost addition to the total health bill of the Nation if your bill is adopted.

If you made any estimates on costs—I did not hear your entire statement, and I am sorry—could you tell us what you think of this estimate, and if you understand the source of the so-called induced costs that add \$8 billion beyond the administration's proposal to the total health bill of the Nation? I assume it is at least in part the result of what they believe would be increased utilization and, therefore, perhaps some driving up of health costs as a result of the limited number of people who are available in the medical delivery system.

Senator KENNEDY. The detailed figures of this legislation have been calculated in the working papers. Actually, I understand they have been submitted to this committee and they come to some \$58 billion Federal expenditures for the Health Security Act. Of course, this is not additional money. For the most part, as you have observed, it is money already being expended by the American people. Obviously, that has been the best estimate of the medical economists for costs of the Health Security Act, which I have introduced in the Senate and which Mrs. Griffiths and Representative Corman have introduced over here. The detailed breakdown, I believe, and how they reached that figure has been provided in considerable detail to the committee. I understand it is most comprehensive and detailed.

It also differentiates the administration's evaluation of the program from our own.

For example, in the administration's program, a continuation of the inflation in cost of manpower, of services of doctors, of hospitalization and all of the rest is built in. It is my understanding if we do not enact any bill in this country by 1974, we will spend about \$100 billion for health. Those are HEW figures.

Mr. CONABLE. These are 1974 figures that I was referring to, and \$105 billion was shown for the administration's proposal and \$113 billion as a result of your proposal.

Senator KENNEDY. I think the percentage, even accepting the administration's figures, is extremely close. There is some difference, and billions of dollars are big in any event.

Mr. CONABLE. Do you assume as I do that the induced cost would be the result of increased utilization?

Senator KENNEDY. It may very well. The reason I answer that in this way is that the fact remains that even with the establishment of

health care as a matter of right in our society, some people will continue to underutilize health services.

In our experience with neighborhood health centers, for example, we find the first thing that any of the neighborhood health centers have to work out is an outreach program because generally it is the poor, whether in rural or urban areas, who are extremely reluctant to use the facilities. You have to really bring people on in. It is quite a bit different from the general assumption that if you provide comprehensive health services everyone is going to use the devil out of the facility. I do not believe that that comment or statement can be justified in terms of the experiences of these neighborhood health centers, many of which are supported by OEO and provide comprehensive health facilities.

So, that figure to some extent would depend upon how extensive utilization would be.

Mr. BURKE. Mr. Karth will inquire.

Mr. KARTH. Thank you, Mr. Chairman.

I just wanted to join our colleague, Bill Green, in extending my thanks to Senator Kennedy for providing the long-time leadership in this field and say, too, I think that regardless of how it is paid for, good health care costs are going to be about the same no matter what plan you have. It just depends upon how it is going to be paid for and who is going to pay most of it.

I am sorry I arrived a few minutes late, Senator, and did not hear all of your testimony. Perhaps you summarized some of it, but as I glanced rapidly over your testimony, I could not help but see what you said about the insurance companies, and I want to know if you wish to clarify what your prepared statement says.

Senator KENNEDY. I don't really think so. As of now, they cover only a third of the total health costs in this country in spite of the fact that they have been in the business for 30 years.

I think the problem remains that many insurance companies have stockholders and they are committed to making profits. Every time there is a claim it threatens profits, and just built into the system there has to be the desire in a competitive system for a reduction of the kinds of services that can be provided. It just seems to me when you are dealing with something which is as essential to the dignity of an individual as health, we should not have the profit motive interfering with people receiving quality health in this country. I think inherent in the competitive system of the insurance companies, just built on into it, are these factors which I think limit them just by definition. There would be those who disagree, but I think it would impede them from meeting this responsibility.

Finally, we do not permit private enterprise to really interfere in the education of the young people in this country. Your acting chairman, Congressman Burke and I come from a State which probably has as wide and diversified a group of educational institutions as any State in the country. I do not think you could find very many that are for profit. There used to be one or two smaller women's colleges in Boston up to 3 or 4 years ago, but I do not think you could find an educational institution for profit today. That is understandable. It

seems to me we in our system feel that education is really too important to really leave to the profit motive.

I personally feel that health is too important as well to permit profit.

Mr. KARTH. The question was somewhat facetious perhaps. However, you implied profit taking and I wonder if there are any accurate estimates on that question?

Senator KENNEDY. Of the individually held policies, up to 49 cents out of every dollar is retained for overhead or for profit.

In terms of the group insurance policies, it is 6.0 cents, I believe, and for the blues, it is 5.0 cents.

The tables which follow are figures obtained from the Social Security Administration. They show that in 1969, 10.8 percent of premium income was not expended as claims. The insurance industry retained almost \$1.6 billion of premium income in excess of expenses. I would like to point out that this retention does not include non-premium income, such as projects from investment. Those figures are not available, but would in all likelihood substantially increase industry retention figures.

According to our best information, those cases in which retention figures for 1970 are below those for 1969, it is due to increased claims expense, not diminished operating expense.

Mr. KARTH. It might be interesting if your staff could come up with a solid, concrete overall total figure. I feel that accuracy is important and that all guesswork should be eliminated if possible.

Senator KENNEDY. We have those available and I would like to submit them for the record.

Mr. CONABLE. Senator, you do not object to the profit system, do you?

Senator KENNEDY. No, not at all.

Mr. CONABLE. Generally it seems to work better than the nonprofit system, does it not?

Senator KENNEDY. Of course, I would agree with the profit system, but we do not have it in education. I really do not think we should in health. I think health is just too fundamental and too basic, and when you have the profit system in there you are going to have the incentives to provide fewer services.

Mr. CONABLE. One of the great problems we have in the hospital area is that there is very little incentive for efficiency. Blues, for instance, pay on the basis of cost which means there is no incentive to keep costs down. Admittedly, if you carried cost incentives too far, it could get us in trouble in terms of quality care, but the problem has been we have had a sharply increasing cost in the hospital service generally, partly as a result of this idea that no matter how much it costs, they would always get something beyond that in repayment for their services.

Senator KENNEDY. I think you stated it accurately. This is for the most part because of the nature of the blues' board which has been rather devoid of consumer activity. There is very little interest in holding costs down. We found practically no review of hospital bills by the blues. As a result, we had an extraordinary example. I mentioned it in the former part of the testimony—a situation out in California. A fellow had a 14-page bill running about \$10,000. The blues just paid that without really investigating that they were charging \$2.50 every time

FINANCIAL EXPERIENCE OF PRIVATE HEALTH INSURANCE ORGANIZATIONS, 1969

[Amounts in millions]

Type of plan	Total income	Subscription or premium income	Claims expense		Operating expense		Net underwriting gain		Net income	
			Amount	Percent of premium income	Amount	Percent of premium income	Amount	Percent of premium income	Amount	Percent of premium income
Total.....	(1)	\$14,657.7	\$13,068.5	89.2	\$2,133.7	14.6	-\$544.4	-3.7	(1)	
Blue Cross-Blue Shield.....	\$6,265.8	6,155.6	5,903.1	95.9	457.7	7.4	-205.2	-3.3	-\$95.0	-1.5
Blue Cross.....	4,434.1	4,365.2	4,271.4	97.9	252.3	5.8	-158.5	-3.6	-89.6	-2.0
Blue Shield.....	1,831.7	1,790.4	1,631.7	91.1	205.4	11.5	-46.6	-2.6	-5.3	-.3
Insurance companies.....	(1)	7,569.0	6,306.0	83.3	1,609.5	21.3	-346.5	-4.6	(1)	
Group policies.....	(1)	5,685.0	5,349.0	94.1	750.4	13.2	-414.4	-7.3	(1)	
Individual policies.....	(1)	1,884.0	957.0	50.8	859.1	45.6	67.9	3.6	(1)	
Other plans.....	933.1	933.1	859.4	92.1	66.5	7.1	7.2	.8	7.2	.8
Community.....	375.0	375.0	349.0	93.1	27.0	7.2	-1.0	-.3	-1.0	-.3
Employer-employee-union.....	490.0	490.0	450.0	91.8	35.0	7.2	5.0	1.0	5.0	1.0
Private group clinic.....	16.3	16.3	14.2	87.1	1.1	6.8	1.0	6.1	1.0	6.1
Dental service corporation.....	51.8	51.8	46.2	89.2	3.4	6.6	2.2	4.2	2.2	4.2

2904

¹Data not available.

Source: Social Security Bulletin, February 1971.

RETENTIONS¹ OF PRIVATE HEALTH INSURANCE ORGANIZATIONS AS A PERCENT OF SUBSCRIPTION OR PREMIUM INCOME, 1948-69:

Year	Blue Cross-Blue Shield plans				Insurance companies			Other plans ²				
	Total	Total	Blue Cross	Blue Shield	Total	Group policies	Individual policies	Total	Community	Employer-employee-union	Private group clinic	Dental service corporations
1948.....	29.7	15.6	14.6	22.0	45.8	30.2	61.7	7.9	(3)	(3)	(3)	(3)
1950.....	23.2	14.5	12.3	21.6	33.9	22.8	47.4	10.0	(3)	(3)	(3)	(3)
1955.....	19.5	11.3	8.6	17.6	28.5	16.1	46.9	8.8	(3)	(3)	(3)	(3)
1960.....	14.5	7.9	7.2	9.6	21.1	9.6	47.1	3.5	(3)	(3)	(3)	(3)
1961.....	14.7	7.8	6.8	10.3	21.0	10.1	47.1	8.4	(3)	(3)	(3)	(3)
1962.....	14.4	7.2	5.7	11.0	20.9	9.4	49.3	9.2	(3)	(3)	(3)	(3)
1963.....	13.3	6.5	5.0	10.3	19.4	8.3	46.0	9.7	(3)	(3)	(3)	(3)
1964.....	12.8	5.6	3.9	9.7	19.1	8.3	45.5	9.5	(3)	(3)	(3)	(3)
1965.....	12.7	6.1	4.7	9.9	18.4	6.9	45.3	9.4	8.2	10.2	10.7	6.9
1966.....	13.5	8.1	6.6	12.0	18.1	6.9	45.6	9.3	8.0	10.2	11.8	6.5
1967.....	14.0	10.4	8.3	15.5	17.4	6.4	47.2	9.7	8.4	10.2	13.3	6.2
1968.....	10.4	6.7	3.7	13.8	16.5	6.2	46.4	8.6	6.2	9.7	5.8	17.2
1969.....	10.8	4.1	2.2	8.9	16.7	5.9	49.2	7.9	6.9	8.2	12.9	10.8
1970.....	8.4	4.2	2.7	7.8	12.5	3.9	41.9	3.8	4.5	1.6	18.0	14.7

¹ Amounts retained by the organizations for operating expenses, addition to reserves, and profits.
² Derived from table 17.

³ Data by type of plan before 1965 not available.
 Source: Social Security Bulletin, February 1971.

the fellow used a heating pad—some really extraordinary charges. That was just being passed on in additional premiums.

So, even in terms of the blues, I think their record generally varies. In some States it has been extraordinarily good, but you run into these problems, and I think as has been pointed out, this is very definitely a problem.

I would just say finally that we passed the Health Manpower Act with the House. It is a \$3.7 billion proposal, most comprehensive that has ever been passed on that. Whether we just provide a lot more doctors or assistant health personnel—great kinds of flexibility—there is no reason they can't go to Los Angeles, Beverly Hills, or Park Avenue.

People say this is one of the dimensions of the health problem, the shortage of manpower. We have nothing in there which says they can't go to practice in the wealthiest areas. We can provide a health maintenance organization out in the community for the delivery of health care, but we don't know who is going to be able to enroll in them. Unless you are going to have a financing mechanism which will permit them to enroll, it will only be the haves that will benefit from these facilities. We have to insure that financing and delivery will work in harmony with each other. That is essential, and that is why it is so important to have these two features brought together. Otherwise, you are not going to have the reform which is needed. No matter what bill is reported, I would hope you would put controls into it, which would contain costs and provide adequate services. Otherwise, we are just going to have continued runaway costs. Obviously, we can in the Health Subcommittee put consumer participation in, but you can put that in as well, which I think is of great importance. A ceiling on costs, consumer participation quality control, and uniform comprehensive coverage. We can do that to some extent by definition. Health maintenance organizations to some extent have that with doctors looking over one another's shoulders. If you can write in the quality control, we are a long way down the road in the work of the health committees of the Senate and the House and also in this committee.

I think the bill by Congresswoman Griffiths and 24 other Members of the Congress, bipartisan support—I think this is really the best way of doing it.

Mr. KARTH. Do you mean limitation on costs?

Senator KENNEDY. As featured in our bill. You have an allocation of so much to be used for group practice. You have a certain allocation for fee for service, but the fee for service would not be an unwritten blank check. You might say you can spend a million dollars in a community for health and you say 90 percent will be done through various group health activities or others and \$100,000 would be fee for service, but fee for service is not unlimited. You can get some kind of ceiling and the fees would be arranged within that definition.

Mr. KARTH. Limitations on fees for prescribed illnesses?

Senator KENNEDY. I think so. I think that can be worked out. It has worked out in European countries with great success. That is the kind of health service the health industry should be trying to provide for us.

You find in Great Britain and the Scandinavian countries that the medical associations police this and they work out any unfairness.

They work out whether there are too many tonsillectomies, or whatever.

Mr. KARTH. Don't you think peer review would help?

Senator KENNEDY. What concerns me, even up in our area, it is you scratch my back and I will scratch yours, in too many of the hospitals of the country. But we do not have the answers on that, and just generally peer review will not be the answer, but it can be useful and helpful.

I would hope that we could find new ways of using computers for quality control. I think there is very interesting potential. Doctors up at the University of Vermont have been very interested in it and have worked it with great success.

Mr. KARTH. Thank you.

Mr. BURKE. Senator, some of the witnesses who have testified before this committee have been very critical of health care in the Scandinavian countries and in Great Britain. Do you know of anyone over there who has advocated repeal of the health care system?

Senator KENNEDY. No, I do not, Mr. Chairman. You hear of certain rigidities, for example, the career structure in Great Britain where the doctors have to stay so long before they can move ahead in certain layers, which is troublesome to some of the doctors. But the interesting thing is the medical societies are working to try to eliminate those rigidities and trying to smooth this out, and they are working in harmony. They are really in the vanguard for bringing about some change and responding to it which was the most encouraging aspect of it.

The features which I thought were so commendable in the English system and, I would think, of the European, is that quality health care is recognized as a fundamental right of people, and the ability to pay does not prohibit people from receiving quality health care.

I remember when I was in Great Britain I went to the Cadbury candy factory where you have great long lines of people. I just went down the line at random and spoke to them, and everybody knew the name of his private practitioner. This idea of an impersonal system was nonexistent. They all had experiences with their doctors. This was not an impersonal system and all of them were very, very enthusiastic about the health service.

Certainly, there was some elective surgery. You hear of situations of 3 year waits and in certain hospitals they feel they have too much private care and the public cannot get a bed. You hear of these kinds of examples, but the medical groups and societies are really trying to work the problems out.

As I understand from talking to three Ministers of Health in Britain—the present one and the two previous ones, Labor and Conservative—they feel the private sector should not be more than 10 percent. They feel they can have a role for the private sector, and this will not affect quality. I found it an impressive system.

Mr. BURKE. Have you found any drop in the applications of those entering into the medical professions in those countries?

Senator KENNEDY. Not at all. As a matter of fact, being salaried employees, they have a merit system that augments their salary to some extent, but they are salaried employees and they welcome it be-

cause they find this eliminates the financial question in terms of the treatment of patients. They appreciate that. They say under their system:

We can recommend whatever we sincerely believe is essential to providing quality health to this person here and we do not have to worry because he does not have the ability to pay. One of the things we are rather amazed at in terms of the American system is the plight the doctors must be in when they say: "We can't suggest either a procedure or drugs because that person does not have the ability to pay. We feel enormously free under this situation where the financial situation of the person we are treating is not a factor. We are here to practice and do not want to spend our time filling out forms."

When you talk to young people in the medical schools we met over there—I asked for a show of hands—you could not find a person in terms of any of the medical students—you could not find any of the young people who would be happy with a return to the fee-for-service system.

I would like to say just finally our Health Security Act does not talk about eliminating fee-for-service. We are involved with a pluralistic system and fee-for-service can be maintained, but the act does not provide the wide open blank check which exists now. That is why I hope no matter what comes out of this committee, you will have a ceiling on expenditures. That is the only way we are ever going to be able to halt this inflation in costs.

Mr. CONABLE. It sounded as though in your exchange here you were conceiving of your system as moving us into the same area as the British. I realize that is not your intention. You do want to preserve some pluralism here.

Is it not true there is an increasing private sector in British medicine again? Aren't people buying additional insurance to get coverage beyond what is covered by national health partly because of cutbacks in the coverage that is granted under the national health system in Britain? I have heard there are increasing numbers of people not opting out but opting for additional coverage there in Britain. Is that correct?

Senator KENNEDY. On the elective surgery, you have to wait up to 3 years in some places in Great Britain. They can get for a small amount of payment the kind of insurance which would accelerate that so they could get the treatment provided in place of a few weeks. So, there is that. But as of today, the private sector is 6 percent which I think is still a very small part in terms of private practice. But with the new sophistications in treatment and skills in the medical area, there are delays in some of the elective surgery which would not be normally considered as essential surgery. Important procedures have a very short waiting period.

