

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

FRIDAY, NOVEMBER 19, 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. James A. Burke presiding.

Mr. BURKE. The committee will come to order.

Our first witness is the distinguished Member of the House, the Honorable Fred Schwengel of Iowa.

We welcome you to the committee, Congressman Schwengel.

You may proceed with your testimony.

STATEMENT OF HON. FRED SCHWENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

SUMMARY

1. It is my view that we have reached that point in time where a national health insurance program of some sort is appropriate.

2. While I have introduced H.R. 9028, I do not urge it on the committee as the only possible solution to the problem. It should be considered along with all of the other plans presented.

3. One of the most important provisions which should be included in any bill reported by the committee is a provision covering catastrophic illness.

4. The financing provisions and provisions for coverage must be realistic and specific, so that we avoid the terrible situations developing under medicare where people think they are covered, only to find after they get home that they are not covered. They are then required to pay back large sums which most of these people simply do not have.

5. We must have additional research to improve health care delivery systems and thus reduce the cost of health care.

Mr. SCHWENGEL. Mr. Chairman, members of the committee, during the past few weeks, the distinguished Members of this body have listened to the thought-provoking testimony of countless witnesses concerned about the future of health care in this country. From even a brief reading of the statements presented before this committee, it would appear that a growing consensus views some form of national health insurance as a necessary and desirable means for correcting many, if not all, of the problems affecting our health care system, particularly in regard to health care financing. The proliferation of alternative health insurance schemes is in itself a measure of importance attached to this whole area.

Along with many of my colleagues, I have come to believe that we can no longer afford as a Nation to adopt a "wait-and-see" attitude in regard to health care protection. Too many American families have

suffered financially and psychologically from the sometimes catastrophic costs of severe illness or injury. Too many sick and disabled Americans have found themselves inadequately protected by existing insurance policies which are limited either in scope of benefits or maximum dollar amounts. With medical care prices rising on an average of 6 percent a year, even the middle income wage earner feels the pinch on his family budget resulting from the basic costs of physician office visits, protective immunizations, high-priced miracle drugs, and essential prenatal and postnatal care for his wife and children.

In the past few years, Congress has done much to improve the availability of health services through financial aid to hospital construction, grants and loans to expand our force of medical personnel, assistance for the creation of OEO neighborhood health centers in deprived areas, and research into new systems for health services delivery. Now, however, the time has come for us, as legislators, to also assume responsibility for assisting our people in obtaining the kind of adequate health insurance protection which will remove the threat of financial indigency so often accompanying the occurrence of illness or poor health.

In 1969, although four out of every five Americans had some form of private insurance protection against the costs of hospital care, less than half the population was protected against the costs of outpatient care such as office or home visits, visiting nurse services, nursing home costs, or outpatient diagnostic screening. Last year, three-fifths of personal health care expenditures were met through third party payments, with the Government responsible for almost 60 percent of this bill, primarily through the medicare program. For the health consumer not covered through Government programs, however, only 71 percent of the outlays for hospital care, 42 percent of consumer expenditures for physicians' services, and a mere 5 percent of the costs of all other types of health care were met through private health insurance expenditures. Thus, for the majority of the nonaged population in this country, the gap between private health insurance payments and the total personal health care bill must be filled through direct out-of-pocket expenditures, philanthropy, or other means.

The majority of the national health insurance bills introduced into this session of Congress are aimed at closing or narrowing that gap between what the consumer himself must pay directly and what this health insurance program accounts for as covered expenses. You, the members of this committee, are well aware of the significant differences among these bills which you are presently considering. Thus, my purpose in speaking here today, is not to describe or espouse the cause of any particular piece of legislation but to add my voice to those before me who have clarified the need for some kind of Government action in this area. I am convinced that we can and should be doing more to assure Americans adequate health insurance protection and that a national health insurance program of some kind provides us with a vehicle for accomplishing this goal.

One other area we must give careful consideration to is that of research to bring down the cost of health care. At the present time the costs of health care are totally out of control. I'm convinced that some diligent research could cut those costs.

- As many of you know, I myself have cosponsored a bill which proposes one approach toward solving the dilemma of inadequate health insurance protection. This bill, H.R. 9028, which has been dubbed the medicredit proposal, contains many significant advantages, perhaps most importantly a provision for extensive coverage of catastrophic illness costs. As we move toward serious consideration of the many different alternatives for health insurance legislation, it may well be that some of the provisions of the medicredit approach, revised by appropriate amendments, will find their way into the final legislation approved by this committee.

Regardless of which bill is finally reported by the committee, it must above all, contain realistic provisions for coverage and for financing. The stories which have recently come to light regarding medicare patients who have been billed for large sums, after they had previously been assured they were covered by the program, are a national disgrace. The services and facilities covered by the program, as well as the financial responsibilities of participants must be clearly and concisely spelled out.

I am confident that much of the current debate surrounding the issues of national health insurance will serve in the end a highly useful purpose. For in this open public forum, we will come to recognize both the strengths and weaknesses in the opposing points of view represented here, the cross section of opinions from the different segments of our society affected by the legislation we will be considering. Whatever the outcome of these hearings, I feel assured that the committee will seek a resolution to this problem which is workable and satisfactory to all Americans, and I hope it will be done at an early date.

Thank you.

Mr. BURKE. Thank you, Congressman Schwengel.

Are there any questions?

Mr. SCHNEBELI. I would like to greet my distinguished friend of long standing, Congressman Schwengel. He has always good ideas.

Thank you for your thoughts, Fred.

Mr. SCHWENDEL. Thank you.

Mr. BURKE. Are there further questions?

Thank you very much for your contribution. The committee appreciates your appearance here today.

Our next witness is our esteemed colleague and distinguished member from Maryland, the Honorable Parren J. Mitchell, of Maryland.

**STATEMENT OF HON. PARRÉN J. MITCHELL, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF MARYLAND**

Mr. MITCHELL. Thank you very much, Mr. Chairman.

Mr. BURKE. We welcome you to the committee. You can identify your associates if you wish and proceed with your testimony.

Mr. MITCHELL. I do appreciate this opportunity to bring to the attention of this committee a matter of grave concern regarding the delivery of health care in America.

Seated to my right is Dr. Harvey Webb, Jr., a member of the board of directors of the American Patients Association, who testified before this committee last week.

To my left is Mrs. Ruby Martin, an attorney with the Washington research project and former Director of the Office for Civil Rights of the Department of Health, Education, and Welfare.

Mr. BURKE. We welcome both of you to the committee. We recognize your associate who testified here last week.

Mr. MITCHELL. Thank you.

First, however, I wish to commend the chairman and all members of this committee for moving forward with an analysis of health care in order to devise a workable, fair system of national health insurance for every man, woman, and child in America.

During the past several years, many proposals for a system of national health insurance, or universal health entitlement, have been discussed and outlined. Last year, 13 plans were placed in the congressional hopper. During this session of Congress, even more suggestions have been made, although the outlines of major plans seem to be getting clearer and clearer.

May I say, Mr. Chairman, that the Congress and the people of this Nation will owe this committee a great debt, as its deliberations serve to clarify even further the issues at stake, the directions we must pursue, and the ultimate commitment this country will have to make.

This committee already has before it the stark figures on the need for a bold revision of health care delivery in America. I will not, therefore, belabor the obvious. Nor do I come before this committee as an advocate for any particular plan or plans proposed by my distinguished colleagues in the House of Representatives. Rather, I would draw your attention to a basic, fundamental, and all-important element that must be included in whatever plan the Congress ultimately approves.

Briefly stated, this element is the assurance that all health care will provide for the primary benefit of those in need and not for the benefit of those who provide health service. National health insurance must be a system that works best for patients, not merely a better reimbursement system for doctors and hospitals.

If that is to be the case, and I submit that it must be the case, if the people of America are to be well served, then it follows that all individuals who may need health care must be guaranteed certain rights. These guarantees, in addition, ought to be expressed by the Congress within the very legislation that will establish universal health care entitlement. In my review of the many health plans submitted by my colleagues thus far, I have been greatly distressed to see no statement that recognized the rights of patients. I believe such a statement is essential at this time.

Mr. Chairman, I place this proposition before you not as mere rhetoric. We have had enough of that. But I am sure this committee is aware as I am of the sense of distrust, the cynicism, that is growing among our fellow citizens toward the institutions and services of their own Government.

Local public services, long regarded with respect or fear or wonder, are now under constant attack by our citizens. And in every case we can see, to a greater or lesser degree, a legitimate cause for complaint or distrust or cynicism.

Just 3 weeks ago, in community after community, voters turned down more money and power for local schools. They are demanding

greater accountability and greater respect for the rights of students and taxpayers.

Civilian review boards are another growing issue in the area of public safety. The police themselves are having to reexamine their role in the community as the demands mount up for a greater concern for civil liberties and civil rights.

I need not tell this committee of the chaos in our social services, particularly in welfare. Here, again, the reform of service delivery is closely tied in not just with fiscal reform but with the reform of professional conduct toward welfare recipients—a respect for human rights while a public service is rendered.

Now, Mr. Chairman, the Congress of the United States is about to embark on a broadscale revision of public health service. This is a massive undertaking of fiscal reform. It will be a massive undertaking of the reallocation of resources. But it will also be a major restatement, in terms of a particular public service, of the promise made by this country's Founding Fathers: That every person is entitled to life, liberty, and the pursuit of happiness and it is the job of Government to protect that universal entitlement.

Therefore, whether we speak in terms of 1776 or of 1976, the issue I raise with you today is the same: Any law establishing a system of national health insurance must carry a clear statement of the rights and protections such a system will provide for all citizens in America.

Let me add that national health insurance is not only a boon to every American; it is a grave responsibility to be shared by every provider of health service—doctor, dentist, nurse, hospital administrator, technician, researcher, medical school faculty, nursing home proprietor, everybody in the health industry. It is imperative that all of them know what is expected of them under national health insurance, just as it is imperative for all citizens to know what kinds of service they are entitled to. For we have seen during these past 5 years of medicare and medicaid the shuttling of patients from private hospitals to overcrowded public facilities, the basketballing of patients. We have seen conditions in nursing homes reach a point beyond human imagination; these conditions have been accurately and painfully described in the Congressional Record by our distinguished colleague from Arkansas, Representative David Pryor. Surely, the Congress never intended that medicare become an instrument of abuse for any needy, sick person.

But we know it has happened. We know that simple safeguards of human dignity and justice were left out of the medicare legislation. Frankly, no one in 1965 would have thought it necessary to write such safeguards into the law.

Mr. Chairman, I know well the historic role played by you and the distinguished members of this committee in drafting and helping to pass H.R. 6675, the medicare amendments to the Social Security Act.

I also know of the great struggles to resolve differences between the two Houses of Congress and among the many groups representing doctors, hospitals, insurance companies, and labor unions. But the differences were resolved, and America took a great step forward in caring for its citizens.

Now, we are all aware of an issue not discussed and never resolved in 1965, an issue that haunts medicare to this day: the great issue of

the rights of patients, the beneficiaries of that great legislative achievement.

Several months ago, I was introduced to a "Health Bill of Rights," drawn up by the American Patients Association, a national organization representing consumers of health service and headquartered here in Washington, D.C. Since then, many individual doctors and hospital administrators have indicated their support for such a statement. In addition, the National Dental Association and the Physicians Forum have come to me with expressions of support in principle for a "Health Bill of Rights" and have urged that such a bill become part of national health insurance legislation.

They feel as I do, and they feel, I am sure, as the members of the committee do, unless the people of America—rich, poor, male, female, white, red, black, brown, or yellow—unless they all feel that this program is in effect for them, that it respects their rights, that it seeks to preserve their health and human dignity—unless this idea is put across, the great dream of national health insurance will be viewed with skepticism, cynicism, and distrust. Let me emphasize that without the trust of those it is intended to serve, a national health insurance system cannot possibly work.

At this time, Mr. Chairman, I would like to present to this committee the 10 brief points in the proposed "Health Bill of Rights" that I introduced on November 1. It is known as House Resolution 679.

1. Every resident of the United States has a right to the best health care available without regard to his or her race, religion, color, national origin, or ability to pay.

This is a categorical statement wholly consistent with the Civil Rights Act of 1964, with the decisions of the U.S. Supreme Court in desegregation and welfare cases, and would be covered by the "due process" and "equal protection" clauses of the fifth and 14th amendments to the U.S. Constitution.

I might note, Mr. Chairman, that President Nixon himself has said he thinks health is a right, one of the few times we both seem to agree. I would assume that the "strict constructionists" he has nominated to the High Court would keep this in mind as health-rights cases come their way in the years ahead.

2. Neither a patient's age nor sex shall be used for discriminatory purposes in the provision of care, nor shall certain age or sex groups be used for experimentation without full medical justification and informed consent.

For years we have exploited the aged, the mentally retarded, blacks and other minorities, the poor, and those in detention centers for experimentation. Puerto Rican, chicano, and black women on welfare were the first guinea pigs for oral contraceptives 10 and 15 years ago. Only last year, the U.S. Food and Drug Administration had to put out new, stronger regulations to insure the getting of informed consent from patients being used by drug companies for a variety of dangerous tests.

Now, with the aged getting increased attention, a whole new frontier of drugs and devices for old people is opening up. We must make sure that such research and experimentation is carried out with the patient's rights fully protected rather than circumvented under a loose national health insurance system.

3. Health care, including medical assistance, shall in no way violate the constitutional guarantee of privacy and of protection against self-incrimination; these rights shall prevail during examination, diagnosis, and treatment, and shall govern the maintenance of all health records, verbal or recorded.

Privacy is as important to a poor child from a welfare family as it is to a wealthy youngster. If they are to be poked and probed by a doctor, let it be done with the curtains drawn. Unfortunately, this simple courtesy—which can be translated into a human right—is less available to the poor and the middle class and most available to the rich.

But I must call your attention to a more basic issue. If everyone is to be entitled to health care, then theoretically there can be a health record on every citizen: His heartbeat, drinking habits, sex life, blood type, rate of metabolism, and so forth. We must make plain to everyone that this is private, privileged information that belongs to the patient.

A system of national health insurance that does not have safeguards against invasions of privacy and self-incrimination will be considered yet another hoax by the people of America. That must never happen. And let Congress say so.

4. Except under emergency circumstances, each patient must be informed of the treatment he is to receive, of the persons who will provide that treatment, of the nature of the treatment, whether it is a generally accepted procedure or experimental, and the anticipated risks and benefits of such treatment to the extent they are known. The patient has the right to give or to withhold consent to treatment.

On the other hand, this is a restatement of what our Nation already agreed to at Nuremberg and Helsinki, following World War II. We vowed, along with all other civilized states in the world, that the horrors of Nazi "experimental medicine" would never again take place. A sick person must have the right to know what is going to happen to him, and who will be responsible for it; and he must retain the right to say "No."

But I am not proposing this particular section because I think American doctors handle patients the way Nazi doctors handled concentration camp internees. What this statement recognizes is that, under national health insurance, everyone benefits, everyone pays, and everyone participates.

In America today, the average person has better than a high school education. This means our citizens—even under the stress of illness—can understand many details of sickness and treatment that might have been beyond the imagination of our fathers and mothers. So I think it is worth stating that patients—those who receive health care—have a right to participate as fully as possible in the delivery of that care. I offer this not as a dim ideal, but as a practical, immediate reality.

I would like to enlarge on this point for a moment, if I may. It is right and proper that in the health field the parameters of research continue to expand. This is right. A great deal of research is now being conducted in terms of genetics. We have seen some indications of experimentation in the area of genetics, and obviously this feature of our

Health Bill of Rights would seek to safeguard against such experimentation.

May I also indicate—and I don't recall where I read this recently—that someone suggested that insofar as the sickle cell anemia condition is concerned, that maybe there ought to be the sterilization of those who carry the sickle cell trait.

Obviously, once again, No. 4 is designed to protect against this type of activity.

5. Where an individual patient cannot give informed consent to recommended treatment because of medical disability, language barrier, or condition of confinement, such consent must be sought from next of kin, guardians, or others who would assume responsibility for the patient's legal and moral rights.

Universal entitlement means the gathering in of everyone, and the Government being responsible for everyone. We know that such a proposition is almost impossible to realize. However, it is not impossible—in fact, it is quite necessary—that Government at least indicate to all citizens that their rights will be protected, regardless of the circumstances.

Such a statement, promulgated by the U.S. Congress would be the signal to the ultimate administering agency of national health insurance to get its machinery moving on responsibility. We must affirm that no man is an island, nor will any man become an island as a result of a national health insurance plan.

I would remind this committee that no fewer than 1 of every 10 Americans speaks Spanish, Italian, Jewish, or a variety of Indian languages as a mother tongue. Yet all of them, along with the English-speaking Americans, would have a right to health care. Let's make sure—as we did not with medicare and medicaid—that neither language nor illness nor locality nor anything else will prevent a patient from maintaining his right to information.

6. The relationship between the patient and the provider of care shall be free of any representatives of enforcement, investigative, financial, religious, or social agencies, except as specifically requested or approved by the informed patient and without duress.

If we are concerned with the health of the individual citizen and intend to cover his every health need, then we had better make sure these needs are not interfered with by persons who have other business in mind. We must let doctors and hospitals know that their primary duty under national health insurance would be to take care of the health problems of our citizens. And we must get police, insurance investigators, private detectives, shakedown artists, collection agencies, and the welfare department out of the way unless or until the patient himself allows them in.

7. No person in need of medical assistance may be turned away or otherwise abandoned by any individual or organization, public or private, capable of providing such assistance. This shall not be construed to be in conflict with the principle of informed consent.

Here we would try to set the record straight for both the patient and the doctor. To the patient we say: "Look here, universal health insurance means just that: Wherever you may be, in whatever condition, someone with medical knowledge will take care of you. You will receive

whatever care is possible and needed, within the context of all your rights." And to the doctor we say: "Don't shrink from exercising your best medical judgment whenever it is needed. Do your job as best you can as a real professional and don't worry about 'getting involved.' We want you involved."

This provision would extend the so-called Good Samaritan law and free doctors and hospitals from the threat of suits where no such law now exists.

We cannot have a contradictory standard: national health coverage along with an abandonment loophole. Today, even under medicare and medicaid, no aged or poor person is guaranteed health service; a doctor or hospital may opt out of the plan and all their patients left to drift. I would hope this never happens under national health insurance.

May I indicate at this point, Mr. Chairman, that there are two things I would like to have inserted in the record. I might as well do that at this time.

The first is a statement from the Joint Commission on the accreditation of hospitals. I think I have sufficient copies here for all the members of the committee.

The second is a reprint from the Congressional Record of an article entitled "Medicare's Secret Data." This is an article by Mal Schechter. I think it will prove most beneficial to this committee in its deliberations with reference to my statement.

Mr. BURKE. Without objection they will both be included in the record at this point.

(The statement and reprint referred to follows:)

INSERTIONS OF HON. PARREN J. MITCHELL, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF MARYLAND

JCAH PREAMBLE

"Equitable and humane treatment at all times and under all circumstances is such a right (of patients). This principle entails an obligation on the part of all those involved in the care of the patient to recognize and to respect his individuality and his dignity.

This means creating and fostering relationships founded on mutual acceptance and trust. In practical terms, it means that no person should be denied impartial access to treatment or accommodation which are available and medically indicated, on the basis of such considerations as race, color, creed, national origin or the nature of the source of payment for his care."

The preamble of the JCAH goes on to consider the rights to privacy: "Every individual who enters a hospital or other health facility for treatment retains certain rights to privacy, which should be protected by the hospital without respect to the patient's economic status or the source of payment for his care. Thus, representatives of agencies not connected with the hospital, and who are not directly or indirectly involved in the patient's care, should not be permitted access to the patient for the purpose of interviewing, interrogating or observing him, without his express consent given on each occasion when such access is sought. This protection should be provided in the emergency department and outpatient facilities as well as on the floors of the hospital. The hospital, like the church of old, must impart at least some sense of sanctuary.

The individual's dignity is reflected in the respect accorded by others to his need to maintain the privacy of his body. To the extent possible, given the inescapable exposure entailed in the provision of needed care, the patient should be aided in maintaining this privacy."

I would like to quote from two more areas that are covered by the preamble of the Joint Commission on Accreditation of Hospitals. The first deals with confidentiality.

"Another important aspect of the patient's right to privacy relates to the preservation of the confidentiality of his disclosures. The setting in which the

patient's history is taken, for example, should be such that he can communicate with the physician in confidence. This is true of emergency departments as well as other parts of the hospital."

Then the preamble covers consent. I quote:

"In many teaching hospitals, and particularly in those which are closely affiliated with medical schools, all patients, regardless of their economic status, may be expected to participate to some extent in clinical training programs or in the gathering of data for research purposes. For all patients, regardless of the source of payment for their care, this should be a voluntary matter. The level of the patient's participation in such activities should in no way be related to the nature of payment for his care."

It becomes apparent that the health field including the American Medical Association, the American Nursing Association, and the American Hospital Association share the feeling that patients' rights must be guaranteed.

I am, therefore, including in the Congressional Record the article "Medicare's Secret Data" which appeared in the Washington Post on September 26, 1971.

The article follows:

MEDICARE'S SECRET DATA

(By Mal Schechter)

In 1939, the fledgling Social Security System warned Congress of a problem vitiating its objective of humane aid to the poor. Political candidates in some states acquired, legally, the names of Old-Age Assistance recipients and deluged them with campaign propaganda, promises and warnings. Tradesmen also used the lists. A few states actually required publication of the names to deter the poor from seeking relief.

Social Security Board Chairman Arthur Altmeyer asked Congress for authority to require confidentiality of records. Not only to protect assistance recipients but also individuals in the payroll tax program of old age and survivors insurance, Congress agreed.

Section 1106 of the Social Security Act to this day ranks as one of the most sweeping secrecy provisions in any federal program. It forbids disclosing "any file, record, or other paper or any information" obtained by the system or provided for official use, except as the Social Security commissioner expressly allows.

A quarter century after Altmeyer's plea, Medicare began.

There lies the rub. For Section 1106, implemented by Regulation No. 1, covers relationships hardly imagined in 1939.

Medicare deals with hospitals, nursing homes, clinical laboratories, physicians, health departments, and insurance companies. What Congress intended as protection of payroll taxpayers and beneficiaries has been extended to Medicare's corporate servants. The "authority to refuse to disclose"—as Regulation No. 1 puts it—has mushroomed, and this restricts the public's right to know about the quality of care it receives and the quality of Medicare's administration.

Much information on specific facilities is not open to the public, such as reports on Medicare-financed inspections of nursing homes and hospitals. These surveys contain information bearing on patient health and safety which could be important to families trying to place a relative. Or to newsmen, students of health care and public administration, or anyone who wants to know how good or bad a community is served by the health establishment.

But nobody can get these reports from Social Security.

In New York State, on the other hand, information on institutional deficiencies gathered by the state is, by law, public information.

Social Security Commissioner Robert Ball says he realizes that deficiency disclosure could help the public and patients, but he emphasizes "undesirable effects." He insists Medicare doesn't certify a facility endangering the patient's health or safety. Therefore, public disclosure of lesser deficiencies in certified institutions "might create unwarranted concern" or an "adverse public reaction (that) could severely hamper an institution's efforts to maintain patient loads while effectuating needed improvements."

SHORTCOMINGS SHIELDED

That serious deficiencies exist under Medicare is hardly hallucination. Federal auditors repeatedly have found Medicare homes lacking complete fire protection programs, required nursing attention, required physician attention, necessary emergency electrical service, and complete nurses' call systems.

Which ones? Don't ask the Social Security Administration.

Medicare certification is hardly an infallible guide to quality. Of some 4,500 Medicare nursing homes mentioned in a Senate Finance Committee report, nearly 3,300 had significant deficiencies, some tolerated for years in the category of "substantial compliance" with standards. The public never is told which homes are in "full" and which is "substantial" compliance. The Finance Committee says administrative legerdemain permits disregard of many standards.

The nation has the word not only of auditors but also of President Nixon that something is seriously wrong with federally subsidized care in nursing homes. Much of the President's recently announced effort to tighten up federal supervision of nursing homes appears directed at officially tolerated abuses—perhaps in good measure tolerated behind a screen of nondisclosure.

Although Social Security has some good words for disclosure, it has backed off from an innovative proposal by the Finance Committee. Last year, the committee proposed that Medicare publish information on deficiencies if an institution fails to correct them within 90 days. The proposal is still pending. Social Security has come up with many reservations to the plan without acknowledging the public's right to information. Ball has argued that "widespread and indiscriminate dissemination of information about deficiencies" may have some undesirable effects.

The public's right to know may be forever in conflict with such official paternalism, whether altruistic or self-serving. Often considered one of the better bureaucracies, Social Security has a record on Medicare nondisclosure that goes beyond nursing homes. It was reluctant to name insurance companies that it found to be poor Medicare fiscal agents, including District of Columbia Blue Shield. It declined to disclose results of a Medicare survey of Boston City Hospital after disaccreditation by the Joint Commission on Accreditation of Hospitals; nondisclosure prevented an attempt to compare certification systems. Social Security is silent on revealing the names of Medicare nursing homes that have highly inflammable carpeting. It has stopped a state agency from describing the administrative process that permitted a leading clinical laboratory to be certified for four years without meeting key standards.

Even reimbursement information has been played close to the vest. When first asked for specific payments to hospitals, the agency said nothing doing; Regulation No. 1. Fortunately, Ball relented because "there is not the same validity in withholding information concerning the payment of public funds to institutional providers of Medicare services as there is in the case of information on Social Security payments to individuals."

Ball made the data available and amended Regulation No. 1—but only to disclose institutional payments, not deficiency data. Alas, the hospital payment data turned out to be inadequate for comparing institutions on costs related to patient load. This raised questions about Medicare's capacity to analyze costs and influence development of cost controls amid medical-hospital inflation. A promise that good comparative data would be published regularly remains unkept.

Given specific hospital payment data, the extent to which Medicare financed certain racially discriminating Southern hospitals was assessed by Hospital Practice. The report led to tightening up of a Medicare loophole. There was no difficulty obtaining specific civil rights data from the Office for Civil Rights of the Department of Health, Education, and Welfare; that office said the records were public information.

SOOTHING THE INDUSTRY

The application of Regulation No. 1 to Medicare may be a historical result of the health industry's opposition to enactment of the program—and especially to its chief spokesman, Wilbur Cohen, then HEW under secretary. After enactment, Cohen, prodded by the White House, emphasized consultation and conciliation. Consumer representatives, including organized labor, followed Cohen. Much of the regulatory work was confidential from the very start. In this atmosphere, Regulation No. 1 was handy.

The bureaucrats who moved over from the cash-payments and disability payments programs had matured at the knee of Regulation No. 1. A history of early Social Security days points to the founding policy of shunning political controversy at almost all costs. This meant a tight lip on information that might stir

things up even more for a young social program in the hostile 1930s. The system had to be above reproach and suffer its pains quietly.

These themes may have figured in the application of Regulation No. 1 to Medicare. The commissioner could have excluded the new relationships from nondisclosure. Psychologically, 1966 may have been 1936 all over again in the bureaucracy. Whatever the reason, frankness with the public has not been a Medicare hallmark where controversy portended—neither under the Democrats nor under the Republicans, who, the bureaucrats are aware, have special ties to protect in the health establishment, especially insurance companies.

Some officials argue that it is enough that congressional committees get information. Still, information on deficiencies does little practical good to the man in the street when deposited on the Hill under a "confidential" stamp. Nor, one might argue, should congressional oversight delimit the public's right to information. Medicare records probably are a mine of information for communities on the quality of medical-hospital care. Disclosure might generate healthy corrective pressures in localities.

The dangers of secrecy, some officials argue, are outweighed by the dangers of disclosing undigested technical information. Raw data might do the public little practical good. The proper rejoinder may be that government must provide the context to give data meaning, with other sources free to comment on the facts. The HEW Audit Agency has such a pattern so readers can judge for themselves.

THE CHANGES NEEDED

A few steps could give the public access to Medicare information. First, Section 1106 should be replaced by a simple statement limiting confidentiality to taxpayer-beneficiary-patient records. All other information should be subject to the 1967 Freedom of Information law.

This statute assumes that all information in federal hands belongs to the people and is disclosable, with certain exceptions—such as internal policy memoranda, trade secrets and patient records. Unfortunately, the 1967 law exempts any antedating statutory authority for secrecy, such as Section 1106. Also lamentably, the law has been laced with bureaucratic interpretations that have created or widened loopholes.

The information law should be amended to narrow the loopholes, especially to make clear that factual material must be disclosed on request in timely fashion. Where doubt exists about "confidentiality," the matter should be examined by a board including non-bureaucrats. For example, the President might name such a board from newsmen, public representatives and bureaucrats. Among other things, they might have power to release the substance of documents after "sanitizing" to preserve necessary patient-beneficiary confidentiality. The board should work rapidly. Its decisions should be subjected to immediate court review.

Further, in the current debate over national health insurance all proposals should carry an explicit requirement for freedom of information, avoiding secrecy from the start. The debate over forms of health insurance, quality of care, economics and efficiency of services, and governmental-versus-private roles might be better informed today if the people had the facts.