As you pointed out before, Health Security will not meet every kind of health need. Some of the chronic care, for example, mental health care, we have certain features which limit benefits. We cannot provide all of it. We have limited types of nursing homes which must be associated with hospitals.

In terms of drugs, we have practically all but not all in their entirety, but there are areas, and that would raise the \$58 billion enormously if we were to provide these others.

I think we have a bill here that will do the job and make a serious and significant impact in health needs and somewhere along the lines

when we are able to better handle these financial situations, obviously we ought to try to fill those in as well.

Mr. BURKE. The reason I raise the question about the applicants in the medical schools, there was some hint on the part of some of those who testified here during the last 2 weeks that if we did not get something that the entire medical profession agreed with, we might not get the cooperation we should have. I doubted the inference of these statements. I believe that the medical profession will more or less follow along and cooperate in every way.

Senator KENNEDY. It has certainly been my experience that the doctors of this country are motivated for care and treatment of the needy and the sick. We have to recognize they are caught up in the system. They have fee-for-service. They did not vote it in. They did not set up the system themselves. They are caught in it. They cannot be blamed for utilizing it or even taking advantage of it. I think they in many instances want the kinds of changes which we are talking about here. I just wish that the spokesmen for organized medicine would be helpful to us in terms of achieving some of these reforms rather than being opposed to these major alterations and changes and providing quality health as a matter of right to people.

Mr. BURKE. I have been greatly encouraged particularly by the statement of the U.S. Chamber of Commerce this past week. Many of them are taking a broader view of the problems this Nation faces in health care.

Are there further questions? There being no further questions, Senator Kennedy, on behalf of the committee, we wish to thank you for your appearance here today. When we go into executive session, more than likely we will be in touch with you and your staff.

Senator KENNEDY. Thank you very much, Mr. Chairman and members of the committee. You have been kind in rearranging and adjusting schedules and I want to thank you very much for the courtesies that have been extended to me.

Mr. BURKE. Our next witness is a distinguished Member of the Congress, the Honorable Donald M. Fraser.

We welcome you here to the committee, Congressman Fraser, and we know that you will make a great contribution.

STATEMENT OF HON. DONALD M. FRASER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. FRASER. I would like to just submit my statement for the record and just comment briefly on one or two points.

Mr. BURKE. You may summarize and your entire statement will appear as so given.

Mr. Chairman, members of the committee, I appreciate this opportunity to appear before you.

I have come here today to discuss the need for major new health insurance legislation. More specifically, I want to indicate my support for the Health Security Act, H.R. 22, which is now pending before your committee.

Until recently, many of us on the political level were only dimly aware of the need for a major overhaul of our Nation's health care

system. Today, most of us in Washington have come to realize that certain basic changes must be made in the total health care system. A new categorical program here—an increased appropriation there—is no longer enough to meet our country's growing health needs.

The full impact of the current health care crisis struck me earlier this year when I held public hearings on this issue in my district, Minneapolis. Invitations to testify were sent to all segments of our local health community. We also extended an open invitation to people in the district to come and talk about their own concerns as health care consumers.

The hearings evoked far more interest than we had anticipated. So many people wanted to testify that we had to triple the time we had originally allotted for the hearings. Sixty-five witnesses testified, representing all fields of private professional medicine, State, county, and Federal agencies and consumer groups.

I was impressed with the surprising degree of agreement on five points.

1. There was a great dissatisfaction with the present confusing and often competing private insurance plans which do not meet many medical costs, do not provide for preventive care and do not cover people who are not regularly employed or considered medically indigent.

2. Witnesses emphasized that not only must more medical services be available, but that these services must be better distributed. For example, 80 percent of American Indians in one neighborhood had never seen a dentist; 30 percent of all women in another area had no prenatal care. Some communities had an abundance of doctors who were specialists but had few general practitioners.

3. It was agreed that an urgent need existed for more doctors, nurses, paraprofessionals, administrators, dentists, technicians, laboratory workers, and staff from neighborhood clinics.

4. Consumers as well as professionals urged that more emphasis be given to preventive rather than curative medicine. This was most effectively described by one of the professors at our medical school, who explained that many people cannot get care until they reach the point of serious illness. Yet, we know that early diagnosis and care can prevent serious illness.

5. The proposal was made repeatedly that we establish groups which would operate on the basis of a flat yearly fee for health care, regardless of the amount of services required or received. Many believed that this approach would provide an economic incentive for keeping people well and preventing illness. The health maintenance organization concept was strongly endorsed by witnesses representing a diversity of economic interests.

These hearings, I think, provided a useful picture of the concerns of one metropolitan area about the health care crisis. We have had a more extensive account of the hearings published in the Congressional Record over the last 6 months.

Minneapolis is the site of one of the Nation's leading medical schools, and we probably have as high-quality health care available to us as any community in the country. But even in our area there are signifi-

cant deficiencies. When we move beyond Minneapolis to the country as a whole, the weaknesses in the current system are even more apparent.

A dozen or more nations give a newborn baby a better chance of surviving his infancy than does the United States. In more than two dozen countries, a man has a longer life. And women live longer in at least seven countries than they do here.

These rankings are for the United States as a whole. For the non-white population, the results are much worse. For the black American, the American Indian, and other minorities, adequate health care is either not available or extremely difficult to obtain. If available, it is more often than not perfunctory, impersonal, and degrading to the dignity of the individual.

The middle-income American knows another kind of health crisis. This is the crisis of steadily rising costs. Even with health insurance, the cost of doctor visits, hospital stays, prescription drugs, and other aspects of health care can be a serious drain on a family's financial resources. Any serious long-term illness can be a disaster to all but the most fabulously wealthy.

The expenditure on health in the United States increased at astounding rates during the past three decades. In 1940, the Nation spent a total of \$4 billion on health care. Since then, the amount has doubled and redoubled regularly. By 1960, we were spending \$27 billion a year; and by fiscal year 1970, \$67.2 billion. Hospital room costs in Minneapolis, for example, averaged \$93 a day in 1970, a 14-percent increase over 1969.

What do we have to show for all this expenditure? Besides high infant mortality rates, low life expectancy, poor care, or none at all for the poor and nonwhite, 100,000 people needlessly die of cancer every year, and another 6,000 Americans die needlessly of kidney failure.

The United States is the only major industrialized nation in the world that has neither a national health service nor a national system of health insurance. Chief reliance for health care protection is placed on private health insurance.

But the record of accomplishment for this insurance system is sadly deficient. Private insurance does not control costs or quality of care. It provides only partial coverage, not comprehensive care. The poor and the medically indigent are largely ignored.

The following 1968 statistics reveal the limitations of the private sector in providing adequate coverage. Of the 180 million Americans under the age of 65:

- Thirty-six million, 20 percent of the total, had no hospital insurance;
- Thirty-nine million, 22 percent, had no surgical insurance;
- Sixty-one million, 34 percent, had no inpatient medical insurance;
- Eighty-nine million, 50 percent, had no outpatient X-ray and laboratory insurance;

- One hundred and two million, 57 percent, had no insurance for doctor office visits or home visits;

- One hundred and eight million, 61 percent, had no insurance for prescription drugs; and

- One hundred and seventy-three million, 97 percent, had no dental insurance.

The promise of private health insurance is largely unfulfilled for large segments of our population. Even those who have some coverage have to pay an ever-increasing amount out of their own pockets.

Between 1950 and 1970, private health insurance's contribution rose from \$800 million to \$13.8 billion. At the same time, out-of-pocket expenses paid by the consumer rose from \$7.1 billion to \$23 billion.

Private insurance companies cannot provide needed health services because they are concerned primarily with actuarial soundness, not with meeting the public's need for health care. The insurance company's focus is on low-risk categories, which means, by definition, people who do not need extensive care.

In 1970 commercial insurance companies retained 26 cents out of every health care premium dollar for administrative expenses and profits. The nonprofit Blue Cross and Blue Shield plans did better—returning all but 7 cents in benefits from every premium dollar.

But the Social Security Administration did best of all with its medicare program, achieving a 97 cents return on the dollar despite the size and complexity of this Federal program.

In my State, Minnesota, the commercial insurance industry met the national average. It did not return 26 cents of each premium dollar in benefits. If its performance had improved so that it did as well as Blue Cross and Blue Shield, an additional \$32 million in premiums paid by citizens would have been returned in benefits during 1970.

We are short of doctors in Minnesota. At a minimum we need at least 300 more practicing physicians. If \$100,000 is adequate to attract one practicing doctor then the \$32 million which would have been provided by a more efficient insurance system would have been used to attract 320 physicians—more than enough to meet our current shortage.

The opponents of national health insurance often raise the spectre of the massive, new Government bureaucracy needed to administer a new Government program. But at the present time, the health insurance industry has a massive bureaucracy of its own for administering several hundred different programs.

One uniform national system of insurance should mean less bureaucracy than we now need to operate the confusing and complicated system of overlapping private programs. The paperwork problem comes from coinsurance, deductibles, and other partial payment provisions that are written into most private plans. Eliminating these restrictions and having the national health insurance pick up the first dollar of costs should do much to streamline the administrative machinery.

After reviewing the deficiencies in the current health care system, and examining the various plans that have been proposed to remedy these deficiencies, I have concluded that only H.R. 22, the Health Security Act, provides the comprehensive approach that will most effectively meet our needs.

The Health Security Act is based on seven key principles; a comprehensive benefit structure, effective cost control, quality standards, equitable financing, increased development of health resources, strong consumer representation, and national administration.

The benefits provided in this legislation were carefully structured to balance our Nation's total health care needs with our available resources and financial capabilities.

These benefits include:

All necessary physician services including preventive medicine, early diagnosis and treatment, and surgery.

All necessary hospital services including care in hospital-affiliated skilled nursing homes, approved outpatient services and home health care.

Broad range of active psychiatric services to help people return to a more normal life.

Dental care for children under 15 including cleanings, fillings, diagnostic, and therapeutic surgery services and orthodontic work to correct handicapped problems.

Medicines furnished to inpatients and outpatients by hospital, and drugs provided to persons enrolled in comprehensive group practice plans. Also, drug coverage for chronic conditions requiring long and costly drug therapy.

Other benefits including therapeutic devices, professional services of optometrists, podiatrists, pathologists, radiologists, and ambulance services.

A single standard of comprehensive benefits for all Americans eliminates the need for costly and separate programs for the poor and the elderly. There are no deductibles, no coinsurance, no exclusions and no waiting periods. There are no cutoffs in dollars, age or number of days for the most important element of health care—physician services and hospital care.

Most importantly, the program is financed nationally. We make use of the social security system which has had a proven record of success since its establishment in 1935.

Social Security taxes provide half the revenue needed. Employers, employees, and the self-employed contribute to the Health Security Trust Fund on the following basis:

Employers—3.5 percent of payroll.

Self-employed—2.5 percent of income up to \$15,000.

Employees and other individuals—1 percent of income up to \$15,000.

Admittedly, the program established through the Health Security Act is costly. A total cost has been estimated at \$75 billion a year. The proponents of the administration's plan incorporated in H.R. 7741, have maintained that the administration's alternative is considerably less costly, with a price tag set at only \$35 billion, a figure which reflects the costs of current Federal programs plus the new programs authorized in H.R. 7741.

But the advocates of the administration's alternative have been counting dollars only if they have been funneled through the Federal Treasury. The two programs may have the same total cost to our society, between \$70 and \$80 billion but the proponents of one claim that their program is more economical because only \$35 billion flows through Federal Treasury with an additional \$45 billion circulating through other financial channels.

I previously noted the relative efficiency of the Social Security Administration in comparison with private health insurance companies as a processor of money. As long as that situation prevails, I am definitely in favor of passing the money through the Federal Treasury. Contrary to what is asserted in other situations, the Federal Treasury seems to be the least expensive conduit.

A new system of financing is obviously the central feature of this new health care program. But implicit in this or any other new program is the promise of effective delivery of service to the American people. This promise would be empty, indeed, if the entire system collapsed under the weight of added Federal dollars.

No national health care program can be developed in a vacuum. Benefits are meaningless unless a great deal of effort is made to restructure the delivery system.

The Health Security Act would begin this long overdue process through the establishment of a Health Resources Development Fund. This fund would be in operation immediately upon enactment of H.R. 22. In the 2 years before benefits begin, \$600,000 million would be made available for development of resources.

Once benefits are available, a percentage of the Health Security Trust Fund will be devoted to an expansion of existing resources and the development of new ones.

By 1976, the Health Resources Development Fund should provide approximately \$2 billion dollars a year for education, training, group practice, and other innovative health programs to improve the delivery of care. It would complement other programs such as those authorized in the 1971 Health Manpower Act, the newly passed bill aimed at increasing the number of doctors, dentists, nurses, and paraprofessionals.

Doctors would receive financial assistance to locate in medically deprived areas and would be eligible for help in organizing into groups.

Ambulatory care is stressed in an effort to reduce reliance on hospitalization. Hospitals are encouraged to expand home health services and skilled nursing care facilities provide more complete care for the patient outside of the hospital itself.

Consumers are given the incentive to join comprehensive prepaid group practice plans because of expanded benefits provided group plan subscribers.

Throughout the health security program, in benefits, financing, and funding—reforms are built in so that we can begin developing the type of health care system the American people need and must have.

The Health Security Act is obviously not the complete and final treatment for the ills of our current health care system. But it represents an important advance over other proposals that have been brought forward to date. I want to conclude by urging adoption of this landmark legislation.

I very much appreciate the interest of the committee in this subject. I think it is one of the problems the country is facing today and I, as a Member of the House, appreciate your hard work very much.

Mr. BURKE. Thank you.

Is this \$32 million in 1 year?

Mr. FRASER. Yes, sir. This \$32 million in health care premiums never gets spent for health care but pays for claims investigations, for

overhead, and for profit, a much more expensive way of doing business than medicare which uses only 3 cents on the dollar for administration.

Mr. BURKE. Are there any questions?

Mr. KARTH. I have no questions, Mr. Chairman, but I do want to take this opportunity to welcome my Minnesota colleague here. He is one of the most able of our Minnesota delegation.

Don, it is always nice to have you.

Mr. FRASER. Thank you very much.

Mr. BURKE. We wish to thank you for your appearance here. You have made a fine contribution and the committee will give sincere consideration to your recommendations.

Mr. FRASER. Thank you very much, Mr. Chairman.

Mr. BURKE. Our next witness this morning is our colleague from the State of South Carolina, the Honorable Wm. Jennings Bryan Dorn. It is good of you to take the time from your busy schedule and give us the benefit of your views on national health. Please proceed.

STATEMENT OF HON. WM. JENNINGS BRYAN DORN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH CAROLINA

Mr. DORN. Mr. Chairman, thank you and the distinguished members of Ways and Means for the opportunity to present my views of national health insurance to your great committee. This committee, through the legislation it has drafted, has deeply affected the lives of all our citizens, from social security and medicare legislation, to Internal Revenue, national economic policy, and foreign trade. The American people greatly respect this distinguished committee for your careful and responsible deliberations, and we look forward to your recommendations on national health insurance.

Mr. Chairman, we need a new approach to the problem of rising medical costs. We have simply reached the point where the cost of medical care, especially any long-term hospital care, is beyond the average American's ability to pay. The astronomical, fantastic, and almost incredible costs of modern medical care concerns the American people and the Congress. The costs of catastrophic illness can easily wipe out the lifetime savings of even people of moderate wealth. Mr. Chairman, each one of us here knows of specific instances where this has occurred. Just the other day the House passed a bill to step up the national effort to cure cancer. We all devoutly hope that this can be done soon, but we also know of cases where this and other dread diseases have caused financial disaster in addition to personal heartbreak and suffering.

Mr. Chairman, American doctors and American medicine are the best. They are the envy of the world. Likewise, we have in this Nation a splendid system of private insurance. We can build on this system, Mr. Chairman. We must take care not to rush into a system of socialized State medicine that reduces each patient to a number.

We can develop a plan, through free enterprise insurance, which guarantees that no American will be financially destroyed by the costs of illness. And we can develop a plan which will allow American physicians to continue to use their own individual professional judgment in treating a patient.

Mr. Chairman, early in this session of Congress I joined in introducing the Health Care Insurance Assistance Act, sometimes called the medicredit plan, which was proposed by the American Medical Association. Our bill would make available to each citizen a private enterprise program of comprehensive medical and health care insurance, covering both the ordinary and the catastrophic expenses of illness or accident. The amount of Government assistance in paying the insurance premiums to existing private carriers would depend on the individual's ability to pay. Our bill would replace the medicaid program, which has been so burdensome for the States, with private enterprise insurance coverage for those now covered under that program. And we are especially pleased that our bill contains a special section on catastrophic illness coverage.

We have been impressed too, Mr. Chairman, by the proposed National Healthcare Act of 1971, the Burluson bill, which I understand has the support of the Health Insurance Association of America. This, too, is a sound approach at free enterprise medical insurance, and it is supported at the grassroots by many citizens associated with our great insurance industry, men who are in close contact with the current problems of high medical costs.

Mr. Chairman, the American people want a solution to this national crisis in medical expenses. But the American people also want to maintain the basic system of free enterprise medicine and medical insurance that has given us the highest standard of medical care in the world. We can build on this system and pass legislation that will guarantee every American that he will not be financially destroyed by the cost of illness.

Again, Mr. Chairman, your committee is to be commended for its tireless and exhaustive examination of every aspect of this problem. Personally I appreciate the opportunity to present my views, and we look forward to your recommendations.

Mr. BURKE. Thank you for your views, Mr. Dorn. Are there any questions? There are none. Our thanks to you again.