Finally, the Senate Finance provision on releasing deficiency information should be enacted without delay. Anyone seeking to learn about the quality of a facility should be able to look it up at a district Social Security office. The same information on institutions in Medicaid and other government programs should be public, as should results of hospital accreditation inspections which form the basis for joining government programs.

Thomas Jefferson once said, "Give the people the facts and they will know what to do."

Medicare should do no less.

Mr. MITCHELL. Eight. All persons have the right to advocate and work for change in the provision of health care. Such activity shall not be used to deny any person access to care at any time of need or the protections of all rights and guarantees.

This committee knows far better than I the degree to which health is becoming a vast, complicated, growing industry. As such, it is suffering all the growing pains of a full-fledged industry: labor orga-

nizing, consumer pressures, nurses' strikes, intern protests, community action, and so on. And that is the way it is going to be for a long time to come, whether we like it or not. With the advent of national health insurance, the pressures for change will grow faster and stronger.

Today as in the past, hospitals can shut out union organizers, militant nurses and young doctors, community activists, poverty lawyers and others. I am told that some hospitals will refuse to treat or provide any care for such "troublemakers."

Maybe that sort of thing can exist when public health service is divided between public and private institutions. But with the advent of national health insurance, our health system will be national and public. Everyone will have a stake in it and—being Americans—some people may turn to militance. But they—even these "troublemakers"—must still be given the right of access to health care. They cannot and must not be abandoned by the health industry.

9. Every person has a right to all information of a public nature which indicates the adequacy, efficacy, and economy of health care provided directly or through third parties by local, county, and State, regional, and national agencies.

Earlier in my testimony, Mr. Chairman, I noted that the people of this country are asking all public servants to be more accountable for their actions. The principle of "open books" is strongly rooted in America. I believe we must reaffirm this principle at the very time we enunciate a system of national health coverage.

For the past 2 years, committees of the Congress have heard witnesses from insurance companies, hospitals, and medical associations try to cover up their lack of information, indicate they just didn't know the facts about important aspects of health care and costs, and confess to not knowing things they promised the Congress they would know.

The disease of misinformation and no information has infected the Social Security Administration and most State health agencies as well. With your permission, Mr. Chairman, I would like to submit for the record an article from the Washington Post, written by a medical reporter, Mr. Mal Schechter, and his experience with the secrecy of the Social Security Administration.

(See p. 3026.)

Mr. MITCHELL. We cannot tolerate this sort of thing with present government health plans. Think how much worse off we will be if citizens do not have access to public information telling them how well—or how badly—the national health insurance plan is working. And think how much worse off the Congress will be if this ninth provision in our "health bill of rights" is omitted from the overall legislation.

May I give you a brief illustration on this point? I think this illustration of number nine will show the kind of thing that we are seeking to safeguard against. There is an old expression used in the South and it is used much less frequently now. It says, "Give me some money to keep the 'haints' off me." Rural poor blacks used to use this expression. Within the last year a black man went into a hospital for a very minor kind of injury. He was in the emergency room and was joking with the nurse and doctors and he said, "Give me a quarter to keep the haints off me."

There was a great deal of discussion. He was a semiliterate. "What are you talking about?" "A quarter to keep the haints off me." They wanted to know what "haints" were.

Finally he got around to saying, "They are ghosts." It was at that juncture that he was examined by two psychiatrists. Obviously the man did not suffer from any mental illness. It was an unawareness of the significance of this local expression.

Suppose that man wanted to sue, he might have experienced a great deal of difficulty. It is that kind of thing that I am anticipating guarding against in No. 9.

10. Health care in the United States is and shall be organized to benefit the general public; hence, all policymaking bodies of institutions, organizations, or agencies devoted to health care and which draw support in any form from public revenues shall have a majority representation from the general public.

This may be the most controversial of the 10 provisions and, hence, has been kept to the last. However, as this committee knows, the Congress and the executive branch have already acceded to the principle of majority representation for consumers on health planning boards set up under the so-called Partnership for Health Act, Public Law 89-749. Neighborhood health centers set up by the Office of Economic Opportunity and continued under HEW have also had majority policy control by consumers. So the idea is not new. However, what would be new is the universal application of that idea to all agencies in a national health insurance system.

I think it is unnecessary now to go into particulars as to how this would be done. There are many models in the fields of education, urban planning, agricultural cooperatives, and housing to help the responsible agency work out details applicable to national health insurance. But now is the time for Congress to again enunciate the principle of public control of health delivery.

Mr. Chairman, these 10 provisions of a proposed "Health Bill of Rights" were brought to my attention by their sponsor, the American Patients Association. However, I would like to add that responsible organizations representing organized medicine have also seen the need to lay out the rights of the patient.

With your permission, Mr. Chairman, I would submit for the record a very fine statement issued by the Joint Commission on Accreditation of Hospitals. The JCAH is composed of members representing the American Medical Association, the American Hospital Association, the American College of Physicians, the American College of Surgeons, the American Association of Homes for the Aging, and the American Nursing Home Association.

While this is an excellent statement, the JCAH can apply it to only about half the hospitals of the United States; the remainder are not JCAH accredited. Further, the JCAH has no enforcement mechanism to make sure the ideas in this preamble are actually carried forward by accredited hospitals.

While recognizing in the area of health a certain amount of health expertise is mandatory, I would also recognize that in terms of the delivery of health care we must secure more significant involvement. I do not take the position that the providers of health care are sort

of sacrosanct individuals who cannot rub elbows with the community, who cannot receive significant inputs from the community.

I think if indeed they do receive such inputs, then the delivery of health care will be greatly facilitated.

Therefore, Mr. Chairman, it is up to the Congress to come forward with a clear statement of patient rights at the very time we build a national health insurance system. Such a statement would not protect any one special group—the poor, the rich, doctors, or hospitals. A health bill of rights is needed by all Americans, wherever they appear in the health delivery system. It is a basic statement of trust and justice, a recognition of the dignity of the individual regardless of the misfortune he may endure in illness. It will let every American know that his Government is as concerned about human rights as about medical bills. Above all, it is a clear statement of shared responsibility, shared commitment, and shared trust between patient and provider.

Mr. Chairman, I again wish to thank you and this committee for the chance to introduce the concept and language of a health bill of rights into your deliberations on national health insurance.

I am certainly available for any questions that the committee might have.

Mr. BURKE. Congressman Mitchell, we appreciate your appearance today and the excellent statement you have made.

With reference to the 10 brief points that you posed, how would these 10 points be enforced?

Mr. MITCHELL. I believe that there are some guidelines at the present time in government for the enforcement of these. If we look to title VI, there is provided a guideline. Title VI of the Civil Rights Act suggests a guideline for the enforcement.

However, Mr. Chairman, and members of the committee, I would like to indicate that I have not spent a great deal of time in terms of planning the enforcing mechanism. I will be delighted to do that and deliberate with the chairman and the members of the committee on a workable enforcement mechanism.

Mr. BURKE. Thank you.

Now you refer to the rights of minorities here. Of course there have been many bills passed on civil rights and the rights of minorities over the past 10 years. Do you think there is a need for additional laws to be put on the books to protect the rights of minorities?

Mr. MITCHELL. I am sorry, Mr. Chairman, maybe I did not make it clear and I apologize for not making it clear. I am not talking about just minorities—on the other hand, maybe I am, because all American's represent a minority of one sort or another—but the bill of rights that I am addressing myself to this morning is a bill of rights for all people, white anglosaxon, protestants, Chicanos. We are concerned with that which should accrue to a human being simply because he is a human being and a citizen of the United States of America.

Mr. BURKE. Will the inclusion of your plan for a national health insurance proposal raise the cost?

Mr. MITCHELL. I do not think so. My hunch is that if anything at all transpires it will probably lower the cost. This would be true because it would set one standard for care. If you set one standard for care then it becomes easier to analyze things on a cost basis.

This could also reduce the cost of, let us say, malpractice insurance because the patient would have full knowledge of what his doctor is doing. Obviously if we reduce the cost there, then we would cut down on the cost of case-by-case litigation in that area. That is just one illustration where I think the implementation of a national health bill of rights would in effect lower the cost of any health legislation that is eventually passed by this Congress.

Mr. BURKE. I was interested in your statement about that elderly black from the South who asked for the quarter. Of course coming from a race of people who have had many ideas and thoughts over the years on what is needed to protect themselves. I do not suppose you have heard of the leprechauns in Ireland although there are many people who do not question the existence of these little men because their cases seem to happen that no one can explain.

I can understand the feeling of this man when he is in the hospital.

There has to be a broader understanding on the part of people of what the thinking is in the minds of people and why they ask certain things and do certain things.

Are there any questions?

Mr. BROTZMAN?

Mr. BROTZMAN. Just to understand your testimony, Mr. Mitchell, and I am referring now to your summary, specifically to points four and five in that summary testimony. You state, taking those two paragraphs together, that except in emergency circumstances you have to get the consent of the patient that you are treating or if you can't get that consent, because he or she might be disabled, then you should get the consent of next of kin, guardian, or others.

My question is this. It is my understanding that is presently the common law. I have always understood it to be thus.

I wonder if you are simply restating what your understanding of the common law is or if you think that there are violations of that particular legal standard. Do you understand my question?

Mr. MITCHELL. Yes. I do. Congressman Brotzman, it is not merely a matter of restating the obvious. The dreadful thing is that this kind of thing was not stated in terms of medicare and medicaid. We know some of the difficulties that patients have experienced because it was not stated.

Let me give you a specific illustration that I have personal knowledge about which suggests to me why this language must be mandatory.

A man entered a hospital in my own home city of Baltimore. He had injured his hand. He was a laborer. After being examined he overheard the physicians and nurses saying they are going to have to amputate two of his fingers. The man almost went berserk. He said, "How am I going to work? I am not going to let you do this."

There was such a confusion raised that eventually a senior physician came down and said, "Of course you are not going to amputate that man's fingers. Let us take some time to see if we can't work to save those fingers."

This was in the emergency room in a large urban hospital.

The press of business, the number of patients, this is the reason why the physicians would suggest a hasty amputation. The more senior physician intervening did save the man's fingers.

As a consequence he is now working, able to continue his laboring job.

Now, I think that illustration points out why I consider it mandatory—

Mr. BROTZMAN. Let us stop there just to save everybody's time. It goes back to what the gentleman from Massachusetts was asking. This is my understanding of the law currently and I think it goes back to what he said as to how that would be enforced in a stronger way than the law currently is.

This is what I am trying to find out.

Mr. MITCHELL. I must confess to you that I have not studied, planned the implementing mechanism sufficiently. Frankly, I intend to do so and will make a second submission to the members of the committee.

I would hope also to receive input from the members of the committee if they find this concept that I am advancing this morning acceptable.

Mr. BROTZMAN. Thank you very much.

Mr. BURKE. Thank you very much, Congressman Mitchell.

You have made an excellent contribution here today.

Without objection the summary of the testimony by Congressman Mitchell and the other items will be included in the record.

Mr. MITCHELL. Thank you very much.

Mr. BURKE. Thank you for your appearance.

(The summary referred to follows:)

SUMMARY

We must assure that all health care will provide for the primary benefit of those in need. All individuals who may need health care must be guaranteed certain rights. These guarantees, should be expressed by the Congress within the very legislation that will establish universal health care entitlement.

Thus far, none of the plans introduced by my colleagues has a statement of the rights of the patient.

Any law establishing a system of national health insurance must carry a clear statement of the rights and protections such a system will provide for all citizens in America.

It is imperative that all health personnel know what is expected of them under national health insurance, just as it is imperative for all citizens to know what kinds of service they are entitled to.

Unless the people of America, all the people, rich, poor, male, female, Black, white, red, yellow or brown, feel that this program is in effect for them, that it respects their rights, that it seeks to preserve their health and human dignity—unless this idea is put across, the great dream of national health insurance will be viewed with skepticism, cynicism and distrust.

There are ten points that should be embodied in a Health Bill of Rights. They are:

1. Every resident of the United States has a right to the best health care available without regard to his or her race, religion, color, national origin, or ability to pay.

2. Neither a patient's age nor sex shall be used for discriminatory purposes in the provision of care, nor shall certain age or sex groups be used for experimentation without full medical justification and informed consent.

3. Health care, including medical assistance, shall in no way violate the constitutional guarantee of privacy and of protection against self-incrimination; these rights shall prevail during examination, diagnosis, and treatment and shall govern the maintenance of all health records, verbal or recorded.

4. Except under emergency circumstances, each patient must be informed of the treatment he is to receive, of the persons who will provide that treatment, of the nature of the treatment (whether it is generally accepted procedure or

experimental), and the anticipated risks and benefits of such treatment to the extent they are known. The patient has the right to give or withhold consent to treatment.

5. Where an individual patient cannot give informed consent to recommended treatment because of medical disability, language barrier, or condition of confinement, such consent must be sought from next of kin, guardians, or others who would assume responsibility for the patient's legal and moral rights.

6. The relationship between the patient and the provider of care shall be free of any representatives of enforcement, investigative, financial, religious, or social agencies, except as specifically requested or approved by the informed patient and without duress.

7. No person in need of medical assistance may be turned away or otherwise abandoned by any individual or organization, public or private, capable of providing such assistance. This shall not be construed to be in conflict with the principles of informed consent.

8. All persons have the right to advocate and work for change in the provision of health care: such activity shall not be used to deny any person access to care at any time of need or the protection of all rights and guarantees.

9. Every person has a right to all information of a public nature which indicates the adequacy, efficacy, and economy of health care provided directly or through third parties by local, county, and state, regional, and national agencies.

10. Health care in the United States is and shall be organized to benefit the general public; hence, all policy-making bodies of institutions, organizations, or agencies devoted to health care and which draw support in any form from public revenues shall have a majority representation from the general public.

Mr. BURKE. Our next witness is a distinguished Member of the Congress, William R. Roy, Member of Congress from the State of Kansas.

We welcome you to the committee, Congressman Roy.

You may proceed with your testimony.

STATEMENT OF HON. WILLIAM R. ROY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Dr. Roy. Thank you, Mr. Chairman and my distinguished colleagues. I would like to submit a statement and then with your permission speak extemporaneously for a few minutes.

Mr. BURKE. You may summarize it and your statement will appear in the record.

(The statement referred to follows:)

STATEMENT OF HON. WILLIAM R. ROY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. Chairman, let me say before I begin, that the matter of National Health Insurance and national health care policy is extremely important from all three perspectives. There is no area of human life more important to an individual than his health, and there can be no area of policy of greater importance to a nation than the health of all of its people.

PEOPLE OF NORTHEAST KANSAS

The people of Northeast Kansas have two major concerns with respect to health care: the first is availability of care, the second is the cost of care.

Availability.—The major single problem with health care in Northeast Kansas is the shortage of health care. Given the current delivery system, the best indicator of the availability of health care services for any population is its physician/population ratio. The national figure is 141 physicians per 100,000 population. This is the ratio cited by a Surgeon General as necessary to protect the health of the people. But the ratio for all Kansans is little more than two-thirds of the national average. Since relatively large numbers of these physicians are clustered in the Kansas City and Wichita areas, in my district, the ratio

is 77/100,000, or about one-half of the national average. Further, many of the physicians are located in Topeka, a city of 135,000. For this reason, the more rural areas of my district have physician/population ratios of only 50/100,000, or one-third of the national average. The situation in my district is by no means unique in rural America. In Arkansas, the physician/population ratio is 81/100,000, in South Dakota 81/100,000 and in Wyoming 96/100,000. The greatest need, then, for the people of my district, and for all rural America, is for health care itself.

Costs.—A second problem with health care in Northeast Kansas is its cost. The cost of health care is becoming, or has become, more than many people can afford.

The cost of health care to the individual Kansan reflects the national trend. It is high and is rapidly increasing. The average per family expenditure for health care in Kansas is \$1,050. The potential costs for prolonged illness are staggering. Hospital costs in Kansas now average \$79 per day, and extended care facility averages \$26 per day. Even limited hospitalization at this rate threatens the economic security of all but our most affluent citizens. And these costs—high as they are—are expected to increase even more in the future. Blue Cross rates have increased by 98.8 per cent in the past four years, and hospitalization rates are up approximately 16 per cent per year over that period. Projections to 1975 indicate a possible Blue Cross increase of 45 percent, a Blue Shield increase of 20.6 percent, and hospital charges of \$120 per day.

The costs of health care that an individual bears as a taxpayer in Kansas are also high. In fiscal year 1971, the Kansas Medicaid budget equals \$42.5 million. The projected figure for fiscal year 1972 is \$52.9 million. The 1972 figure represents an increase of 46 percent in the Medicaid budget in three years. Medical care now totals almost 40% of the benefits budget of the Kansas Department of Social Welfare.

PHYSICIANS

The physicians of Kansas are also concerned about the state of health care in Kansas. Their concerns, which reflect their continual day-to-day commitment to the health of Kansans, are primarily for the quality of care. Physicians are well aware of the problems of availability and the cost of care, but because of their unique vantage point, they are even more concerned with the quality of care provided.

Physicians are committed to providing health care of the highest quality. They, above all, seek to provide care that is biomedically sophisticated and humanely responsive. But physicians know that the quality of care provided today is not always optimal. They know about studies and medical audits which indicate variances in frequency of treatment modalities and deficiencies in the efficacy of care. They are aware of patient complaints about cold—sometimes uncaring—institutions and facilities. But physicians understand that there are basic deficiencies in our health care system which lead to the decreased quality of care. These include the length of the workweek with its residual effect on the continuing education and general life of the physician, bureaucratic requirements which decrease the amount of time available for direct delivery of care, and the omnipresent threat of a malpractice suit.

1. The Work Week.—Various studies have indicated that physicians in the United States average between 60 and 70, or even more, hours of work per week. In some areas, this may greatly increase to the point that some physicians are on call literally 14 to 16 hours a day, seven days a week, every day they are in town. In such instance, the effects of these extreme hours are two-fold. First, perhaps of greatest concern to the doctor is his education. Knowledgeable observers have indicated that the half-life of knowledge in the medical field is as brief as five years. In such case, the physician knows that if he is to provide his patients with the latest, most sophisticated scientific care, he must continually read, continually concern himself with what has been only recently discovered, learned, proven. The length of a physician's work week makes it difficult for him to spend adequate numbers of hours studying difficult and complex biomedical problems. Today the physician is often frustrated because of his lack of ability to provide care of the highest scientific nature. The second problem with the length of the work week, often ignored by altruistic physicians, is the deterioration of his personal life. It has been demonstrated by sociologists and other students of the area, that physicians are affected by high rates of suicide,

narcotic addiction, and divorce. These often result from the physician's willingness to subordinate himself to his commitment to his patients. This problem, in turn, affects the quality of care provided, since an individual, unable to spend the amount of time necessary to insure his own personal life, can only lose that most priceless ingredient of the physician-patient relationship—warmth and humanness.

2. Bureaucratic Requirements.—In recent years, the administrative tasks required of a physician have significantly increased. The filling out of forms, the completion of records, the signing of reports have all increased to the extent that they now take a significant part of a physician's time. While this administrative detail has been developed, certainly with good intentions for cost and quality control, it is clear that the highly trained and committed physician now spends many hours per week doing paperwork. This is time which might well be better spent providing care to patients; hours so taken from the treatment of patients must surely decrease the total quality of the care provided by a physician and his colleagues.

3. Malpractice.—In recent years, the increased frequency of, and publicity given to, malpractice suits has come to threaten every physician. The effects of this threat are two-fold. The first is, of course, financial. In recent years, the costs of malpractice insurance has skyrocketed. In some states, the increase has been more than 200% in a period as brief as three years. For example, in the State of Kansas, the costs of malpractice insurance today average \$779 for a general surgeon. A second effect of the threat of malpractice suits is perhaps more subtle, but perhaps even more important; it is, psychological. For today, in a society which is already sadly lacking in trusting relationships, the physician can no longer be merely concerned with the best care for his patient; he must also be concerned about protecting himself, insuring himself, against the threat of malpractice suit. This protection is reflected by defensive medicine; the increased use of tests and other treatment modalities perhaps not always necessary for optimal patient care. This threat is also responsible for a decrease in the warmth and intensity of the relationship between a physician and an unknown patient.

CONGRESSMAN

As a Congressman, I am concerned about the three basic areas previously discussed—availability of care, cost of care, and quality of care. But as a Congressman, my view is somewhat more national in scope. For while the problems of my constituents and my former peers are of primary importance to me, the problems of all Americans must also be my concern. In this case, the three problems previously considered are seen in the following terms:

Availability of Care.—While the problem of availability of care in rural areas is indisputable, the problem of availability, in national terms, is also great. For not only is care unavailable in rural areas, it is also unavailable in many urban inner-city areas; and even in more affluent areas, related problems of accessibility and continuity of health care arise. If we look at inner-city areas we find, for instance, areas of South Chicago, the South Bronx, East Los Angeles, and areas of other major cities where the people must travel up to two hours, by public transportation, to receive care. Physician/population ratios in these areas are often less than one-quarter of the national average. And beyond the problem of availability of care is the problem of accessibility, that is, the availability of health care resources to individuals in the community. For even where health care personnel and facilities exist, they may be so poorly located and managed that those who need the services are, in fact, unable to utilize them. An additional problem is that of continuity. Care may be available and accessible, but over a period of time, discontinuous. Individuals seeking health care may not be treated as a single person with continuing or a variety of health problems, but may be reduced by the system to a mere multiplicity of health problems, each one unrelated to any previous or simultaneous other.

Escalating Costs.—Perhaps in the area of escalating costs, the experience of my constituents is most representative of the National experience. Costs of health care are high and are rising for all Americans. The major additional point which occurs to a Congressman is the effect of the increase of cost on the Federal government. The cost, for instance, of hospital insurance for Medicare beneficiaries for fiscal year 1971 increased from an initial 1965 estimate of \$2.9 bil-

lion, to an actual 1971 figure of \$5.5 billion. As you are as aware as I, the hospital, or Part A, trust fund for Medicare has now a 25-year estimated deficit of \$242 billion.

Quality of Care.—The problem of quality of care, as seen by a Congressman, is basically the same as seen by a physician. Peer review studies and medical audits indicate serious deficiencies in the quality of care in some instances in some areas, and tendencies in the system which leave physicians burdened with too much work, hassled with bureaucratic requirements, and threatened by malpractice suits must concern us all.

SOLUTIONS—GENERAL PRINCIPLES

If these are the problems, then, as they occur to the people of Northeast Kansas, to the physicians of Kansas, and to a Congressman, what sorts of legislation may be proposed. In this consideration of solution, three factors are of overriding importance. These are:

1. The legislation must be truly solution oriented; 2) The legislation must be complex in nature; 3) The legislation must be evolutionary in format.

1. Solution Oriented.—In developing a solution to the problems described above, those problems which generally are considered to be the components of the "health care crisis," it is clear that the Congress must, at last, deal in terms of real solutions. For too long we have been told that we have no problem, or that the problems are small, or that the solutions are easy. It is clear that these facts are not so. There is a crisis; care is not universally available; care is expensive, even unaffordable; the quality of care varies. Congressional action in the health area must now, at last, be definitive. It must recognize the serious nature of these problems and truly seek to solve them.

2. Complexity.—While realizing that the problems are real, are serious, and must be solved, it must also be realized that the problems are complex and that no simple solution, no single approach, can solve them all. The factors involved in a solution must deal with all of the components of the health care system—manpower, facilities, knowledge, financing, and organization. Solutions must involve major changes, major improvements in all of these five areas.

3. Evolution.—In addition to being complex, a resolution of the crisis, the solutions to the problems must be evolutionary. That is, it must build on the strength of the present system, it must seek to resolve problems within the present system. The expense and the social dislocation of a non-evolutionary program might well be greater than even a continuation of the present crisis.

SOLUTIONS—SPECIFIC DETAILS

In developing a solution to these problems—to the problems of availability, cost and quality of care—the role of National Health Insurance is important. For as classical capitalist economy theory explains, the importance of financing is primary. With funds, many things become at least possible. Without funds, very little at all can be accomplished.

Any National Health Insurance legislation should seek, above all, to deal directly with and solve the problems best addressed by any financing proposal. It should also address indirectly problems best addressed by manpower and re-organization of the system legislation.

The two areas best addressed directly by financing legislation are the problems of cost to the individual consumer of health care, and the problems of inflation in the health care system.

First, in dealing with the problems of cost, the problem most easily approached directly by a financing proposal, it is important that National Health Insurance legislation deal, at a minimum, with the two major cost problems in the American health care system today. The first problem is the need for basic, or first dollar, financing by America's poor. This sort of financing should not be limited to those who may be categorically related, or those who are totally without employment, but should be broad and general oriented so that all of America's poor and working poor will no longer have health care denied to them because of its cost. Also, National Health Insurance should finance benefits as comprehensive as those available for other Americans; National Health Insurance should in no case offer cheap, second-class benefits to the poor. The second cost problem that financing proposals should address is the need of all Americans to be protected against catastrophic costs of health care. All America's people

should now be protected against high costs of prolonged hospital and physician care. Again, this coverage should be comprehensive, widespread and limited in no way; it should, in fact protect all the American people. A second area of direct concern to the structuring of National Health Insurance legislation is that it should, in fact, stop—or at a minimum prevent further—inflation in the health care system. This means that, on the one hand, it will need to have cost controls as an integral part of its structure, and on the other hand, it must contribute to an increasingly efficient health care delivery system in the United States. This leads us then to the second area of discussion.

A financing proposal must reinforce and indirectly support changes and improvements in the health care system which are the primary concern of other legislation. Of major importance is recent legislation in the manpower area. Also of importance is legislation supporting the development of Health Maintenance Organizations. The National Health Insurance program must reinforce all the provisions of these programs. Specific techniques might include additional funds for providers serving in underserved areas, provision for funds for new types of health personnel, and the easy provision of funds on a prepayment or capitation basis.

Beyond solving the above described problems, National Health Insurance legislation should not create new problems, or at the very minimum, should create as few new problems as possible. In this regard, three major factors are important.

1. *Consumer Free Choice.*—It is clear that the American consumer functions better in any system in which he is given a choice of goods or services. In the health care area, this now means the choice of a number of different physicians and hospitals. In the future, it may mean a choice between different health care delivery systems, or in certain areas, a choice among physicians within a single health care delivery system. The factor of choice and ability to change, however, must be preserved.

2. *Administration.*—Complicated administration, expensive administration, should be avoided. This is especially relevant to questions of physicians and other providers currently in short supply and who are harassed by present bureaucratic requirements.

3. *Decentralization.*—National Health Insurance should be structured in a way so that citizens and providers can determine and control their own part of the health care system. Decentralization which allows any specific locality to make changes easily, will increase enthusiasm for the day-to-day operations of the entire system by the people who, of course, all live and will receive care in local situations.

CONCLUSION

In conclusion, then, Mr. Chairman, let me thank you for hearing my testimony today. The 92nd Congress will consider no more important a matter than National Health Insurance.

Dr. Roy. Thank you, Mr. Chairman.

As you know, I represent the 2d district of Kansas. I am one of the four physicians in Congress. My association with private practice goes back about 15 years. I am a former president of my county medical society. I was a vice speaker of the house of delegates of the State society and, chairman of one of five commissions, the commission on education, at the time of my election.

Due to the consideration of the 15 majority members of this committee I have the good fortune of serving on the Interstate and Foreign Commerce Committee on the Subcommittee on Public Health and Environment. This gives me, I think, a singular perspective on health care and health care legislation.

I have reviewed some of the statements previously made during these hearings, including statements by the AMA, by the American College of Obstetricians and Gynecologists, by Dr. Hall and by Mr. Fraser.

I can agree with many of the things said.

For example, we took our subcommittee to Topeka, Kans., last spring. As Mr. Fraser related with regard to his hearings on health

care, we had more people than we could possibly handle who wanted to make statements regarding the health manpower situation in north-east Kansas.

I have had an opportunity to study, since I have been in Congress, the health care legislation which has previously been passed. Of course, I have had some personal experiences with medicare, medicaid, comprehensive health planning and regional health programs.

I have also been aware of the health legislation proposed and of the hearings you have been holding for the past 5 weeks. I congratulate you for your diligence and industry and I wish you wisdom since I consider national health insurance to be one of the two or three most important domestic issues to be considered by the 92d Congress.

As I have viewed all this I have had many questions about the model that we are trying to establish. Where are we going? What is health care going to look like in 1980 or 1990? I do not have an answer for that. I don't think I can give you a model or make any specific prediction in this area.

I do feel that we are in a state of becoming, as far as health care and health legislation. I do feel we are looking at a decade or more perhaps of important health care legislation. But I think even after this we will probably need to continue to be in a state of becoming, because we have such great changes in our society and such great changes culturally that I think we would make a great error if we cast any particular health care system in concrete.

I feel strongly we should use the components of the present health care system. As we sort these things out I think there are three areas in which we are going to have to achieve a considerable amount of improvement if we are going to do that which we wish to do: bring quality health care to all Americans at a price that they can afford to pay.

The first thing we have to do is to remove payment as a barrier to receiving health care. That is, of course, the primary consideration before this committee at the present time.

There are many considerations which I am not an expert about, for example, whether we have regressive or progressive taxation, which taxes indeed are regressive or progressive, whether we have tripartite financing and so on. But I know there are people, as you know there are people, who do not receive health care because they do not have the \$10 necessary to purchase health care at a particular time.