Is Mr. Pepper present in the room? Congressman Claude Pepper from the State of Florida is our next witness. It is good of you to take the time to come before the committee on this matter. You may proceed.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. PEPPER. Mr. Chairman, I appreciate this opportunity to testify before this committee on behalf of H.R. 22, which I have cosponsored with the distinguished members of the committee, Mrs. Griffiths of Michigan and Mr. Corman of California.

As you know, Mr. Chairman, I have for many years been deeply interested in the problems of health care in this country. During the wartime years of 1943 and 1944 I was Chairman of the Senate Subcommittee on Wartime Health and Education. That subcommittee was established to find out why so many of our young men were unable to pass the physical and mental examinations under the draft.

During the course of the subcommittee hearings, I learned that our national medical system was not what we thought it was. The reality

was driven home by the alarming fact that of the 13 million men who had been examined for military service, more than 4 million had been rejected for reasons of health.

The testimony of succeeding witnesses revealed why this was so. Their statements described an overall shortage of health personnel, particularly in rural areas; the existence of substantial financial barriers to health care for low-income workers; and the particularly grave health problems confronting American Negroes.

Mr. Chairman, it should be a source of grave concern to all of us that much of that testimony is still relevant today, still relevant because the defects in our health care system which were so vividly described almost 30 years ago still exists, and, if anything, have become graver and less accessible to traditional solutions.

I am pleased, therefore, to have this opportunity to speak in favor of H.R. 22, the health security proposal, which, of all the bills proposed to meet the Nation's health needs, is the only one designed not only to assure financial protection against the costs of illness, but also to change the organization and delivery system of health and medical services. H.R. 22 would extend protective coverage to every man, woman and child who has resided in the United States for 1 year or more, with the exception of active-duty members of the uniformed services.

The range of benefits envisioned by this bill would include (1) comprehensive health services, including diagnosis and treatment of disease, physician's services, preventive care and physical examinations, physical and mental rehabilitation and therapy, specialists' services, including such things as surgery and psychotherapy; (2) institutional benefits, including hospitalization without limit, ambulance services, skilled nursing home care, home health services, including homemaker services; (3) eye care, including examinations and allowances for eyeglasses and frames; (4) comprehensive dental services to all children under age 15; (5) allowance for prosthetic devices and durable medical equipment; and (6) prescription drugs. The few benefits excluded under H.R. 22 apply to over-the-counter nonprescription drugs, dental services for adults, and custodial (as differentiated from "skilled") nursing home care, "personal comfort" items, and certain forms of cosmetic surgery.

The health security program would be financed by a Federal payroll tax on employers—3.5 percent—and an individual tax on employee's wages—1 percent, a tax on unearned income; and allocations from general revenues to match the employers' share of contributions.

Under H.R. 22, effective cost controls would be secured through Federal Government contracts with providers of care on a prospective or negotiated basis. These contracts would provide substantial financial incentives for medical and dental groups, county medical societies, hospitals and other nonprofit organizations to provide or arrange for comprehensive health services under a single contract and to employ sophisticated management methods. Individual physicians, dentists and other health professionals would be paid under one of the following methods: fee for service, capitation, and for salary. With respect to fee-for-service payments, the amount of fees would be determined by fee schedules or relative value scales prescribed by regulation after

consultation with representatives of the program. The administration of fees could, under the bill be delegated to a medical or professional society.

Capitation would be available only to independent physicians and dentists in general or family practice. An annual amount would be paid for each person enrolled to receive all services from the practitioner.

In addition, upon agreement, a practitioner could be paid a full-time salary, or, in some case, a part-time salary as a supplement to other methods of compensation.

The program would be administered by the Department of Health, Education, and Welfare. A five-member, full-time Health Security Board, appointed by the President with the consent of the Senate, would serve under the Secretary of Health, Education, and Welfare. The Board would be responsible for general administration of the program, including policy and regulations, control of expenditures, standards, and reimbursement for providers of services.

A National Advisory Council, appointed by the Secretary, would advise on general policy, regulations and allocations of funds. The Council would include the Chairman of the Health Security Board and 20 members, including representatives of consumers—who would be a majority—and providers of services.

The program would be administered through 10 regional offices of the department and approximately 100 local health service areas. Regional and local advisory councils, comparable to the National Advisory Council, would advise the regional offices.

H.R. 22 contains a number of major proposals directed at improving the health care delivery system. They include:

1. For the 2 years before the program begins, appropriations of over \$200 million would be provided to support health planning, to assist in alleviating shortages and maldistribution of facilities and manpower, and to improve the organization and delivery of health services. After the program starts, continuing support for such efforts would be provided through the Health Resources Development Fund. This fund would receive, in the first year, 2 percent of the total income, and this allocation would be increased by 1 percent—at 2-year intervals—until it reached its ultimate rate of 5 percent.

2. H.R. 22 directs the Department of Health, Education, and Welfare to undertake planning to improve the supply and distribution of manpower facilities and the organization of health services, with the provision of ambulatory services on a comprehensive basis given the highest priority.

3. H.R. 22 also provides for grants to public agencies or nonprofit organizations for up to 90 percent of the expenses of planning and developing a new comprehensive health service system. In addition, loans would be made for the construction costs of a new system, up to 90 percent of cost. Existing comprehensive health service systems could receive similar development grants and construction loans for expansion of their facilities, to a maximum of 80 percent of costs. Additional financial support is available to newly-established or enlarge comprehensive systems for as long as 5 years, and special grants can be made for equipment and to help meet the costs of improved management methods.

4. The Health Security Board, consulting with the State planning agencies, is authorized to establish priorities for meeting manpower needs. Funds may be provided for the following purposes:

(a) training of medical students for general or family practice or for specialties in critical shortage;

(b) training for professional and paramedical occupations (priority would be given to those professionals who agree to work in shortage areas and in comprehensive health service systems);

(c) development of new kinds of health personnel, especially those useful in connection with comprehensive health service systems; and

(d) financial assistance for members of disadvantaged groups who are training for health occupations.

Mr. Chairman, this bill takes a long-neglected first step in meeting the problems that have been presented to the Congress for over 25 years, and which have grown greatly in magnitude within the last decade. Your early approval of this legislation is urgently needed.

Mr. BURKE. We thank you, Mr. Pepper, for your good statement here today.

Our next witness is Congressman Michael J. Harrington from the Commonwealth of Massachusetts. We are pleased to have you with us and please proceed.

STATEMENT OF HON. MICHAEL J. HARRINGTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. HARRINGTON. Mr. Chairman, thank you for allowing me to appear before you today.

You are holding extensive hearings in an area of primary concern to every American—health, and I am hopeful that the information you have compiled will result in legislation which will give the Americans the decent health care they deserve.

I have cosponsored the Kennedy-Griffiths bill because I believe the problem of health care is so acute that only a comprehensive, compulsory national health insurance system will solve it. The abysmal failure of the present system to give proper health care to the poor, the elderly, and the middle class at reasonable cost necessitates a dramatic change. The Kennedy-Griffiths bill is a start in the right direction and I commend Senator Kennedy and Congresswoman Griffiths for the leadership and initiative they are showing on this critical matter. I intend today to suggest several areas where their bill should be expanded—but none of these suggestions are in any way intended to detract from their achievement in putting together a first-rate piece of legislation in an area of great complexity.

I do not intend to take up the committee's time with a repetition of the statistics which demonstrate the overwhelming need for the Kennedy-Griffiths bill. Instead, I will address myself to three areas where I believe further attention is needed. They are adequate treatment for the mentally ill, provisions of custodial care for the chronically ill, and comprehensive health care planning.

MENTAL ILLNESS

The majority of those suffering from mental illness are the poor. They have been the subject of much discussion before the committee, since it is they who also receive the worst health care. Discussion has centered on ending discrimination against general health care for the poor but little has been said about mental health.

Those with the least education and the lowest income have the highest rates of admission to State and county mental hospitals and to out-patient psychiatric services. Within this group, older citizens (those over 55) have the highest rate of mental illness with women at a rate almost double that of men.

Nor are the poor the only group in need in this area. To an increasing degree our large labor unions have gotten involved in the problem of mental illness among their members. The United Auto Workers health program is a model in this field, and as International President Floyd Smith of the IAM points out—

As industry becomes increasingly automated more jobs become monotonous, boring and frustrating. They not only provide no satisfaction, but, by decreasing the workers' sense of personal contribution, undermine his sense of individual worth. As the environment for humans in industry becomes more sterile the climate for alcoholism, drugs and anti-social behavior becomes more fertile. This entails a significant loss not only for workers individually but for the nation's productive capacity as a whole.

Along with other labor organizations, our union has tried to negotiate pre-paid psychiatric care provisions in collective bargaining contracts. We have had some success. But our efforts are little more than a band-aid where major surgery is required. Just as physical health care is too enormous for privately negotiated insurance plans the problems of mental health cannot be solved without establishing a comprehensive base of government support for a wide range of services.

The simple fact is that very few Americans today can afford private psychiatric care out of their own incomes.

In fact, 10 percent of the total population—or 20 million people—have been or will be hospitalized for mental illness at some time during their lifetimes. In 1969, one out of every three hospital beds in the United States was a psychiatric bed. It has also been estimated that up to 25 percent of the population will need some kind of psychiatric care during their lifetimes. We are therefore talking about between 20 million and 50 million people.

Why then is it that every bill before your committee discriminates against the mentally ill? The answer is twofold.

First: American society does not like to think about mental illness. It is not considered a "real" illness. If the sick person would only "exercise some self-control and pull himself together" he'd be fine. This arrogant, frightened, ignorant viewpoint is false and unjust. The advances made in medicine—particularly in pharmacology—linking mental illness with physiological problems and the evidence of the effectiveness of psychotherapy demonstrate that mental illness is indeed real.

Second: There is a great fear that the cost of treatment for mental illness—if it were available to everyone—would be prohibitive. Studies made of different national health insurance plans have shown no marked increase in the use of psychiatric facilities. The increases

have been offset by a corresponding decrease in the number of visits to the regular family physician. (Doctors report that a high percentage of their patients are suffering from psychosomatic complaints.)

Studies of the various group practice prepayment plans providing comprehensive outpatient psychiatric care have shown that about 5 to 20 persons per 1,000 enrollees receive some outpatient psychiatric care each year. Average number of visits per patient ranges generally from 7 to 15, and total visits per 1,000 enrollees range from about 50 to 170. Total visits for psychiatric care comprise from 1 to 4 percent of total visits for all conditions, including preventive care.

Hospital admissions for mental conditions generally range from about 2 to 4 per 1,000 covered population annually and comprise about 2 to 3 percent of all hospital admissions. Days of care for mental conditions range from about 25 to 60 days annually per 1,000 population, and comprise about 5 to 7 percent of the days of care for all conditions. The average per diem cost of care for mental illness is *lower* than that for all conditions (since there are no charges for operating room, anesthesia, X-ray and laboratory examinations) and the overall cost of hospital care runs about 3 to 5 percent of that for all conditions.

There is no good reason—from the data shown—why insurance coverage of hospital and outpatient care for mental conditions should not be as extensive as that for general illness.

The problem is that such coverage is now limited to a small percentage of the population. And in many cases, persons with a history of mental illness cannot receive adequate coverage.

I have received several letters from the parents of mentally ill children and from the Association for Mentally Ill Children in Massachusetts. These letters show so clearly the need for adequate coverage, that I would like them to be placed in the hearing record at this point. The unnecessary pain and suffering to which our present health care system subjects children and their parents is so horrible that it must be changed. The letters speak for themselves (see attachment A).

Your committee, Mr. Chairman, has a unique opportunity to do a service to Americans by allowing them the same right to mental health as is now claimed for physical health.

Let me briefly summarize the provisions for mental health care in the National Health Insurance Partnership Act, the National Health Care Act of 1971, the AMA medicredit plan, and the Health Security Act.

THE NATIONAL HEALTH INSURANCE PARTNERSHIP ACT OF 1971

The National Health Insurance Partnership Act of 1971, does not require that an approved basic health care plan include outpatient or inpatient psychiatric services. Section 603 of the bill, setting forth the benefits which must be included in an approved employer-employee-financed health plan, states that a plan must include "physician's services (except when provided by a psychiatrist) to an inpatient of a hospital," and "physician's services (except when provided by a psychiatrist), . . . for a person who is not an inpatient of a

hospital." Similar restrictions on coverage of psychiatric services would apply to benefits under the Family Health Insurance Plan, proposed under title II of the bill.

THE NATIONAL HEALTH CARE ACT

The "Minimum Health Care Benefits" spelled out in the National Health Care Act of 1971, include three visits per year to a physician in his office or in an ambulatory health care center. Presumably, these visits could be used for treatment by a psychiatrist. This plan also covers the first 30 days in a general or psychiatric hospital per illness and full charges for physicians' services while institutionalized. Over a 6-year period following enactment of the proposed legislation, additional benefits would be phased-in. Additional visits to a physician for treatment of mental disorders would be unlimited in number and would be subject to a 50-percent copayment by the patient.

THE AMA "MEDICREDIT" PLAN

The Health Care Insurance Assistance Act of 1971 embodies the "Medicredit" approach to health care financing supported by the American Medical Association. Under the bill, a qualified private health insurance policy eligible for Federal income tax credits would have to include at least the following benefits relating to mental health care: 1) 60 days of inpatient hospital care for psychiatric treatment; 2) outpatient diagnostic tests and emergency services; and 3) psychiatric care by a physician regardless of where the services were provided—number of visits unspecified.

HEALTH SECURITY ACT

The Health Security Act of 1971, introduced into the House by Representative Martha Griffiths and into the Senate by Senator Edward Kennedy, would provide for 45 consecutive days of psychiatric in-patient care during a benefit period. Covered services do not include institutional care of a person as a psychiatric patient unless that person is receiving *active* treatment (as opposed to maintenance or custodial care) for an emotional or mental disorder.

Psychiatric services to an ambulatory patient are covered only for active preventive, diagnostic, therapeutic, or rehabilitative service with respect to mental illness. If the patient seeks care in the organized setting of a comprehensive health service organization, or a hospital outpatient clinic, or other comprehensive mental health clinic, there is no limit on the number of consultations. The care of a psychiatric patient in a mental health day care service is covered for up to 60 days. If the patient is consulting a solo practitioner, there is a limit of 20 consultants per benefit period. Psychologists' services are covered if they are part of institutional services or are furnished by a comprehensive health service organization. Services of independently-practicing psychologists are not covered.

Of all the legislation the Health Security Act has the best mental health provisions. I am in full sympathy with the requirement that time in a mental hospital should be spent on "active" treatment. Cus-

todial care, which I shall discuss elsewhere, should no longer be tolerated for the mentally ill. I can understand why a 45 day limit has been placed on hospitalization, but I cannot wholeheartedly approve. There is no such limit for physical illness. If a patient requires active treatment after 45 days why should he be penalized. I would suggest that ideally, no limit be placed on the number of days allowed in a mental hospital. However, I realize that one reason for such a limitation is to create an incentive for moving people out of the hospital and to encourage the use of community mental health centers. I applaud these objectives and endorse them.

Nevertheless, there will be some small number of persons who will require extended hospitalization. I would therefore suggest a minimum of 90 days of active treatment. If the limit were 90 days almost every patient (not just a majority) would be covered. If the patient cannot respond at the end of 90 days, I further suggest that either on the doctor's recommendation or by some type of peer group recommendation or some other method, the patient be allowed to continue active treatment, subject to a review every 30 days. I know that there are problems in peer group review, and I am not advocating this as a solution to the problem. I don't have enough expertise to offer the ultimate answer to the proper review mechanism. I hope the committee will look into it.

Mr. Chairman, the number of patients being discussed here is very small, the cost is very small—to us—but it would be disastrous to their families if they had to bear the burden. Statistics clearly show that the number of hospitalized patients is dropping, and gives further evidence that the cost of adequate hospitalization for those who need it is not beyond the resources of this Nation.

The number of inpatients in State and county mental hospitals as of June 1970 was 338,592. This represents a drop of 35,192 patients, or a 9.5-percent decline over the past year. Thus, for the 15th consecutive year, the population of these institutions has declined. Accompanying this trend is the number of net releases from mental institutions. The number has tripled from 126,000 in 1955 to 395,000 in 1970; 1970 was the first year that the number of net releases exceeded the number of admissions.

The cost per day for the average resident patient in State and county mental hospitals has risen from a figure of \$12.59 per day in 1969 to \$14.89 per day in 1970. Compare this to a cost of approximately \$85 per day in our best private mental hospitals, and we can see that the treatment in the mental hospitals cannot possibly be as good as the average patient needs. Yet, there are many families that cannot afford even the cost of the State hospital, who are afraid to put a member into a State hospital, but have no choice. When the cost for a year's stay in such a hospital is \$5,434.85 it is clear that most families simply can't afford to pay.