The second thing we are going to have to do, and I think we made a great step forward with the President's signing the Health Manpower Act of 1971, is increase the number of health care personnel. I think it behooves all of us to be certain that we get adequate appropriations for this act which has recently been passed and signed into law. I think we are also going to have to be very careful to oversee HEW and be sure they spend the money in the manner in which the Congress intends.

But we can have personnel and we can have the ability to pay and we are still not going to get the job done. We have to reorganize our health care delivery system. It is not enough for people to have money if physicians and other health care personnel are not available in their

area. It is not enough for the Nation to have enough personnel if these personnel are maldistributed and cannot be reached by individual patients.

So, committee, with the help of the administration, and I would congratulate this administration for its white paper and for the way it has focused on health care, is looking at the health maintenance organization as a means of changing the health care delivery system.

What we have right now is basically a fee for service indemnity insurance system. What we may have if we continue to have inadequate legislation, if we continue to make promises that are not fulfilled, is a national health service.

Now we have no bill before us which would establish what I would call a national health service. I think this bespeaks the wisdom of the Members of the Senate and House in not placing such a bill in the hopper. But, I do feel there is a definite threat that if we do not change the system so that we have available accessible health care personnel and continuity of health care, that we may well go to a national health service. I do not feel this would be in the best interest of patients or those who provide care or for the Nation as a whole.

Now the things that we would like to do of course, in addition to insuring availability, accessibility, and continuity of care are monitoring quality and control costs.

We have various programs such as the foundation program in Stockton, Calif., where physicians have been enthusiastic and have done a great job of monitoring quality.

We know it can be done. I think we would like to see such programs adopted all across the Nation.

People have to have the ability to pay for health care, and I think we would like comprehensive benefits under any program. I would like to particularly stress the comprehensiveness of benefits. I think you gentlemen are all aware of the fact that the average cost of health care for our senior citizens is now about \$791 per citizen and that they are now paying about \$226 out of their own pocket when only a few years prior to the passage of medicare they were paying approximately the same amount and in 1965 they were paying \$400 out of their own pocket.

But the second thing about comprehensiveness of benefits is the matter of cost control. We have had great increases in cost for many reasons, but one of these reasons has been the impetus to put the patients in the general, acute hospital. I have gone through this many times personally with patients. In their words, "Doctor, my insurance will not cover anything you do unless I am in the hospital." There is a great temptation, particularly if you know that they may say this or that perhaps their financial condition is such that they are tempted into saying, "Well, I just won't have these last tests unless you hospitalize me." We often run into that situation as practicing physicians.

At the other end we see people ready to go home and if Aunt Suzy cannot get there on Friday we keep the patient in the hospital until Monday. You know this is very expensive and very extravagant. I feel comprehensive benefits are extremely important to control costs.

I again congratulate you on your hearings, I wish you well as far as

the bill that you write. Of course, then the wisdom of the rest of us will come into operation as far as approving or disproving your bill. I hope you are not in a position that physicians sometimes find themselves in, of having an operation that is a success but the patient dies.

I feel this is critical legislation in the sense that we are making a great promise to the American people. If we are going to insure that our people have the ability to pay, we are going to have to provide the proper distribution, availability, accessibility, continuity of health care, and we are going to have to provide adequate health personnel to meet the needs of our people. I think there is no greater national responsibility than to provide for the health of the people of our country.

I am extremely pleased that we are moving in that direction.

If there are any questions, Mr. Chairman, I will be glad to answer them.

MR. BURKE. On behalf of the committee, I wish to thank you for your appearance and your statement. The committee recognizes that you are eminently qualified to discuss this subject.

As for the action of the 15 members on the Democratic side, putting you on the Interstate and Foreign Commerce Committee, that was done because of your expertise in this field.

Now, I would like to ask you if you would like to make an observation on what can be done about the doctor shortage and the health care shortage that exists in some of our urban areas, particularly in the ghetto areas of the country and in the rural areas throughout the country.

There are statements indicating that there is at least a shortage of 50,000 doctors here in the country and there is a great need for additional health care in many of the rural communities of the country.

Dr. Roy. We have several choices in that regard.

We have an Emergency Health Personnel Act, which is only a short step and I would not pretend that it will meet the need, whereby public health service physicians can be assigned to the greatly underserved rural or inner city areas. As I said, this is a small step.

The second approach, of course, is to increase the number of our health personnel over the period of the next few years.

Additionally, the Health Manpower Training Act encourages the training of family physicians. We also provided economic incentives through forgiveness of indebtedness for people to go into these areas. Although I don't have great faith in this program.

I don't think any of these will be enough. At the extreme, of course, there is a situation similar to what I think Senator Stennis said about a volunteer army. We will have a volunteer army when we draft them.

I think the health maintenance organizations hold some hope of putting physicians into the underserved areas. I especially feel if our medical schools will stress service as much as they have stressed teaching and research, that the medical schools which are many times located in the inner city areas, many times available to underserved rural areas, can develop what we would call satellite HMO's. In other words, we can use HMO's to put physicians and other health care personnel into these areas. I think this is the most hopeful solution I see at the moment.

Now, with reference to the inner city areas, the health maintenance organizations will have great problems because of the inability of many people, especially those who do not qualify for medicare but are still among the medically indigent, to afford the dues. So, I think if we slip some type of national health insurance under this reorganization plan then we will give more promise of putting health care personnel in the inner city areas especially.

Those are several approaches, Mr. Chairman. I think all of them are important.

I don't want to make this too long an answer. I think there are basically two reasons doctors don't go out into the rural areas.

No. 1, within 6 months they are overworked. They have all the work they can do and the future holds nothing for them except a continuation of this 18-hour day or maybe even a 24-hour workday, unless they get out of town.

The second thing, of course, is the lack of professional association. Again, I can see medical schools placing instructors and assistant professors there for 2 or 3 years, along with some personnel in training. I think it is an excellent opportunity to again teach various types of health care personnel to work together in a real practice situation. I feel this is our greatest hope.

Mr. BURKE. Thank you.

Are there any questions? Mr. Betts?

Mr. BETTS. Doctor, I want to compliment you on your statement. I think it will be helpful to the committee. There is one statement you made I did not quite understand I would like to pursue it if I could. That is the question of cost control.

Did you get into the subject or intimate that possibly under present programs of medicare, medicaid, Government sponsored programs, that a lot of people are sent to hospitals who really don't need to be?

Dr. ROY. Mr. Betts, I wasn't making specific reference to medicare and medicaid. I think there are large numbers of people in our acute and general hospitals right now that do not need to be there, including medicare and medicaid patients.

There has been an increasing successful job of utilization review, but often there is no place to send these people.

To be honest, as you have heard many times, the extended care program has been a total disaster. I have been through this with patients and the retroactive decisions not to pay has really upset a lot of physicians and a lot of patients financially, emotionally, and otherwise.

But at the present time doctors are often not able to treat the patient where he can be most optimally treated because the payment mechanism which he has does not kick in at that particular point. Again doctors try to be honest in every way, but it is extremely difficult to send an 81 year old woman home from the hospital to her 85 year old husband over a weekend rather than wait until Monday when somebody else will come to help in the home.

Mr. BETTS. Would you say maybe we ought to give more attention to the program for care and treatment in the home?

Dr. ROY. Yes.

Mr. BETTS. I mention that because one of the witnesses here the other day, I think it was a doctor from Salt Lake City, head of the

clinic there, expressed the opinion that a great deal of the cost could be cut down if doctors could get some sort of reasonable reimbursement under these programs and an incentive to treat in the home rather than in the hospital.

Do you have any thoughts as to what incentive we might use to do that or do you think it is cheaper in the long run?

Dr. Roy. Yes; I think we could save expenses by having treatment, especially of our older people, in the home. For example, by weighing the patient daily we may pick up the warning that the patient is going to go into heart failure. By this alone, by discovering that he or she is retaining fluid, we may avoid a prolonged hospitalization.

There has been very little intention in the past to go into this. There has been some interest in the public health departments. I think it is a matter of organizing this, and having some grants available in order to train this type of person. You don't need highly skilled persons to go in there to be sure there is food in the refrigerator, that the person appears well, that the home is clean and that the surroundings are such that good health will be maintained.

Mr. BETTS. Take his temperature?

Dr. Roy. Take his temperature and things of this sort. I think a program in my district, a homemakers program at Kansas State University was a huge success. I am a little bit uncertain right now as to the funding situation. They brought in people, some without a high school education, and trained them as homemakers to go into the homes of senior citizens.

These people were being hired throughout the State. People were looking for more of them. I think this type of program must be encouraged.

Mr. BETTS. Thank you, Doctor.

Mr. BURKE. Mr. Brotzman?

Mr. BROTZMAN. Thank you, Mr. Chairman.

I would say, Doctor, your testimony has been most helpful to the committee.

Dr. Roy. Thank you.

Mr. BROTZMAN. I want to get to the point about the availability factor that you mentioned which I think probably is plaguing this committee as much as anything else, in fact, I would assume the whole Congress.

Before I came on this committee I happened to serve on the same one you do now, the Interstate and Foreign Commerce and served on the same subcommittee, and helped to draft legislation at that time which provided certain incentives to get doctors out into rural America and also into the core areas of our big cities by the forgiveness of a certain percentage of their student loans.

Obviously I don't think it is constitutional to pass a law that says that a doctor has to go to a certain specific spot because I think it would probably be involuntary servitude.

Dr. Roy. I have given that some thought. I think the only way to do it is to have them in the service.

Mr. BROTZMAN. There would have to be some kind of conscription under the guise of a national emergency, I believe, and then put them out.

Dr. ROY. And we don't want to do that.

Mr. BROTZMAN. No, absolutely not. I have been wanting to ask a doctor this question and it kind of gets back to this point, using your analogy relative to the all volunteer Army.

It seems that we need a lot of help from within the medical profession, itself. I like what you said about trying to give greater emphasis in medical schools to this thing called service. But we have to be pragmatic at the same time, because I imagine most medical students have sacrificed, their wives have sacrificed, to finally gain their sheep-skin and be admitted to practice.

So there are a lot of factors that are marshaling against going out to an "undesirable" area.

However, within this framework, I wondered if within the structure of the medical societies, if there has been much attention given to a voluntary type of agreement, with rotation of the type that we do have in the military, whereby you could get people who would serve for a period of time, perhaps a time certain, on a voluntary basis and then of course be free to go wherever they wished after that point.

That may be such an idealistic proposition that it may have no appeal at all but I have been thinking about it as I have listened to testimony here. Day after day we talk about the problem. But there really aren't any good answers presented yet that I have heard as to how we are going to solve it. Until we solve that one I think we have an awful big question about making whatever we do here actually functional and to deliver that health care to our American citizenry at a cost that they can afford as you have quite accurately stated.

Is there discussion of this type within the medical profession itself? Is there concern over it. Is there any progress?

Dr. ROY. First of all there is great concern because of the reasons that I stated. I really think this is a club whereby if we don't get this job we are going to see changes that will not be evolutionary but perhaps revolutionary so far as our health care system is concerned.

I think it is a matter of somebody having an arm on somebody. The medical schools have 20 percent of the physicians in the country under their umbrella, so this is the reason I mentioned the medical schools.

Now, a second group which could do this is the group practice or the medical foundation under some type of organized agreement. For example, an organization in Topeka, Kans., could arrange to provide care for a community 25 or 30 miles away. It could do this by having one or two physicians, one or two nurse clinicians, or nurse assistants in this area.

I think this is what we are going to have to see before we can get doctors in rural areas. We are going to have to see somebody who for some good reason, is willing to send somebody out into this area. This type of organizational structure provides the needed incentive.

Again we are going to find people who are going to want to live there for 30 years and practice there for 30 years. But in many places we are going to have to rotate personnel.

Mr. BROTZMAN. I think that is right.

I think if doctors got out to rural America and tasted local conditions and small community living a lot of them would want to stay there.

Dr. Roy. My personal observation is that a lot of dentists are now beginning to start new practices in small towns. They enjoy the living circumstances, their families like horses, clean fresh air, things of this sort, and they are going into rural areas to practice.

But a dentist can limit himself somewhat to an 8- or 10-hour day. He doesn't get the constant battering that a physician in a small town has from being on call 24 hours a day.

I agree with you that this is a very difficult area, the most difficult area as I see it. The difficulty is not making the ability to pay available to each American, it is not even training personnel. If we put enough money and effort in it, we can train personnel. Lots of people want to become doctors and nurses and paramedical personnel.

The greatest problems are availability of personnel, accessibility of those people to patients once they are available, and continuity of care.

Mr. BROTZMAN. I think you are right. I don't think there is a shortage of applicants to want to be a doctor or a paramedical personnel as you have correctly said.

Dr. Roy. I am enthusiastic about foundation programs. I am enthusiastic about prepaid group practice. I think these things have potential to go with assistance.

I am not locked in with any idea, I am not married, so to speak, to the details in even the singular idea of HMO's. But I think there is a necessity for one-stop shopping, that is one point at which an individual can get into the medical care system and thereafter be guaranteed medical care.

This is not only a matter of concern for poor people; I have seen people in other professions and people of middle class or even the so-called upper class who will go to one doctor who may be doing more things than he should be doing and so they are not really getting quality care. But they go because they know he is there.

In other words, they are not getting continuity of quality care. They are going where care is available, where care is handy because it is difficult at the present time to get into a system so that all of the scientific knowledge and ability which physicians and others have is brought to bear on the health of the individual.

Mr. BROTZMAN. To refresh my memory and then I will conclude, the bill we just passed, I think the President signed it, came out of your committee. How many doctors is that supposed to produce in the next, what is it, 3 years?

Dr. Roy. It will produce 50,000 additional physicians by 1980. I have no fear of an oversupply of physicians. I was disappointed that the President of AMA mentioned this possibility in his inaugural address last spring. I think again one salient fact that we are all aware of is that for the 11,000 or 12,000 physicians we produce in this country every year we are importing, so to speak, 5,500 foreign physicians.

I was shocked to read in the American College OB-GYN testimony that whereas formerly 92 percent of the physicians in gynecology in residence were educated in this country, today only 53 percent of the residents in this specialty field are educated in this country; 47 percent are imported to go into residency. You don't have to go to very many general hospitals to find out that they are just packed with

interns and residents from foreign nations and also American citizens of our own country who have gone to Guatalahara or elsewhere in order to get medical training.

Mr. BROTZMAN. Thank you very much.

Mr. BURKE. Mr. Gibbons?

Mr. GIBBONS. Thank you, Mr. Chairman.

Dr. Roy, I want to personally welcome you here and commend you for the care you have exercised on this legislation and all the other legislation I have had the pleasure of watching you support.

Dr. ROY. Thank you.

Mr. GIBBONS. Let me ask you some things about this. Apparently you feel that H.R. 22 goes too far too fast, is that right?

Dr. ROY. Yes, I think it locks us in right now to some details that may or may not be desirable. In other words, I think the stick and the carrot with respect to group practice is almost overwhelming.

I think monolithic is indeed a cliché, but when we have one office in Washington and 10 offices around the country prebudgeting all the health facilities it looks a little too revolutionary for my mind.

Mr. GIBBONS. Do you think that medical care ought to be free to everyone?

Dr. ROY. I think we should mandate that everybody has a means of paying for health care.

Now there are several alternatives in this area. For example, we can assure that everyone has a health insurance policy that is comprehensive as defined by the Congress. I think it is obvious to all that we are going to have to do a better job of paying for medical care for the poor and what we have termed the medically indigent than we are doing presently.

Mr. GIBBONS. We had a doctor in here the other day who was conducting a program in Miami. He said, as I recall his testimony, that free medical care did not promote overutilization in his program.

I would wonder, based upon your experience, do you think that if it were free it would promote overutilization?

Dr. ROY. I am not greatly concerned with overutilization of medical care. About 95 percent of the people I took care of leaned over backward to "not bother" me. Many times they even let their health get into bad shape before they called or before they came to be seen.

Five percent of the patients, who were usually at the extremes of the economic spectrum, either the very rich or the very poor, were inclined to overutilize. But it wasn't a great number.

I am not greatly concerned about the "worried well" swamping our system if everybody has the ability to pay. I could be incorrect but this has not been my personal experience.

Mr. GIBBONS. If everybody is in effect provided either with prepaid insurance or prepaid medical care who should finally set the cost of this program? Should we leave it to the providers to set the cost? Should Government interfere in some way? How should we do it?

Dr. ROY. I think the Government is going to have to interfere in some way as far as cost, especially as we put tax dollars into this. There are several ways of doing it. One of course is to require the delivery organizations, the hospital or group of physicians, whoever it may be, to present a plan indicating how they are going to control costs, review this plan for acceptability and then insure they do it.

Peer review, can also be very important in this regard by decreasing unnecessary utilization of hospitalization, tests and so forth by physicians, which occur and run up the cost.

We have to worry about overutilization but we also have to worry about something that I like to term—I did not originate it—suboptimization, especially as we get into cost incentives for not hospitalizing people. We may find that people are not hospitalized who need to be. A classic example of suboptimization as far as control of cost is concerned would be patients with strokes. Many stroke victims will drown in their own secretions in the first 24 hours and that certainly is the least costly way to take care of them. If they survive, the physical therapy and other care that follows is extremely costly. So I think we have to be alert for suboptimization. There is no question in my mind that health care personnel, physicians and others, are going to practice the highest standard of medicine that they can under the given circumstances.

Mr. GIBBONS. How do you go about setting the pay scale of a professional man when there is no restraint on what he can charge because no matter what he charges somebody is going to be able to pay it? How do you go about doing that?

Dr. ROY. I am somewhat attracted by the idea of capitation and prepayment. If a group of physicians, as foundation program or practicing as a group, guarantees care for a number of dollars per patient per year that is one way of controlling costs. Another way of controlling costs is by peer review. But this is somewhat difficult because often peer review is solely within an organization you may have some situations where foxes may be guarding the chicken coop. It is hard to tap one's peers on the shoulder and say, "Gee, you are a lousy doctor" or "You are a lousy Congressman" or "You are a lousy this or that." This is an extremely difficult thing to do.

Mr. GIBBONS. Let me ask you about capitation and tell you a little humorous incident that happened to me one time. It had nothing to do with medical care but maybe the analogy will help illustrate the point I am trying to make.

Years ago I was in the service. We were in an isolated place. We had to live on a food allowance. If we had real good planning we had neither feast nor famine but sometimes toward the end of the month when the per capitation allowance was running low we used to have something we called jam sandwiches. That was two pieces of bread just sort of stuck together with nothing between them except imagination.

And then other times we were trying to spend all the money at the end of the month and we ate every luxury food you could find.

Now, in a capitation system where you have hospitalization involved that is very expensive, and other things that are very expensive, when you start to run out of money toward the end of the year what do you do?

Dr. ROY. Let me divide that up. With respect to capitation I do not see the professional component of care joined with hospitalization. I don't think physician groups can take that kind of risk. We have had experience with this in Shawnee County, Kans. Back in the sixties the medical society contracted to take care of old age assistance beneficiaries for \$6.50 per month per individual.

As we did work we reported units, for old age assistance beneficiaries and the welfare patients. We also paid for drugs and we paid for hospitalization.

I think \$18 was the most I ever got for delivery and prenatal care because little money was left after paying hospitals and pharmacists their full fees. The hospital cost component is so big that I don't think we can saddle physician groups with the risk of hospitalization.

I do think we can prepay them for the professional component alone on a capitation basis.

Mr. GIBBONS. That is interesting.

I had not thought of it in that regard. You would have a per capita-tion fee for physician services, professional service so to speak?

Dr. ROY. Yes, but for HMC's; but we expect others, physicians and patients, to prefer fees for service and indemnity insurance.

Mr. GIBBONS. And then perhaps a per capitation fee that would involve the hospitalization?

Dr. ROY. H.R. 22, of course, goes to the prebudgeting in this regard. I don't believe that because you have capitation in the one case that you necessarily have to have it in the other. It could be a combination of approaches. There is no question that indemnity insurance programs which in the last few years have required certification of the delivery of care either by the hospital; the physician or others have had associated rapidly increasing costs.

Mr. GIBBONS. I don't really understand the per capitation system too well so let me ask you some questions about that.

In a capitation system would you run the risk of the professional man choosing a lot of easy cases and passing up the hard ones? How in a capitation system would the professional man be rewarded?

Dr. ROY. How would he be rewarded?

In a foundation he might be awarded on the basis of fee for service. In a foundation system you might have five specialists here, four internists, maybe a sole practitioner over there, and an ob-gyn specialist in another place. Each could be rewarded on a fee for service.

Whether that fee would come up to \$5 a point or \$10 a point would depend on utilization. This is the way it would work there.

With some groups, doctors are on salary presently. This could continue. In the Permanente Association, so far as Kaiser is concerned, they usually award bonuses in addition to salaries of physicians if certain efficiencies have occurred. There is an award system. There has always been a great question in my mind, and I can't answer it for you, how you reward an institution or a facility.

Do you reward it by making it bigger, letting it build extra beds, or adding more equipment? It is not an easy question.

It certainly can work as far as the professional component is concerned. I think this has been proved by the group health association groups. I think it has also been proved by the San Joaquin Foundation and the other foundations.

Mr. GIBBONS. You have to think in terms of analogy. I think in terms of my own law practice. If you took everybody in on a capitation basis you sure would be looking for the easy cases and avoiding those tough ones.

Dr. ROY. I did not address myself to that.

Mr. GIBBONS. How would you avoid that in the medical practice?

Dr. ROY. Again, as we look at health maintenance organizations which are prepaid groups or foundations there are several ways to do this.

One is the requirement that they take a cross section of the community. A second requirement is open enrollment, 30 days when anybody can become a part of this way of delivering care. But there are great problems with "skimming" and "skimping" as you set up organizations.

Anybody can take care of the middle class, well, and young much less expensively than they can take care of the economically deprived or older people. This is something we have to work on.

The skimping part of the thing goes back to what I was talking about as far as the stroke or not hospitalizing patients when they need it.

Mr. GIBBONS. Doctor, before I close, I want to say that I hope that over in your Interstate and Foreign Commerce Committee, in your work on trying to fund medical schools, you will find some way for the system to work better than it has in the past. I don't want to be partisan about it because it is not a partisan matter and I don't want it to be partisan matter, but in both Democrat and Republican administrations I have been trying to help to get a new medical school funded in my area. I tell you it is almost impossible.

The program does not work well. It has too many reviews and too many decisions by too many people and too little actual cash to ever get the job done.

It is ridiculous for us to sit here in this Congress and decry the shortage of doctors and to make it as difficult as it is to get a few million dollars for a medical school for which in my case the State of Florida has already put up its share of money.

The program doesn't work. Sometimes when you have some hearings over there on that subject I am going to come over and unload on you all the trials and tribulations I have found over a long period of time in trying to get money to build a medical school. It is terrible.

Dr. ROY. I am acutely aware of the lack of funds in this area. With my tunnel vision I always look with envy on the fact that we can build a C-5-A for \$58 million. We can build a good medical school for \$58 million any place, any day, but we can't seem to get hold of the \$58 million.

Mr. GIBBONS. You can't even get hold of \$7.5 million, much less \$58 million. I have never seen such a bunch of beartraps set up in getting Federal money for any other program.

Like most Members of Congress I have been involved in this process of trying to get money for things for my constituency but I have never run into the amount of trouble that you run into on medical school funding.

Dr. ROY. I will be discouraged or encouraged by what happens on the \$3 billion of appropriations that we are asking for health manpower in the next 3 years. I think this is critical as we look to the entire picture of health care. Health manpower is one of the three things we have to do that I mentioned earlier. I am sure that the people here have an awareness of this and that they will help in every

way that they can as far as getting the full appropriations made. Then we will do all we can to get them spent by HEW.

Mr. GIBBONS. The Veterans' Administration has a policy of building hospitals or their new hospitals as close to medical schools as possible.

I have the ridiculous situation in my district of having a \$22 million Veterans' Administration hospital that will open next year and for want of this \$7½ million from the Federal Government they can't get the medical school across the street off the ground.

Here we have one branch of government trying to carry forth a united program, one branch of government already having spent \$22 million, and the other part of the government still sitting on their hands and not being able to come up with a paltry sum of \$7½ million.

To use Mendel Rivers' phrase "it is so ridiculous it is ridiculous."

Mr. BURKE. Mr. Duncan will inquire.

Mr. DUNCAN. Thank you, Mr. Chairman.

Dr. Roy, how would you suggest that we go about training the additional allied medical manpower that you referred to a moment ago. Apparently there is great shortage in that field.

Dr. Roy. One thing is I think they have to be trained in association with other health professionals. Again, going back to the Health Manpower Training Act, we have written in the special grants section moneys whereby people may be trained together. Physician assistants, clinicians, nurses, and others are going to be a health care team and to be efficient they are going to have to be trained together.

Now I am not familiar at this time with the 1970 act which I dealt with the training of allied health personnel. I don't know how much money there is, whether it is being used properly. So I can't answer what is being done. I can stress the principle of training the health care personnel together.

Mr. DUNCAN. In some locations we find that some of the vocational schools are training technicians and practical nurses. What are your thoughts on that?

Dr. Roy. I think the training of health care personnel generally is a public responsibility. Again I think there are many good State programs for training LPN's and I think this is proper. Training should be a public responsibility, not a hospital responsibility whereby we have to add one or two dollars to the room charge in order to pay interns, one or two dollars to the room in order to have a nursing school and so on.

Mr. DUNCAN. Do you believe that the LPN's could be trained in some vocational schools or extended educational schools?

Dr. Roy. They cannot be trained in vocational school without affiliation with hospitals.

Mr. DUNCAN. I mean, with affiliation in the community.

Dr. Roy. Yes; I think they can be trained there. I think we are doing a good job in Kansas in this respect. So far as nurses, the so-called associate degree schools have done a good job. I think we are looking to the day that the diploma school is going to be phased out. We are going to have either baccalaureate degree or associate degree nurses with 2- and 4-year training programs that can be built on with respect to further academic degrees.

Mr. DUNCAN. What is your idea in a comprehensive health delivery program as to the continuation of the Veteran's Administration hospitals? Do you believe that should be continued separately?

Dr. Roy. I would look forward to the day that the Government is not involved in directly providing services for veterans. I don't think we provide direct services well. I look forward to the day we do not have public health service hospitals, of which there are now eight.

I would like to see veterans receive good or better treatment than now. But I would like to see it available in their communities.

Again there would be no barrier for them to pay and no barrier for others to pay, so there is no reason they should not be able to receive care elsewhere than the VA hospitals.

The VA hospitals are big; they have nearly 9,000 beds. It is a large budget. It is a program that has been well supported. Thank God, it has. It is a program I would see going for a decade or two or more as we make this transition in health care. The last thing I would want anybody to think is that we would cut the legs out from under the public health hospital recipients or the veterans until we have something else to offer.

By the same token, the hospitals should continue to be used. I am not speaking of abandoning a facility. I am speaking of a different method of delivery where we don't have to have special things for veterans because veterans or people who are analogous to veterans elsewhere in our society can't get care.

Mr. DUNCAN. Thank you.

Thank you, Mr. Chairman.

Mr. BURKE. Are there further questions?

Thank you very much, Dr. Roy, for your contribution here today.

Mr. DUNCAN. Mr. Chairman, could I have unanimous consent to insert a report from the Hamblen County, Tenn., Medical Association?

Mr. BURKE. Without objection, it will be included at this point in the record.

(The report referred to follows:)

C. H. HELMS, M.D., F.A.C.S.,
Morristown, Tenn., November 8, 1971.

Hon. JOHN J. DUNCAN,
House of Representatives,
Washington, D.C.

DEAR SIR: I have received the White Paper, "toward a comprehensive health policy for the 1971's." I have a few comments which might be pertinent that would not be heard otherwise.

This paper makes no attempt to analyze basic differences in the health behavior patterns of different races or different socioeconomic groups.

It has long been recognized, since the days of Hippocrates, that certain people living in certain areas are peculiarly susceptible to certain illnesses. A typical example of this would be the coal miners and the so-called black lung disease. There are, however, many other examples of this. To say that the poor and the racial minorities fair worse than their opposites, may appear on its face to be a severe criticism of our medical system. However, it should be realized that the poor and the racial minorities are subject to illnesses not commonly found in other groups. An example of this would be the incidence of cirrhosis of the liver among the Bowery population of New York City. Compare this to the incidence of cirrhosis, let us say, in a population in upper Manhattan. The alcoholic, who acquires cirrhosis because of living patterns, gradually dissociates

himself from the rest of society and sinks to a lower level in the economic structure. His behavior pattern precludes his return to a normal life unless the pattern itself is broken.

Moreover, various studies have shown that the poor constitutes not only an economic group but also a genetic group in our population. Some of the poor are rising along the economic ladder; in other areas, people who are not now poor are rapidly descending down the economic ladder. There remains, however, within that nebulous class of people, a genetic group who by centuries of inbreeding have made themselves peculiarly liable to a whole variety of diseases and disorders which do not occur normally at the higher socioeconomic levels. None of these elements has been clearly defined by medicine or by sociology, but the presence of such factors is well recognized by both groups.