A second area in the coverage of mental illness also concerns me. This is the restriction on the number of visits allowed to a psychiatrist. The Kennedy bill places no limit on the number allowed if the psychiatrist is part of a health maintenance organization. The limit is 20 if he is in private practice. I recognize that this provision seeks to provide incentives for the formation of HMO's, and that is an effort

I fully support. This recognition of the worth of HMO's is one of the important innovative features of the Kennedy-Griffiths bill. But it will take us some time to reach that goal and in the interim I am concerned at the plight of those who find no HMO available to them, or who for some other reason will be continuing treatment with a single practitioner. Ideally, there should be no limit on private visits in these circumstances. If the person is sick he should be allowed to see his doctor. Realistically, I know that there are strong inclinations to limit the visits. As I have demonstrated, when the private plans began covering subscribers for psychiatric visits there was no overwhelming increase in the number of persons seeking such visits, and the cost did not become staggering. If the committee is convinced that some control is necessary, I would ask two things—first, limit the visits to no less than 20, as we see in the Kennedy bill. Second, require that a study be made within 5 years of the cost and utilization of psychiatric services. At that time revise the restrictions in light of the data. I think we will see a considerable loosening of restrictions against mental health coverage. Let us not shut the door once and for all in this Congress.

Finally, Mr. Chairman, we must at all costs preserve the community mental health centers. Approximately 400 mental health centers are or will be in operation in the near future. At the present time, funding for these centers is on an extremely tenuous basis, with legislation providing such funding running out in the next 2 years. It is essential for progressive and good mental health, that these centers remain open. They have contributed immeasurably already to keeping patients out of the hospital and to providing adequate outpatient care. If national health insurance does not provide some form of reimbursement to these facilities, and does not make it a clearly mandated goal that these facilities shall continue in operation, we will have lost one of the best, most economical, and most farsighted health organizations in existence.

To summarize, at a minimum the following provisions for mental illness should be included in any bill reported out of this committee:

- (1) Full coverage of 90 days of hospitalization, per benefit period;
- (2) Further hospitalization if the patient's doctor of peer group review determines it is necessary;
- (3) A review every 30 days of extended hospitalization;
- (4) Coverage of "active" treatment only;
- (5) A minimum of 20 visits to a psychiatrist on an outpatient basis, per benefit period;
- (6) Full coverage of all prescription drugs;
- (7) Full coverage of community mental health center assistance, and strong provisions providing Federal funding for continuance of such centers;
- (8) Full coverage of home visits by qualified staff members of clinics or comprehensive mental health centers;
- (9) Full coverage for 90 days stay in day mental hospital with same provisions for extension as full-time hospital, per benefit period;

(10) Full coverage for 90 days stay in night mental hospital with same provisions for extension as full-time hospital, per benefit period; and

(11) A 5-year study to determine costs of mental health insurance with an eye toward removing restrictions if data demonstrates feasibility.

Mr. Chairman, President Kennedy in his message on mental illness and mental retardation in 1963 stated:

Mental Health Services should be financed in the same way as other medical and hospital costs. At one time this was not feasible in the case of mental illness, where prognosis almost invariably called for long and often permanent courses of treatment. But tranquilizers and new therapeutic methods now permit mental illness to be treated successfully . . . within relatively short periods of time—weeks or months, rather than years. . . .

President Kennedy was right 8 years ago. Is the Congress ready to act now? I hope so.

CHRONIC ILLNESS

The second area of concern to me is the care—particularly custodial care—of the chronically ill. The image conveyed to the American public is that the Congress is seriously considering legislation which will provide comprehensive health benefits for everyone. That image is false. These bills do not cover everyone, and it is my intention today to bring to light and to discuss the fact that those needing custodial care are not even being considered for coverage under any national health insurance proposal.

Let's not fool ourselves, but most of all let's not fool our constituents. Some people are not going to get the right diseases. Some people are going to need longer term care than the Congress or the President wants to give them. And these are generally the people with the least political clout—the aged living in nursing homes, the mentally retarded, the mentally ill who require a sheltered environment and have no home to return to. If it is indeed too expensive to provide these individuals with adequate health coverage, let's drop our mantle of hypocrisy and admit that there are limits to what we can do. If we can afford to provide them with coverage then let's demolish once and for all the idea that "custodial" care is not "health" care.

Our society has consistently differentiated between health services and social services. It is time to take another look at our definition of services and determine how and why we ever got into such a silly bind. It is increasingly clear that better health—and less expensive health care—may come for many in a middle ground between home and hospital. It has been estimated that 10 percent or more of the chronic long-term patients in the Massachusetts State mental hospitals could be released if they had foster homes or half-way homes to which they could go. Studies of the severely retarded have demonstrated that with adequate training and education, most can learn to function on a minimal level. Yet we spend twice as much as we need to keep such individuals in State facilities simply because we lack the funds and imagination to look for and use the alternatives.

I would like to see any health care bill reported out of this committee include unlimited coverage for custodial care—defined as nursing homes, half-way houses, foster homes, and where necessary in-

stitutionalization. The emphasis should be permanently on alternatives to institutionalization.

A look at the statistics of the numbers of chronically ill proves the need for both home care and "custodial" care coverage.

It is evident that Americans are living longer. Since 1900, the life expectancy for the American male has risen from 48 years to 67 years and for American females from 51 to 74 years. Yet the United States currently ranks 22d in the male life expectancy and seventh in the female life expectancy of all the major industrial nations of the world. A male in Sweden can expect to live 5 years longer than the average American male and a female in the Netherlands can expect to live nearly 2 more years than the average American female. Of course, part of this is due to American affluence and our way of life, but the major reason for their longevity is their nation's health care system.

Since 1901, the United States has had 40 Nobel prize winners for medicine. We have prevented or controlled formerly fatally infectious diseases such as pneumonia, typhoid fever, and tuberculosis. Yet, these other nations have a more comprehensive health care and health delivery system which provides their people with adequate care at a cost that is not prohibitive. To these nations, health is of the first priority.

With these advances in medical sciences, more and more Americans are reaching the ages at which they become vulnerable to arthritis, emphysema, rheumatism, heart disease, cancer, multiple sclerosis, Parkinson's disease and other chronic illnesses.

Of the 22 million Americans suffering limitations from chronic illnesses over 12 million are severely enough affected that they had to discontinue their major activity (job, housework, or studies). An additional 4 million are disabled to the degree that they could hold no job at all.

Nearly 11 million Americans suffer from arthritis alone. Rheumatism afflicts another 6 million. Heart diseases have stricken nearly 15 million Americans with another 13 million suspected sufferers. Over 500,000 people suffer from multiple sclerosis. Parkinson's disease which is primarily among the crippling neurological diseases afflicts over 1 million individuals, and 50,000 more Americans will be afflicted with this disease every year.

Diseases such as diabetes, which afflicts nearly 3 million citizens, can be controlled if diagnosed—but nearly half of the sufferers do not know they have it.

The incidence of chronic respiratory diseases, particularly emphysema, has been recognized by health authorities as a growing menace because of the increasing contamination of our environment. In the last 5 years, emphysema cases have risen over 109 percent. People affected by bronchitis and/or emphysema number well over 4½ million. The number of deaths per 100,000 caused by emphysema has increased from 5.4 in 1960 to 11.1 in 1970, more than a twofold increase in just one decade. Because their disease is progressive and their ability to breathe is affected, emphysema patients need continuous care, beyond the hospital. Home care is essential and expensive. In time, with enough research, there might be a cure. Until then, the needs of the afflicted must be met.

Over 800,000 persons suffering from chronic illness are strictly confined to their homes. A typical case was related to me in a letter from

Mrs. Eva M. Rees, executive director of the Visiting Nurse Service of New York. Mrs. Rees wrote:

Mr. D., a woman of 45, has multiple sclerosis. Her illness has progressed to a point where she is unable to do any self care. She is completely dependent on helping persons for bathing, toileting and nutrition. Her husband works, her 3 sons are of school age, and with no other family members available, a home health aid was essential for her care. Mr. D's income was inadequate to meet medical expenses and they were therefore able to qualify for Medicaid assistance and home health aide services was provided 8 hours a day, 5 days a week. With exchanges in eligibility, however, the Ds no longer qualified for Medicaid assistance and although several voluntary agencies tried to provide assistance, this 45 year old woman had to be sent to a nursing home where she will likely remain until she dies.

This kind of governmental insensitivity is cruel to both the patient and her family, and results in a much more costly form of treatment. It would be both more humane and less expensive to stay at home.

This committee has already heard the projected cost of hospitalization for the next few years. People who suffer from the chronic illnesses will be forced to meet these costs. Yet, the incomes of families with a severely chronically ill person are less because of the inability to work. When the chronically ill person is the head of the family, disruption of earned income may be acute. When another member of the family is the one afflicted, earning losses may not be quite as severe, although other expenses may be incurred in the forms of attendant care, housekeeping, or special equipment.

According to the social security survey of the disabled, the median family income of disabled adults in 1965 was \$5,270—compared to an average family income of \$6,817. And families with a severely disabled adult had incomes of \$3,156—an amount bordering on the poverty level. These people must meet costs estimated at between \$900 and \$1,000 a month.

Home health care must be provided for the chronically ill. But adequate custodial care deserves equal consideration and action. More than 1 million Americans are in nursing homes, 270,000 mentally retarded individuals are confined to institutions.

Ten percent of all persons suffering from multiple sclerosis will need the full range of custodial care.

A percentage of individuals suffering from other illnesses which I have discussed will need custodial care.

Let me use cancer as an example. Victims of cancer, which kills two out of every three people it attacks, in almost all cases undergo a long-term treatment period and they or their families must face astronomically high costs.

In a letter that I received from Mr. Richard T. Mayes, treasurer of the Children's Cancer Fund of America, he says:

The problem of how families of average means can pay for custodial care of the critically or chronically ill short of help from the national Treasury is beyond the scope of this organization to even suggest a solution. Private or charitable organizations could not even scratch the surface of meeting the expense of medical and custodial care for the millions of children threatened or afflicted with cancer in its many forms.

I can say quite frankly that all the funds that this small but devoted hard working group can generate in a single year would not be adequate to pay the expenses for more than few victims being treated for any serious cancer illness, of children up to age 14 years.

I have received many other letters from organizations representing the chronically ill and all endorse better coverage explaining why. I would like to insert them at this point in the testimony (see attachment B).

The initial tests and follow up diagnosis and treatment for children suspected of cancer costs between \$1,000 and \$5,000 in New York City. Therapy alone in a hospital will cost \$200 a day for a period of 2 or 3 weeks. That, Mr. Chairman, will cost a family around \$4,000. After the therapy is the survival period, this may last 2, maybe 3 years. This will include numerous visits to the hospital and much custodial care. The cost for the family if the child will survive 2½ years, which is the average, is \$35,000. In any NHI proposal, there must be adequate provision for custodial care for the victims of these diseases. The costs are too prohibitive for adequate care.

For elderly patients, help is no easier to find. Dr. Lichtman, director of the DeWitt Nursing Home in New York, has reported that not more than 12 people in all of New York City were certified by the Social Security Administration for any type of custodial care in an extended care unit.

The costs of care cannot be counted in terms of pure dollars. Over 224 million days of work were lost in 1963 due to chronic conditions. A total of 6.2 million man years were lost that year because of death illness. The value of this work in terms of 1963 price value minus one-fourth of the man-years that would probably be nonproductive was \$23.8 billion.

Mr. Chairman, there is a special area of chronic illness that I would like to discuss now. This is the case of the mentally retarded—who under all NHI proposals are not adequately covered. Over 6 million Americans are mentally retarded. A mentally retarded child is born every 5 minutes. Over 20 million family members are affected directly—that is almost one in every five families.

Yet, Mr. Chairman, at least one third of the mentally retarded presently in institutions, if they receive the proper care soon enough, can be productive, self-supporting members of society. But institutional care with costs nearly \$10 a day and there are 270,000 retarded persons in institutions. This money goes for food, clothing, and shelter. Little, if any, effort is made at education or training. A father making \$30 a day might have to pay one-half of his wages just to keep his child alive. To expect parents to meet these costs at the expense of the rest of the family—which in three-fourths of cases is poor—is incomprehensible. The mentally retarded have a fundamental human right, to proper health care. The fact that he needs more help, both financially, educationally and medically, is all the more reason to help him.

Most mental retardation originates in the prenatal period or in early childhood. The need for increased prenatal and well-baby care is covered under the Griffiths bill and the other proposals. The question is what happens when the retarded baby grows up. Will the family have to assume all costs. Or will the State simply pay to put him away in an institution where there is little or no hope of improvement.

Recommendations

1. That national health insurance provide unlimited nursing-home care.

2. That national health insurance provide for transient and permanent half-way house care.

3. That national health insurance pay for the care of the severely and mildly retarded and that such insurance cover the cost of special training and education.

4. That national health insurance be redefined to include social services necessary for decent health care.

5. That the chronically ill—not in custodial care—be provided with the at home, constant services, medication and equipment they require to maintain themselves, and that such services be provided to everyone regardless of ability to pay.

Chronically ill Americans have been one of the most neglected groups in our history. With over a million Americans in nursing homes, over 250,000 mentally retarded receiving custodial care, with over 22 million Americans limited in their activities by chronic illnesses, it is time that we end the discrimination against those who are sick. Any health legislation must include measures for them. Any program that will purport to end the crisis in the health system and does not include adequate health care for the chronically ill, the mentally ill, and the mentally retarded—any one who needs custodial care—is betraying the confidence of the American people.

Mr. Chairman, I ask that: in any health insurance legislation that this committee proposes you remember the American people—the working man who has a family to support—and include an amendment that would adequately cover those Americans in need of custodial care. The structure of the health care system and any requirements of the financial support mechanism must be subject to the needs of the patient whether they be physical, mental, emotional, or socioeconomic.

HEALTH PLANNING

The third area I wish to discuss is that of proper health planning. We now face a crisis in health delivery. For too long we avoided dealing with the inadequacies of our health care delivery system by simply pricing health care beyond the means of a substantial segment of our population. Now that we have begun to recognize our national responsibility to overcome financial barriers to proper medical treatment, we find that we do not have a system capable of furnishing treatment to all of those who need it.

The Kennedy-Griffiths bill's emphasis on HMO's is a critical first step in establishing this system. I believe that other steps must be taken as well to create a genuine system in place of the uncoordinated, archaic, unresponsive machinery we now have.

WBZ radio and TV in Boston have put forth two editorials on health care entitled the National Urban Coalition "Counterbudget and Our National Health." Both editorials are concerned with health planning and I would like to quote them:

"Counterbudget" sets two fundamental objectives which we agree should guide the hunt for a new national health program. One is to assure access to adequate health-care facilities to all Americans. The second is to provide more efficient organization and utilization of those facilities, to control costs.

... Simply adopting an insurance program won't do anything to assure a change in the distribution of health care. Very simply the spread of manpower and facil-

titles is more important than financing in determining the number of people who get health services and the quality of the care they receive.

"Counterbudget" notes that the most pressing supply need is for manpower. There just aren't enough trained people to care for Americans today. The poor suffer most because doctors and other health personnel are less willing to practice in the inner cities and rural areas. But everyone suffers at least somewhat, due to higher costs for health care.

The Coalition recommends steps to increase the supply to doctors and dentists. But it feels the most urgent manpower requirement is for more nurses and so-called paramedical personnel—doctors' assistants, dental technicians, mental health workers and neighborhood health aides.

This is something that involves government at every level and private interests as well. But in the federal budget alone, the Coalition study urges an 80 per cent increase in support for health manpower development over the next five years. It also means a chance for better health for millions of Americans. Let's get moving on it.

The problem is more than inadequate manpower utilization. It is also improper utilization of existing facilities.

For instance, the North Shore Children's Hospital in Salem has many empty beds and has had to close an entire floor. Yet, this is one of the finest children's hospitals in New England. The reason is not that children are healthier than ever before. The reason is that other hospitals which may be a few minutes closer to home are taking children, while they delay admission of adults who also need care. Many hospitals in the Salem area could simply convert their children's wings into adult care units and transfer the children to the North Shore Children's Hospital.

What we have here is in fact a form of "competition" between hospitals which results in an underutilization of a very fine hospital and a downgrading of health care for adults in the area. The hospitals in an area should coordinate their services so that costs can be cut and the quality of care can be improved. The situation which the North Shore Children's Hospital finds itself in is patently absurd, and until we as consumers demand that the narrow self-interest of the medical profession give way to sound management and planning, we will pay the price.

There are complaints from other sections of the country that hospital beds are empty. We also hear the cry that there is a tremendous doctor shortage. Both of these facts are true. But, here again, sound planning would alleviate a lot of the problem. With an increased emphasis on ambulatory, preventive medicine, fewer hospitals will have to be built and in increasing number of hospitals will have empty beds. We could save millions of dollars by determining those areas where increased out-patient care will cut the number of hospital beds needed, and by planning for the utilization of the money previously spent on construction, we would use existing facilities to their better ends.

I am no expert in the field of health planning. I can't pretend to offer the committee any concrete solutions. Several people, including Professor Elliott Krause at Northeastern University, are working on the solutions and I suggest that the large and complex body of information on this be studied by the experts and implemented. Yesterday afternoon I received an excellent letter from Dr. B. R. Hutcheson of the Massachusetts Department of Mental Health. Dr. Hutcheson makes some very good recommendations for health planning on both the State and Federal level. I would like to insert the text of the letter at this point in my remarks (see attachment C). It is possible to point

to failures in the health care system and to lessons we might learn from those failures. The August 1970 issue of *Hospitals*, the Journal of the American Hospitals Association, provided the following information about the true reasons for the rise in hospital costs.

Hospital per diem costs rose continuously throughout the decade, but during the postmedicare period, they rose 34 percent more rapidly than during the premedicare period. While labor costs rose more rapidly than nonlabor costs during the premedicare 4 years, they rose substantially less rapidly than nonlabor costs during the postmedicare period. The rate of growth of hospital assets also sharply accelerated in the post-1965 years.

Admissions to hospitals also rose throughout the decade, by 21 percent over the 1961-69 period. But the supply of hospital beds—certainly one major indicator of the supply of hospital services—more than kept pace, rising 25 percent over the same period. While the rate of increase in supply of beds was about the same during the 4 year periods before and after medicare—12.4 percent after—the rate of increase in admissions to hospitals sharply declined in the years after medicare and medicaid took effect—admissions in 1965 were up 13.2 percent over 1961; in 1969 they were up only 6.8 percent over 1965. In other words, during the postmedicare period, the number of beds increased substantially more rapidly than admissions.

Occupancy rates have risen throughout the sixties, reaching 78.8 percent in 1969. But almost two-thirds of the increase has come in the last 4 years; that is, since medicare. The Hospitals statistics indicate, however, that the increased occupancy rates of the latter period are virtually entirely due to a sharp hike in the average length of stay of patients in the hospital—7.6 days in 1961, 7.8 days in 1965, 8.3 days in 1969. It may be possible to speculate that with medicare or medicaid insuring that a patient's full stay in the hospital would be paid for, the hospitals took advantage of the situation and hold onto patients longer, thus increasing their income. It costs the hospital almost as much to maintain an empty bed as a full one, but with an empty bed, there is no income to offset the expense. In any case, hospitals' patient loads are still far below capacity, even after the increase in occupancy rates of the last decade. One would not expect the relatively small hike in occupancy rates of the last few years to have had a major impact on prices.

From the Hospitals figures, it seems clear that hospital prices did not rise under the impact of a soaring demand. Rather the critical feature of the post-1965 period was that medicare and medicaid, like Blue Cross and other insurance plans, paid hospitals whatever they claimed as their true costs for providing patient care. The cost—the price paid by the reimbursement agencies and the basis for the price paid by patients who pay their own bills—were not set in a free marketplace, where the supply and demand argument might have some relevance. Instead, the hospitals were able to set their cost virtually arbitrarily. Equipment, higher salaries for everyone, building renovation and expansion—hospitals can add them into their costs and get reimbursed.

Medicare and medicaid have driven hospital costs up. But not by stimulating consumer overuse—relative to supply—of hospitals. Costs rose because the hospitals appropriated money for their own benefit.

Obviously, we need far greater controls over the costs of medical care. We must develop some kind of standard by which to judge the validity of medical charges. Because health care is complex—no two people react exactly alike to the same illness—we cannot have standards that are so rigid they allow for no leeway. But we cannot maintain a blind, unquestioning attitude toward medical costs.

One solution—and this is simply a suggestion from a layman—might be the one stressed by the National Advisors Commission on Health Manpower in 1967. This would be for insurance organizations—whether they be private or the Federal Government—to provide incentives to economize by their payment schedule so that the most efficient producers of care receive the greatest net income. Conversely, those who are least efficient should be penalized for their inefficiency. By setting reasonable standards, those who exceed them would receive a bonus and those who cannot reach would have fees reduced. Such economic incentives might have startling and pleasing results.

I urge the committee to include a good planning program in any legislation reported out. Without decent planning we will be throwing money down the drain and will perpetuate a health system which does none of us any credit. It is time for the overview. We have done enough one-step problem solving with the result that our health care system is fragmented and crumbling. Let's put it back together again on a stronger foundation.

Thank you.

Mr. BURKE. Thank you for giving us your thoughts on this important matter. Are there any questions? If not, we appreciate your comments to us here today. The attachments to your statement will be included in the record at this point.

(The attachments referred to follow:)

ATTACHMENT A

OCTOBER 22, 1971.

DEAR REPRESENTATIVE HARRINGTON: I am writing to you in regard to the great need of a National Health Insurance for mentally-ill children.

As the mother of an autistic boy, I am finding it very difficult to pay for his medical and dental care without aid. My son is non-verbal. Because of this handicap when he is ill, I have no way of knowing what or where he is having pain. I cannot afford to guess. This always results in a visit to the hospital.

With normal children an accident requiring stitches can be done quite quickly and simply. The mentally-ill child needs to be asleep; therefore, there is the added expense of operating room, anesthesia, and an over-night stay in the hospital.

Recently we had a dentist bill of eight hundred dollars (\$800.00) due to hospitalization. We are struggling to hold on to our home and keep up with all the other financial obligations.

Your kind interest in this vital matter is greatly appreciated.

Sincerely yours,

OCTOBER 28, 1971.

HON. MICHAEL J. HARRINGTON,
House of Representatives,
Washington, D.C.

SIR: I am the parent of a severely emotionally disturbed fifteen year old daughter. Her condition has also been described at various times as autistic, both terms being a form of mental illness. She has been so afflicted since birth.

The Association for Mentally Ill Children (AMIC) has informed me that you are sponsoring a national health insurance plan and that you would be interested in knowing of the needs of these children and their parents in connection therewith.

As you may know, these have been the "forgotten children" of America. Their parents have struggled almost alone in attempting to better their lot in life. Although not counting the cost, in an effort to aid them we have found that like most unfortunates, the attempted cure has been expensive, very often to the detriment of the remaining children. I believe that these expenses should be included in a bill such as yours. It would seem that such a bill is justified only if costs such as these are reimbursed.

The following are several examples of what I mean. She was unable to attend public school and our only choice was to keep her at home or send her to an institutional school out of state. We felt she was an integral part of our family and only we could offer her a chance at a normal life. We prevailed on a nursery school-kindergarten in Roxbury to accept her at age 6 and allow her to spend the day with normal children and develop as much as possible. This went on for only six years at a cost of approximately \$1,000.00 per year. She was on expensive medication during this time (and since) which could be tallied, I suppose, into the thousand(s) dollars bracket. We have been able to find only one dentist who will treat her but this requires an anesthetist and other attendants leading to a bill of \$200.00 or \$300.00 each time she requires work. I could go on with other examples but I think enough is included to show that in addition to unmeasurable heartbreak, a great financial burden is imposed on the patients.

I appreciate this opportunity to communicate with you and thank you for your kind consideration.

Very truly yours,

OCTOBER 26, 1971.

MICHAEL HARRINGTON,
*Representative, State House,
 Boston, Mass.*

DEAR MR. HARRINGTON: We are the parents of a four-year-old daughter, who has been diagnosed encephalographic, autistic, mentally retarded, and emotionally disturbed.

Our trips to the neurologist and pediatrician are quite frequent, and at one time she was taking four prescriptions a day.

We were also sent to the Putnam Childrens' Center for psychiatric evaluation, and our insurance company paid a grand total of \$10.00 on a \$350.00 bill.

We are also forced to send her for nursery and therapy at the Cerebral Palsy Center in Lawrence (they are also equipped to handle other handicapped children) because there isn't a state program for her at present. Without assistance, we are paying approximately \$130.00 per month for this education. We feel this is necessary until another appropriate program is available. She had been refused at the state program at the Fernald School.

We are also having to send her to a special dentist dealing with children who do not communicate. I do not have facts regarding this expense whereas she is having her first appointment on Nov. 4. But, I know that our insurance company, which is Washington National, will not cover such dentistry.

As you can see, the expense of having a handicapped child is great, and the insurance program we have does not help us with this special type of coverage. We are beginning to feel the pressures of financial burden, and we wish you much success in obtaining insurance coverage for children with such special needs.

Sincerely,

OCTOBER 25, 1971.

GENTLEMEN: I am writing in regards for Health Insurance for Emotionally Disturbed Children. Children of this nature involve quite an extensive medical and dental expense. A regular dentist will not take him so I have to take him to the Children's Hospital Dental Clinic which charges more per visit. When he had to have fillings he had to go to the hospital and stay two days.

He has more white corpuscles than red so he has to get blood tests every year. He also has to have evaluation tests, E.E.G.'s and attend Seizure Clinic. As you can see Health Insurance would alleviate this financial burden.

Yours truly,

OCTOBER 30, 1971.

Hon. MICHAEL J. HARRINGTON,
The Congress of the United States,
Washington, D.C.

DEAR REPRESENTATIVE HARRINGTON: Like so many parents of children diagnosed as suffering from early childhood mental illness, I have known the burden of large medical bills which have run into thousands of dollars and which have ranged from frequent psychiatric visits and regular therapeutic day care programs to expensive dental care to comprehensive evaluations including neurological exams and EEG's to bills for medication.

I don't know how many other families have had our experience of being unable to get any kind of health insurance coverage for their mentally ill children, but this was a worry and expense for six or seven years. When our Army health insurance was terminated because of his father's discharge from the service, we tried to arrange for coverage through Blue Cross, Continental Casualty and others. He was rejected by all; he was not even considered for partial coverage because of his disability. His case was reviewed every few years but always with the answer "No". Two years ago I was able to have him included under a group plan of Blue Cross because I worked for a large company and there were no questions asked. However I am never quite sure about the validity of his coverage. Should his disability be questioned, after a medical crisis, as grounds for denying him coverage, we would be in serious financial trouble. We have been fortunate that he has had no prolonged physical illness or serious injury that would require hospitalization, or we would have been wiped out financially.

Although it sometimes seemed unfair to my other child to deny him in order to pay his bills, I had no choice. I had to do what was medically prescribed for my handicapped son, but how I wished there was some kind of aid to help with the bills!

I hope that the health problems of those who have chronic illnesses, mental or physical, will receive the careful consideration of Congress in developing a national health care program, so that families burdened by the care and worry of a handicapped child, need not be burdened by excessive financial hardship.

Sincerely,

OPEN STATEMENT TO THE SPONSORS OF FEDERAL LEGISLATION PROVIDING FOR
NATIONAL HEALTH INSURANCE

SEPTEMBER 1971.

GENTLEMEN, It has come to my attention that the proposed federal legislation providing for a National Health Insurance Plan does not, at present, include full coverage for treatment of mental illness. This is, in my view, a serious flaw that will only serve to compound the most grievous failure in the present practice of American medicine. Anyone familiar with the National Health Programs of European countries (Sweden, Denmark, Germany, for instance), can surely attest to you from experience that financial coverage for mental illness is of critical social and medical importance.

The fact of mental illness alone has a destructive effect upon the family unit. The prognosis is usually uncertain and with it comes the kind of despair that drains confidence and hope and makes one fear the future. And it is at that time of distress, when one is least able to cope with it, that our system places on the family a huge and almost intolerable burden of expenses. The emotional shock, in other words, is compounded by a prolonged threat to the material resources of the family. I cannot imagine that this is medically defensible and the social destruction caused by this depressing burden is, as you must be aware, very severe.

You may perhaps have sensed that I am speaking here from personal and very painful experience. Because of unsuspected and undetected injuries at

birth (we could not afford private medical care at that time), both of our boys are afflicted by severe emotional and speech impairments resulting from brain damage. They cannot live in a regular social setting and need special schooling. When they were less than three years old we began to seek treatment for them. The costs of private therapy, extending over a period of years, were so great that I could not even begin to defray them from my salary. My wife was thus compelled to work full-time, even at highly irregular hours, in order to pay the bills from clinics and psychiatrists. And she had to do this at a time when she herself was suffering from serious fits of depression and needed medical attention and therapy. We spent well over ten-thousand dollars on psychiatric therapy alone.

After waiting for many years, we were finally fortunate enough to find a residential children's clinic that would accept our boys and offer them treatment and schooling during the week. But with this the financial problems did not end, of course. The state of Massachusetts bills us for \$80 a day for these services. Since my daily income is less than \$40, I cannot possibly hope to meet these expenses. My debts to the state are rising steadily and must by now amount to \$60,000. Fortunately, the Department of Mental Health has charity enough not to enforce payment. But the laws clearly state it could do so and could thus lay claim to whatever assets I have or may have in the future. This, gentlemen, is a miserable way to live, especially when one is used to paying one's bills and feels guilty when one cannot. And when and where will it end? I may still have to provide for these children twenty or thirty years from now unless they do recover.*

I therefore urge you to include the coverage for treatment of mental illness—diagnosed as such by a certified medical board—in your projected health plan. What a relief it would be to pay a premium of let us say, \$150 a month and then feel entitled to medical care without incurring a burden of financial guilt. And as far as potential abuse is concerned (upper-class couch psychiatry, for instance), I am sure that any competent physician can tell genuine mental malfunction apart from social or emotional affectation.

I beg you earnestly to consider my plea.

Sincerely yours,

DEAR MRS. CUTLER: The following is a list of expenses we have had for Health Evaluations:

Dr. Dodge, St. Louis.....	\$1, 500
Dr. Scholl, Boston.....	200
Dr. Yerkes, Brookline.....	2, 400
Emerson special therapy.....	200
Dr. Lofgren, Boston.....	400
Prescription Ritualin.....	50

Sincerely,

ASSOCIATION FOR MENTALLY ILL CHILDREN,
REGION III CHAPTER,
Arlington, Mass., November 13, 1971.

Hon. MICHAEL HARRINGTON,
Washington, D.C.

MY DEAR MR. HARRINGTON: I have recently been informed of your interest in the problems of emotionally-disturbed children. As president of the Region III Chapter of the Association for Mentally Ill Children I would like to convey to you some ideas of the problems which parents in our group have consistently faced. Although I speak in general terms only, I can assure you that my comments are supported by personal knowledge of many specific cases. I believe that these comments are, therefore, generally applicable to most such children throughout the state and the country as well.

Children who are in the categories that are referred to as severely emotionally disturbed or mentally ill comprise a relatively small group whose needs are both poorly understood and great. A very large portion of these children have a basic mental capability that is either normal or near normal (some may be

*My boys are presently 7 and 9 years of age.

above normal); however, for a wide variety of reasons they are functioning at a level of performance considerably below their potential. The reasons for their difficulties are in most cases poorly understood and difficult to diagnose. In a recent survey of parents within our chapter it was revealed that eighteen (18) different diagnoses have at one time or another been applied to a sample of nineteen (19) different children, in some cases as many as six (6) different diagnoses being applied to one child. An examination of this survey also reveals that there are large differences both in the degree and nature of the problems among the nineteen children involved.

The complex, poorly-understood nature of these problems and the relatively small number of children involved (which results in poor public understanding of them) are the roots of our current problems. These are that this group of children, with a very few exceptions, is not getting an adequate level of care and training properly planned to meet their needs. As a consequence our current expectancy must be that the majority will never make significant progress and will end up in custodial care in institutions. The price of such a situation in terms of lost potential, of long-term cost of sometimes unnecessary custodial care, of parental frustration, and of knowledge that we as able American citizens have not provided an opportunity for full participation in the joys of life to this unfortunate minority of children, is indeed very great. For the reason it is my belief that these children need and deserve very special consideration in planning any program for general public health care, such as the various proposals now being considered by Congress.

Over the past few years there has been great progress in improving our capability to help these children. New schools and new classes using innovative techniques have been established which are beginning to yield very encouraging results, sometimes with children who had previously appeared to be hopeless. Some of these programs involve use of behavior modification techniques; many involve very intensive levels of instruction with a high instructor/pupil ratio; most involve a careful programming of instruction to fit the individual needs and capabilities of each child. Only a small number of our children is currently receiving the benefits of such programs; however, their existence provides a ray of hope for all. Possibly more importantly, a considerable reservoir of professional personnel skilled in new techniques is beginning to accumulate.

There are currently two principal obstacles to providing adequate care for these children. The first is lack of funds to provide the necessary facilities. The second is the need for effective management of the process of providing care and training for them. The first and foremost is the financial aspect. The cost of training and education for these children varies widely dependent upon the nature of each child's problem and the type of facility into which he is entered. Representative programs and approximate costs are illustrated below:

1. Special education class for emotionally-disturbed children—\$2,000/year.
2. Class in private day school for emotionally-disturbed children—\$3,000/year.
3. Residential schools for emotionally-disturbed children—\$8,000 to \$10,000/year.
4. Intensive day school program for emotionally-disturbed children—\$8000/year plus.
5. Intensive residential school program for emotionally-disturbed children—\$20,000/year.

These rates are representative of actual situations in Massachusetts when available financial help can be obtained from the 750 program. Most of this help is in categories one (1) to three (3) described above and the availability of such help is limited by budgeting considerations, bureaucratic inertia, etc., so that only a portion of our needy children can obtain that care. In addition, because of the variations in causes and the lack of precise diagnoses it is often difficult for parents to establish that their children are eligible for these programs. For children who are to any extent seriously disturbed the very intensive programs illustrated by categories four (4) and five (5) above, are needed for a period of two to three years to upgrade their performance to the point that they can benefit from the less intensive programs.

It is quite apparent that very few parents can afford programs in categories three (3) to five (5) above and many, probably most, cannot afford the less expensive ones in categories one (1) and two (2). For those that can there is normally a financial sacrifice that causes hardships for all other members of the family. Thus we see a situation in which only the erudite relatively wealthy minority of people are in positions to provide proper care for their emotionally-disturbed children. The poor, the uneducated, the members of under-

privileged classes cannot hope to be able to provide adequate care and training for their children.

The best way to provide for our mentally-ill/emotionally-disturbed children is by considering them as being a special class of people suffering from "catastrophic illness" who are placed in a special category to be funded entirely by the government under the national health program expected to be legislated into law in the coming session of Congress. Having been assured that funding is available when needed the existing school capacity will expand rapidly to meet the need. By establishing a special category the second major obstacle to providing adequate care and training can also be overcome. A small unit within the administrative structure supervising the national public health programs can be created to run this program. It would hopefully be manned primarily with professional personnel who are especially qualified to handle these children. They could therefore see that children are provided care and training on the basis of need and not of diagnosis.