By the same token, to select racial minorities on the basis of their skin color and say that they fair worse than their opposites may be an interesting fact but not necessarily a criticism of the present medical system. I am quite sure, that within any racial minority, you will find those who are well and who are fairing better than the average as well as their opposite who are fairing worse. Again, it depends upon a matter of environment, genetics, and living patterns as to how they will live and how healthy they will be.

This basic criticism of the White Paper may be extended to almost all areas in which indices are presented.

For example, our ranking is 13th in infant mortality rates which should be studied closely. This can only be interpreted in the light of genetic trends and chronic diseases of adults. It is a well known fact that infant mortality is more common in infants born of chronically ill parents than in infants born of well parents. In the United States, chronic illness is successfully managed in an overwhelming majority of cases; i.e., diabetes mellitus for one example. Children born to such adults will necessarily experience a higher mortality rate. No gross ranking of infant mortality can be used as a standard for criticizing the American care of neonates. Only if the causes of infant mortality are compared can a really intelligent analysis be performed. Also, the timing of infant mortality is an important factor.

The details of such timing are complex. The majority of incompleting pregnancies is thought to result from disorders in the germplasm of the fetus, or in problems of implantation. Some infants will be aborted at an early stage of pregnancy, some congenitally malformed infants will be born. Not all abnormalities are visible. Malformations in the chemical apparatus of the body can produce an infant with hyaline membrane disease, diabetes mellitus, hypothyroidism, and a host of other abnormalities which carry a very high rate of mortality in this age group. Probably the commonest cause of infant mortality is prematurity. In many nations, those infants which we are carrying through to a premature level, would have been aborted early in pregnancy. No account is made for such problems in stating that our ranking internationally as thirteenth in infant mortality rates.

Another criticism can be leveled at the statement that the average fees for general practitioners are lower than for the specialist. When a general practitioner sees sixty to seventy patients per day, he is unable to give them more than three or four minutes of his time. He charges \$5 to \$7 for this time. With a specialist, the consultation may require forty-five minutes to an hour, for which he may charge \$25. Is there really an inequity here, or is not the specialist giving more of his time for relatively less money.

My basic criticisms of the proposed structure offered by the Administration for handling health problems are twofold.

Granted that economics must be considered in applying standards for health control, I should hope that the primary standard for judging the adequacy of any program would be the quality of care that the patient obtains. It may be a purely qualitative criticism, but I do not believe that any system which is controlled by nonmedically trained people can provide the highest quality care. No matter how highly qualified a group of advisors, a man must have knowledge of his primary problem before he can form a valid decision. The picture given in the White Paper is that of a large medical bureaucracy under the control of individuals whose motivations are going to be largely political, rather than medical. I cannot believe that such a system, currently utilized in many other countries with far less beneficial results than our free system of medicine in the United States, can provide the same high level of medical care and developing medical technology as is being given to the country, today.

My second basic criticism of the system is that it is oriented toward sociological inequity rather than medical inequity. One example of this is the student assistance program which will provide aid to the disadvantaged, whoever they may be, but will deny the same aid to those who come from families who are paying the taxes to help the disadvantaged. By all means, let us help the disadvantaged student; however, the burden of education is just as great on the individual from the upper middle-class income bracket, and I can see no good reason why he should be discriminated against by this program. Again, no quality control for those students being selected for assistance under this program is provided. I do not necessarily believe that an individual will make a good doctor merely because he comes from an income bracket of \$5,000 a year or less. The system also fails to appreciate the natural economics of medicine in its current state. It is obviously more economically sound to have highly organized centers of medicine in a few areas of the country than to spend the same capital outlay to provide such centers all over the United States. It would be cheaper to provide transportation assistance to individuals into these centers, rather than to try to create such expensive centers throughout the United States. If it were economically feasible for a small town the size of Morristown, to support open heart surgery, renal transplantation, corneal grafts, and a host of other complicated procedures, I am sure there would be the physicians here now to provide these services.

In summary, I am unimpressed by this paper. Its composition is largely in terms of nebulous statements without the necessary detail to sustain the arguments. While many of its criticisms of the present national medical scene are sound and accurate, I believe that its interpretation of these stems from political rather than medical objectives. And, finally, the solution, if it can be called such, offered by the Administration will produce a form of medicine in the United States within the next half century, which will be sterile, because of lack of individual incentive; will practically preclude private medicine within twenty-five years, as it is rapidly doing on a similar basis in the Provinces of Canada; and will ultimately result in a large group of disinterested physicians who will be putting in eight-hour days, receiving their paycheck at the end of the week, without very much interest for their patients, their profession, or the state of medicine in general.

Respectfully,

C. H. HELMS, M.D.,

Secretary, Hamblen County Medical Society.

Mr. BURKE. Congressman Frank Thompson. Please come forward. We are most pleased to have you before the committee.

STATEMENT OF HON. FRANK THOMPSON, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. THOMPSON. Mr. Chairman, I am pleased to present this testimony in favor of H.R. 22, the legislation to establish a national health security program. I am gratified to note the extensive hearings which the committee has scheduled on the many bills designed to reform the health care system of our country. I am hopeful that these hearings will take us to the point where the committee can report a bill to address one of the most urgent problems facing our people.

I will not belabor the fact that our present health care system is inadequate, often frighteningly so. We spent almost 8 percent of our gross national income on health care, and as medical costs spiral, we are not, compared to other highly industrialized nations, enjoying high cities, but there is a town in Wyoming that has advertised unsuccessfully for a doctor for 6 years. Millions of Americans suffer days of hospitalization that could have been avoided by a proper system of early detection and prevention of disease. We need not more money, but money spent wisely, efficiently, and with an equal concern for all our citizens. We need, in short, a total revamping of our health care system.

Perhaps the outstanding feature of the Health Security Act, and the feature which most clearly distinguishes it from the other proposals for reform of our present health care system, is its comprehensive nature. I say comprehensive not only because health security covers all citizens and includes payments for almost all medical services, but because health security speaks to the need for reform in our total health care system. I think Senator Kennedy summed this up very neatly when in introducing the bill on the Senate floor, he stated, "the basic principle of the health security program is two-fold: To establish a system of comprehensive national health insurance for the United States, capable of bringing the same high quality health care to every resident: and, to use the program to bring about major improvements in the organization and delivery of health care in the Nation."

A brief description of the bill makes this clear. Starting July 1, 1973, every individual residing in the United States will be eligible to receive benefits under the health security program. There will be no requirements of past individual contributions, as in Social Security, and no means test, as in medicaid. Within certain limits, the benefits available under the program will cover the entire range of personal health care services, including the prevention and detection of disease, the care and treatment of illness, and medical rehabilitation. There are no cutoff dates, no coinsurance, no deductibles, and no waiting periods. Benefits will be paid for a full range of physicians' services, including surgery if furnished by a specialist on referral. All necessary hospital services will be covered without limit, including pathology and radiology. Skilled nursing home care will be covered up to 120 days. Coverage for dental services will be limited initially to those under age 15, but after a period of time, eligibility will expand until all persons are covered. Certain psychiatric services will not be covered nor will prescription medicines unless provided through a hospital or organized patient care program. I should emphasize again, however, that the health security plan will pay for almost all health services without cost limits, in accordance with medical need. An additional benefit to those receiving medical attention will be that health security will make all payments directly to the provider of health care; the patient will not be billed for covered services. Hospital and other institutional providers will be paid on the basis of approved prospective budgets. Group health organizations, which will be encouraged under this plan, may be paid by capitation, or by other appropriate methods. Independent practitioners may be paid on a fee for service basis, as most are now, by capitation, or by other means.

To finance such a comprehensive program, a health security trust fund will be established, and money for the fund will be raised as follows: 50 percent from Federal general tax revenues, 36 percent from a 3.5 percent tax on employer payrolls, 12 percent from a 1 percent tax on wages and unearned income up to \$15,000 per year and 2 percent from a 2.5 percent tax on the income of the self-employed up to \$15,000 per year. It is important to stress here that the system will predate on a yearly budget, which will constitute the main cost control feature of the entire mechanism, and, just as significantly, will apply the brakes to our soaring health costs. Such a budget will encourage

efficiency and planning, areas neglected in our present system. It will promote preventive care and the use of out-patient facilities rather than expensive, long term hospitalization.

The health security board will administer the program under the authority of the Secretary of Health, Education, and Welfare. Through the 10 existing HEW regions, and further through local regions, the Board will set policy and budget funds based on the needs of the individual regions.

The health security program is not only a method for paying for health care needs, but it is a program for upgrading the total health care system. To modernize the system, we must encourage the organization of health services involving teams of professional, technical and supporting personnel. An essential feature of our program then is the Resources Development Fund. Operating on money set aside from the trust fund, approximately \$2 billion a year will be available for resources development. The funds will be used to support innovative health programs in manpower, education, group practice development and other areas. The fund may provide substantial grants to comprehensive prepaid group practice plans; it will help to develop the availability of medical assistance in certain areas now without adequate service. It will provide special financial incentives for modern methods of organizing health care. Of the many bills being considered by this committee, only health security establishes such a wide ranging grant program for upgrading health care.

Another area upon which health security will have a major impact is quality control. The fact that there are wide variations in the quality of health care throughout the country is well documented. Health security will establish national standards for participation by both individuals and institutional providers. National standards will be set for professional personnel licensed after the program begins: hospitals, skilled nursing homes, and group practice programs will be eligible to participate if they meet established national standards. With the higher standards of health care, and the increase of services, there will naturally be the demand for an adequate supply of properly trained men and women for health care. The health security funds will subsidize training and utilization of new types of personnel, and to expand training facilities for the total range of health professionals: doctors, nurses, physicians' assistants, dental hygienists, etc. Grants and special stipends will encourage cooperative use of personnel in short supply and will be keyed to low income areas.

The attempt to reconstruct America's health care system must not involve only those who provide the services, but those who receive them. Health security recognizes this: a national advisory council, which will assist the board in policy development and budgeting will be comprised of both health service providers and consumers of health care; nor does the Health Security Act neglect local citizen participation in the program; section 126 of the act stipulates the establishment of local advisory councils, and consumers of services must constitute a majority of each council. These councils will function in an advisory capacity relating to the administration of the program in the local area; and it will have a prime responsibility in the handling of complaints. I think the bill is very clear in its commitment to make the health care system community oriented.

The cost of health security for this country has been the subject of considerable dispute and misunderstanding. I don't deny that it will require enormous amounts of money to bring our health care system into the 20th century. For example, in fiscal year 1970, the benefits provided under the program would have totaled \$41 billion. Yet this money is not new money; it was money already spent, often inefficiently, by individuals' employers and governments for health care. Under health security, such expenditures would be redistributed, with a heavier burden falling to the Government.

It is also true that the other bills being considered by this committee would cost the Government less than health security. Yet, while they save money for the Government, each perpetuates the pernicious dual health care system that presently burdens our country. Reduced to its most simple form, this is a system that provides good health services for those who can afford them, and inadequate service for those who can't. H.R. 22 is the only proposal that provides care on the basis of need, rather than on one's ability to pay.

In calculating costs, one should, of course, keep in mind the hidden costs of not changing our present system; costs in inflation which is moving this country to spend, according to Federal estimates, \$156 billion for health care in 1980; costs in misery for families financially ruined by catastrophic illnesses and hospitalization; costs due to the glaringly unjust distribution of medical services in this country, costs which weigh heaviest on those who can afford it least.

Certainly health security will increase the demand for services; the alternatives to health security, which all maintain the barriers to utilization of services such as deductibles and coinsurance features, will continue to prevent low-income families from using services. Yet these are precisely the families that must be included in a comprehensive health care system. By revitalizing health care through health security, by encouraging economies of scale, by rewarding cooperation and community involvement in health care, by preventing illness and increasing the number of well, productive citizens, we will more than offset the cost of increased services. And we will build a national system of health security that will begin to bring adequate and reliable care to everyone in our Nation. Thank you.

Mr. BURKE. Thank you for your interesting statement. We appreciate your being with us.

Our next witness is the Honorable William E. Minshall, our colleague from the State of Ohio. Come forward, Mr. Minshall and proceed as you will.

STATEMENT OF HON. WILLIAM E. MINSHALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. MINSHALL. Mr. Chairman, as a cosponsor of the Fulton bill, H.R. 4960, I urge the committee to give medicredit your most serious consideration.

In my opinion this legislation offers the most coverage to the American people, with particular emphasis on those incapable of providing for themselves, while retaining the virtues of free choice in the best of our Nation's traditions. The medicredit system provides an attractive, practical method of meeting the Nation's health needs without jeop-

ardizing quality health care or placing a bankrupting strain on the Federal budget.

At this point in the record I would like to submit the following analysis of H.R. 4960, the medicredit proposal.

Mr. BURKE. Without objection it will be included in the record at this point.

(The material referred to follows:)

HEALTH CARE INSURANCE ACT OF 1971 (MEDICREDIT)
A PROPOSAL FOR FEDERAL FINANCING OF HEALTH INSURANCE

Medicredit would: (1) pay the full cost of health insurance for those *too poor* to buy their own, (2) help those who can afford to *pay a part*—if not all—of their health insurance premium. The less they can afford to pay, the more the government would help out, (3) see to it that no American would have to bankrupt himself because of long-lasting, catastrophic illness.

(This bill addresses itself only to *financing* health care; other legislation and programs involve medical manpower supply and distribution, the method of delivering care, and other problems such as environment, health education, and peer review.)

ANALYSIS

Federal Contribution

The Government would pay 100% of the premium for low-income beneficiaries (an individual and his dependents whose combined income for a taxable year would not give rise to any income tax liability). For others, the Government would provide scaled participation ranging between 97.5% and 10%, favoring lower-income persons, in the payment of premiums for basic coverage, and would pay in full the premium for catastrophic expense coverage. A table of allowable percentages for related income tax liabilities is included in the bill.

The extent of participation would be determined with reference to federal income tax liability of an individual in a particular year (base year). A health care insurance policy, qualified under this program, would run for a 12-month period beginning in the year following (benefit year).

Health Insurance Certificates; Income Tax Credits

A beneficiary eligible for full payment of premium by the Federal Government would be entitled to a certificate acceptable by carriers for health care insurance for himself and his dependents. Eligible beneficiaries with whom the Government would be sharing the cost of premium could elect between a credit against income tax or a certificate. The carrier, as defined in the bill, would present certificates received in payment of premium to the Federal Government for redemption.

Qualification of Participating Carriers

To participate in the plan, a carrier would have to qualify under state law, provide certain basic coverage, make coverage available without pre-existing health conditions, and guarantee annual renewal. An assigned risk insurance pool among carriers would be utilized as appropriate.

Health Insurance Coverage

A qualified policy would offer comprehensive insurance against the ordinary and catastrophic expenses of illness. Basic benefits in a 12-month policy period would include 60 days of inpatient care in a hospital or extended care facility (but any two days in an extended care facility would count as one of the 60 days). Other basic benefits would provide emergency and outpatient services and all medical services provided by doctors of medicine or osteopathy. The catastrophic expense protection would pay incurred expenses for benefits in excess of the basic coverage, including hospital, extended care facility, inpatient drugs, blood, prosthetic appliances, etc.

Deductibles

A policy purchased under this program will contain:

(a) Under the basic coverage—a deductible of \$50 per hospital stay, and 20% coinsurance of the first \$500 of medical expense and on the first \$500 of emergency or outpatient expenses; and

(b) Under the catastrophic illness provisions—a corridor, between the basic coverage and the catastrophic illness coverage, of expenses to be incurred by the beneficiaries before payments under the catastrophic illness provisions would begin. The amount of the corridor would be based on taxable income (that is, net income after all tax deductions and personal exemptions): 10% on the first, \$1,000, 15% on the next \$3,000, and 20% thereafter.

A family of four, having an adjusted gross income of \$6,100, would have a taxable income (after all tax deductions) of \$2,900. Its corridor would be 10% of \$2,900, or \$290.

Health Insurance Advisory Board

A health insurance advisory board of eleven members, a majority of whom shall be practicing physicians, and including the Secretary of HEW and the Commissioner of Internal Revenue and other persons qualified by virtue of education, training, or experience, would be appointed by the President with Senate consent. The Board would establish minimum qualifications for carriers, and in consultation with carriers, providers and consumers, would develop programs designed to maintain the quality of health care and the effective utilization of available financial resources, health manpower, and facilities. It would report annually to the President and Congress.

Mr. BURKE. Thank you Mr. Minshall, for your statement with respect to H.R. 4960 and your analysis thereof. I do not hear any questions. Again, the committee's thanks to you.

We are pleased to have with us today our colleague from the State of Virginia, Hon. Thomas N. Downing. Welcome to the committee, Mr. Downing.

**STATEMENT OF HON. THOMAS N. DOWNING, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF VIRGINIA**

Mr. DOWNING. Mr. Chairman, I want to thank the committee for this opportunity to offer this statement in behalf of H.R. 4961, which I have cosponsored with 91 of my colleagues.

I am sure there is no need at this point in the hearings to catalog for you the many problems which make up the present health care crisis in this country. The testimony of the scores of witnesses who have preceded me is documentation enough.

One of the components of that crisis, the rising costs of health care and the corresponding rising costs of plans designed to protect against such expenses, have eroded the ability of millions of men and women, not just the poor, to meet even their minimal health needs. All of the national health insurance bills now before this committee are directed toward a goal which we all share—adequate health care for all Americans. However, some of these proposals would achieve that goal through a total restructuring of the present system for financing and delivering health care services.

We must, I believe, question the wisdom of jettisoning the present health care system which, with all its shortcomings, now provides quality health care for millions of Americans. Certainly we must question the projected costs of such proposals—in the case of the Griffith-Corman bill (H.R. 22) the additional cost to the taxpayer is estimated at \$59.4 billion.

On the other hand, Mr. Chairman, medicredit, the proposal embodied in H.R. 4961, would build upon the health care system which has already evolved in this country. If enacted, it would assure every individual and family—no matter how limited their financial resources—of adequate health protection.

For those in low-income categories, this protection would be theirs without expense or contribution on their part. For those with moderate and higher levels of income, medicredit would provide a system of cash incentives to enable them to protect themselves against major health care costs.

In essence, our proposals would provide tax credits against individual income taxes to offset, in whole or in part, the premium cost of qualified health insurance policies. A qualified policy must provide specified basic and catastrophic benefits, and the maximum amount of the tax credit would be based on the premium cost of this policy. The amount of the credit for a family would be graduated on the basis of the family's income tax liability with the larger credits available to lower income groups. Families with little or no tax liability would receive a payment voucher for purchase of the insurance. All persons could voluntarily elect coverage under the plan, except those age 65 and over who would remain under the medicare program.

With respect to the scope of benefits, H.R. 4961 would require as basic benefits under any qualified plan, 60 days of inpatient hospital services, including maternity service; all emergency room and outpatient services provided in the hospital; and all medical services provided by a doctor of medicine and a doctor of osteopathy, whether performed in the hospital, home, office, or elsewhere.

The basic administration of this program would rest with private insurance carriers and plans to allow for the marketplace to play an active part in maintaining cost control and insuring quality programs. In addition, H.R. 4961 would establish a Health Insurance Advisory Board, chaired by the Secretary of Health, Education, and Welfare, and including public members would provide the guidelines necessary to carry out the program; and plan and develop programs for maintaining the quality of health care and the financial resources and effective utilization of available health manpower and facilities.

In summary, H.R. 4961 provides a balanced, flexible program which provides the greatest financial support to those in the greatest need; builds upon, instead of dismantling, the present health care system; utilizes to the fullest extent the experiences and talents of the private insurance carriers and plans. Of equally importance medicredit would be relatively easy to manage, and the administrative cost to the Government would be less than that of other proposals now being advanced. Thank you.

Mr. BURKE. Are there any questions? If not, we thank you for bringing us your thoughts on this important subject.

The Honorable Neal Smith from the State of Iowa is our next witness today. The committee appreciates your coming to us with your views. You may proceed.

**STATEMENT OF HON. NEAL SMITH, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF IOWA**

Mr. SMITH. Mr. Chairman, I appreciate having this opportunity to express my views on what should be done to improve the medical care delivery system in this country, with particular emphasis upon the rural areas, towns, and smaller cities.

One-third of our Nation's citizens live in what are described as rural areas, the total population of which exceeds that of 100 of the largest cities in the United States. These people have a total population which exceeds that of all but eight of the countries of the world.

Of the 25 million Americans listed as poor, some 14 million live in rural communities. But whether one is poor or middle class employed and working, one of the primary difficulties they face today is that there is not a sufficient system of preventive medical care for these people living in the rural areas and smaller cities. There are not enough physicians to provide this kind of care; and indeed in most of the towns and cities, there is no physician, including thousands of towns and cities where there was at one time a full-time physician for that community only. Not only have the physicians left these areas without adequate attention for preventive medical care, but also no one has replaced them that could provide this kind of service.

The American Medical Association provides statistics showing that there is only one doctor for each 2,145 residents in rural areas. In the most densely populated areas, there is one doctor for only 442 residents. There are 132 counties in the United States without a single physician, and this situation is becoming worse.

I think that a recent Wall Street Journal article clearly points out the difficulty of retaining the physician in the small community. An excerpt from the article is as follows:

As discouraging as the enfeeblement of the old rural-health-care system is the fate of one major effort to preserve it. Last year, the Sears-Roebuck Foundation reluctantly killed a 14-year old program to help rural towns attract doctors by establishing well-equipped medical centers. By 1970, 52 of 162 such centers were closed and empty.

BEATING THE DRAFT

"The premise on which the program was found—that a good facility will recruit and retain a physician—was no longer valid," a foundation spokesman explains. "There are fewer and fewer doctors who are willing to staff these clinics. It's an injustice to a community to encourage them to build these clinics when the likelihood of getting a physician is remote."

Doctors reject a rural practice for diverse reasons. Because medical training has become increasingly sophisticated, many of them wind up as specialists; their specialized expertise is in greater demand in larger cities than in thinly populated areas. In the country, the round-the-clock demands on a doctor, and "professional isolation" from his peers, seem uninviting. And disadvantages of small-town living, such as schooling that sometimes is inferior and limited cultural activities, deter doctors.

I am saddened but not surprised by the fact that the Sears-Roebuck Foundation has reluctantly killed a 14-year-old program to help rural communities attract physicians by establishing well-equipped medical centers. I never did think that would work. Doctors cannot be enticed into locating where they do not prefer to live and practice. Forgiveness of debt for education and furnishing facilities will not even shift the shortage from one area to another.

One of the major problems in rural areas is that these people who work for a living both on farms and in factories must go many miles to a larger city to a doctor's office for just minor medical problems. A puncture of the hand, the need for a tetanus shot, the need for an antibiotic to curb a minor infection, immunization against an epidemic, all of these things require not only traveling several miles to the doc-

tor's office but taking off a day from their work in order to wait for the doctor and receive the minor medical attention. The cost of the doctor's fee is small compared to the loss of time, and together, the cost is so great that they avoid preventive medicine and take the chance on becoming very ill. If they become very ill they can go to a hospital and get good care and so the doctor's time then is spent taking care of people that should have never been ill enough to have to go to a hospital to start with.

I am convinced that doctors in these county seat cities must operate clinics in the smaller towns and have them staffed with a nurse practitioner or doctor's assistant. These nurses and paramedical personnel with a direct telephone line and other modern communication methods could have the necessary supervision and yet perform services that simply are, as a practical matter, not existent in these rural towns and smaller cities of America. We are not going to have enough doctors so that people needing a tetanus shot can have it taken care of by a doctor who has spent years becoming an expert on the entire body or a specialist on the heart or some other part of the body. We are not now talking about whether we should lower the quality of medical service. What we are talking about is whether these people have any preventive medical service at all. At the present time, as a practical matter, they have no quality because they have no service.

I want to urge this committee to make provisions in any legislation reported by the committee to allow payments to nurses and paramedical personnel who operate clinics or are available in these rural towns and small cities even though they are not under the direct supervision at all times by a doctor on the premises. They should be permitted to be paid for making house calls on elderly citizens, operating well-baby clinics and performing those kinds of services. They could recognize whether a patient needs immediate attention by the doctor and sift through the patient load, so that if a doctor does come to the clinic 1 day per week, his time can be used to see those who need to be seen the most. Many doctors have told me that they believe this kind of assistance is the only way we can solve these problems, and they would like an opportunity to use this kind of assistance. Although many physicians would use this approach, rules do not permit it at the present time. I think they are going to be changed very soon, and if the Federal legislation permits payment under these circumstances, it will encourage the change of the laws so that people who now have no preventive medical care available can receive it.

There is now also serious concern in the medical community relative to malpractice law suits. Doctors simply cannot perform all of the services that are demanded of them, and there is constant pressure to delegate some of the services in their offices and to not have enough time to spend on those who need the services the most. If the pressure of the circumstances causes them to make an error in judgment, or if they delegate some authority which the State law or medical practice regulations do not authorize, they are subject to malpractice suits. Encouraging States to make it legal to delegate this authority under certain guidelines should make a substantial contribution to reducing the malpractice suit problems. Some would like to go to the extreme and prohibit malpractice suits. This would compel those who suffer

life disability to forgo any possibility of being paid by an insurance company for this disaster and ultimately result in not spending the risk that this will happen when one goes to a doctor's office. On the other hand, we all recognize that some law suits should not have been filed and request damages clear out of proportion to the loss incurred. Sometimes these suits are sustained on the basis of illegal delegation of authority or failure to provide the full quality of services purchased. Making it legal to delegate certain authority should help relieve the abuses in the malpractice law suit situation.

I serve on the Appropriations Subcommittee which recommends appropriations for the Department of HEW including the National Institutes of Health and other health-related agencies. We have heard testimony from experts throughout the field of health care who all agree that the situation is serious. I have asked deans of medical schools and others how fast they could increase the supply of doctors. There are many problems involved in doubling or tripling the number of doctors, and I am convinced that this situation cannot be solved quickly enough merely by increasing doctors. It is not practical to think that it can be. What is required is to permit physicians to delegate some of the medical services to others. We do have a lot of nurses in this country who, with a very short supplemental training course, could operate clinics in direct communication with a physician's office and as a family nurse practitioner render tremendous services which are badly needed and not being furnished today. Since the problems of licensure and certification have historically involved the laws or medical practice regulations of each of the 50 States, it will not be easy or fast to change these requirements so that some of these services can be delegated.

I recognize that any Federal law in this area would not be the primary responsibility of this committee. However, in writing a Federal health law it would provide the payment of a large share of the services involved. This committee and the law that it recommends can have a tremendous impact and offer great encouragement toward securing these changes. It not only would be socially desirable and contribute to increasing the medical care services available in this country, but it also could reduce greatly the outlays in money required to provide medical services. The cost of preventive medicine is small compared to the cost of remedial services. Hospital costs have leaped 204 percent in the last 10 years and the competition for these services would be much less if preventive medicine had been practiced to a greater extent.

I visited refugee camps in the Middle East where we have been paying about one-half of the cost of medical and other services for refugees who have almost complete preventive medical services and as a result almost no one needs to go to the hospital. Although they have complete medical service, the cost is only about \$10 per year per refugee. I talked to the doctors who head the services and they say they will put the medical care for these refugees against medical care available for average citizens in any country and that the whole secret is that through the medium of the refugee camp dispensaries, they can practice preventive medicine. If anyone becomes seriously ill, they send them to very well-equipped hospitals in central cities, but the

rest of the medical care problems are taken care of within a few blocks of where the people live at a dispensary or clinic.

There are a lot of people on social security in this country who have not had a house call from a doctor in years and are not able to get to a clinic in some central city. For practical purposes, they do not have what anyone could call adequate medical service even though they will be able to go to a hospital in the event of a serious illness if they reach it in time.

I would like to see the establishment of some model clinic projects with nurses and technicians in close communication with the doctor. Although you will primarily be dealing with authorizing payments for services, in view of the fact that legislation you propose will effect total payments required, I believe you could in some way become involved in encouraging or establishing these model clinic projects.

There are still some people, including some Members of the House, who believe we can solve this problem in the rural areas of the United States by forgiving part of the indebtedness a doctor requires in securing his education or in some way bribing a doctor to go to the smaller town. A community of about 800 near where I live, Monroe, Iowa, made an all-out effort to secure a doctor. The people of the town built a clinic for a doctor but he only stayed a few months and the clinic is no longer being used. There are many reasons why doctors will not live in these communities when a group practice situation or a specialist position is available in the larger city. In some instances it is plainly a matter of living where they want to live or their family would prefer to live. At the income they can earn, forgiving the repayment of a few thousand dollars is of no significance compared to living and working where they prefer. I think it is time to quit looking for easy gimmicks and time to quit thinking that money alone will solve this problem. We need to look for ways to reform and encourage reformation of the delivery system. This committee can make its contribution by permitting payments for these preventive medical services.

I thank the committee for its time and apologize for such a lengthy statement. However, I think it is one of the most important questions in the country today and that your action with regard to the matters that I have covered could very well reduce the cost of medical care under this bill by billions of dollars over a period of years.

Mr. BURKE. Are there any questions? I hear none. Thank you very much, Mr. Smith.

We have with us today Hon. Lawrence J. Hogan from the State of Maryland. Thank you for coming to the committee to give your thoughts on national health insurance. You may proceed.