With the type of program described in this letter our emotionally-disturbed/mentally-ill children should be able to get the training which will permit them to perform up to their full potential. This should reduce the case load in our mental institutions in the long run, thereby realizing net economies. In addition our society would benefit by the efforts of the "useful citizens" who are the successful products of this program. Lastly, our national conscience would be satisfied by knowing that we have fulfilled our moral obligations to our unfortunate children.

I and all members of Region III Chapter appreciate your interest and receive encouragement from your efforts.

Yours very truly,

CHARLES E. HARRISON, *President.*

Below is a list of approximate costs incurred during the last six years in caring for our seriously disturbed child.

Evaluations:

Boston Floating Hospital.....	\$100
Kennedy Memorial Hospital.....	100
Benhaven School.....	100
Putnam Childrens Center.....	25
Frammingham Youth Guidance Center.....	35
Parmenter Health Center.....	15

Tuitions per month:

Putnam Childrens Center (2 years).....	70
Benhaven School.....	35

In-patient treatment per month: Kennedy Memorial Hospital—80 percent covered by insurance—forced to remove our child when insurance payments reached \$10,000 (8 months).....

1,500

Out-patient treatment: Orthopedics, Neurology-Kennedy Memorial (1 year).....

200

Therapies:

Boston Floating Hospital—2½ years (per month plus transportation, parking).....	70
Robbins Speech Clinic—2 years (per year plus transportation and parking).....	225
Vitamin program (1 time cost).....	50

Medications.—Tranquillizers and anticonvulsants; variable costs.

Dental work.—All work except examination and cleaning requires overnight hospitalization.

ATTACHMENT B

VISITING NURSE SERVICE OF NEW YORK,
New York, N.Y., November 12, 1971.

HON. MICHAEL J. HARRINGTON,
House of Representatives,
Washington, D.C.

DEAR REPRESENTATIVE HARRINGTON: I was most gratified to learn, through a colleague, of your concern about the need for custodial care services. This is

indeed one of the most serious gaps in present or proposed plans for delivery of health services. I am therefore taking the liberty of sending you some observations on this subject, in the hope that they will be useful to you in preparing your testimony.

As the largest voluntary nursing agency in the United States, Visiting Nurse Service of New York has accumulated considerable experience in the care of the chronically ill in their own homes. In 1970, we made a total of 262,804 home nursing visits, approximately 80% of which were to care for patients with chronic long-term illness. Of these visits, 55% were to patients 65 years of age or over.

As I am sure you know, Medicare benefits under both the hospital and medical plans are provided with many restrictions and qualifications. Many persons over 65 believe they are entitled to service following hospitalization or for illness at home only to learn that unless there is documented need for skilled services, either nursing, physical therapy, or speech therapy, and they can be certified as essentially homebound, Medicare will not reimburse the individual or the certified home health agency for services. Medicare benefits can now be described as essentially covering services only for acute, short-term conditions and to all intents and purposes omitting the personal care services needed by many elderly and chronically ill persons to enable them to remain out of institutions. The following examples, which represent thousands of problems known to us, may explain this situation more clearly.

Mrs. M., a 78 year old widow, had surgery for the removal of cataracts. The nurse was requested to visit to instill eye drops and to reinforce teaching the patient that she must avoid strenuous activity for a period of about one month. At the time she made her visit, the nurse found the patient living alone in a 3-room apartment on the 4th floor of a walk-up building. Mrs. M. was very anxious about her eyes and her ability to manage. Since the instillation of eye drops is not considered a skilled service, Medicare would reimburse only for 2 to 3 visits to permit the nurse to teach the patient the procedure. Also, importantly, there could be no reimbursement for the home health aide whose assistance with shopping, meal preparation, bathing and cleaning, the nurse considered absolutely essential for the patient's maintenance during this critical time.

Mr. S. is a 74 year old man with a diagnosis of Parkinson's disease. He lives with his 72 year old wife who is finding the burden of his increasing disability beyond her physical strength. Mr. S. can no longer move about with any independence and his wife is unable to care for him and assist him with exercises. The nurse visits regularly to bathe him and do exercises. Her visits, however, are not reimbursed by Medicare since Mr. S.'s condition is chronic and the services and care he needs are at a maintenance or custodial level. The home health aide assistance (the aide could help him with exercises between nursing visits and could do much to relieve Mrs. S. of her many responsibilities) is also not covered by Medicare for such a patient and it is, unfortunately, too expensive a service for VNSNY to provide with no source of reimbursement. Mrs. S. is now faced with what is for her the terrible reality that she must soon make plans for institutional care for her husband.

We realize that, as the law is interpreted, Medicare was not designed to meet the needs of chronic illness of the elderly. Unfortunately, however, age for many individuals is in itself a chronic condition and in addition, as our statistics show, this age group also has to cope with such long-term debilitating conditions as diabetes, stroke, heart trouble and cancer.

Chronic disease occurs at any age, of course, and those who qualify for Medicaid assistance are able to obtain at least some of the services needed to be maintained in their homes. But, as you know, Medicaid eligibility criteria differ widely from state to state and even in New York, which initially had a very liberal policy, and the cutbacks and added restrictions have eliminated many patients who need home health services. For example:

Mrs. D., a woman of 45, has multiple sclerosis. Her illness has progressed to a point where she is unable to do any self care. She is completely dependent on helping persons for bathing, toileting and nutrition. Her husband works, her 3 sons are of school age, and, with no other family members available, a home health aide was essential for her care. Mr. D.'s income was inadequate to meet medical expenses and they were therefore able to qualify for Medicaid assistance and home health aide service was provided 8 hours a day, 5 days a week. With changes in eligibility, however, the Ds no longer qualified for Medicaid assistance and although several voluntary agencies tried to provide assistance,

this 45 year old woman had to be sent to a nursing home where she will likely remain until she dies.

With the current trend toward reducing the numbers of persons eligible for Medicaid and the possibility that policies regarding covered services will be made consistent with those of Medicare, there will soon be no source of help for the chronically ill patients who can and should be maintained at home. Their only option will then be enforced institutional care, a costly and wasteful solution for the tax payer and certainly a tragic one for the individual. Voluntary funds cannot hope to fill this wide gap.

I trust that the above comments will be of some help to you. If there is any additional information we might be able to provide, please do not hesitate to write to me. A copy of our Annual Report and a service leaflet are enclosed should you wish some further background about our service.

Sincerely,

EVA M. REESE,
Executive Director.

NOVEMBER 11, 1971.

MICHAEL J. HARRINGTON,
*Armed Services Committee,
House of Representatives,
Washington, D.C.*

DEAR MR. HARRINGTON: This is in response to your letter of November 1 to Dr. Creech. I will discuss this with the Policy Committee and write you in more detail later. However, in view of the fact that you will testify within the next week, I will respond immediately. I am thoroughly in accord with your concern that the National Health Insurance Program will not cover custodial care, domiciliary care, and some of the very major needs of the chronically ill. The most common cause of illness at the present time in the United States is heart and stroke disease and the second most common is cancer. Indeed, one person in four will develop cancer. While brief hospitalization can cover the needs of some patients with cardiovascular and cancer diseases, a substantial number of patients require more prolonged treatment in the hospital, intermittent re-hospitalization, and unfortunately, a substantial number of patients, particularly with stroke and metastatic cancer, may require prolonged custodial care. Our hospital and the vast majority of hospitals in the country at present are acutely overcrowded, and part of this relates to the lack of custodial care facilities and support; and thus such patients remain in general hospitals where the expenses are very substantial and where their presence limits the availability of beds for the more acute problems. I am sure that I speak for our organization when I express the very great need for extended facilities and support in the custodial care areas and that this should be given major consideration in the national health insurance legislation. We appreciate enormously your interest in this problem. Please call or write if I can be of further help. As already indicated I will as soon as possible forward to you the opinions of other members of our Policy Committee.

Best regards,

EMIL FREI III, M.D.

AMERICAN HEART ASSOCIATION, INC.,
New York, N.Y., November 12, 1971.

HON. MICHAEL J. HARRINGTON,
*House of Representatives,
Washington, D.C.*

DEAR SIR: As a result of your letter of November 1 to Dr. Hundley, I have been asked to provide you with statistical information on the number of persons who cannot live alone because of their need for long-term care and the number who have no homes to go to where long-term care is available.

I'm not sure that these questions can be answered exactly as posed however, there are some data available which you may find helpful.

Unpublished estimates from the Division of Health Resources Statistics, National Center for Health Statistics, DHEW indicate that there were 850,000 residents in nursing and personal care homes in 1969, 294,000 of which had "heart trouble." For more detailed results from this survey, may I suggest you

contact Mr. Siegfried A. Hoermann, Director of the Division of Health Resources Statistics.

Enclosed is a table published by the Division of Health Interview Statistics, also in the National Center for Health Statistics, which shows a distribution of non-institutionalized persons with a mobility limitation according to the degree of limitation. The column entitled "Confined to the House" may be helpful in answering the question regarding noninstitutionalized persons who require long-term care. Further information regarding these data may be obtained from Mr. Elijah L. White, Director of the Division noted above.

Do not hesitate to call if we may be of further assistance.

Very truly yours,

SAMUEL J. CASTRANOVA,
Assistant Director, Statistics and Data Processing.

TABLE 4.—AVERAGE NUMBER AND PERCENT DISTRIBUTION OF PERSONS WITH LIMITATION OF MOBILITY BY SELECTED CHRONIC CONDITIONS CAUSING LIMITATION, ACCORDING TO DEGREE OF LIMITATION: UNITED STATES, JULY 1965-JUNE 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in app. I. Definitions of terms are given in app. II.]

Selected chronic conditions	Average number of persons in thousands ¹				Percent distribution ²			
	All degrees of mobility limitation	Has trouble getting around alone	Needs help in getting around	Confined to the house	All degrees of mobility limitation	Has trouble getting around alone	Needs help in getting around	Confined to the house
Persons limited in mobility.....	6,312	3,114	1,766	1,432	100.0	100.0	100.0	100.0
Tuberculosis, all forms.....	.....	.....	.....	.....	.....	.....	.....	.....
Malignant neoplasms.....	95	.....	.....	64	1.5	.....	.....	4.5
Benign and unspecified neoplasms.....	60	.....	.....	.....	1.0	.....	.....	.....
Asthma-hay fever.....	179	88	.....	74	2.8	2.8	.....	5.2
Diabetes.....	141	54	.....	63	2.2	1.7	.....	4.4
Mental and nervous conditions.....	312	129	54	129	4.9	4.1	3.1	9.0
Heart conditions.....	797	382	122	294	12.6	12.3	6.9	20.5
Hypertension without heart involvement.....	212	96	44	72	3.4	3.1	2.5	5.0
Varicose veins.....	123	80	.....	.....	1.9	2.6	.....	.....
Hemorrhoids.....	50	.....	.....	.....	.8	.....	.....	.....
Other conditions of circulatory system.....	245	99	65	81	3.9	3.2	3.7	5.7
Chronic sinusitis and bronchitis.....	118	55	.....	59	1.9	1.8	.....	4.1
Other conditions of respiratory system.....	152	84	.....	60	2.4	2.7	.....	4.2
Peptic ulcer.....	60	.....	.....	.....	1.0	.....	.....	.....
Hernia.....	82	48	.....	.....	1.3	1.5	.....	.....
Other conditions of digestive system.....	146	67	.....	63	2.3	2.2	.....	4.4
Conditions of genitourinary system.....	175	72	.....	82	2.8	2.3	.....	5.7
Arthritis and rheumatism.....	1,541	810	438	293	24.4	26.0	24.8	20.5
Other diseases of muscles, bones, and joints.....	208	128	47	32	3.3	4.1	2.7	2.2
Visual impairments.....	656	256	239	160	10.4	8.2	13.5	11.2
Hearing impairments.....	82	.....	.....	34	1.3	.....	.....	2.4
Paralysis, complete or partial, impairments (except paralysis) of back or spine.....	686	202	298	186	10.9	6.5	16.9	13.0
Impairments (except paralysis and absence) of upper extremities and shoulders.....	42	.....	.....	.....	.7	.....	.....	.....
Impairments (except paralysis and absence) of lower extremities and hips.....	717	350	267	99	11.4	11.2	15.1	6.9

¹ Summations of conditions causing limitation may be greater than the number of persons limited because a person can report more than 1 condition as a cause of his limitation; on the other hand, they may be less because only selected conditions are shown.

² Percentages may add to more than 100 because a person can report more than 1 condition as a cause of his limitation; on the other hand, they may add to less than 100 because only selected conditions are shown.

Source: Division of Health Interview Statistics, National Center for Health Statistics, DHEW, Public Health Service Publications No. 1,000, series 10, No. 61.

MUSCULAR DYSTROPHY ASSOCIATIONS OF AMERICA, INC.,
New York, N.Y., November 12, 1971.

HON. MICHAEL J. HARRINGTON,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN HARRINGTON: This is in reply to your recent letter concerning the amendments you intend to introduce to assure custodial care for the chronically ill under National Health Insurance coverage. We commend your initiative in bringing the plight to this segment of the population to the attention of the members of the House Ways and Means Committee.

As you may know, MDAA's Patient and Community Services Program does not include provision of payment for custodial care (see attached brochure). These payments, made on a national scale, would be prohibitive for any voluntary health agency. The high costs of custodial care can best be met through a federally funded program such as you suggest.

Victims of the dystrophies and muscular atrophies—especially those types afflicting children—suffer from a rapid wasting of the skeletal musculature. The patient's ability to carry out the activities of daily living decreases, and the family finds it harder to cope with the resulting problems. Custodial care provides a solution to this tragic situation.

We greatly hope your amendment will include provision for the patients suffering from dystrophy and related disorders.

With every best wish.

Sincerely,

ROBERT ROSS, *Executive Director.*

CHILDREN'S CANCER FUND OF AMERICA, INC.,
New York, N.Y., November 12, 1971.

HON. MICHAEL J. HARRINGTON,
Washington, D.C.

DEAR CONGRESSMAN HARRINGTON: Thank you for your letter of November 9th regarding the hearing of the House Ways and Means Committee on November 18th. I hope our letter to you may prove useful—the subject of childhood cancers certainly is of special national concern.

Regarding your request for statistics, we are not really equipped to provide much in the way of facts and figures, but we have obtained some data from the Sloan-Kettering Cancer Research Center which may be of help to you.

The annual deaths from all forms of cancer in the pediatric age to 15 years is estimated at 4000 for the country, with the greatest number in New York perhaps because this city has the most specialized facilities for dealing with cancer cases.

As you know there are many forms or types of cancer and costs vary greatly according to the type and stage of the illness, early or delayed detection, and the standing of the hospital or clinic treating the case. The initial test and follow up diagnosis and treatment costs between \$1000 and \$5000 in NYC. (Leukemia cases—the largest percentage of childhood cancer—\$1000 to \$1500. Therapy—in hospital—about \$200 a day for 2 or 3 weeks—say \$4000. The survival period—about 60 visits over 2 to 3 years—from \$5000 up to \$35,000. The average survival period for children is 2½ years—the cost up to \$35,000. Many do not survive that long, although important strides in the field of prolonging young lives have been made and research is continuing on a variety of fronts.

One may conclude that thousands of children die of cancer without ever having the opportunity to have a doctor's care—their parents being without the financial resources for expert advice.

As you will see, childhood cancer can be the most costly illness—a real tragedy for parents.

Early detection is all important because there may be the possibility of cure, or life may be considerably prolonged with expert diagnosis and treatment. But there is a critical shortage of pediatricians in local communities who have the degree of expertise and experience in the vast cancer field. Symptoms of cancer in children are apt to masquerade as indicating other childhood illnesses which only in-depth training and greater knowledge in the cancer speciality could remedy.

Because of these considerations, our Board decided several years ago that trying to pay individual hospital bills was beyond our limited means, and that to do the most good for the greatest number of afflicted youngsters our resources and efforts should be directed to a program of providing opportunities for young doctors to receive specialized training, expert knowledge and actual experience of pediatric oncology. To date we have enabled 218 young doctors from various hospitals and communities to benefit from this project.

In our opinion only programs on a national scale will produce adequate results.

With the earliest possible detection of cancer among children, in our opinion every school doctor in the country should be obliged to have specialized knowledge in this field and at least once a year make a thorough check-up of every child in his school. Funding to be a Federal responsibility, shared by States.

Of course the number one priority is action to limit the population explosion—more babies require more doctors with expert knowledge throughout the nation, and many young doctors cannot afford the time or the financial burden of special training whenever or where-ever such facilities to acquire expertise may be available.

Then it follows that national efforts to speed up the Conquest of Cancer now being debated in Congress are all important—despite the fantastic problems of financing such programs.

Wishing you every success,
Sincerely yours,

RICHARD T. MAYES, *Treasurer.*

INSTITUTE FOR MUSCLE DISEASE, INC.,
New York, N.Y., November 15, 1971.

HON. MICHAEL J. HARRINGTON,
*Armed Services Committee,
House of Representatives, Washington, D.C.*

DEAR SIR: Thank you for your recent letter relative to your efforts in behalf of chronically ill persons. At the present time practically no provisions for custodial care are available to patients with muscular dystrophy and related disorders. The importance of custodial care is determined by the features of neuromuscular disease.

The clinical course is one of slow and unremitting increase in weakness commonly with development of contractures that further accentuate the disability. Walking, use of the arms, and even the common activities of daily living become impossible. After reaching the stage when he has become confined to a wheel chair, the patient faces a period of from a few to many years during which his disability progresses to complete infirmity. The period when the patient is largely or completely dependent upon others is longer than with most other major diseases.