**STATEMENT OF HON. LAWRENCE J. HOGAN, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF MARYLAND**

Mr. HOGAN. Mr. Chairman, as the sponsor of two national health insurance measures pending before this committee, I appreciate the opportunity to present my views in support of H.R. 817 and H.R. 4963.

I would like to discuss these two bills in reverse order, citing first the more general plan of which I am a cosponsor with numerous of our

colleagues in the House and Senate. Certainly, the members of the committee have already received the testimony of the original sponsors of the Health Care Insurance Act, or the medicredit plan as it is more commonly known. I do not want to belabor the committee with further explanations of the effect of this legislation. I would simply like to offer my support for the type and scope of health insurance provided in this bill as opposed to some of the other measures pending before this committee.

The medicredit plan envisions a Federal Government program which would pay health insurance premiums for the poor, and allow income tax credits for all others toward the purchase of private health insurance plans. In doing so, this approach is, I believe, more rational, more realistic, and more palatable to the American taxpayer than some of the other measures which have been proposed.

Mr. Chairman, formulating a national health insurance program that will satisfy all sectors will be a massive undertaking for this committee and for the Congress. I would simply hope that the committee will give full consideration to the views of the many House cosponsors of this medicredit bill that this is a sound approach.

More importantly, however, I would like to bring to the committee's attention a bill which I originally introduced in the 91st Congress. While the overall national health insurance debate may straggle on and on, I think it is imperative that this committee act on the need for catastrophic illness insurance protection. Although one medical writer has suggested that enactment of a catastrophic health proposal would be catastrophic because it would curtail the momentum for passage for a national health insurance measure, I have to disagree. As a cosponsor of both the medicredit plan and the National Catastrophic Illness Protection Act, I am convinced that they are not mutually exclusive concepts. Naturally, I would prefer to see a national plan reported including a title on catastrophic illness insurance.

Briefly, I would like to give some background information on this major piece of legislation. I originally introduced this bill on June 30, 1970, and subsequently reintroduced it with 14 House cosponsors. Simultaneously, it was introduced in the Senate. This year we have 17 cosponsors on H.R. 817 and 4133 before this committee and we have three sponsors of S. 191 in the Senate.

Mr. Chairman, I first became interested in the need for this kind of medical coverage after witnessing the personal tragedy of a good friend and former business associate. He suggested the idea for this legislation after watching a rare, catastrophic illness strike and ravage his young son.

The National Catastrophic Illness Protection Act of 1971 would, if enacted, allow our Nation's families to protect themselves against the scourage of catastrophic illness. The bill would provide the mechanism for such protection in a manner which could involve a very small Federal expenditure.

Catastrophic illness, by definition, would comprise those illnesses which require health-care expenses in excess of what normal basic medical or major medical coverage provides protection for. Once a family finds itself faced with having to pay for health-care costs of an extended nature, they are saddled with a financial burden that is staggering to comprehend.

Imagine, if you will, what it means to finance for years hospital care which will run between \$80 and \$100 a day after your routine insurance has been exhausted. For middle-income Americans who earn too much to receive welfare and who are not rich enough to even begin to meet such obligations, the result of catastrophic illness is instant poverty. The family is driven to its knees.

Such a family, which has probably already watched one of its members incapacitated and perhaps destroyed medically, also finds that its financial stability has disintegrated. Usually, private hospitals cannot afford to provide care after the family can no longer afford to pay for the hospital's services. This means that the afflicted member of the family must be transferred to whatever public facility exists to treat patients under such circumstances. Unfortunately, these public institutions are often understaffed, underequipped, and horribly overcrowded. All too often they become depositories where families must leave their children or other loved ones, because the doors of all other possible assistance have been slammed in their faces.

Catastrophic illness does not refer to a special or rare disease. It is any disorder—from the exotic calamity to the common coronary. It is the fall from a step ladder in a home, a highway accident, or even the untimely sting of a bee, which cost one family over \$57,000. It is anything that happens to any of us that causes medical expense in excess of what the actuaries tell us we should expect. Virtually every family becomes medically destitute when that point is reached. Fortunately, only a small portion of medical cases are of such magnitude. But for the thousands of families who, through no fault of their own, find themselves pummeled into such an abyss, there is—currently—no hope.

While catastrophic illness is nondiscriminating in whom it attacks, when it attacks and where it attacks, it seems that a tragically high number of these cases involve children. When a child is the victim, the parents are often young marrieds who find themselves depriving their healthy children of a wholesome family life in order to finance the health care of a sick child. Often, the havoc is so great that the young couples must watch their dreams go down the drain as all present and future planning is marshaled toward the single goal of finding the money to pay for their ill child's care. While nearly all of the pediatric diseases that are catastrophic are individually rare, in the aggregate they afflict more families than most of us would imagine. The list of obscure diseases such as Tay-Sachs disease, Niemann-Pick disease, Baucher's disease, Fabry's diseases, metachromatic-leukodystrophy, leukemia, muscular dystrophy, myasthenia gravis, and the scores and scores of other maladies that destroy our people at enormous emotional and financial cost to their families appears endless.

Obviously, when catastrophic illness strikes the head of a household—the breadwinner—the disaster is compounded.

We are too great a nation to stand idly by—leaving our families that are victimized by catastrophic illness to their own devices. They have no devices. They are alone.

The National Catastrophic Illness Protection Act will go a long way toward militating against the problems of catastrophic illness because it will stimulate our insurance industry to provide coverage that will allow any family to protect itself fully against the costs of

catastrophic illness. The legislation would foster the creation of catastrophic illness—or extended care—insurance pools similar to those that have been successful in making flood insurance and riot insurance feasible.

Because all participating insurance companies would be required to promote the plan aggressively, and because we would be dealing statistically, with a small minority of all claims, the cost per policy should be low. As more people buy this new protection as part of their health care program, thereby spreading the risk, the cost should drop even more. The Federal role would be limited to reinsuring against losses in those instances where insurance companies paid out more in benefits than they took in in premiums. As the insurance industry gained experience under the plan they would be able to sharpen their actuarial planning so that such losses would be limited, if they occur at all.

We have taken careful steps to preserve the State role in insurance administration and to allow the Secretary of Health, Education, and Welfare to participate in the actuarial review of the policy rate structure in order to assure that the rates charged for those new policies are fair to all parties concerned.

Perhaps the most attractive feature of this legislation is that it would be free of all of the constraints that are plaguing existing federally funded health care programs. We would not be overburdening an already overburdened social security system in order to finance the plan. Families who choose not to participate in the program would not be required to do so. However, on the other hand, families desiring to secure this protection would be assured of an opportunity to do so.

Under my program a deductible formula would be used to stimulate each family to provide basic health care protection. It would only be when this deductible level had been exceeded that the catastrophic insurance protection plan would be utilized. Under our formula, a family with an adjusted gross income of \$10,000 would have to either pay the first \$8,500 of medical expense or have provided themselves with \$8,500 worth of basic insurance protection to offset the deductible requirement. Coverage from existing basic health and major medical plans would generally be sufficient to satisfy this deductible amount. However, if a family with an adjusted gross income of \$10,000 incurred expenses during the period of a year that exceeded \$8,500, our catastrophic or extended care program would be available to see the family through the period of financial burden when they would ordinarily be left on their own without help.

Again, because relatively few families would experience medical costs of this magnitude in a single year, the costs for this insurance should be quite reasonable—especially as more and more of our citizens availed themselves of its protection.

In developing this legislation I have met with many individuals uniquely experienced in the problems of catastrophic illness. I have discussed this proposal at great length with members of the medical community and have consulted leading members of the insurance community. More important, I have met with families that have been victimized by catastrophic illness. I have studied their plight in great detail. I know that it is wrong that these families are, in effect, abandoned—almost as a small boat adrift in stormy water.

I know that we can do something to help them and we do not have to spend ourselves into Federal bankruptcy to do it. All we need to do is utilize a concept that has been tested successfully in other analogous areas.

Mr. Chairman, for the committee's further information on this complex legislation I am attaching a copy of the section-by-section analysis of the measure.

Finally, Mr. Chairman, I would hope that in its deliberations on these various proposals the members of this committee would give due consideration to the need for mental health provisions in whatever measure is finally reported by the committee. Although in recent years mental health coverage has been added to many private health insurance policies, in many instances there are sharp limitations as to scope and duration of coverage. A national health insurance program should not carry forward this type of discrimination against the mentally ill.

I appreciate the opportunity to present this statement of my views on national health insurance and catastrophic illness protection.

Mr. BURKE. Does that conclude your statement? Are there any question? I hear none. Thank you again, Mr. Hogan for bringing us your thoughts.

The Congressman from the State of New York, Hon. Benjamin S. Rosenthal is our next witness. We welcome you here, Mr. Rosenthal, and you may proceed as you wish.

STATEMENT OF HON. BENJAMIN S. ROSENTHAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. ROSENTHAL. Mr. Chairman, I am pleased to have this opportunity to present my views on health care reform to this distinguished committee.

We are not here today to decide if there is a crisis in health care in the United States. That there is, I think, we would all agree. The question is rather what to do about it.

I am convinced we cannot stop short of comprehensive reform—a better word would be “revolution”—in the financing and delivery of health care for more than 200 million Americans.

Last year we spent \$70 billion on health care—more than \$325 for each man, woman, and child—yet this Nation ranks worse than 10 to 17 other countries in life expectancy and infant mortality.

No only are we spending more today on health care than we were a decade ago—a 170-percent increase from \$26 billion—but we are giving it a bigger share of our national wealth—from 5.3 percent of the gross national product to 7 percent.

Nearly two-thirds of that increase in expenditures in the last 10 years has not been for additional services but merely to meet price inflation. Overall medical costs have increased twice as fast as the cost of living; hospital costs alone have risen five times as fast as other prices.

And what are we getting for our \$70 billion?

We rank 13th among industrialized nations in infant mortality; 11th in life expectancy for women; 18th in life expectancy for men; about 150 U.S. counties do not have a single doctor and another

150 have only one physician; twice as many black infants die in the first year of life as whites; poor people suffer four times as may heart conditions, six times as much mental illness, arthritis, and high blood pressure as their more affluent neighbors; there is a national shortage of 50,000 physicians, 150,000 medical technicians, and 200,000 nurses.

Let me put it another way:

There is a significant shortage of trained medical personnel—ranging from doctors and nurses to technicians and paraprofessionals—and of proper facilities; and the personnel and facilities which we do have are inadequately distributed geographically. Compounding this is the problem of skyrocketing costs.

What, then, should we be getting for our \$70 billion?

Everyone, all Americans, should be getting the same high quality of health care and at prices all can afford.

There is no conceivable reason why a person should get better health care because he lives in a better neighborhood, has a better job, has the right color skin or has more money. Health care should not be made available according to conditions of economics, age, sex, race, employment, or any other factor than one need.

There is no conceivable reason why the wealthiest, most technically, and scientifically advanced Nation on earth cannot also be the healthiest.

This has been aptly termed the paramount issue of the 1970's. I have joined nearly 80 colleagues in cosponsoring H.R. 22, the Health Security Act of 1971. I endorse this bill not as the solution to the problem, but because I believe it comes closer than any yet offered to making the American health care system truly the best in the world.

This is a consumer program, not a health industry-insurance company program, and the consumer will have a major voice in setting policy and running the system. Of course, the medical profession will also play an important role, but this will be a health care partnership, not a dictatorship.

The essential key to health care reform is a fundamental shift in emphasis from crisis medicine to preventive medicine.

The more we do today to prevent illness and keep the population healthy, the less we will have to spend tomorrow on cures and treatment.

Adequate health care is not a privilege. It is a fundamental right of all Americans.

This is basically contrary to the predominant philosophy of our present health care system—health service now centers around the independent practitioner, with care a privilege rather than a right, something bought and sold as though it were a commodity.

We must revolutionize this system. We must step back at every level and critically reexamine the total health care system. The drastic revisions in health manpower, distribution, financing and training, the great task of reeducating both physicians and patients to a new health care system must begin now with innovations and encouragement at local, State, and Federal levels.

The President has shown he is aware of the national crisis in health care, but he has not demonstrated a willingness to take the steps necessary to solve it.

I welcome his support for the group practice concept, which he calls health maintenance organizations, and his support for increasing the supply of medical manpower in rural areas and urban ghettos. But I cannot support very much of his strategy for dealing with the problem.

One of the most serious shortcomings of the President's proposal, and of several others such as the American Medical Association's medicredit, is reliance on the private health insurance industry.

The private health insurance industry, which has traditionally shown far greater interest in wealth than health, must bear a large portion of the responsibility for the skyrocketing medical costs we are experiencing.

It has shown itself either unwilling or unable to do much, if anything, about keeping prices down. Its emphasis on treatment in hospitals rather than in less expensive outpatient facilities has helped send costs up.

The administration plan is industry-oriented when it should be consumer-oriented. The insurance companies can take care of themselves—it is time to help the American people for a change.

Another major area in which the profit motive has become an obstacle to good health is drugs. Currently large manufacturers spend an immense amount of time, effort and money on product promotion and differentiation, creating "new" drugs barely different from existing, effective drugs merely to receive a Government patent. Thus, unnecessary new drugs are "discovered" while needed research is neglected.

Patent laws giving a pharmaceutical firm a 17-year monopoly on a new drug serves only to make money for the manufacturer at the expense of the consumer. Some drugs, as a result, are priced beyond the reach of the persons who need them.

Price differentiation for the same drug throughout the country exemplifies the ludicrousness of the present system. Studies by various newspapers and consumer groups show identical drugs often costing five, 10 or even 20 times more in one section of the country than in another, even from one part of the same city to another.

There are many other flaws in the administration plan—the poor, near poor, and the elderly would get far less protection than the rest of the population; even middle-income families would be hard pressed to meet the large deductibles and copayments required of them in major illnesses; medicare hospital coverage for the elderly would be decreased, as would Medicaid help for the poor.

I am skeptical of the commitment improving health care when it comes from an administration that has vetoed several pieces of needed health legislation; impounded millions of dollars appropriated by the Congress for health programs; cutback spending on biomedical research and forced the closing of 19 National Institutes of Health centers.

As part of the new health care system that we must build, there must be a new health team. We need to expand the supply of medical manpower through the training of allied health personnel such as physician's assistants, child health practitioners, community health workers, and family planning aids.

Within the new health team system, duties and responsibilities would be allocated on the basis of actual capabilities for performing specific

tasks, rather than by possession of a categorical title. Ideally, the distinctions among health personnel should be made on the basis of the nature of the judgments that each level is capable of making. This fluid system, directed by its most highly trained member, the physician, could provide superior health care with maximum efficiency, low cost, and better service for its recipients.

I hope this committee, Mr. Chairman, will write legislation that will free our health resources from their narrow wasteful roles and divert them to the growth and expansion of the team system.

There is virtue in the concept of close physician-patient contact. But the population needs and environmental health problems stemming from neglect in housing, nutrition, and preventive medicine shameful for a country of our wealth—have overwhelmed the capacity of the old system.

That system must be changed.

I support a system of prepaid national health insurance based on the proven social security concept. All the evidence indicates this public insurance system operates with greater efficiency and lower cost to the consumer than the private insurers.

I do not support a system that would abolish the personal doctor-patient relationship. Every person should be able to choose his own doctor, if he wishes, and all persons should have equal access to the same high quality of medical care and at prices they can afford.

I do not support a system of national health service in which the Government owns and operates all facilities, and everybody works for the Government. What I have in mind is a true partnership between the private and public sectors; between the health professional and the patient. There will be Government financing and administrative management, accompanied by private provision of personal health services through private practitioners, institutions, and other providers of medical care.

To be truly effective and meet the needs of the American people, the Nation's health care system must become more consumer oriented. That means those who pay the bills, the health consumers, must have a strong, effective role in making policy and operating the system.

It must be a system truly responsive to the needs of the people, a health care system appropriate to our advanced and affluent Nation's needs and desires.

Mr. BURKE. Are there any questions for Mr. Rosenthal? If not, thank you, sir, for being with us today.

Mr. CARNEY? Our next witness is the Honorable Charles J. Carney from Ohio. Welcome to the committee, Mr. Carney. We are pleased you are here today to give us your statement.

**STATEMENT OF HON. CHARLES J. CARNEY, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF OHIO**

Mr. CARNEY. Mr. Chairman, I appreciate the opportunity to present my views on national health insurance. For almost 30 years, Congress has been debating the merits of various proposals which would create a federally financed health insurance program. Today we have before us the culmination of this long series of legislative proposals designed to improve the financing and delivery of health

care in America. Of all the different health care proposals introduced during the 92d Congress, the Health Security Act of 1971 stands out as the only program which would assure equal health care protection for all Americans and provide for a rational and innovative reorganization of the Nation's health delivery system.

The problems affecting our health care system are too well known to the members of this committee. You have listened to hours of expert testimony from witnesses well-versed in facts which attest to soaring inflation in medical care costs; facts which show that America is not No. 1 in health, but only in health expenditures; facts which reveal the disorganization, duplication, and inefficiency in our present system; facts which lead to one inevitable and disheartening conclusion—that the very system supposedly designed to safeguard and improve our Nation's health has shown itself to be the greatest stumbling block to the achievement of its intended purpose.

Along with the many other sponsors and advocates of the Health Security Act, I believe the time has come when we must completely revamp the system through which we finance and deliver health care. The far-sighted and innovative program laid out in H.R. 22, the Health Security Act, has been designed with just this purpose in mind.

First of all, health security would establish a uniform set of health benefits to which every American would be entitled, regardless of his income, place of residence or employment, or his current health status. Unlike the majority of existing private health insurance plans, the federally-financed health insurance program established by health security would cover the entire range of essential health care services without deductibles, coinsurance, or other limitations which needlessly prevent people from seeking health care in advance of an illness. Under health security, the individual would be protected by a program designed to prevent illness and maintain good health, rather than by insurance policies which pay for benefits only after a person has become sick.

Second, health security would place a lid on the cost of health care by requiring the providers of health services to live within a budget predetermined on a yearly basis. The program would emphasize coordinated, areawide planning. Regional and local authorities would be responsible for eliminating waste and inefficiency by refusing to provide funds for unnecessary services. Under the present system the private insurance industry has been unable to curtail rising medical costs. Bills from providers of services have gone largely unquestioned. When costs for services have increased, the private insurers have merely passed the added cost on to the health consumer in the form of higher premiums. Health security would not only correct this situation but also reward efficiency by offering financial incentives to organized providers of care who have operated at a cost-saving.

Third, health security would encourage a reorganization of the health delivery system through the formation of organized groups of providers. Additional health services would be made available to individuals who enrolled in these comprehensive health care organizations, \$600 million would be specifically set aside in a health resources development fund to provide assistance for the formation and devel-

opment of comprehensive health care organizations, for the training and education of needed health personnel, for the construction and improvement of facilities in which these organizations would operate.

I have mentioned only a few of the many outstanding features in the health security program. I am hopeful that my remarks and those of the many witnesses to follow will reinforce in the minds of the members of this committee the distinct advantages that will accrue to the people of this country through enactment of H.R. 22. Thank you.

Mr. BURKE. Thank you, Mr. Carney. We appreciate your fine statement.

We have with us today Hon. Manuel Lujan, Jr., Congressman from the State of New Mexico. We look forward to your statement on this subject, and you may proceed as you wish, sir.

STATEMENT OF HON. MANUEL LUJAN, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mr. LUJAN. Mr. Chairman and members of the committee, H.R. 8101, "The National Family Health Protection Act," embodies a concept I believe is vital in providing satisfactory health care for all of our citizens: economic competition.

Our Nation was founded on the principle of private enterprise and it has stood us in good stead for almost two centuries. And competition is the incentive for businesses and individuals to provide the best products and service at the lowest possible cost, with efficiency as one of the better byproducts.

In the field of health care, private enterprise has given the United States one of the highest standards in the world. However, as our society has grown more complex, segments have not been reached as successful as they might. Furthermore, as the practice of medicine becomes more sophisticated, many people who can afford normal health expenses are suddenly caught by extraordinarily high costs that cannot be met through the average health plan coverage.

Our first attempts—medicare and medicaid—at solving this problem have failed for what I believe are two basic reasons:

1. They are incomplete, providing coverage to less than a quarter of our population.

2. They do not involve the private sector.

My bill would change both factors. It would cover, with few exceptions, our total population and would give free enterprise the chance to function effectively in health care delivery.

A person would be issued a health protection certificate which would provide specified benefits; it would be good for 1 year and would be guaranteed renewable. This individual redeems it with the qualified company of his choice. And choice is the key to my bill. It is the only bill that has been introduced that provides for choice. And I believe that this is what will cause my approach to be successful and the lack of it is what will cause the others to fail.

The Secretary of Health, Education, and Welfare will establish standards that all companies must meet, and will also issue a list of the minimum health care services that the health protection certificate will purchase. After that, it is up to the qualified companies to compete among themselves for the opportunity to provide the services and

satisfy the customers. If an individual feels that he is being treated unfairly or unsatisfactorily in some way, he can redeem his certificate with another company the next year. He is not forced to continue dealing with the same company, year after year, regardless of service.

Along with providing better service to our citizens, it will stimulate business to seek new ways to solve old problems which will be money saving for all concerned.

Speaking of costs, I estimate that the coverage my bill will give will not significantly increase the amount of money spent on health care by the Federal Government. At the present time, we are spending close to \$21 billion a year. If passed, my bill would increase this by about \$4 billion. It would supersede medicare and medicaid and calls for a report on the legislative changes that would be needed to include all other Federal health care programs in the national program.

Since the funding that now supports these programs would be rechanneled to my national health protection, the new money required to operate it would not constitute a heavy burden for our citizens if my figures prove to be accurate. I estimate that a 5-percent surcharge on our adjusted income tax will provide the increase.

What about coverage? My bill would provide general hospital inpatient care, outpatient care, extended care, physicians', dentists', and home health services, laboratory and X-ray, medical supplies, and ambulance service. Although it is certainly not as generous as Senator Kennedy's it will also not cost an estimated \$65 billion more, and more importantly, will provide those basic services that can wreak havoc with the lives of many of our citizens.

Therefore, I strongly recommend that the Ways and Means Committee give careful consideration to H.R. 8101; I believe that the members will find that this is a most valid solution to one of the most grave problems facing our Nation today.

Mr. BURKE. We appreciate your comments here today. Thank you for coming, Mr. Lujan.

This concludes the public-hearings phase of our consideration of national health insurance proposals.

The record will remain open for the submission of data, statistics, and further statements until the close of business Friday, December 10. The record will then be printed as expeditiously as possible.

The committee has no present plans for executive sessions on this subject until after the first of the year.

The committee now stands adjourned, subject to the call of the Chair.

(Whereupon, at 11:40 a.m., the committee concluded the public hearing on national health insurance proposals.)

(The following statements and communications were received by the committee for inclusion in the record:)

U.S. SENATE,
COMMITTEE ON COMMERCE,
Washington, D.C., September 30, 1971.

HON. WILBUR MILLS,
Chairman,
Ways and Means Committee,
House of Representatives

DEAR CHAIRMAN MILLS: The attached is a copy of the Children's Catastrophic Health Care Act of 1971 (S. 2434) together with the remarks I made in intro-

ducing it on August 5, 1971. This bill, now pending before the Senate Finance Committee, would amend Title V of the Social Security Act to substantially expand the Crippled Children's Services Program and the Maternal and Infant Care Program authorized under that title.

The Crippled Children's Program would be expanded to provide care to all children once their annual health care expenses exceeded a certain fixed percentage of their parent's annual taxable income. In the case of a child whose family earns no more than \$15,000 per year, this percentage would be 5 per cent. For others, it would be 5 per cent of the first \$15,000 plus 10 per cent of all additional income. Under this plan, then, coverage would be determined by the extent of the treatment a child needs rather than, as is now the case, by the kind of ailment he has. Consequently, we would no longer be confronted with the situation wherein a child with cleft palate, for example, receives treatment with another with, say diabetes, goes untreated. Another advantage of this plan is that it would require all parents, regardless of their income, to accept reasonable financial responsibility for their youngsters' health care while at the same time not requiring any family to go entirely bankrupt before becoming eligible for assistance.

The Maternal and Infant Care projects would be expanded to include all of the states and to provide maternal care for all low-income mothers and health care for their babies during their first year of life. This expansion would be entirely in keeping with the importance of maternal and infant care and the fact that preventive care is much less expensive than traditional corrective care.

In addition to the advantages mentioned above, I would also note that implementation of the kind of plan outlined in S. 2434 would not require the creation of any new agencies or bureaucracies.

Obviously, S. 2434 is offered as a serious working paper rather than as a finished legislative product. Consequently, I sincerely hope you and your colleagues on the Ways and Means Committee will give the concepts advanced in my bill your very serious consideration in the course of your deliberations over a national health care program.

Best personal regards.

Sincerely,

WARREN G. MAGNUSON,
U.S. Senator.

Enclosure.

[From the Congressional Record]

Mr. MAGNUSON. Mr. President, the health care crisis has come to command more concern within the Congress and throughout the Nation than has any other single domestic issue. Even more important, this concern has been translated into serious legislative proposals by many Members of the Congress, by the administration and by many private groups outside of Government.

As chairman of the Appropriations Subcommittee on Labor-HEW I can assure the Senate that this concern is wholly justified and that this commitment to action is absolutely imperative. More than a year ago when I opened the 1970 health appropriations hearings I warned that the Nation was fast approaching "a health crisis whose proportions defy adequate description." I continued:

This crisis extends from our medical schools to our hospitals, from our laboratories to our clinics. The dimensions of this crisis are stark. The United States today is not even among the leading nations of the world in life expectancy of men, women or infants. We are producing new doctors at a rate of fewer than 9,000 per year; we are lagging in health research; we lack adequate facilities to apply the fruits of accomplished research to the health care needs of our expanding population.

I accepted this post as Chairman of this Subcommittee because I believe that the health and welfare of our people must be an urgent concern of this Government. In my second year as Chairman, I am even more determined and more convinced that more must be done.

And, today, Mr. President, in my third year as chairman of this subcommittee, I am still more determined and still more convinced that still more must be done. It is a vast task and I am indeed encouraged by the number of Senators who have come forward and squarely confronted this crisis. The distinguished senior Senator from Massachusetts deserves special recognition and credit for

having giving much impetus to this national concern by introducing his National Health Security Act in the last Congress. Also, of course, the hearings which he and the other members of the Health Subcommittee have held throughout the Nation in recent months have focused even more attention on the health crisis and have produced valuable information that will be most helpful to the entire Congress as we seek to develop a final health insurance program. As a co-sponsor of Senator Kennedy's National Health Security Act, both last year and again this year, I truly admire his leadership in this vital area of national need.

The distinguished chairman of the Finance Committee is also deserving of special praise for having introduced last year the concept of catastrophic health insurance. I have utilized that concept in writing the bill I intend to introduce today, and I believe it is an extremely important concept which commands the closest consideration of every American who is seriously committed to resolving the health care crisis.

These and all of the other health insurance proposals offer important ideas, concepts and mechanisms which, when molded together into a final bill, will, I am sure, furnish the Nation with an effective and fiscally responsible national health insurance system. This is an objective singularly worthy of the vast amount of time, study and hard work which I know Chairman Long and the other members of the Finance Committee will expend in writing a final Senate bill.

Mr. President, neither I nor any other Senator would advocate that Congress move rashly or recklessly in its efforts to establish a national health insurance system. That is a task which will require much deliberation, time-consuming as that may be. However, we cannot afford to ignore the particularly crucial and pressing problems posed by major childhood illnesses which continue to maim many children simply because their parents cannot afford proper medical treatment and continue to leave thousands of families destitute with nothing but unpaid medical bills to show for years of savings. Nor can we continue to ignore the fact that each year thousands of infants are born deformed or die within their first year of life simply because they are born to low-income mothers who cannot afford proper maternal care for themselves or sufficient health care for their babies.

The dimensions of these two problems are shocking. For example, birth defects alone—just one category of major, or catastrophic, childhood illnesses—currently affect 2.5 million Americans under the age of 20. So that other Senators may have a clearer view of just this one part of the overall problem presented by catastrophic childhood illnesses I ask unanimous consent to have printed in the Record at this point in my remarks a table listing the major birth defects and the number of children afflicted by them.

Prevalence of common birth defects

| | |
|--|-------------|
| Mental retardation of prenatal origin..... | 1, 170, 000 |
| Congenital blindness and lesser visual impairment..... | 300, 000 |
| Congenital deafness and lesser hearing impairment..... | 300, 000 |
| Genitourinary malformations..... | 300, 000 |
| Muscular dystrophy..... | 200, 000 |
| Congenital heart and other circulatory disease..... | 200, 000 |
| Clubfoot..... | 120, 000 |
| Cleft lip and/or cleft palate..... | 100, 000 |
| Diabetes..... | 80, 000 |
| Spina bifida and/or hydrocephalus..... | 60, 000 |
| Congenital dislocation of hip..... | 40, 000 |
| Malformations of digestive system..... | 20, 000 |
| Speech disturbances of prenatal origin..... | 12, 000 |
| Cystic fibrosis..... | 10, 000 |

In almost every major category of birth defects listed in the table there are more afflicted children than there are people in a major city. And, while low-income children are more prone to be victims of birth defects because of the insufficiently of maternal care presently available to their mothers, children from higher income families are in no way immune from these tragic defects. Clearly, then, when one adds the number of youngsters who are born in good health but later contract major illnesses or suffer serious accidents to the 2.5 million children suffering from birth defects he finds a national problem of truly catastrophic dimensions.

And it is a problem which is financially catastrophic to individual families. The care of a child with a major defect, illness, or injury generally entails prolonged hospitalization, care by a wide array of highly trained professionals and expensive equipment. Medical bills rapidly mount into the thousands of dollars, surpassing the coverage offered by even the better private insurance plans and far outstripping all but the richest family's ability to pay. When the average family's income is well below \$10,000 and when most Americans earn far less than the average, how can we expect families to pay medical bills ranging into the thousands of dollars and often coming year after year after never-ending year? We cannot, Mr. President, and we should not.

An equally tragic and shocking picture comes into view when we examine the plight of the infants who are born every day into low-income families. Because women from these families so often cannot afford proper maternal care during their pregnancies or adequate obstetrical care at the time of delivery, their babies far too often come into this world unhealthy as well as poor. And the same poverty which denied their mothers adequate maternal and obstetrical care continues to rob these infants of the health care that is so crucial in the first year of life. As a consequence of this national neglect, the incidence of prematurity among infants born to low-income parents is about 12 percent as compared to the national average of 8 percent. Premature infants—and particularly those born into poverty—are especially apt to be born with major health problems, to be malnourished and to die within their first year of life. While the national infant mortality rate is unacceptably high—21.8 deaths in the first year per 1,000 births—the rate for babies of low-income parents is often twice as high, or about 43 deaths per 1,000 births. As a nation founded upon the dignity of human life can we tolerate this situation where infants are maimed for life or even die for no other reason than that their mothers are unable to obtain proper medical care for themselves and their babies? We should not, Mr. President, and we cannot.

The problems posed by catastrophic childhood illness, by insufficient maternal care for low-income families and by inadequate health care for their infants cannot be left unresolved while we continue the long, arduous task of devising a workable legislative solution to the entire health care crisis. We must act now to solve these problems.

Mr. President, we can act now for we need not, construct new administrative structures or engage in the extensive deliberations that are necessary whenever we set out to build a new program from the ground up. Instead, we can begin immediately to resolve these problems by building, as the bill I am about to introduce would do, upon two ongoing programs that have long since proved their effectiveness. These are the crippled children's services program, operating in all 50 States, and the maternal and infant care program, located in 33 States. Both are authorized under the present title V of the Social Security Act and are administered by the Department of HEW.

I am hopeful, then, that Senators will carefully examine the approach offered by this legislation, suggest ways in which it can be improved and give serious consideration to the possibility of implementing this approach, perhaps as part of the social security bill now being considered by the Finance Committee, so that we begin as soon as possible to deal with the tragic problems I have outlined above.

Mr. President, I now introduce for appropriate reference the Children's Catastrophic Health Care Act of 1971 which would become the new title V of the Social Security Act, replacing the current title V entitled "Maternal and Child Health and Crippled Children's Services." As I have indicated it would substantially expand both the crippled children's program and the maternal and infant care program authorized under the current title V. In addition, it would continue a variety of other title V programs of significant importance in our effort to make adequate health care available to all Americans. Under my bill, these programs would be funded through the normal appropriations process as is now done—not through payroll deductions or taxes. States would continue to share the cost of their expanded crippled children's programs—to be renamed the children's catastrophic health care program—and their maternal and infant care programs. However, they would only be required to continue their funding at its fiscal 1971 level. Other costs would be paid by the Federal Government.

Mr. President, the children's catastrophic health care program authorized under my bill would expand the existing crippled children's program in three im-

portant ways. First, it would provide care and services to children in all families—not just to those who come from low-income families as is presently the case. Second, it would expand coverage to include all health care costs once they exceeded a fixed percentage of a family's income. Third, it would standardize the coverage provided.

My own State of Washington presents telling examples of the problems which hobble the crippled children's program. Today, only 4,000 Washington youngsters are being treated under the crippled children's program although the State director estimates there are at least 16,000 children in need of treatment. In other words, without new legislation of the type I am proposing, only one-fourth of the children in my State who need treatment will receive it. And the story is no more encouraging in other States.

Eligibility standards vary widely from State to State. Since not all children can be served at existing funding levels, arbitrary eligibility standards are drawn. Most States, for example, provide services for children who require orthopedic surgery or plastic surgery to correct handicaps, but only a relative few provide services for children with chronic medical problems or congenital defects.

In Washington, children are covered for treatment of cleft palate and club-foot, but they are not covered for cystic fibrosis, hydrocephalus or epilepsy. Nor are children in my State covered for kidney disorders—such as hemophilia—diabetes, cancer, eye disease or chronic brain disorder. I need hardly remind the Senate that these health problems for which children in my State are not covered are the most devastating, the most tragic, and also the most expensive to treat. Today, then, in my State, families with children suffering from one or more of these health problems cannot expect any assistance from the very program established by Congress to cover the cost of their treatment.

Nationally, mental health services for children are not covered under the crippled children's program as they would be under my bill. This is particularly important when one realizes that there are at least 1 million children in the United States today who require these crucial, but costly, services.

There are many other examples. For instance, hydrocephalus is a condition in which a grossly abnormal amount of fluid collects around the brain, creating pressure on the delicate brain tissues that leads to permanent mental retardation, loss of physical capacity, and even death. An operation can be performed to relieve this pressure and to prevent its destruction, but it is not covered under the crippled children's program. And the list goes on and on. Metabolic disorders such as rickets—which causes permanent deformities—and urinary tract disorders—which cause deterioration of the kidneys, high blood pressure and death—can be treated by special medicines and by corrective services. But, once more, the present crippled children's program does not cover the cost of such medicines or surgery.

Perhaps the most tragic example of all is presented by cystic fibrosis. Thousands of American youngsters die needlessly from this disease because we have neglected to make its costly treatment available to more than a fraction of its victims. One out of every 1,500 babies born in the United States are born with cystic fibrosis. In 1950, half the children with this disease were dead by age 3 and only 10 percent lived to the age of 10. But with new methods of care, modern treatment centers now treat cystic fibrosis victims so successfully that the median age of death in these centers is now 21. And no less than 50 percent of all children afflicted with this terrible disease survive past the age of 20 when treatment is available. But, because of inadequate funds, only a minute fraction of cystic fibrosis patients receive the care medical science has made possible. Enactment of the Children's Catastrophic Health Care Act would make this treatment available to all of these children.

In sum, the arbitrarily drawn eligibility standards that now govern crippled children's services mean financial ruin for families. But the greatest tragedy—one which I cannot overstress—is that unnumbered thousands of children are permanently crippled or doomed to an early and tragically unnecessary death because their parents cannot afford treatment for health problems that can be cured.

The Children's Catastrophic Health Care Act would eliminate the arbitrary eligibility standards drawn by the States and would provide adequate funding to insure that all eligible children receive the treatment they require. The new national eligibility standard would be based not on kinds of disease but rather on the cost of treatment in relation to family income.

Under this legislation a child would be eligible for free catastrophic health care and services whenever the cost of his treatment became prohibitively expensive. For a family with annual taxable income of \$15,000 or less, the program would pay all of a child's annual medical expenses which exceeded 5 percent of the family's income. A family earning more than \$15,000 would become eligible when their child's medical fees exceeded the sum of 5 percent of the first \$15,000 of their income and 10 percent of everything above \$15,000.

This means that for a family earning \$8,000, the children's catastrophic health care program would pay all medical costs which, for any child in any year, exceeded \$400. For a family earning \$10,000 the program would pay costs in excess of \$500. For a family with an income of \$16,000 it would pay costs in excess of \$850, and for a family with income of \$20,000 the program would pay all costs in excess of \$1,250. No family, therefore, would be financially ruined by the medical bills brought on by catastrophic childhood illnesses, defects or injuries.

In the program's first year, all children under the age of 7 would be covered. In succeeding years, benefits would be available to these children and all new babies, hence in the second year all children under the age of 8 would be covered, in the third year all children under the age of 9 would be covered and so on until in 1983 all children—under 18—would be covered.

The second major section in my bill and its effect on the existing title V maternal and infant care program can be described quite briefly. This bill would expand these programs, now serving only 33 States, to include all 50 States. Furthermore, it would provide maternal care to all low-income mothers and health care to all of their infants during the first year of their lives.

The maternal and infant care special project grants currently serve only 125,000 of the 750,000 mothers who need this type of assistance. For this fortunate one-sixth, the evidence demonstrates that the results of the maternal and infant care program has been a dramatic reduction in infant mortality, malnutrition and attendant diseases. Under the Children's Catastrophic Health Care Act this maternal and infant care would be available to all low-income women and their babies. In addition, all infants, regardless of their families' income status, would be eligible for free diagnostic services.

The Children's Catastrophic Health Care Act, then, would build upon an already functioning, already proven system to: first, provide comprehensive health care to all children suffering from major defects, diseases or injuries; and second, provide comprehensive maternal and infant care for all low-income mothers and their babies. This legislation offers a practical method for dealing almost immediately with the most urgent health care problems of our children. Furthermore, by making, this care available to children as soon as they are born—and, in fact, almost from the day of conception—we would prevent the occurrence of a great many painful and expensive defects and diseases. Consequently, early enactment of this legislation would not only save many children the agony of unnecessary sickness but would also save the nation the huge sums it will have to expend for corrective care if we delay acting until comprehensive national health insurance becomes a reality.

Mr. President, in addition to the crippled children's services program and the maternal and infant care program, title V of the Social Security Act authorizes a number of other programs which, while much smaller, are an important part of the Nation's overall health effort. Under my bill most of these programs would be continued through fiscal year 1977 and strengthened with separate funding authorizations. These programs and their annual funding levels under my bill are:

Programs to promote the health of pre-school and school age children—\$50 million.

Family planning services—\$5 million.

Projects of regional or national significance in the advancement of maternal and infant care—\$10 million.

Projects of regional or national significance to the improvement of the treatment of crippling diseases—\$10 million.

Training of health personnel, particularly personnel to work with children who are mentally retarded or afflicted with multiple handicaps—\$20 million.

Research projects designed to advance the care and treatment of crippled children, pregnant women and infants—\$10 million.

In closing, Mr. President, I wish to reiterate three important points:

First, this legislation is not an alternative to a comprehensive national health insurance system. As my cosponsorship of Senator KENNEDY'S National

Health Security Act evidences, I am a proponent of a truly comprehensive system. And I believe we must move toward implementation of such a system just as rapidly as we possibly can without sacrificing sound legislation for speed. Rather than being an alternative to a comprehensive program, The Children's Catastrophic Health Care Act offers an important first step toward the development of a comprehensive program.

Second, this bill avoids duplication or the creation of new paper-strangled bureaucracies by building upon an existing and effective program.

Third, this bill is not offered as a finished legislative product. Instead, it is offered as a working paper. Hopefully, it will be considered by other Senators and particularly by those who are now studying the new social security bill and who will eventually be designing a final Senate health insurance bill. And, hopefully, it offers an approach which, after appropriate committee refinement, will receive the Senate's approval.

Mr. President, I ask unanimous consent that the entire text of my bill, The Children's Catastrophic Health Act of 1971, be printed in the RECORD at this point.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

A bill "The Children's Catastrophic Health Care Act of 1971"

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Children's Catastrophic Health Care Act of 1971".

AMENDMENT

Title V of the Social Security Act is amended to read as follows:

TITLE V

STATEMENT OF FINDINGS AND PURPOSES

SEC. 501. The Congress finds that—

(1) Safeguarding the health of all the nation's children is not only humane, prudent and compassionate but also mandatory for the nation's best interests;

(2) The expense of providing adequate health care to children suffering from major illnesses often comprises a financial catastrophe for families and too often stands as a barrier between children and their well-being;

(3) The failure to provide children with adequate health care solely because of their families' financial limitations is so inimical to the national interest as to comprise a national catastrophe;

(4) The health or ill-health of children in their later years is directly related to the maternal care or lack of maternal care which their mothers receive and to the care which they receive during the first year of their life;

(5) Of the 750,000 infants born each year to low-income families, 600,000 are borne by women who do not receive adequate maternal care;

(6) The mothers of half of all such infants receive no maternal care whatsoever; and

(7) The inadequacy or total lack of maternal care available to women from low-income families leads to a disproportionate incidence of prematurity, congenital defects, still births and infant deaths among infants born to low-income families.

Therefore, it is the purpose of this Act, to ensure adequate health care to children suffering from major illnesses, to ensure adequate care to all infants born to low-income families, and to ensure adequate maternal care to all women in low-income families.

DEFINITIONS

SEC. 502. For the purposes of this Act—

(1) "The Secretary" shall mean the Secretary of Health, Education, and welfare;

(2) "Low-Income Family" shall mean any family so defined by the Office of Economic Opportunity, Income Poverty Guidelines; and

(3) "Infant" shall mean a child in his first year of life.

CHILDREN'S CATASTROPHIC HEALTH CARE PROGRAM

Sec. 503 (a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1972 and for each succeeding year thereafter such funds as the Congress shall deem necessary.

(b) Care and services included under this section shall include the diagnosis of illness, the provision of medical, surgical and corrective care, the provision of aftercare, the provision of such facilities as are necessary for providing such care and the identification of children requiring such care provided that—

(1) In the case of a child whose family's annual taxable income is \$15,000 or less, the combined cost determined pursuant to sec. 505 (a) (3) of all such care and services provided in one twelve month period shall exceed 5 per centum of the family's annual taxable income; or

(2) In the case of a child whose family's annual taxable income is greater than \$15,000 the combined cost as determined pursuant to Sec. 505 (a) (3), of all such care and services provided in one 12 month period shall exceed the sum of 5 per centum of the first \$15,000 and 10 per centum of all income greater than \$15,000.

(c) Care and services authorized under this section shall be initiated:

(1) in calendar year 1971 for only those children who will not have reached the age of seven years as of December 31, 1971;

(2) for calendar year 1972 and in succeeding years for (A) all children eligible under (1) until such children reach age 18; and (B) all children born in such years until such children reach age 18.

(d) The Secretary shall pay to each State that has a State plan approved under Sec. 505 such sums as it requires to pay that part of the cost of care and services provided a child under this section which—

(1) in the case of a child whose family's annual taxable income is \$15,000 or less, is greater than 5 per centum of the family's annual taxable income; or

(2) in the case of a child whose family's annual taxable income is greater than \$15,000, is greater than the sum of 5 per centum of the first \$15,000 of such income and 10 per centum of all such income greater than \$15,000.

(e) Subsection (d) notwithstanding, the Secretary shall pay to each State that has a State plan approved under Sec. 505 such sums as it requires to carry out the provision of Sec. 505 (a) (9).

MATERNAL AND INFANT HEALTH CARE

Sec. 504 (a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1972 and for each succeeding year such sums as the Congress shall deem necessary.

(b) The Secretary shall pay to each State having a State plan approved under Sec. 505 such sums as it requires to provide comprehensive maternal care to all women of low-income families, and to provide comprehensive health care to all infants born to low-income families, and to provide diagnostic services for all infants of all families.

APPROVAL OF STATE PLANS

Sec. 505 (a) To be entitled to payments under Sec. 503 and Sec. 504 a State must have a State plan which—

(1) provides for carrying out the purposes of Sec. 503 and Sec. 504

(2) provides that the State shall pay no less in any fiscal year for care and services authorized under Sec. 503 and Sec. 504 of this Title than it paid in the fiscal year which ended June 30, 1971 for care and services authorized under Sec. 503 and Sec. 504 of Title V of the Social Security Act as in effect prior to the enactment of this Title.

(3) provides that the cost of care and services provided under this Act shall be reasonable as determined in accordance with standards established by the Secretary;

(4) provides for the administration of the plan by the State health agency or the supervision of the administration of the plan by the State health agency or the administration (or supervision thereof) of the plan by another State agency approved by the Secretary;

(5) provides such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis,

except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are necessary for the proper and efficient operation of the plan;

(6) provides for the training and effective use of paid subprofessional or paraprofessional staff, with particular emphasis on the full-time or part-time employment of persons of low-income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in providing services and in assisting any advisory committee established by the State agency;

(7) provides that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

(8) provides for cooperation with medical, health, nursing, educational and welfare groups and organizations and, with respect to the portion of the plan relating to care and services authorized under Sec. 503, with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically or mentally handicapped children;

(9) provides, with respect to the portion of the plan relating to care and services authorized under Sec. 503, for early identification of children in need of such care and services through provision of such periodic screening and diagnostic services as may be provided in regulations established by the Secretary;

(10) provides a program (carried out directly or through grants and contracts) of projects of the type described in Sec. 508 which offers reasonable assurance, particularly in areas with concentrations of low-income families, of satisfactorily promoting health of children and youth of school or preschool age;

(11) provides a program (carried out directly or through grants and contracts) of projects which offer reasonable assurance, particularly in areas with concentrations of low-income families, of satisfactorily promoting the dental health of children and youth of school or preschool age;

(12) provides for the development of demonstration services (with special attention to dental care for children and family planning services for mothers) in needy areas and among groups in special need;

(13) provides that acceptance of family planning services provided under the plan shall be voluntary on the part of the individual to whom such services are offered and shall not be a prerequisite to eligibility for or the receipt of any service under the plan;

(14) provides that, where payment is authorized under the plan for services which an optometrist is licensed to perform, the individual for whom such payment is authorized may, to the extent practicable, obtain such services from an optometrist licensed to perform such services except where such services are rendered in a clinic, or another appropriate institution, which does not have an arrangement with optometrists so licensed;

(15) provides with respect to the portion of the plan relating to care and services authorized under Sec. 503, for payment by the treated child's family or legal guardian or by third parties of that portion of the costs not paid by the Secretary pursuant to Sec. 503(d) or Section 503(e);

PAYMENT TO THE STATES

SEC. 506(a) From the sums appropriated under Sec. 503 and Sec. 504 the Secretary shall pay to each State which has a plan approved under Sec. 506 for each quarter, an amount, which shall be used exclusively for carrying out the State plan.

(b) (1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under Subsection (a) for such quarter, such estimates to be based on—

(A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of subsection (a), and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived; and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay the amount so estimated to the State in such installments as he may determine proper, provided that, such amount shall be reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

OPERATION OF STATE PLANS

SEC. 507. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under Sec. 505 finds—

(1) that the plan has been so changed that it no longer complies with the provisions of Sec. 505; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision the Secretary shall—

(1) notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until he is satisfied there will no longer be any such failure to comply; and

(2) shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure) until he is satisfied that there will no longer be any such failure to comply.

SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

SEC. 508. (a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1973, and for each of the four succeeding fiscal years \$50,000,000.

(b) Funds appropriated under this section shall be used for grants to promote the health of children and youth of school or preschool age, particularly in areas with concentrations of low-income families.

(c) Grants authorized under this section shall be made to the State health agency of any State and (with the consent of such agency) to the health agency of any political subdivision of the State, to the State agency of the State administering or supervising the administration of the State plan approved under section 505, to any school of medicine (with appropriate participation by a school of dentistry), and to any teaching hospital affiliated with such a school.

(d) Grants authorized under this section shall not exceed 75 per centum of the cost of any project for which grants are made.

(e) No project shall be eligible for a grant under this section unless it provides—

(1) for the coordination of health care and services provided under it with, and utilization (to the extent feasible) of, other State or local health, welfare and education programs for such children;

(2) for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary) of inpatient hospital services provided under the project, and

(3) that any treatment, correction of defects, or aftercare provided under the project is available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control; and unless

(4) it includes [subject to limitations in subsection (e) (1) (2) (3)] at least, such screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, both medical and dental, as may be provided for in regulations of the Secretary.

(f) The Secretary shall make such regulations as are necessary for the purpose of administering the grants authorized under this section.

SPECIAL PROJECT GRANTS

SEC. 509. (a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1973, and for each of the four succeeding fiscal years \$25,000,000.

(b) Appropriations authorized under this section shall be allotted by the Secretary in each fiscal year such that—

(1) \$5,000,000 shall be available for grants to State agencies administering or supervising the administration of a State plan approved under section 505 for the provision of family planning services;

(2) \$10,000,000 shall be available for grants to State agencies (administering or supervising the administration of a State plan approved under section 505), and to public or other nonprofit institutions of higher learning (situated in any State), for special projects of regional or national significance which may contribute to the advancement of services for children who are crippled or who are suffering from conditions leading to crippling; and

(3) \$10 million shall be available for grants to State agencies (administering or supervising the administration of a State plan approved under sec. 505) and to public or other nonprofit institutions of higher learning (situated in any State) for special projects of regional or national significance which may contribute to the advancement of maternal and child health.

(c) The Secretary shall make such regulations as are necessary for the purpose of administering the grants authorized under this section.

TRAINING OF PERSONNEL

SEC. 519 (a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1973 and for each of the four succeeding fiscal years \$20 million.

(b) From the sums appropriated under this section the Secretary is authorized to make grants to public or nonprofit private institutions of higher learning for training personnel for health care and related services for mothers and children, particularly mentally retarded children and children with multiple handicaps.

(c) In making grants authorized under this section, the Secretary shall give special attention to programs providing training at the undergraduate level.

(d) The Secretary shall make such regulations as are necessary for the purpose of administering the grants authorized under this section.

RESEARCH PROJECTS RELATING TO MATERNAL AND CHILD HEALTH SERVICES AND CRIPPLED CHILDREN'S SERVICES

SEC. 511(a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1973 and for each of the four succeeding fiscal years \$10 million.

(b) With the funds appropriated under this section the Secretary is authorized to make grants to or make jointly financed cooperative arrangements with public or nonprofit institutions of higher learning, and public or nonprofit private agencies and organizations engaged in research or in maternal and child health or crippled children's programs, and contracts with public or nonprofit private agencies and organizations engaged in research or in such programs, for research projects relating to maternal and child health services or crippled children's services which show promise of substantial contribution to the advancement thereof, provided that—

(1) special emphasis shall be accorded to projects which will help in studying the need for, and the feasibility, costs, and effectiveness of, comprehensive health care programs in which maximum use is made of health personnel with varying levels of training, and in studying methods of training for such programs; and

(2) grants under this section may also include funds for the training of health personnel for work in such projects.

(c) The Secretary shall make such regulations as are necessary for the purpose of administering the grants authorized under this section.

ADMINISTRATION

SEC. 512 (a) The Secretary shall make such studies and investigations as will promote the efficient administration of this title.

(b) Such portion of the appropriations authorized under this title as the Secretary shall determine, but not exceeding one-half of 1 percent thereof, shall be available for evaluation by the Secretary (directly or by grants or contracts) of the programs for which such appropriations are made.

(c) Any agency, institution or organization shall, if and to the extent prescribed by the Secretary, as a condition to receipt of grants under this title,

cooperate with the State agency administering or supervising the administration of the State plan approved under title XIX in the provision of care and services, available under a plan or project under this title, for children eligible therefore under a plan approved under title XIX.

OBSERVANCE OF RELIGIOUS BELIEFS

SEC. 513. Nothing in this title shall be construed to require any State which has any plan or program approved under, or receiving financial support under, this title to compel any persons to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan or program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such persons object (or, if such person is a child, his parent or guardian objects) thereto on religious grounds.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., November 19, 1971.

JOHN M. MARTIN, JR.
*Chief Counsel, Committee on Ways and Means,
Washington, D.C.*

DEAR MR. MARTIN: I am sorry about the confusion attending my desire to appear before the Ways and Means Committee to testify on my views concerning national health insurance. These plans went astray when I was taken ill Wednesday morning and my continued ill health prevented me from testifying today.

I am enclosing a copy of my statement and a longer statement describing my health proposal, and I am hopeful that you will include it in the transcript of the hearings.

Again, thank you for your understanding in this matter.

Sincerely,

WILLIAM R. COTTER,
Member of Congress.

Enclosure.

STATEMENT OF HON. WILLIAM R. COTTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mr. Chairman, Members of the Committee, it is a distinct privilege to appear before you today.

I do not envy your task as you legislate in this most complex area, but I am confident that you will accomplish your goal.

The subject of health insurance is one that I have had experience in. For six years, I was the Insurance Commissioner for the State of Connecticut and part of my responsibilities was to regulate the health insurance industry. Out of this experience, and my concern with health care in general, I proposed legislation, H.R. 8351, which contains features I feel should be incorporated in a national health insurance plan. In preparation for this testimony I considered giving a detailed description of my bill, but have decided instead to share with you those concepts which, I believe, are most important to national health care.

First, it must be understood at the outset that the health care crisis is largely a problem of rapidly increasing costs and poor distribution of medical services. While this is a problem of significant proportion, it is not a problem that requires a complete federal health effort. Briefly, I believe that the public and private sectors of the economy should be involved in the health field, but that the public sector should be more directly involved in the planning of health care. Traditionally, both the federal and state governments have been relegated to a funding role, but this has to be changed. The federal and the state governments should become involved in two additional areas: the content and financial aspects of public and private health insurance, and the restructuring of state and federal governmental institutions that handle health problems. Both are complex problems, but both are so interrelated that each must be dealt with to meet our

health care problems. I am sure this Committee agrees that our citizens should have adequate health insurance at reasonable cost. To achieve this goal we must address the complex cost and delivery problems. Frankly, I believe we must have a restructuring of our health delivery system.

I. THE NEED FOR ADEQUATE HEALTH INSURANCE

A. Concept of Minimal Benefits

It is essential that any plan that is to be called a "National Health Insurance Plan" place a uniform benefits floor under the health needs of U.S. citizens.

To do this, any legislation reported by this Committee should not only affect specific groups of citizens as did Medicare (the aged) and Medicaid (the poor), but every citizen. Public and private health insurance plans should be required to have certain legislatively prescribed minimal benefits. This can be accomplished by giving a tax deduction for insurance policies that contain these minimal benefits and for supplemental health insurance policies which are purchased in conjunction with a minimal benefits plan.

I wish to point out that in order to qualify for a tax deduction the supplemental policy must be truly supplemental and not contain any of the elements in the minimal benefits policy. By using this approach, the consumer will be able to understand and compare the costs of various policies that contain only minimal benefits. For example, if there are two identical minimal benefits policies, the consumer will be in a better position to choose one with a lower premium and high deductible, or a higher premium and lower deductible. In either case, the consumer will be able to understand what his minimal coverage will be, and supplementary benefits policies would be separate and would not include features of the minimal benefits. Therefore, there would be no duplication of coverage, or more importantly, dual payment for the same coverage.

The main point is, however, that by using tax incentives and, in the case of the poor and the aged, tax dollars, both public and private insurers will be required to put a uniform floor under the health needs of our nation's citizens.

Public and private insurers should work together to reach this goal.

I cannot stress too strongly that no group should be given lower benefits than any other. The aged and the poor—traditionally singled out for different treatment—under the new federal national health plan I envision would receive the same minimal benefits as individuals able to purchase private insurance.

B. Content of Minimal Benefits

I do not propose to cover each item in minimal coverage in my bill, but I want to discuss the general features which should be included in a national health care bill.

First, national health insurance should cover inpatient and outpatient care, including visits to doctors' offices.

Many private health insurance plans encourage unnecessary hospital utilization since they only offer benefits for doctors' services rendered in hospitals. This has resulted in over-utilization of hospitals, with resultant increased costs, and, perhaps, less adequate coverage because benefit levels are lowered as the premium dollars are used to pay escalating and unnecessary hospital costs.

There is another reason for my concern in this area. Most citizens' medical costs are not only tied up in health insurance premiums, but in those "uncovered doctor's visits" that soak up the wage earner's salary. Thus, a vast amount of health costs are not covered by any insurance.

Further, as in my bill, the schedule of minimal benefits should include necessary dental benefits. Since necessary, as opposed to cosmetic, dental costs are an integral part of the wage earner's medical costs, I believe they should be included in any comprehensive plan of minimal health benefits.

If the minimal benefits are reasonably comprehensive, there may be a need to phase them in over a period of time to allow the manpower and equipment to reach the level necessary to supply the expected demand. In my longer statement, I go into greater detail about the minimal benefits I suggest.

C. Co-Payments & the Ability to Pay

I am of the opinion that the benefits in a national health insurance plan should include certain standard co-payments to discourage frivolous use. Deductibles could be allowed to provide varying ranges of premium costs. However, the federal minimal benefits schedule should include a provision that incorporates an "ability to pay feature". I believe that these co-payments along with deductibles

should be strictly limited by the ability of the person to pay. In H.R. 8351, I have incorporated a limitation on the amount of such co-payments and deductibles predicated on the wage earner's income. Such a provision is a realistic approach to handling catastrophic health coverage.

D. Premium Costs

While the co-payments and deductibles are a very real cost to the individual policy holder, it is the premium that is the heaviest financial burden to both the individual and the employer. I have posed the idea that only those citizens that secure insurance with minimal benefits be eligible for tax deduction. The individual taxpayer would be allowed a maximum deduction of \$700. The employer would be allowed a deduction of 100% of the premium cost if he pays 65% of cost by 1973 and 75% of cost by 1975. However, to be eligible for this tax deduction, the individual or employer must secure insurance that provides the minimum benefits. This differs from existing practice whereby any health insurance premium, regardless of benefits levels, is an allowable deduction.