The care of the incapacitated person during practically every hour of all the days and nights of many years is a burden almost too heavy for the shoulders of the mother and father. And yet, this burden often is even larger, for muscular dystrophy is hereditary and commonly affects more than one person in a family.

Presently, no effective treatment is available. Management is limited to general measures with whatever attention the parents can give to the physical and emotional needs of the patient. Appropriate measures that would meet these needs in any adequate way could be available only through custodial care. Such care is beyond the capacity of private health agencies to furnish, and could be supported only by the Government.

Another consideration of note is the following: although no effective treatment can now be offered these patients, medical research into the cause and treatment of muscular dystrophy is supported by Muscular Dystrophy Associations of America on a world-wide basis, and it is hoped (but cannot yet be predicted) that therapeutic aid will become available to these patients. Medical scientists, on the one hand, seek a treatment as early as possible, but the patient's disability, on the other hand, progresses steadily toward complete infirmity and a fatal outcome. Respiratory and cardiac failure, which are the main causes of death and arise from the ravages of muscular dystrophy, may be prevented or delayed by the general health measures included in proper custodial care. Custodial care would render an important service in prolonging the lives of these patients while effective treatment is being actively sought.

I know that all persons affected with these incapacitating disorders owe you a debt for your interest and for your noble efforts in their behalf.

Very truly yours,

ADE T. MILHORAT, M.D., *Director.*

ATTACHMENT C

THE COMMONWEALTH OF MASSACHUSETTS,
DEPARTMENT OF MENTAL HEALTH,
Boston, Mass., November 16, 1971.

Representative MICHAEL HARRINGTON,
Washington, D.C.

DEAR REPRESENTATIVE HARRINGTON: I am writing to you because of my conversation with Mrs. Sullivan of your staff and with Dr. Krause. It so happened that I heard you on television on Saturday evening and applaud your statement in which you urge one level of care for health and mental health services.

I am responding to Mrs. Sullivan's request that you are interested in receiving concrete suggestions about the kind of mental health and health legislation that is really needed at this time. Nearly everyone is beginning to be fed-up with the plethora of solutions that are flooding the scene and the following illustrative factors adversely effect the present system and suggestions are made about what might be done about it.

At the State level

Semantic difficulties have impeded really effective partnerships between Federal, state, and local agencies. These difficulties exist in part because of the many overlapping programs and conflicting guidelines. A most important concept to act upon, however, is that services in every state need to be planned on a geographic basis with a robust citizen participation taking place at the community level in each individual geographic functional unit. In the Commonwealth of Massachusetts there are 39 such geographic Human Service areas, and this enables a golden opportunity to really plan and deliver health and children's health services in a new way. What is presently lacking is a mechanism for combining Federal, state, and local funds at the area level, so that there will be true coordination among public and private agencies. In Massachusetts there are approximately 30 geographic Human Service areas and in the United States it is estimated that there would be about approximately 1800 such geographic Human Service areas. Since each service area is a distinct geographical unit, it would vary in size and population. Usually, the population would not be over 250,000 and not under 50,000.

Each such Human Service area should be given the statutory authority at the Federal and state level to plan and pay for health services. The most viable method of doing this would be through *Human Service corporations* and plans are enclosed of a Human Service Corporation which is developing in Lowell, Massachusetts. We are all aware of the fact that health is big business and as such it deserves our care and attention with true citizen participation in every phase of its planning and delivery. In Massachusetts the present reorganization of state government sets the stage that would facilitate any Federal legislation that was passed. Thus, Massachusetts is in the forefront of the states of the nation in terms of the organizational arrangements present in its state government, and the comprehensive health legislation which you contemplate would be of great service to the nation by building upon the structure present in Massachusetts. If one considers the possibility of 39 Human Service Corporations here in Massachusetts, one has to consider who the corporate directors would be and how they would function. The experience in New York with school committees has shown that school committees composed entirely of elected officials do not have the time (on a voluntary basis) to address themselves to the multifold and complex issues about which a school committee must decide. An example of this difficulty is a school committee contemplating a contract with a Teacher's Union. They have neither the time, the skill, nor the staff to approach these complex kinds of problems at the level they should be approached, and this would be ever more true in regard to corporation members trying to make a decision about health services delivery in a particular service area. I am including here also, the difficulty they would encounter in really achieving true citizen participation in the affairs of health at the community level. The suggestion is made that a Human Services Corporation should be composed of approximately 21 to 30 members who are able to make decisions about the allocation of resources in a Human Services Area and that one-third of these members should be elected; another third of them should be executive directors from the largest health agencies in the area; and that the other third should be citizens who either work or live in the hypothetical service area that we are considering. The departure being suggested is that the corporation members should be *salaried directors*,

since they would be making important and complex decisions and, furthermore, have money for a staff of 3 or 4 who would have the capability of carrying out technical investigations or studies in order to report these back to the Human Service Corporation.

At the present time throughout the United States, money for medical care is not allocated equitably in regard to need. It is being allocated in a *haphazard fashion without any relation to the actual needs of the people*. I will give an example of this from our own Chapter 750 plan that we have in Massachusetts. If we take one Human Service area that has 40,000 children in it, and another human service area that has 20,000 children in it, we may find twice as many children being sent out of state at taxpayer's expense from the region that has 20,000 as from the area that has 40,000 children (please see enclosed "Toward an Equitable Distribution of Public Funds for Children Receiving Public Assistance in the Commonwealth"). It is thus important to make a distinction between the money which the corporation has to carry out investigations on its own to satisfy itself about the state of health affairs in a Human Service area, as compared to its authority to allocate resources for programs locally. The overall allocation of resources should be determined by a formula from the federal and state level to the local area. The Human Service Corporation then would have the authority to decide within certain broad outlines what and where resources will be allocated in each individual Human Service area. What is being suggested here is that a formula be developed for allocation of resources locally to the Human Service Corporation, in much the same manner that the Feds use a formula in deciding how much money will go to individual states.

One of the primary difficulties with the present health delivery system is that no one is responsible or accountable for actually delivering services and knowing what the state of health care is in a particular Human Service area. If an individual wants to find out how many have lead poisoning in his community there is really no one who has responsibility for such an important health matter; the same is true for any number of other disease entities and conditions. For this reason the suggestion is made that each Human Service Corporation should publish an annual report in which indices of health would be tabulated. Let us take, for example, infant mortality; at the present time the infant mortality of your community cannot be compared to the infant mortality of another community. For this reason it would be desirable to have corporations publish indices of health care, so that trends could be noted, in order to have an idea whether things were improving, staying the same, or getting worse.

The Health Services improvement bill was put in by the present administration as a method to put under a single organization the Regional medical program, the Comprehensive Health Planning program, and the National Center for Health Services Research and Development. But what this Bill does not point out is how putting these programs all together achieves the goal of providing a framework for cooperative effort! But there is no doubt about the fact that the Federal Government framework must contain the laws which will implement successful comprehensive health *planning and implementation* at the local level. It is important to point out here that Bills which are aimed at coordination, but do not spell out specifically how coordination will occur should not be enacted into law. There is a great deal of rhetoric about coordination of services, but unless a true mechanism entailing and specifying accountable responsibility is provided then it will not occur. No one will be in charge.

At the Federal level

It is impossible to consider comprehensive legislation without considering the three levels of government, Federal, State and local. The legislation at the Federal level is the most important and the following new organizational arrangements are suggested:

The great variety of different health services listed below should all be grouped together into a single Bureau of Comprehensive Health Services. At the present time there is fragmentation of activities and much duplication of effort, and a first objective would be to collapse all of these into a total of 7 or 8 Programs or Divisions. The mélange of federal health programs presently include such programs as the Maternal and Child Health Service, Regional Medical Program, DHEW, Community Health Service-CHP, Federal Health Programs service, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the National Center for Health Services Research and Development, HMO's,

Indian Health Service, etc., etc. All these should be functionally coalesced into 7 or 8 Programs or Divisions. For example, one would have responsibility for the state of child health in the United States. Each of the 7 or 8 Program or Division directors would serve in staff roles to the Director of the Bureau and he would be responsible to the Administrator of Health Services and Mental Health Administration. Such a proposed reorganization of the Federal government health and mental health service system might proceed in a 2 stage phase, in much the same way as the Massachusetts state government reorganization is proceeding, i.e., setting up the skeleton structure first, then having studies discerning the primary functional roles and areas of responsibilities of the various state agencies, with recommendations for final legislation.

The state structure here in Massachusetts is in a state of flux, but the final legislative recommendations here in Massachusetts could be molded by present ongoing legislation presently being considered at the federal level. At the present time a variety of planning activities go on in regard to health that could be integrated and combined and it seems quite clear that Community Health Service-OHP and the Regional Medical Program *should be integrated into one group*, and in Massachusetts should be related to the presently existing 7 regions. The staffs of these 2 groups could then be deployed vis a vis the present 39 Human Service Areas so that existing Federal health data is made available to the Human Services Corporation which is established in each community. These data which are given to the Human Services Corporation should be confirmed and further assessed by the technical staff responsible directly to the Human Services Corporation. This would be a check and balance procedure so that the Corporation will not get all its input from the Feds. Another important function of the redeployed Comprehensive Health Planning group and the Regional Medical Program group would be to ascertain whether Federal funds were really being spent for the designated purpose. In other words these combined groups would play a critical role in regard to actual accountability in regard to the use of these federal funds. The combined CHP and RMP would also be important in helping the Human Services Corporation to mold a comprehensive plan for 39 Human Service Areas. Guidelines for these annual plans of proposed program development would be set at the federal and state level. It is suggested that the CHP and RMP be deployed to the Human Service Area level (i.e., the community level). The state and federal regional group would have important functions in regard to resource allocation, including veto power over plans for new facilities and buildings. Thus, a clear distinction is made between such functions as resource allocation, accountability and planning versus service-delivery for a specified dollar amount. All Federal funds for health services would be through the Human Services Corporation at the community level, including HMO's and OEO neighborhood health projects.

In essence then, the Human Service Corporation is the service organization and is the final arbiter for the designation of funds in relation to the mix of services that should be available at the area level. Lines of communication from other federal agencies having to do with health services, research, planning, and etc., would be funneled first to the Federal and State agency and from there to the regions and then to the areas. It should be possible, for example, for the present National Center for Health Services, Research and Development (NCHSR & D) to make contact with the Federal or State representative at the regional or Human Service Area. (In the new Federal reorganization suggested the NCHSR & D would of course be integrated into one of the 7 or 8 Programs or Divisions having a similar function). All local agencies including OEO should have the responsibility for becoming a part of a health plan and must come under the purview and must have the approval of *and be administered through the Human Services Corporation*. Consumers have their say in this system at the local area level, which is the most important place for them to have their say.

The above plan is a brief overview of a proposal which would constitute a functional and operational reorganization of the welter of federal health programs which presently threaten the health care system with a clutter of pluralism. This would involve a massive decentralization—and high time. The overlapping functions and roles of Federal Programs make for poor use of appropriated funds and tends to set one federal agency against another.

Sincerely,

B. R. HUTCHESON, M.D.,
Assistant Commissioner for Children's Services.

ATTACHMENT D

AMERICAN CANCER SOCIETY, INC.,
New York, N.Y., November 10, 1971.

Mr. MICHAEL J. HARRINGTON,
Armed Services Committee,
House of Representatives,
Washington, D.C.

DEAR Mr. HARRINGTON: Mr. Lane Adams has referred your letter concerning custodial care of the chronically ill to me for reply, because American Cancer Society service to the cancer patient is a responsibility of my office.

I am enclosing a copy of our National Service Manual which outlines very generally the services that are provided for cancer patients through our Divisions. I will comment on several areas concerning chronically ill patients that are inadequately funded at this time.

We attempt to keep the patient at home and the family unit intact as long as reasonably possible. To do this we lean very heavily on the visiting nurse programs and the homemaker-home health aide programs. In some localities we reimburse these programs on a per visit basis; in others we make annual grants. Our resources are limited, however, and we meet only a very small portion of the need. Insurance that would recognize the necessity of providing these services for the chronically ill would be invaluable.

In other situations, the patient cannot be cared for at home for a variety of reasons and nursing home care for the chronically ill is required. Insurance should cover the nursing home care as long as it is medically required.

Finally, there are those cancer patients whose disease is so advanced that they are considered terminal and must be cared for in a terminal care facility. These facilities have difficulty in attracting staff, and unfortunately a disproportionately large staff is required to render proper care. Insurance should recognize the need for these facilities and make provision for the high staffing costs.

I believe that the National League for Nursing at 10 Columbus Circle and the National Council for Homemaker-Home Health Aide Services at 1740 Broadway, both in New York City, might have some additional information.

I hope my comments will be helpful. We are most appreciative of your interest and wish you every success in your presentation before the House Ways and Means Committee.

Sincerely yours,

WILLIAM M. MARKEL, M.D.

Mr. BURKE. Our next witness today is the Honorable Bella S. Abzug from the State of New York. We welcome you, Mrs. Abzug, and we are glad you could come to the committee to give us your views on national health insurance. Please come forward and proceed.

**STATEMENT OF HON. BELLA S. ABZUG, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF NEW YORK**

Mrs. ABZUG. Mr. Chairman, the American medical system, long assumed by Americans to be the world's finest, is under vigorous attack, and with good reason. Almost alone among the prosperous industrial nations, we have treated medical care as a commodity not very different from any other and have largely permitted the marketplace to regulate its organization, distribution, financing, and quality control. There may be reason for producing and distributing automobiles this way, but it is no way to regulate the provision of a service that is a sine qua non of decent life.

Numerous legislative proposals now face the Ways and Means Committee. All purport to improve our medical care system; some are plainly rearguard actions by frightened segments of the health care marketplace, desperate to preserve their influence; others offer trivial

reforms that are far too limited to alter the consistent failure of American medicine to serve all Americans. Only the Health Security Act, which was introduced in the House by Representative Griffiths and four other members of this distinguished committee and in the Senate by Senator Kennedy, and of which I am a cosponsor, demonstrates an accurate comprehension of the disgraceful gap between what our medical system is and what it should be.

I intend first to make a few remarks about the problems of our existing health care system and then to comment on pending legislative proposals to change it.

WHAT IS WRONG WITH TODAY'S HEALTH CARE?

Distribution of services

Health services are not distributed according to the need for them. The poor suffer disproportionately from preventable but unprevented diseases and conditions like anemia, acute rheumatic fever, tuberculosis, malnutrition, and maternal death during childbirth, because there are too few hospitals and doctors serving them and because medical services cost more than they can pay. Rural areas, too, lack medical facilities, and there are entire counties without a single doctor.

We do not produce the right mix of medical personnel and services.

We have too few doctors in general practice but an excess in the more glamorous surgical specialties.

We have too many hospitals, sources of prestige to communities and community leaders, but too few outpatient facilities.

We have failed to attack our serious public health problems.

We, the world's most prosperous country, have tolerated crippling malnutrition in rural and urban poor and debilitating occupational diseases in miners and chemical workers.

We might have had present-day levels of auto safety years ago, had we cared to; and many experts feel we could have had a nearly crash-proof car by now.

We allow treacherous tires on our cars, highly flammable clothes on our backs, corrosives and poisons in our kitchens.

We have been halfhearted in our attempts to regulate the fouling of our air and water, sluggish in protecting our citizens against medical hoaxes, and timid in controlling the tobacco industry, a major cause of the cancer we are about to try to conquer.

Organization of medical care

Proper medical care, whether received through clinics, groups, or individuals, requires the attention of a generalist, who will be responsible for all aspects of preventive care and treatment of most medical problems, and readily available specialists who will deal with problems of greater complexity and advise and teach the generalist. Medical facilities should follow a similar pattern, with small installations for simple care and procedures, general hospitals for more difficult but still common problems, and sophisticated regional centers for treatment of obscure diseases, housing of expensive but infrequently used equipment, and maintenance of complex services requiring extraordinary skill, such as open heart surgery. Obviously, records must be kept and must flow freely from one level to another, and the pa-

tient's movement from one level to another should be straightforward and unimpeded.

In fact, we have none of this. Most people have no doctor who is regularly responsible for their well-being. They do not know how to find out whether they need a specialist or what kind they do need. They do not know what tests to have annually. Their records do not travel with them. Our institutions all wish to be total services facilities; consequently, there is a fabulous redundancy of equipment and puerile competition for training fellows, patients, and Federal grants.

One reason for the development of a medical organization that leaves patients confused and undirected is the failure of medical institutions to bother asking patients, the consumers of health services, about their preferences. Any reorganization that fails to achieve significant consumer input will be unlikely to satisfy consumer needs better than the present one.

Financing

Medical care is a fundamental right, like police protection or primary education. The need for services should be sufficient reason to receive them. Personal wealth should be irrelevant. No bargain basement compromises can be countenanced, because medical care, unlike many commodities for which a cheap version will serve as well as a costly one, comes really only in two qualities: good enough and not good enough. The latter, no matter how cheap, is without value and fraudulent.

Americans have for years accepted the principle that the fundamental services provided by the Government for all people, such as national defense, the judicial system, pollution control, food and drug regulation, et cetera, should be funded out of general revenues, and that these revenues should be collected principally by means of a progressive income tax. Medical care is just such a basic service and should be so funded.

The per capita cost of our medical care is rising rapidly and is already large compared with other industrial nations. This large relative cost, which has not brought us superior quality, is the consequence of several facts of the medical marketplace. The first fact is the doctor shortage, creating a sellers' market that will persist for the foreseeable future. The shortage is exaggerated by our failure thus far to make use of skilled paramedical personnel. The second fact is the position of the medical insurance companies, acting as fiscal intermediaries between patients and services but failing utterly to exercise the cost control that should be part of their function. There are several reasons for their indifference to rising medical cost. Their premium rates are adjusted to provide a set rate of profit, often by a cost-plus arrangement. Larger cash flow thus means a larger profit. Insurance companies invest money they hold, and larger cash flow also provides more investment capital.

A very costly example of the insurance industry's failure to encourage efficient use of services has been their willingness to pay for unnecessary hospitalization. Because hospitalization has always been the catastrophe against which people most wanted protection, far more people own hospitalization insurance than have coverage for non-hospital costs. Diagnostic evaluations are therefore routinely per-

formed in hospitals, where their real cost is large but where they are a covered service if a bogus "emergency" diagnosis is given. The same evaluations could be done more cheaply in outpatient facilities, but their cost would not be covered. Insurance companies have made no effort to discourage this practice by refusing to pay for these pseudoemergencies, but have merely raised their rates to cover the deceptive practice.

The third fact is the outrageous profiteering and inefficiency of the medicine-associated industries, notably the drug industry. Drug manufacturers have an average rate of profit twice that of the average American company, although they have no unusual risks. Fully a quarter of their income is spent on promotion and marketing, a practice resulting in overuse of drugs and use of heavily promoted, new and expensive drugs instead of older, less expensive preparations which may be just and suitable. The modern medical sideshow is justified as needed to cover the cost of the development of new, wondrous drugs, but research and development is only 6 percent of drug sales, and of that, the greater part is devoted to development of trivial modifications of known drugs rather than a search for significant new ones. These conditions are well known to the Department of Health, Education, and Welfare, since they are discussed in the fine report of the Task Force on Prescription Drugs released in 1969. The task force pointed out that we permit this organized drug abuse by providing overgenerous patent arrangements, permitting doctors to derive the bulk of their pharmacological information from company representatives and publications, and by approving for manufacture new medications that, although safe, are not different from already available preparations except in price. At the retail level, prescription prices are rarely advertised, and markups generally are a percentage of the cost of the drug, and absurdity, since dispensing a costly drug is no more work than handling out a cheap one.

Elimination of the sellers' market for doctors by increasing the supply of medical personnel, rationalizing the use of medical resources by eliminating the incentive to hospitalize, and controlling the profits of health industries all can reduce costs considerably. Add to that the prospective benefits of product safety measure, industrial safety measures, preventive medical and dental care, and control of air and water pollution, and the national savings become vast.

There is no reason to interpose private insurance companies between Federal collection and distribution of funds. Insurance companies have consistently failed to exert a useful influence on the cost, utilization, and quality of medical care, and this regulation must take place at the Federal level. To pay private companies for administering a federally financed and regulated program is wasteful and senseless; such companies have no useful role in the health field.

Quality control

Some optimists would argue that while care is too expensive, hard to obtain, and fragmented, the individual providers—the doctors and hospitals—do perform well. In fact, little is known about the quality of hospital care, and nothing is known about the quality of fee-for-service practice. To find out, we would have to review office records, prescription habits, therapeutic decisions. We would evaluate periodi-

cally the currency of practitioners' knowledge by relicensing or continuing education requirements. We would investigate the effectiveness of in-hospital peer-review committees. But we do none of these things. Thus we have only indirect and fragmented evidence about medical care quality. We do know, however, that Americans are operated on much more frequently than people in England. We know that certain drugs widely recognized as having no justified place in the market, like Panalba, were extensively used for years until subjected to FDA disapproval. We know that hospital-acquired infections are common in many institutions, quite rare in others. And finally, every doctor who is willing to answer candidly will admit that he knows doctors who are too foolish, too old, or too irresponsible to meet even minimal standards of performance.

The point is not that doctors and hospitals are wretched; it is that we don't know much about them, because we don't look. They are self-regulating which means in medicine, as in every other human endeavor, unregulated except when disaster has struck or appears ready to strike. A proper national health insurance plan will set standards of care, evaluate performance in relation to these standards, and deal firmly with violations.

HEALTH CARE LEGISLATION

The health insurance proposals before the Ways and Means Committee vary as widely in cost (\$2 billion to \$70 billion) as they do in ambitiousness, but there are no bargains to be had. The total cost of medical care, now estimated at \$70 to \$80 billion per year, is more or less fixed, whether paid out of Federal revenues or private resources. The question is whether reforms are going to affect a trivial part of that care and its cost or whether they will impinge on all aspects of the medical system. To emphasize this once more: we can only judge these legislative proposals as part of the whole cost of medical care. The "expensive" Health Security Act, at \$70 billion, does not cost more than the administration's "cheap" National Health Insurance Partnership Act, at \$15 billion, when you add to the latter the \$55 billion that will be paid by private and other governmental sources. The difference between the various proposals is not the cost, it is what we get, and what we get should be measured against the problems outlined above,

Some of our health care problems are more obvious, though not necessarily more important, than others. Obviously, the disaster of a catastrophic illness, destroying well-ordered, prudent families, is an event with which we all empathize, and there are many proposals to insure against this scourge. At the same time, Congress clearly is moved by the plight of the penniless and several proposals do provide free health insurance for them. The AMA-devised medicredit plan, or Health Care Insurance Assistance Act, is one of these. It also provides some help to the near poor, though not much, since a family of four with a net income of about \$5,500 would receive a Federal payment of only 10 percent of the cost of insurance. Such measures as these are directed at the extremities of the health care problem; they make no impression at all upon the body of our expensive, inefficient, fragmented, nonquality-controlled medical system.

Even worse, medicredit would pour new billions into the health insurance companies that have financed, supported, and encouraged the present system. In testimony before the Senate Finance Committee, Secretary Richardson said that the bill "would have little effect on the organization and delivery of medical care or on controlling rising costs. The proposal would inflate demand for services yet it does not promote appropriate ways to use the leverage of new funds to help influence the quality and efficiency of services." The Secretary is correct, but similar criticisms apply just as strongly to the administration-backed National Health Insurance Partnership Act.

The administration bill purports to offer a new national health strategy, principally through encouraging doctors and hospitals to form comprehensive health care institutions, the health maintenance organizations (HMO's) and encouraging people to join them. I believe that an HMO, offering total, prepaid health care, can in fact be a more efficient provider of high-quality, unfragmented care than can doctors scattered about the community, and can perform patient education and preventive services, keep and organize records and evaluate therapy, to an extent impossible for the solo practitioner. It is the basic unit of an intelligent health care system if it is held to high standards and if its performance is under constant scrutiny by the people who receive its services and pay its bills. The existing HMO's, such as HIP in New York, Kaiser-Permanente on the west coast, group health in Washington, and many others, have grown rapidly in recent years, indicating that despite some criticism of understaffing and a tendency to discourage use of the facility, these units have provided considerable patient doctor satisfaction.

Unfortunately, the HMO question would seem to be a bit of a smoke-screen at present, since, unlike the Health Security Act, the administration bill does not provide much financial inducement for people to join HMO's or to doctors to form them. The proposal's principal feature is the requirement that employers buy three-fourths of a health insurance plan for their employees and employees' families. The minimum plan cannot have a very large cash value since there are substantial deductible and coinsurance. The dollar value of the insurance could be applied, at the employee's option, toward membership in an HMO, but there would be an additional cost to the employee equal to the actuarial value of the deductible and coinsurance, which is probably larger than the value of the insurance. The attractiveness of the HMO's will be inversely related to the extra money the family must pay to join.

An HMO needs doctors as well as patients. The National Health Insurance Partnership Act does not attempt to control fees paid to private practitioners. Will large numbers of doctors give up the huge incomes of private practice for the merely generous incomes of the HMO?

If the administration bill does not move consumers and doctors effectively toward HMO's, it offers nothing more than the same new billions into private health insurance, without any more organizational change, that medicredit would produce, and we've seen what Secretary Richardson thinks of that. The administration bill also shares with medicredit the particularly condescending features of deductibles and

coinsurance, which are present because of a widely held view that poor people enjoy going to the doctor and will go often just for fun, even if they are not sick.

In his national health insurance speech President Nixon stressed cost consciousness. He said:

Only as people are aware of these costs will they be motivated to reduce them. When consumers pay virtually nothing for services and when, at the same time, those who provide services know that all their costs will also be met, then neither the consumer nor the provider has an incentive to use the system efficiently.

It is very strange to put the responsibility for cost control on the patient, who, not being a doctor, does not know whether he is "sick enough" for medical care. (Interestingly, the HMO's supported by the administration do not have deductibles or coinsurance.) Cost control should be exerted by regulating the fees paid to providers, but this form of cost consciousness is not mentioned in the administration bill. It seems to me to be a basic principle that we want no person to wonder, when he feels sick, whether he should spend money for treatment. Incredibly, it is a principle which both the present system and most of the pending bills stress. It has always been the situation faced by the poor. We want even the poor person to see a doctor, who can decide on the basis of his expert knowledge whether to treat the patient or reassure him. If we can educate patients so that they recognize certain symptoms as not serious, that will be excellent, but we do not want them to stay away because they don't have the cash.

The Health Security Act, in contrast to all of the other proposals before the committee, will promote broad organizational changes and will attack most of the ills of our health care system. As I will point out, it is far from a perfect bill, but it is worth reviewing briefly some of the beneficial changes it will promote with respect to problems outlined earlier.

DISTRIBUTION OF SERVICES

Wealth will no longer determine the amount or quality of one's medical care. There will be no financial barrier to seeking services; providers will be compensated directly by the system. The act sets aside 5 percent of the total money in the trust fund for health planning and for dealing with a variety of distribution problems. Funds will be available for training specialists in short supply, for encouraging desirable geographic movements, and for planning and building facilities which are necessary to provide services. There is a commitment to equalize throughout the United States the availability of services by channeling more funds into areas which are now poorly served.

ORGANIZATION OF MEDICAL CARE

The Health Security Act encourages doctors to enter HMO's or comprehensive health service organizations, as the act prefers to call them, by taking away the enormous fees now possible in fee-for-service medicine. Payments for a given service will be an appropriate fraction of the money available to care for a person's total health needs, that is the capitation payment. Therefore, comparable services delivered on a fee basis and on a capitation basis will lead to comparable incomes,

except that the efficiencies of the HMO in terms of better use of para-medical personnel, office space, et cetera, may well permit greater net earnings to the HMO doctors. With rewards more or less equal to the advantages to the physician of HMO's, such as easily available consultations, regular schedules and well-defined night call, and provisions for inservice continuing education, should prove adequate to bring doctors into that form of practice.

The act provides funds for organizing new forms of health care delivery. Its governing board has the power to eliminate redundant service by ordering a provider to cease providing it, and to demand that new services be offered. Further, there is, for the first time an attempt to develop a consumer input into the medical care system. I will return to this a little later on.

FINANCING

Money for health care insurance and planning will come half from general revenues and half from employer and employee taxes. This is a far more progressive format than that of the administration bill, although it suffers from the same flaws as our entire tax system does, generally failing to collect enough money from wealthy people. Payroll taxes appear at first to be a tax on businessmen; in fact, they are quickly passed along to consumers or compensated for by lower wages.

Private health insurance with its attendant costs will no longer be needed under the Health Security Act. Although the doctor shortage will not be eliminated overnight, the spiralling costs due to the sellers' market will be controlled by regulation of fees for service and capitation payments. Overutilization of hospitals will be discouraged since outpatient services will be paid for.

QUALITY CONTROL

Among current health proposals, the Kennedy-Griffiths bill is the only one concerned with the quality of services delivered. All providers will be committed to furnishing information needed for peer review of utilization and for review of surgical procedures. Institutional providers will have to have good records, a proper utilization of review mechanism, and a therapeutics committee. HMO's must provide continuity of care, easy referral, and easy access to their services.

Practitioners will have to meet Federal standards in addition to State licensing criteria and will have to meet Federal continuing education requirements. Their participation as providers can be terminated for inferior care or unethical behavior. They cannot be paid for services delivered in a nonparticipating hospital.

In addition to its concern with the quality of services provided by health professionals and institutions, the Health Security Act will study broad trends in mortality, disease indigence, and therapeutics, attempting to evaluate the quality of the health care system as a whole.

The Health Security Act will encourage rational drug prescribing by paying only for drugs that are efficacious and safe and by requiring that doctors practicing outside the scrutiny of health institutions and their therapeutics committees identify the disease they are treating and use a drug known to be effective in treating that disease.

Despite the contentions of its critics, the act encourages pluralism in delivery of care, permitting providers to organize in almost any way they choose, and be paid either on a fee-for-service basis or by capitation methods. It is "monolithic" only in that it will control the amount of payment and the quality of care.

The scope of the Kennedy-Griffiths bill is impressive, but it does have some key deficiencies. A bill called the Health Security Act, proposing to bring to all citizens equal and high-quality health care, cannot justifiably avoid dealing with aspects of public policy that have a large influence on health. Thus, while concern with auto safety has resided largely in the Department of Transportation, the death and injuries of tens of thousands of people in highway accidents has large health implications. Similarly, malnutrition, industrial disease, dangerous household products, air pollution, and smoking should be recognized as basically health problems. Allocation of resources to deal with them and studies of the efficacy of such allocations should flow from an agency whose concern is health.

Although the bill empowers the Health Security Board to eliminate redundant services, it does not make explicit the desirability of having institutions, especially hospitals, be organized, pyramidally, with, for example, large numbers of relatively small general hospitals and a much smaller number of regional centers where usually difficult or rare problems could be dealt with, where costly programs would be sufficiently utilized to justify their cost, and where high-quality clinical research could be maintained.

The financing of health care under the Kennedy-Griffiths bill can also be criticized. Without entering into any discussion of our supposedly progressive income tax, I question the degree to which the bill relies upon payroll taxes and social security-type levies. These are not progressive at all; in fact, the social security tax is quite regressive, since it has an income ceiling. At the very least, this ceiling should be eliminated. A payroll tax, in addition to being passed along to consumers, tends to make workers cost more and thus encourages an already dangerous trend toward substitution of capital for labor. The most equitable and most rational financing mechanism would be from general revenues. It is condescending to suppose that Americans cannot understand that excise taxes take their money away just as unpleasantly as income taxes do.

The Health Security Act does not make a sufficient commitment to ending medical profiteering. It should be a stated goal that profits of medical industries not be larger than those of the average American industry. Measures suggested by the 1969 Task Force on Prescription Drugs would represent a fine start toward this end.

Although the Health Security Act will provide rigorous standards of quality control—there are essentially no standards now—it fails to set for solo practitioners the sort of demands it makes of doctors in comprehensive health service organizations. This makes little sense, since the solo doctor is often quite isolated from contact with other physicians and from new information. The act should authorize the Health Security Board to set up local peer review committees for participating practitioners who do not belong to institutions already having such committees. Furthermore, it is time we recognized that while the M.D. degree, like a diamond, is forever, the knowledge and

skills that came with it are not so permanent. In addition to requiring continuing education, the bill should demand periodic relicensing of physicians and possibly of other health professionals.

Perhaps the most important responsibility facing the organizers of health care is assuring that the system can never again become so isolated from and unresponsive to the people it serves. The Health Security Act provides for a health security advisory council made up of more than 50 percent health consumers. This council also has regional and local counterparts. The function of these councils is to advise the governing Health Security Board on matters of policy. Unresolved disagreements between board and council will be presented annually to Congress, but it would seem that the board can ignore with impunity most of the council's recommendations. One mechanism for partially easing the imbalance in power between board and council might be to give the council explicit standing before the Federal courts in cases involving questions of whether the board has carried out its functions properly.

Consumer input may be even more important at the level of primary patient care, but there are few requirements in the Health Security Act for such input. Comprehensive health service organizations are required only to consult with enrollees regarding policy; this provision is inadequate unless expanded. At the very least, it should provide that unresolvable disputes be brought promptly before the local board for mediation, and before the courts if need be. Hospitals, nursing homes, and medical facilities other than the comprehensive health service organizations are not required to have any consumer input at all. This is a serious deficiency. All medical institutions receiving any public funds should be required to consult with the people they serve, have consumer representation on all peer review and other committees, and respond to criticism from enrollees.

This said, a hopeful word is in order. The current feeling that providers and consumers inevitably have hopelessly different aims, needs, and preferences is probably false. It is our institutions that make it seem so. Once the relations between health professionals and patients are no longer predominantly fiscal, they can relate to one another as parties interested only in quality health care.

While I consider the flaws in the Kennedy-Griffiths bill real and significant, I must emphasize again my conviction that it is the only health insurance bill before the Ways and Means Committee that will change our health care system at all. It asserts for the first time a national interest in equitably distributed, progressively financed, intelligently organized, high-quality medical care and takes a giant step toward that goal. The other bills are tranquilizers, quieting the demand for medical reform without meeting it. They are worth little and would be worse than nothing, because they would create an illusion of our having acted, an illusion that would stifle real reform for years to come. Let us have something better.

Mr. BURKE. Does that conclude your statement? If so, thank you, Mrs. Abzug, for being with us today.

The committee stands adjourned now and will meet at 10 a.m. tomorrow.

(Whereupon, at 3:10 p.m. the committee adjourned, to reconvene Friday, Nov. 19, 1971, at 10 a.m.)