E. Cost Controls

Tax relief must be balanced, however, by adequate controls over premium cost. The individual, the employer, and the federal and state governments cannot be asked to bear any increased premium costs while public and private insurers and, indeed, the entire medical industry goes happily along increasing costs at a rate of 12% to 15% per year.

There should be federal and state governmental mechanisms to check and control such inflation. In H.R. 8351, I suggest that a National Council of Health Advisors should establish a strict auditing procedure for both private and public health insurers. Such an audit could be administered by a State Health Planning Council to assure that the premium charged by the insurer contains no excessive or hidden profits. I am aware, for example, that many insurance companies, while showing how much they have "lost" on medical insurance are, in fact, enjoying substantial fiscal benefits from operation funds, cash flows, and other forms of working capital. I believe that it should be mandatory that excess profits be returned to the consumer in the form of lower premiums.

The insurer—both public and private—should be carefully scrutinized. By having a state agency administer this standard audit, the serious jurisdictional problems can be avoided.

II. REFORM OF HEALTH INDUSTRY

A. New Governmental Structure

The second area that must be covered is the structure of new health delivery systems. I briefly touched upon this in the preceding section.

I believe that this Committee should consider requiring the establishment of new State and federal agencies to administer the allocation of health resources. These resources extend not only to physical plants, but also to the location of certain specified health care facilities. For example, heart care facilities, kidney machines, cobalt machines, etc.

I am very aware and acutely sensitive to the separation of powers. It is for this reason that I suggest that both state agencies and a federal agency be created.

Before I outline such an administrative apparatus, one thing must be made clear. These proposed agencies should have real power and authority. The critical needs and shortfalls of our health care system will only be compounded by a new series of advisory boards or "suggestion creators". There must be a real "shared responsibility" for health care decisions, but responsibility for decision should be easily located.

B. State Health Planning Councils

With this as a basis, I feel that as a condition for receiving federal health dollars (i.e. Medicare, Medicaid, or even programs beyond the jurisdiction of this Committee, such as Hill Burton and medical student loans) each state should be required to set up a State Health Planning Council within three years by appropriate state legislation.

As the Committee goes over this list of duties and responsibilities I suggest for the state councils, there may well be concern over the social and political

implications of the scope of these suggestions, yet I ask you to consider this: The reason for these hearings and your interest is that you perceive that something is very wrong with our health care system. A patchwork quilt approach has not worked in the past, and it will not work in the future. Health costs—a leading factor in the Health crisis—will not be reasonable if we continue the “business as usual approach”.

I submit that the medical personnel, private and public insurers, and physicians have done little to hold down the cost of health care. They have also resisted efforts to change the system. What is required is more effective governmental action, in which these groups participate but do not dominate and paralyze. That is the reason that I propose that the State Health Planning Council have more than 50% of its membership representing the consumer. However, on the state council there should be positions for representatives of the physicians, health administrators, and other health industry personnel. This is how the “shared responsibility” that I mentioned earlier should be implemented. Private health personnel should be represented but not dominate a powerful State Health Planning Council.

Such a state council should have these powers and duties:

(1) To establish a state health plan that acts as *the* guide for the allocation of state and federal health expenditures; therefore all construction or equipment acquisition requiring potential public funding will have to be approved by this health council;

(2) To accredit all health care institutions from hospitals to nursing homes and outpatient clinics. I believe the state council should be able to proceed on its own initiative here but that the Congress should subsequently study the issue to ensure that the highest quality facilities are being provided for our citizens;

(3) To establish rates of reimbursement for institutional fees and medical services. The former can be predicated on health institution's budgets that are accepted by the state council, the latter could include a range of rates for typical services. I can anticipate the cries of “socialized medicine”, yet such name-calling will not contribute to the solution of the key element in our current health care crisis—the high cost of health care;

(4) The organizational responsibility to oversee the private and public aspects of health insurance. Specifically, the council should require that every insurer provide minimal benefits as a condition for licensing in that state. Further, the council should administer detailed audits of private and public insurers to ensure that no excess profits are being made.

C. New Federal Program

State efforts to reduce costs and rationalize health systems must be met by new federal action. The Executive Council would serve to organize and coordinate federal efforts and would have these specific tasks:

(1) Create a uniform national audit for public and private insurers which will be administered by state health planning councils;

(2) Establish uniform national certification and licensing procedures for all paramedical personnel. This is necessary to effectively utilize the existing medical manpower. All too often, highly skilled medical assistants are not allowed to perform duties for which they are trained, because physicians are held legally liable for the performance of these activities, and are hesitant to allow others to do them. By a standard license or certification method, trained medical personnel will be able to perform medical services they are trained for;

(3) Coordinate state and local efforts with national health goals.

I describe these responsibilities at greater length in an accompanying statement.

III. CONCLUSION

Let me again state my main premise—the health care crisis is based on two issues: increased cost of health care, and a poor allocation of health resources. I believe that a national health care plan should cover these two problems, first by providing adequate health insurance for all Americans by placing a floor under their medical needs, and second, by restructuring our health delivery system.

I appreciate the opportunity to testify before you today.

[From the Congressional Record, May 12, 1971]

THE COTTER HEALTH PLAN: A PUBLIC AND PRIVATE PARTNERSHIP TO INCREASE THE QUALITY AND LESSEN THE COSTS OF HEALTH CARE

(Mr. COTTER asked and was given permission to address the House for 1 minute and to revise and extend his remarks and include extraneous matter.)

Mr. COTTER. Mr. Speaker, during my campaign and after the election, I made the problem of health care one of my primary interests.

Today I am introducing legislation that reflects my considered judgment on how best to handle what has been called the "health care crisis."

These facts are well known but bear repeating. The costs of health care are astronomical. During the last 10 years, the costs of health care have increased 17 percent per year. It is reasonably estimated that the cost of health care will be \$200 billion by the 1980's. The total cost in 1960 was \$26 billion.

Current insurance plans do not cover out-patient care, much less dental and vision care.

Medical manpower is a constant source of concern. By 1980, there will be a shortage of 26,000 doctors, 56,000 dentists, 210,000 nurses, and 432,000 paramedical personnel.

I do not have to recite before this House the areas of the country that have little or no medical capability. The problems are especially acute in our inner cities and in our rural-areas.

Before I outline my proposals, I want to inform my colleagues about my general assumption and values.

First, I represent the city of Hartford, the insurance capital of the Nation. It is estimated that thousands of my constituents are involved in health insurance. I am not willing to see those jobs shipped to Baltimore, the home of the Social Security Administration, until such time as it is shown that the insurance industry—scrupulously controlled as I will recommend—is unable to do the job.

Second, from my position as the Insurance Commissioner for the State of Connecticut for 6 years, I have become familiar with the problems of both quality health care and public-private health insurance coverage. Thus, I have studied in detail the strength and weakness of our health delivery system.

The proposal I am placing before the House today reflects this experienced study. I believe that there must be a partnership between private industry and government to assure the highest quality health care at the most reasonable cost.

The Cotter Health plan is not cheap—medical care is not cheap, but my plan represents a distinct departure from the "business as usual" attitude that permeates the medical industry and the Government in the face of overwhelming evidence that this Nation now faces a health crisis. This crisis will worsen unless there is a new direction charted—and charted soon. That is what I am proposing today.

Briefly, my plan would establish minimal benefits that, when fully phased in, will provide better health coverage than is presently available. Under the terms of my bill all citizens will be covered.

Medical and dental insurance coverage for all citizens provided by expansion and upgrading of medicare, required employee health plans, individual health plans for the self-employed and State health plan pools for the poor and near poor.

Creation of Federal and State health planning councils which will control allocation of health resources, set hospital rates and doctors fees, control profits of health insurance carriers, set uniform medical and paramedical licensing standards and continually review the state of health care in the Nation.

Increase the supply of medical manpower by creating three new medical-dental schools associated with existing Army, Navy, and Air Force hospitals and by expanding student loans for budding doctors, nurses and paramedicals. Graduates of military medical schools and recipients of loans could serve several years in medically disadvantaged areas of the country to repay their obligations.

The bill is complicated because the subject matter is complicated. Complex problems do not yield to simple answers. Therefore, I want to take this opportunity to explain my proposal in detail.

HOW TO INCREASE COVERAGE

There are many suggestions about how to secure adequate health insurance coverage. One plan suggests that the best way to assure complete coverage is for the Federal Government to assume full and complete control of the health care of all citizens. Cost estimates for a fully Federal program of health care are between \$50 and \$80 billion. Other plans leave many citizens with inadequate coverage or coverage at high costs. I know from my experience as insurance commissioner of the State of Connecticut for 6 years that health care is increasingly expensive and the health care system is plagued by inadequate planning and lack of resources. However, I do not believe that a complete Federal takeover is feasible or is, in the long run, cost-effective.

There remains the very practical need to provide adequate health coverage at a reasonable cost. Yet, such a basic health plan must be understood by the layman so that he can choose intelligently the type of coverage he requires. The best means to accomplish these goals is to establish a set of minimal, yet adequate, Federal standards for health care benefits that will be required of both governmental and private health insurance programs. This is what I am suggesting.

COTTER HEALTH PLAN

Under the Cotter plan, these minimal health standards will be increased in three phases and, when fully effective, December 31, 1978, each basic health insurance plan will be required to have these features:

COTTER HEALTH PLAN: MINIMAL BENEFITS

Cotter plan has minimal benefits phased in at three separate time periods so that the medical infrastructure can be "beefed up" to handle them. These minimal benefits will be fully phased in by December 31, 1978; however, the State health plan for the poor and near poor will be fully phased in by December 31, 1976.

The requirement of minimal benefits, which exceed most health insurance coverage today, allows the individual citizen to know exactly what coverage he is getting. Currently it takes a very skilled legal technician to understand the various insurance plans.

Other major provisions of the minimal benefits:

(a) Tax relief—There is a straight Federal tax deduction of up to \$700 for health insurance premiums.

(b) Catastrophic coverage—There is a limitation on the amount of copayments, coinsurance and deductibles, if any, an insured citizen will have to pay. The total cost of these payments will be a small percentage of his income.

Examples of benefits and copayments when minimal benefits are fully phased in by December 31, 1978. N.B.—All yearly copayments and deductibles, if any, are limited to a small percentage of yearly income.

NONINSTITUTIONAL CARE

Each doctor's visit—insured pays \$2—for mental illness, insured pays 50 percent for all visits after initial six visits.

Home visits—insured pays \$5.

Diagnostic tests, X-rays, laboratory analysis, electrocardiograms—insured pays nothing.

Family planning services and supplies—insured pays nothing.

Health checkups—

For babies: 15 visits up to 6 years old—insured pays nothing;

For citizens 6-39: complete examination every 5 years—insured pays nothing;

For citizens 39 on: one complete examination every 2 years—insured pays nothing.

Dental care—

Annual oral examination including X-rays and cleaning—insured pays nothing;

Amalgam fillings, extractions, dentures—insured pays 20 percent.

Drugs approved by Secretary of HEW as life-sustaining—insured pays \$1 per prescription.

Rehabilitation—prosthetic devices, physical therapy, speech therapy—insured pays 20 percent.

Vision care—

Children under 19—annual examination and one set of glasses—insured pays nothing;

Citizens over 19—annual examination and one set of glasses—insured pays 50 percent.

INSTITUTIONAL CARE

Semiprivate or psychiatric care—per illness—insured pays \$10 the first day and \$5 per day thereafter—300 days maximum;

Skilled nursing home—insured pays \$2.50 per day—100 days maximum;

Approved home care—insured pays \$2 per day—270 days maximum;

Physician's services when institutionalized—insured pays \$2 per visit;

Maternity care, including prenatal and post-natal care—insured pays 20 percent.

CATASTROPHIC COVERAGE

In my bill, I specifically provide for catastrophic coverage by placing a limitation on the amount of copayments and deductibles. The aggregate amount of payments above the premium could not exceed \$800 for a family whose adjusted gross income is \$10,000, even though he may require treatment costing up to \$50,000.

The formula which is applied to all minimal benefits insurance is a limitation of 4 percent of adjusted gross income for all persons with an adjusted gross income of \$5,000, a limitation of 6 percent for persons with an adjusted gross income of from \$5,000 to \$7,500, and a limitation of 8 percent for those with an adjusted gross income of \$7,500 or more.

This is a major feature of the Cotter health plan. For the first time all citizens will have adequate medical coverage without courting bankruptcy.

WHO WILL BE COVERED?

Under my plan the minimal benefits will be included for medicare, all private health insurance plans, and all Federal and State health plans. Let me discuss each in turn.

THE ELDERLY

The coverage for medicare will be upgraded until it meets these minimal benefits. Where medicare exceeds this coverage, the higher medicare benefits will still be in effect.

In addition, my bill would open medicare to all persons not currently eligible for part A by requiring a \$27 per month payment. I have been informed that there are approximately 300,000 citizens over 65 who can take advantage of such a provision. In addition, I would extend medicare coverage to include widows and/or widows with or without dependent children, the blind, and disabled, and early retirees who are now receiving social security benefits. Other programs of medical insurance for citizens over 65 will have to provide these upgraded benefits as well as retirement health insurance provisions. The cost estimate for medicare is approximately \$7 billion over current medicare costs. The costs, while heavy, do extend and provide more comprehensive coverage to our elderly citizens. This is a just and necessary cost.

Since I have studied the problems of the aged, I realize that even small payments strike very deeply into the fixed incomes of our elderly citizens. Thus, under my plan, elderly citizens who cannot afford to meet their payments will be covered by the State insurance pool which I will describe shortly.

PRIVATE INSURANCE PLANS

Private health insurance plans cover most citizens under 65. Of the approximately 164,000,000 citizens under age 65, 103,000,000 are covered by some form of health insurance. Benefits and costs vary widely. Most citizens do not understand the nature of their medical coverage. Under the Cotter plan all the minimal benefits will be clearly defined by law. All supplemental benefits packages cannot have features already in the minimal package. Therefore, no double payments for the same benefits.

The establishment of minimal benefits will be accomplished by several means: First by tax deduction of \$700 to all citizens securing insurance with minimal benefits; second insurance packages containing minimal benefits will be eligible

for employers to use as tax deductions; third, and most important, requiring that each provider of health insurance meet these minimal standards as a condition for being licensed in each State.

Further, under my plan the employer as a condition for continuing employee health insurance as a tax break must not only provide the minimal benefits, but must pay 65 percent of cost immediately and 75 percent by 1975. Of course, collective bargaining can be used to increase the percentage or extend coverage.

I want to return to one point for a minute. Under my plan there would be a straight deduction with a \$700 maximum for each family's Federal income tax. The estimated revenue loss is \$3 billion. In doing this, my plan not only gives better coverage but allows higher tax deductions for the individual taxpayer while producing increased health coverage.

POOR OR NEAR POOR

One major problem with any comprehensive proposal is how to care for the poor and near poor. By applying the minimal benefits fully phased in by 1976, a State health care plan can meet the needs of our less fortunate citizens.

The State health care plan will be a State pool funded by State and Federal subsidies and by private insurers. It would have all the minimal benefits by 1976. These benefits stress preventive care and are, therefore, able to replace the discredited medicaid program. Each citizen would be required to pay according to his financial ability, but he would receive better and more comprehensive health care. For example, a family of four with an income of \$4,000 or less would contribute nothing to the premiums. A family of four with an income of \$5,000 would contribute \$15 monthly which would be a deduction from the Federal taxes.

In addition, the State health pool would be available to the "uninsurable" person although he would be required to pay the full premium charged by the State for covering a single individual. If the uninsurable person were a member of a family, the other members could secure whatever coverage they desired at the most reasonable cost.

Those poor citizens eligible for medicare under the old law or under the new provisions of this bill can have the State health care plan pay their premiums to medicare.

NEW ORGANIZATION FOR HEALTH CARE

Many of our current problems in health care are directly attributable to inadequate planning, and a lack of effective and responsible administration.

The time is long past when we can afford to have people who have vested material interest in the health delivery system dominate and control that system. The State and Federal Governments must act constructively and forcefully in this area. Therefore, I am proposing to create in each State, a State health care planning council—SHPC.

STATE HEALTH PLANNING COUNCIL

Under my plan, each State will be required, within 1 year of enactment, to create a State health planning council. If it does not do this, it will not receive any Federal assistance related to health, including medicare, Hill-Burton, or any other Federal medical funds.

This SHPC will be composed of 15 members. It will be dominated by nine consumer-oriented members who have not had any prior connection for 5 years preceding their appointment with any organization which deals with any aspect of the medical delivery system. These nine members will be joined by two doctors, two hospital representatives, and two private insurers. They will be given great authority to determine the course of the health system within their State.

For example, the SHPC will be required, within the first 2 years, to establish a comprehensive State health plan that will serve as a guide to all State health efforts. And they will be given the power to implement this plan. They will, for example, be required to approve, or disapprove, the use of all Federal or State funds for any construction or any service related to health care. Secondly, they will be required on a periodic basis, to certify all health care facilities. Those health care facilities that are not certified cannot receive State or Federal funds and cannot be utilized in fulfillment of the minimal health benefits that I have already described.

This power will give the council the ability to rationalize the health delivery system. No longer will there be four or five acute cardiac wings within one city that go unused. No longer will there be duplication of costly equipment: For example, three cobalt treatment facilities within close proximity. "Prestige" items will be subordinated to items of demonstrable and immediate long term value.

This State council will establish rates of reimbursement to hospitals and doctors. They will arrive at the figures for hospitals and health care costs by requiring each institution to submit a detailed budget which the council must approve. This approved budget will be the basis for allowable charges.

The council, as I have mentioned, will also set rates for doctor's fees that can be paid under the State health plan and the minimum benefits under approved employees' programs and qualified individual health care insurance plans.

Furthermore, this State council will have the power and the responsibility for overseeing the private health insurance industry. It is required to establish that all initial insurance packages by each insurer meet the minimal benefits as a condition for licensing with the State. Furthermore, the State planning council is to require that all supplemental insurance policies, those over the minimal benefits, do not include any element covered in the minimal benefits plan.

In addition, the council is required to secure from licensed health insurers, detailed audits based on the audit form prepared by the executive council of health advisers which I will describe below.

These audits are to be studied by the State policy council to insure that the profits are within the parameters established by the executive council; if the profits exceed this parameter, the State council is required to have the insurers reduce their premiums as a condition for the retention of their license.

The State council is further allowed to enter into intra- or inter-State health agreement to further the attainment of quality health care and is required to provide a yearly report to the executive council within the guidances established by the executive council on the conditions of health care within the State.

The State health planning council will also have the authority to establish regional groups to meet the local problems although the council must retain the final authority over these local decisions.

THE EXECUTIVE COUNCIL OF HEALTH ADVISERS

To assure nationwide coordination of the various means to attack the problems in our health care system, I am recommending the establishment of an Executive Council of Health Advisers.

This 12-member council will be comprised of six consumer representatives who have not had any connection with the health industry for 5 years preceding their appointment. In addition, the Secretary of Health, Education, and Welfare will be a member of this Council.

The Executive Council is to report annually to the President and the Congress on the nationwide aspect of the health delivery system after detailed study of the annual reports of each State health planning council. The Executive Council then is required to make an early evaluation of this information and report directly to the relevant bureaucracy and legislative branch with recommendations for either regulations or legislation, whichever is appropriate. It is necessary to have the Council report directly to the responsible agency or legislature because in all too many instances, commission reports, panels, kind other similar recommendations are not effectively translated into bureaucratic regulations or legislative proposals.

As I mentioned before, the Executive Council is required to create uniform audit forms for private and public insurers that will be given to the State planning council. This uniform audit is to include costs and profits and the definition of profit will be exacting, so that no excess profits will be made by either public or private insurers. Excess profits must be used to reduce premiums.

The Executive Council is also required to produce, within 5 years, national certification and license procedures for all medical personnel, from doctors to paramedical personnel. These procedures will be enforced through the mechanisms established by the State planning council. It is necessary to define what each person is allowed to do within his sphere of competence. The problem has been graphically brought home by the sight of many qualified paramedics returning from Vietnam and not being allowed to perform even the most elemen-

tary functions in a hospital or outpatient care center. There must be professional licensing of these people so that all criteria manpower needs in the health care area can be alleviated.

Finally, the Executive Council is required to prepare legislation to establish what will be an "FDIC" for all public and private health insurers within 2 years. This legislation must be mandatory for all private insurers.

HEALTH MANPOWER

The problems of the health delivery system will not be solved by new effective administration alone, although that is a crucial component of the Cotter plan.

We need more personnel and better distribution of resources and personnel.

First the personnel: This Nation needs more qualified personnel in health. Existing programs, while beneficial, must be supplemented, expanded and even, in places, radically changed.

I believe that loan programs should be expanded, not only in the size of the loan, but in what the loan can be used for. Medical students, nurses, and allied health personnel should be allowed to secure loans to cover tuition fees, and in addition, reasonable amounts for room and board, and supplies and other related costs. These will be long-term, low-interest loans, and there is a forgiveness feature that allows the loan to be significantly reduced if the individual serves in an area determined by the Secretary of Health, Education, and Welfare and the State health planning council to be in need of these skills—the inner city and rural areas.

My bill also provides for the Secretary of Health, Education, and Welfare to contract with individuals or teams of health professionals to serve in areas of critical need. Thus, the bill provides the capability to channel more than adequate medical resources into areas that now have little or no health capability.

My bill authorizes over \$300 million for these programs.

Federal health manpower programs will come under the purview of both the executive health planning council and the State health planning councils. They will study and determine both curriculum and certification of institutions and licensing of medical personnel. They could investigate the intriguing idea of "Capitation" whereby schools receive funds based on the number of qualified graduates they produce.

AMBULATORY HEALTH CARE CENTERS

During my recent campaign, I stressed the need to concentrate on more outpatient diagnosis and treatment. As I have already explained, the minimal health benefits specifically include and encourage outpatient care.

In title IV of my bill, I establish a new Federal governmental program to create ambulatory health care centers. The goals of these ambulatory centers are not solely restricted to diagnosis and treatment, but as well, to the detection and prevention of illness before it becomes serious.

High quality medical care must be available to all our citizens. This is one means to achieve this goal.

The exact nature of ambulatory health care centers should be determined by medical experts. Therefore, I have left the specifications for the contents of ambulatory health care centers to the experts. However, I have specified in my bill that the highest priority is to be given to those areas that are medically deficient.

This novel approach should be tested. Over-crowded, high-cost hospitals are not the place to perform routine examinations or tests and treatment. They should be used only by those who really need them. With this new outpatient capability, I believe we can have more effective utilization of our hospitals.

Incidentally, ambulatory health care centers can be attached to existing medical institutions or can be mobile units. A new medical delivery system should be aggressive in searching out disease and illness—not passive.

The ambulatory health care center concept, I submit, is a reasonable and necessary means to achieve this goal.

THE NEW MEDICAL-DENTAL MILITARY ACADEMIES

As I contemplated the lack of medical manpower, I was struck by the under-utilization of military hospitals for teaching purposes. Since the end of World War II, there have been only six new fully operating medical schools and 10

new fully operating dental schools. I believe that we can supplement our doctor and dentist manpower needs in a very cost-effective way by establishing combination medical and dental academies for the Army, Air Force, and Navy.

Therefore, I have proposed in my bill that these medical-dental academies for each service be established. To save costs, these academies will utilize existing U.S. military hospitals.

The appointment procedure will be similar to those now used for the Service Academies, although the Secretary of Defense will work with the Secretary of Health, Education, and Welfare to establish the criteria for admittance. After completion of his academy training, the doctor or dentist must serve 3 years in the Armed Forces or in an alternative 3-year service approved by the Secretary of Defense in consultation with the Secretary of Health, Education, and Welfare.

I believe that this novel idea, coupled with the manpower programs I have suggested, will lessen the projected medical manpower shortage.

THE COTTER HEALTH PLAN A ROONDOGGLE TO THE PRIVATE INSURANCE COMPANIES

I specifically want to raise the question whether my plan is a large and costly gift to the private insurance industry. Given the nature of my constituency, this is a legitimate question.

Admittedly, my plan does continue the role of private health insurance. But more importantly, for the first time, it establishes control and direction over the entire health insurance industry.

How is this accomplished?

First, health insurance companies will have to provide minimal benefits so that each individual purchaser understands what he is getting.

Second, all supplemental benefits, those over and above the minimal benefits, cannot include parts of the minimal benefits package. Therefore, no double payment for the same benefit.

Third, again for the first time, public and private insurers will have limits set on profits. Excess profits must be returned to the consumer in the form of lower premium payments. I have carefully drawn the section on profits required in the universal audit so that there will be leeway given to companies to hide profits.

Fourth, the State health planning council and the executive health planning council are dominated by consumer representatives. These members can have no prior connection with the health industries including insurance for 5 years preceding their appointment. This means that the regulations of the insurance industry will be under the jurisdiction of people who are most concerned about the effect of health insurance on the consumer.

Finally, I have required that all private health insurers join an FDIC-type of institution so that citizens will not be faced with companies going out of business and having no coverage.

These steps I feel will insure the highest professional competency of both public and private health insurers and still retain those incentives that are directly related to the retention of the private nature.

It should be noted in conclusion that the executive health planning council and the State health planning council will retain jurisdiction over the health industry and any loopholes in the bill can be rectified by either regulation or, if necessary, submission of stronger Federal legislation.

For the benefit of my colleagues and the readers of this Record, I am enclosing five appendixes that will give an overview of the Cotter health plan:

APPENDIX A

COTTER HEALTH PLAN: COVERAGE OF ALL CITIZENS

1. Aged—Aged and all citizens on Social Security except AFDC (welfare). Cotter plan expands and extends service of Medicare. Over 300,000 older citizens are not eligible for Medicare "A" and my plan allows them to join for \$27 per month. If Medicare or any other retirement health plan has benefits that exceed the minimum benefits, the better benefits are to remain in force. The elderly poor will have their Medicare premiums paid for by the State Health Plan: Part A, if necessary, and Part B, the supplementary benefits that are currently available to all elderly citizens.

2. Employee Health Plans—Most citizens will be covered under these plans. All employers must provide health insurance that meets the minimal benefits or not

receive any tax breaks for providing health insurance. Furthermore, to receive this tax break, employers must pay for 65% of the plan and 75% by July 1, 1974.

3. **Individual Health Plans**—Covers self-employed or those not wishing to utilize one of the other plans. All insurers must provide an initial insurance policy that meets the minimal benefits. Any supplementary insurance must be clearly identified and not have the features included in the basic minimal benefits policy.

4. **State Health Plans**—Poor and near poor can join a state health insurance plan. It is funded by a combination of state, Federal and private insurance funds and stresses preventative care. Cost of purchase of this coverage is pro-rated on the ability to pay basis.

APPENDIX B

COTTER HEALTH PLAN: MINIMAL BENEFITS

Cotter Plan has minimal benefits phased in at three separate time periods so that the medical infrastructure can be "beefed up" to handle them. These minimal benefits will be fully phased in by December 31, 1978; however the State Health Plan for the poor and near poor will be fully phased in by December 31, 1976.

The requirement of minimal benefits which exceed most health insurance coverage today, allows the individual citizen to know exactly what coverage he is getting. Currently it takes a very skilled legal technician to understand the various insurance plans.

Other major provisions of the Minimal Benefits:

(a) *Tax Relief*—There is a straight federal tax deduction of up to \$700 for health insurance premiums.

(b) *Catastrophic Coverage*—There is a limitation on the amount of co-payments, co-insurance and deductibles, if any, an insured citizen will have to pay. The total cost of these payments will be a small percentage of his income.

Examples of benefits and co-payments when minimal benefits are fully phased in by December 31, 1978 (*N.B.* All yearly co-payments and deductibles, if any, are limited to a small percentage of yearly income.):

NON-INSTITUTIONAL CARE

Each doctors visit—insured pays \$2. For mental illness, insured pays 50% for all visits after initial six visits.

Home visits—insured pays \$5.

Diagnostic tests, x-rays, laboratory analysis, electrocardiograms—insured pays nothing.

Family planning services and supplies—insured pays nothing.

Health check-up:

For babies: 15 visits up to 3 years old—insured pays nothing.

For citizens 6-30: complete examination every 5 years—insured pays nothing.

For citizens 30 on: one complete examination every 2 years—insured pays nothing.

Dental care:

Annual oral examination including x-rays and cleaning—insured pays nothing.

Amalgum fillings, extractions, dentures—insured pays 20 percent.

Drugs approved by Secretary of HEW as life-sustaining—insured pays \$1 per prescription.

Rehabilitation—prosthetic devices, physical therapy, speech therapy—insured pays 20 percent.

Vision care:

Children under 19—annual examination and one set of glasses—insured pays nothing.

Citizens over 19—annual examination and one set of glasses—insured pays 50 percent.

INSTITUTIONAL CARE

Semi-private or psychiatric care—per illness—insured pays \$10 the first day and \$5 per day thereafter—300 days maximum.

Skilled nursing home—insured pays \$2.50 per day—100 days maximum.

Approved home care—insured pays \$2 per day—270 days maximum.

Physician's services when institutionalized—Insured pays \$2 per visit.
 Maternity care, including prenatal and post-natal care—Insured pays 20 percent.

APPENDIX C

COTTER HEALTH PLAN: NEW HEALTH DELIVERY SYSTEM

STATE HEALTH PLANNING COUNCILS

Each State is required to have a 15 member council (9 of whom are consumer representatives).

State Councils are required to:

Develop a comprehensive State Health Plan within two years which eliminates medically deprived areas within the State.

Approve the use of all federal and state medical funds to avoid duplication and to proceed according to the comprehensive State Health Plan.

Certify all health institutions including hospitals, outpatient clinics, nursing homes, etc.

Establish rates for health care institutions by prior approval of the health care institutions' budgets.

Establish rates for medical services including doctors' fees.

Control public and private insurers by requiring stringent audit procedures, regulating the rate of profit, requiring excess profits be used for the reduction of premiums, and by requiring all insurers to have minimal benefits in order to be licensed in the State.

EXECUTIVE HEALTH PLANNING COUNCIL

White House Agency composed of 12 advisors (6 of whom are consumer representatives).

Executive Council is required to:

Conduct a continuing review of the national health delivery system, and to submit regulations and legislation to eliminate the deficiencies as identified.

Prepare a detailed audit to be used by the State Health Planning Councils to determine profits of insurers and require that excessive profits be used to reduce premiums.

Set uniform medical licensing standards for all medical personnel from doctors to paramedicals, thus allowing paramedicals to perform certain functions for which they qualify.

Submit legislation to the Congress within 2 years to establish an FDIC-type of government agency that would guarantee the financial solvency of insurers so, should they fail, the customers would be protected.

APPENDIX D

COTTER HEALTH PLANS NEW CHANGES IN THE MEDICAL INFRASTRUCTURE

New Army, Navy, Air Force Medical-Dental Academies:

Use the existing major military hospitals e.g., Walter Reed-Army, Bethesda-Navy, Wilford Hall, Texas-Air Force, to train new doctors and dentists.

Require these doctors and dentists to serve either in the Armed Services for three years or for this same period of time in medically-deprived areas determined by the Secretary of Health, Education and Welfare.

More Medical Manpower:

Expanded the size of student loans to aspiring doctors, dentists, nurses and paramedicals and allow the loans to include living expenses. Do this by providing almost \$300 million additional loan capacity. Encourage service in medically-deprived areas by forgiving loans at the rate of $\frac{1}{3}$ a year for service in these areas.

The Executive Council is required to establish certification and license standards so that paramedicals can perform services for which they are qualified, thus relieving the doctors from many routine chores.

The Secretary of HEW is allowed to contract directly with medical personnel to serve in medically-deprived areas.

Discourage the over-utilization of hospitals by the provision of new ambulatory Health Care Centers to encourage out-patient care. My plan provides over \$200 million per year for this necessary program.

Discourage the construction of "prestige" items that are duplicated within the same region. The State Health Planning Council will have to approve all construction within its establish Comprehensive state-wide health plan.

Require strict control over medical costs.

All health institutions, including hospitals, outpatient clinics, and nursing homes, in the state must submit a budget to the State Health Planning Council. The budget, as approved by the State Council, will be the basis for fees that the institutions will charge.

In addition, the State Health Planning Council is to set up a schedule for fees for all services prescribed under minimal benefits, including medical services.

APPENDIX E

COTTER HEALTH PLAN: IS IT A BOONDOGGLE FOR THE PRIVATE INSUROR?

Cotter Plan does continue a role for the private health insurance industry but the industry must submit to new and more stringent controls.

1. The insurer will be required to report his profits. I have carefully drawn the section on profits to include various funds that are conveniently described as operating expenses but, in effect, produce profits. Excessive profits must be turned into lower premiums.

2. Each insurer in the state must provide minimal benefits. The customers then have the capacity to shop around for the least costly program.

3. All supplementary benefits will have to be identified as such and cannot have coverage identical to minimal benefits. Therefore, citizens will not pay double for the same coverage.

4. The State Health Planning Council and Executive Health Planning Council responsible for controlling the insurance industry, both public and private, are dominated by consumer representatives—9 of the 15 members of the State Health Planning Council and 6 of the 12 members of the Executive Council are to be consumer representatives who have had no prior connection with the health industry for the preceding 5 years.

5. Finally, the consumer is protected by the requirement that the public and private insurer must join a FDIC type of agency that will protect the consumer from an insurer blandly announcing he is going out of business.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., October 1, 1971.

HON. WILBUR MILLS,
Chairman, House Ways and Means Committee,
Longworth House Office Building.

DEAR MR. CHAIRMAN: I would like to commend you for your recent announcement that public hearings on national health insurance will be the next major order of business for the Ways and Means Committee.

As a co-sponsor of the Health Security Act of 1971, I am pleased to know that this legislation will be considered in the near future by the Committee.

I know there is no need to impress you with the urgency of the health-care situation. Skyrocketing costs and declining health standards have brought our nation to the brink of catastrophe.

The Health Security Act would establish a comprehensive health-care system which would bring needed medical and hospital services within the financial reach of every American.

I cannot emphasize too strongly my extreme sense of urgency regarding the need for prompt action on this legislation.

Kindest personal regards.

Sincerely yours,

WILLIAM D. FORD,
Member of Congress, Michigan.

STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The American public looks to Congress for leadership in finding a satisfactory approach to a realignment of national priorities to include an adequate health

care system as a basic human need and right equal to or transcending those already accomplished such as national defense and public education. In so fulfilling the Preamble and Article I Section 8 of our Constitution, the Ways and Means Committee faces a task with tremendous complexities.

Occupational therapy has been part of the health care delivery system in the United States for more than a century and has been an organized profession for more than half a century. In 1967 our organization, the American Occupational Therapy Association (AOTA), observed its 50th anniversary. Our membership totals more than 12,000, including Registered Occupational Therapists and Certified Occupational Therapy Assistants.

POPULATION SERVED BY OCCUPATIONAL THERAPY

Our members have been involved and serve today at all levels of health care: in planning, in screening, in programs preventing health deterioration or injury, in diagnostic, evaluative, treatment, rehabilitation and health advocacy services. They function in hospitals, extended-care facilities, clinics, public and special schools, rehabilitation centers, and home health agencies. A wide variety of patients are referred to occupational therapists including those who are blind, infants born with physical deformities or brain dysfunction, persons whose life style has been permanently altered by serious illness, such as cancer or stroke, those who are emotionally ill, those who are permanently or temporarily incapacitated by accidents, persons who are mentally retarded, and many others.

Occupational therapists work not only with physcians who specialize in rehabilitation medicine, in ophthalmology, orthopedic surgery, pediatrics, internal medicine, general surgery, psychiatry and other specialties, but also with each of the other health professions such as nursing, speech and audiology, physical therapy, nutrition, psychology and social work.

CURRENT PROBLEMS

With this long history in the provision of treatment and consultation in patient management and care, occupational therapists, like most health professions, have appreciated the fact that programs such as Medicare and Medicaid have brought health care to larger numbers of Americans who previously received little or none. Concurrently as practicing occupational therapists, we have experienced many of the frustrations and complications which have accompanied the implementations of these programs. The problem of controlling costs is, in itself, an extremely difficult one compounded by the fee-for-service medical care establishment and the absence of economy incentives or pre-payment insurance plans.

With these and other considerations in mind, the American Occupational Therapy Association makes these observations and suggestions to the Committee:

COMPLETE COORDINATION CARE

1. Whatever decisions are made about the extent of the population to be covered, coverage should provide complete care. The law should avoid splintering of the sort which characterizes much of the operation of the present Medicare program. Types of services to be authorized and reimbursed should be those justified (documented) as necessary to help assure the recovery and sustained optimum health of the patient. This should include access to occupational therapy services where needed in all types of treatment situations, as well as to those of other established health professions and occupations.

COVER NO-INCOME, LOW-INCOME, INCOME-VULNERABLE

2. If coverage of virtually all people, as proposed in H.R. 22, is not possible for financial or other reasons, Federal health insurance should be extended first to those unable to pay: 1) those who are dependent on public support for their existence, 2) those whose incomes are below the Federally-set "poverty-level", and 3) without diagnostic selectivity, those catastrophically or chronically ill or injured whose own and family incomes are precariously reduced by large or continuous medical expenditures.

This health phase of the welfare problem should be assumed by the Federal government in much the same manner that the health needs of the aged were assumed six years ago, and for much the same reason. As this Committee is well

aware, the lowered incomes of retired people and their concomitantly greater need for health care were influencing factors in the decision of the Congress to enact the Medicare law in 1965. The same approach should now be used in consideration of improved coverage for other Americans. Those with little or no income and with a far higher incidence of disease and disability fact the same problems as do those over 65. The profoundly or chronically ill with incomes vulnerable to total dissipation by medical expense, with families whose health is then jeopardized by precipitous income reduction and who themselves risk becoming dependent upon public support for daily living, surely also have needs similar to those Congress recognized in the elderly.

The problem of the cost of care of profound or chronic illness, often viewed as financially impossible for the Taxpayer, must be dealt with in the health phase of welfare, not only for the benefit of the recipient but also to give public visibility to this problem and so prevent it falling between coverage by national insurance and all other funding resources. Its position in the establishment of health-cost priorities must be determined.

Extension to the no-income, low-income and income-vulnerable groups would produce a program providing complete health care: the elderly based on the present social security contributory system, the others financed through Federal funds.

BASIC ESSENTIALS OF A PUBLIC HEALTH-CARE PLAN

3. All health care programs receiving public support or assistance must:

(a) Provide uniform coverage and services for all persons enrolled regardless of race, national origin, creed, age or geographic location;

(b) Provide for comprehensive health care, including the full range of services for prevention, diagnosis and treatment, rehabilitation and restoration, and the coordination of such health services with social services, housing, educational and vocational programs as are needed to assure maximum recovery and permanency of benefits obtained;

(c) Provide for and specify occupational therapy and related health disciplines in all situations where such services are documented as a necessary component of the total patient management plan contributing to the full recovery and maintenance of optimum health of the patient.

(d) Protect against unnecessary costs and other abuses by building in a combination of peer and utilization review mechanisms augmented by a system of periodic spot check audits.

COSTS-BENEFITS OF A COMPLETE CARE PLAN

A plan which provides incomplete coverage, attends only to acute problems, permits care only of the diagnosis which prompted the request for care without regard for other conditions subsequently identified, or allows only for immediate correction without continuing maintenance of that correction, wastes dollars, time resources and human value. Inclusion of all needed services and, specifically, rehabilitation and restorative care, is a critical factor in determining the cost benefit of the plan. Selective appropriate use of occupational therapy collaboratively in total patient care contributes to the following values:

(a) returning persons to self support and tax producing activity, avoiding tax consuming dependency on public support or high cost extended care, nursing care, or mental hospital beds.

(b) increasing human worth and dignity of the severely handicapped, increasing their productivity by reducing their dependency through self care training, assistive devices, work simplification and sheltered employment.

(c) releasing relatives for employment, thus production of taxes, by increasing the self care ability of the severely disabled.

(d) improving quality of living for the able bodied and handicapped alike by engaging persons in satisfying constructive activity in community and leisure time involvement to displace idleness, neighborhood mischief, drug experimentation and abuse, crime in the streets and other destructive activity (acts of violence are now a major source of catastrophic injuries and may outnumber strokes in the admission rates of rehabilitation hospitals.)

STANDARDS AND CONDITIONS OF ALL HEALTH DELIVERY

For the rest of the population, the continued operation of private and voluntary health insurance plans should be improved through (1) the issuance of Federal

standards pertaining to the operation of health insurance and health care programs, (2) the issuance of model state laws governing quality controls and cost controls for the operation of health insurance programs in the states, and (3) the provision of mechanisms for informed consumer input and public education programs on prudent selection of health and medical services and expenses.

If such an approach is taken, the experience gained will be of value in making later decisions regarding how best to further improve health insurance coverage in the United States.

IMPINGING PROGRAMS

4. While accident prevention and consumer protection are not directly a matter of responsibility for this Committee, it is occupational therapy's view that there will never be a satisfactory method to cope with illness and injury until our nation has taken bolder steps to protect consumers against unnecessary hazards in consumer products, on the highway, in the home, at work and school, in the environment in which we live and in our current pattern of retirement at a forced chronological age.

COUNCIL ON HEALTH CARE PLANNING POLICY, PRACTICE

5. There should be established by statute in the Department of Health, Education and Welfare, or in a separate Department of Health, a Council on Health Care Planning Policy and Practice, with representation on the Council of informed citizens and persons from each of the principal health professions including occupational therapy. This body, advisory to the Secretary, should meet not less than four times annually to advise the Secretary on all aspects of the numerous health care programs for which he is responsible under several laws. Representatives of each discipline and the consumer should speak to the public's health needs as each uniquely sees them. In concert, work should be centered on improved access to and quality of care, coordination and planning in delivery of services, financial and administrative expenditures for effective delivery, and meaningful use of health information and care. -

In addition to its value in direct relationship to any national health insurance plan, such a Council would have the opportunity to view the great variety of health activities in the Department and their relationship to all health efforts; to consider other Federal activities and services in health care (such as the Veterans Administration and the Armed Forces); and bring this kind of broad view to bear in consideration of all major health proposals affecting the American people.

In conclusion, the Armed Occupational Therapy Association wishes to express its appreciation for the devoted efforts which the Ways and Means Committee has made to find a satisfactory basis for improving the health of the people of this country. We will continue to be available to assist the Committee in any way we can.

STATEMENT OF THE ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION

Mr. Chairman, members of the Committee. The Association for Hospital Medical Education appreciates this opportunity to comment before this Committee during its discussions on national health insurance plans for the people of the United States.

Through its membership, the Association for Hospital Medical Education represents the medical educational programs in approximately 600 community hospitals. The hospitals are fairly large, averaging about 450 beds. These hospitals have in their graduate education programs—intern and resident education—approximately 40% of the intern and resident education positions in the United States. Additionally, over 125,000 practicing physicians in the United States belong to or relate to the medical staffs of these hospitals. Therefore, the professional concern and interest of the membership of the Association for Hospital Medical Education encompasses a majority of the practitioners of clinical medicine in the United States.

The Association for Hospital Medical Education does not wish to specifically debate the pros and cons of individual national health insurance plans. It seems clear, at this time, that each of the several plans has many practical advantages and some disadvantages. We would, however, like to offer certain concerns for your consideration in the deliberations of this Committee following hearings.

More than any other industry, health care is dependent on personal services requiring knowledge and skill. The capability for rendering health care today is dependent on people to obtain health care information, set up a priority of care needs, and deliver care. Seventy percent of the gross budget of hospitals is for personnel costs. The proportion of personnel costs for ambulatory care in offices is probably much greater. Other industries such as agriculture, construction, and heavy machinery, by comparison, rarely expend more than 40% in personnel costs.

The teaching of knowledge and skills required for health care services has been met to a large degree by the providers of the health care services. As the demand for new services has been created by advancing knowledge, hospitals and medical centers have taught this knowledge. This process has, in reality, been effective and includes opportunity for flexibility to meet a wide variety of training needs. The requirements for funds to support these education programs have been extensive. To date, a significant portion of this support has been acquired through patient care charges on the users of health care services. Although this system has some built-in defects, it also contains an assurance of continuation of the system with constant flexibility and capability for change. Thus, essential experimentation with new ideas is protected if not encouraged. It is important not to establish a monolithic system which constrains experimentation and function. In reality, systems reflect their financial interest. The system of financial support of medical care and medical education should avoid dependency on a single source of funding.

There should be formal recognition of the financing responsibility for those essential elements to render medical care. As pointed out above, the largest segment of medical care cost is people. People are not immortal in spite of our incantations and efforts. Therefore, survival of health care is dependent on education of replacements. Industry recognized in the late 1940's and early 1950's that a significant amount of its resources should be invested in research and development. Indeed, the existence and success of industry today is in direct proportion to this investment. It is said that the auto industry invests between 5 and 10 percent in R&D; the aircraft missile industry 30 to 40 percent, and the electronic industry even more. In health care, which is dependent on people, the development element is the education of the servers.

Certainly, we all agree that medical research is a key to progress and such investments are essential. However, today we are concerned with delivery of what we know in a cost-effective manner. This requires continuing education of all levels of personnel from the housekeeper to the practicing physician. An effective on-the-job or course-oriented continuing education program requires money for organization and management.

The Association for Hospital Medical Education recommends that a minimum of 10% of all health care institutions' annual budget be invested in development through the education process. Likewise, we believe that all physicians should commit no less than 10% of their time to education either by participation in their own continuing education or in the education of physicians in preparation for their practice. Their budgets that influence their final income should reflect this necessary and worthwhile requirement. For those institutions assuming the costlier responsibility of graduate medical education, there should be the support of their fellow institutions to allow this as a justifiable cost. For they are dependent on the graduate education centers for the physicians they need. For those institutions that cannot support graduate education programs there should be a commitment to continuing medical education.

In summary, Mr. Chairman and members of this Committee, in recognition of the fact that health care is dependent on personal services requiring knowledge and skill, the Association for Hospital Medical Education recommends that:

- (1) There be a formal recognition of the financing responsibilities for those essential elements to render medical care;
- (2) The system of financing support of medical care and medical education should avoid dependency on a single source of funding;
- (3) A minimum of 10% of all health care institutions' annual budget, and 10% of health care personnel time be invested in development through education so that there will be a continuing supply of highly qualified practitioners of health care to provide these essential services.

Again, we appreciate this opportunity to comment and hope that our recommendations will be given appropriate consideration during the deliberations of this Committee.

STATEMENT OF JAMES S. MCCAUGHAN, JR., M.D., PRESIDENT, MID-OHIO
COUNCIL OF MEDICAL STAFFS

THE TRUE MEDICAL CRISIS

The public is being incessantly bombarded by all communications media with misleading statements and half truths to prove that there is a "medical crisis", and this "crisis" consists of disproportionately rising costs of medical care coupled with poor quality and maldistribution or unavailability of care.

I am James McCaughan, M.D., and I practice general and thoracic surgery in Columbus, Ohio where I am on the staffs of several hospitals, one of which is located in the ghetto. I am also the Chief of Surgery at the Columbus State School for the mentally retarded. In the course of my medical career I was trained in a university and had training and experience in community hospitals, state-owned mental hospitals, city-owned general hospitals and military hospitals. I have been on the teaching staff of three medical schools, have had American Cancer Association and National Heart Association fellowships and several grants for research. Being actively engaged in taking care of ill people I do not have the time nor the huge monies nor facilities to prepare masses of data, however as a person actively participating in medicine and doing the work and not just accumulating data, and as a person who will have to continue in the system, I think I have some observations which cannot be made by any other group of people.

The rise in the cost of medical care is being called exorbitant, and the private physician is being charged as one of the main culprits. The same chart is repeatedly brought out showing physicians' fees rose 50% during the past decade while the consumer price index rose only 20%. These speakers do not point out that the Bureau of Labor Statistics shows that the prices of *all services* are up 50% since 1957-59 compared to 20% for commodities. Medical care is a *service*, not a commodity. U.S. News, December 8, 1969, using U.S. Dept. of Labor statistics reported that while medical care had risen 12.9% since 1967, insurance and finance costs had risen 21.4%, public transportation 13%, meals at restaurants 12.7%, shoes 12.7%, meats, poultry and fish 13.6%, and owning a home 18.2%.

The cost of the U.S. Congress has risen 156%, federal employee wages rose 105%, and non-professional hospital workers wages rose over 200% during the last decade.

While the Consumer Price Index rose only 5.5% and physicians' fees rose 8.1% in the past year, the U.S. News and World Report of February 15, 1971 showed last year's average increase in pay of union workers including wages and fringes were: bricklayers 15%, building laborers 15%, carpenters 13%, electricians 12%, painters 12%, plasterers 12%, plumbers 14%, and in the construction industry wage increases are being sought of over 100% over the next three years. Remember, physicians have no fringe benefits, no paid vacations, no paid retirement plans, no paid health plans. Malpractice insurance costs have risen over 300% in the last five years.

The quality of medicine in this country is claimed inferior because of a supposedly higher infant mortality, the United States being thirteenth in selected countries. However, no cognizance is given to the fact that in some of these countries that have a supposedly low infant mortality, such as Sweden which is #1, a birth does not have to be reported for five years and a death might never be reported. In some of these countries the father, not the physician, voluntarily reports births; the criteria for live births are not the same in all countries. The Demographic Year Book of the United Nations, from which this information is taken, spends five pages pointing out why statistics of different countries are not necessarily comparable. "Answers to these questions will not be found through comparison of disconnected studies with varying study designs. Although few comparisons may be possible, fortuitously, they lack the assurance which is to be derived from a well designed study planned to give answers to specific questions."

In The Netherlands, which ranks #2, only 60% of infants are delivered by physicians.

The life expectancy at birth for males in the United States is eighteenth, with 66.8 years in 1965 compared to Sweden with 71.6 years. Does this mean that more men in the United States smoke and die of cancer of the lungs, that we have a greater incidence of coronary artery disease, or that we have more automobile accidents involving men? I don't think it can mean it is due to

inferior medical care because the same United Nations Demographic Year Book of 1968 shows in Sweden the deaths per 100,000 population due to pulmonary tuberculosis are 25% greater, suicide 95% greater, benign peptic ulcers 78% greater, pneumonia 84% greater, influenza 186% greater, benign prostatic hypertrophy 116% greater, neoplasm 25.5% greater, stroke 13.7% greater, diabetes 5% greater than in the United States.

Poor quality medical care or unavailability of medical care is blamed as the major if not only factor for a greater incidence of disease among the poor in this country by those promoting national health insurance. United Auto Workers' president, Leonard Woodcock, states: "In almost every category the rate of serious illness among the poor is two or three times higher than the population as a whole."

"The United States is seventh in maternal mortality".

"Among the poor in this country, infant mortality rates are five times greater than among the affluent".

Every other socio-economic pressure or influence or cause is completely disregarded, and inferior medical care is blamed for these sad statistics. I would like to present a case history to show you some of the real problems and let you try to fix the cause. I received a call at 3 o'clock one morning to come to an emergency room in the ghetto area. A nineteen year old black girl was brought in by the rescue squad after being stabbed in the chest during a fight with another girl in a bar. When I arrived there about twenty minutes later I observed that the veins in the girl's arms were sclerosed and she stated this was from shooting heroin. When I asked her how she got the money for this she stated by prostituting. On further examination of her I found she was about five months pregnant. She also had a seven month old child at home. She presently was receiving Aid For Dependent Children. After I treated this girl, about 4 o'clock in the morning, an elderly black woman came to the door of the emergency room with a little four or five year old neatly dressed black girl. They wanted to know if the little girl could see "Auntie", who was lying on the litter in the emergency room.

Many of the problems of the ghetto and the poor are summed up in this one case. If this nineteen year old girl or her unborn child died during or after birth it would only be statistics, and accordingly her death will be attributed to poor medical care. If this black girl dies of an overdose of heroin, alcoholism or tuberculosis or syphilis or stab wound at an age earlier than expected for the non-poor, statistics will show it attributable to poor or inadequate medical care.

When there are problems, the least we can expect is the whole truth.

Although this nineteen year old girl presents a tragic problem, far more significant is the problem of the four or five year old child, because left in this environment chances of her winding up on a slab ten or fifteen years from now would seem to be the almost one hundred percent. Besides that, she probably will have a couple of children of her own, and the children of the nineteen year old girl presented will be out on the street.

You can put one of President Nixon's Health Maintenance Organizations or even a private physician next to this child and you will never appreciably improve the quality or quantity of her life until you change the socio-economic environment she lives in or remove her from it.

Fortunately, Senator Peter H. Dominick, who sits on the same Health Subcommittee as Senator Edward Kennedy, and who has been hearing the same testimony, is prudent enough to seek and see the whole truth, though Senator Kennedy obviously is avoiding the whole truth for political ambitions. Senator Dominick on April 15, 1971 stated, "In truth, infant mortality for the most part is a social rather than a medical problem. Factors such as poverty, malnutrition, poor housing, poor education and racial or ethnic differences are much more highly correlated with infant mortality than such factors as the number of physicians or hospitals."

"Somewhere out of such a free debate, a national consensus must develop, consensus that rests on facts and solid theory, not on the whims of doing something to improve the situation or on notions of reaping political credit for the final product."

In Philadelphia during an influenza epidemic I walked the Puerto Rican and black ghetto streets at 1:00 AM seeing patients, and as I would leave one apartment building somebody would call from across the street to go see them. These people were being ravaged by this epidemic. They lived in tenements with

two or three children sleeping in each bed, four to six adults in a 12 x 12 room, roaches running over the beds and kitchen table. About this time a television program showed the squalid living conditions of South American natives. I could have filmed that program right in the center of Philadelphia.

On another occasion, in the middle of the night, under police protection I delivered an unregistered black woman in a third floor apartment where there was no electricity—only kerosene lamps. However, only six blocks away the best maternity care was available, free, at the Jefferson Medical College.

These people do not have inferior medical care, they have inferior everything. The spread of disease is dependent upon sanitation, nutrition, education, living habits, etc. More people die and are injured by stabbings and gunshot wounds in the ghetto areas than in the rest of the population. Why are these deaths not blamed on poor medical care?

Senator Yarborough stated in Senate hearings in 1970 that there are "thousands of small towns and countless urban slum areas where our citizens go years without seeing a doctor . . . All of this is because it is economically more attractive to work in Austin rather than Three Rivers, Texas."

If financial rewards were the only reason for practicing medicine, most physicians would leave the big cities and go to these small communities where there is a demand for them. However, as with every other human being and profession there are many factors that enter into a physician's choice for a region to practice. It is true, there are not many physicians in certain areas of the country, however there are not many lawyers or other professional people there either. Some physicians choose certain climates; others are influenced by wanting to move away from their home; others want to remain close to their home; the availability of cultural and educational facilities are a strong influence on many people; the physical safety of working in certain areas is a factor. Many physicians and nurses will not make night calls to the hospital in the ghetto area that I attend because they have to drive through the ghetto area to get to it. I have a friend who is a surgeon in Cincinnati and every time he makes an emergency call at night in a certain section of the city, he carries a loaded 38 revolver on the seat beside him.

Thus merely providing financial incentives to practice in these areas will not have much of an attraction. This is especially true in light of the harassment and discreditation that honest physicians and dentists have received when they went into these areas and worked there day and night at reduced fees and still made large sums of money because of the prodigious amount of work they were doing. They were immediately suspect and denounced as being greedy over-utilizers, and investigated by the government.

The public is being told that they will receive the same or better care under a national health program than they now receive from private physicians and it won't cost them any more money. The Department of Health, Education and Welfare itself has estimated the Health Security Act will cost over \$77 billion annually by 1974 or over \$1000 per worker annually whether ill or not.

What evidence do we have from past experience with government intervention in medicine that this new government medicine will be better? John Gilligan, Governor of Ohio, had motion pictures taken of conditions at the State Hospital for the mentally insane to be distributed around Ohio to show the horrible conditions that exist in a state-owned hospital. As a private physician as well as the Chief of Surgery at the State School for the mentally retarded in Columbus, I can state, conditions exist at the School which would not be tolerated for one day in a private hospital. The Division of Mental Hygiene notified Ohio's twenty-six State Hospitals in March 1971 that doctors not licensed in Ohio could be barred from practicing in state facilities. In the past, limited licenses were issued for doctors who had not passed state medical board examinations so they could work in state facilities. This is still prevalent.

The Veterans Administration Hospital system with 166 separate institutions and a 1.9 billion dollar annual budget is one of the largest socialized medical systems in the world. This is a "true system" compared to the private medical system that Mr. Leonard Woodcock called "un-coordinated, wasteful, over-specialized . . . absolutely incapable of meeting the real health needs of the public." The physicians and all personnel are paid by the federal government. All equipment and facilities are owned by the federal government. Patients receive free care unlimited.

On June 1, 1970 Senator Edward Kennedy made a speech in Congress asking unanimous consent that Senator Allen Cranston's testimony about the inadequacy

of the VA Hospital system be accepted into the Congressional Record. He introduced the statement, "It is disgracefully understaffed, with standards far below those of the average community hospital. Many wards remain closed for want of personnel, the rest are strained with overcrowding. Facilities for long-term treatment and rehabilitation, indispensable for the kind of paralytic injuries especially common in this war of landmines and boobytraps, are generally inferior."

Reports of the VA's own Chief of Services were entered into the Congressional Record such as: "tight budget policies have imposed serious fiscal constraints on our abilities to employ adequate personnel and provide necessary facilities"; ". . . insufficient equipment, insufficient personnel and grossly inadequate support in the crucial areas of pathology, radiology and clinical laboratory and physical medicine"; ". . . radiology equipment is obsolete in the worst sense of the word, broken down in the very true sense of the word".

Mark J. Musser, M.D., Chief Medical Director of the Veterans Administration stated in the A.M.A. News of March 8, 1971 in response to a question on the future of the VA Hospital system if some form of national health plan arrived: "We set out to do two things, first to determine how the VA as a health care and delivery system might better relate and hopefully cooperate with the private sector. Second, to determine how we can modify the resources of the VA so it has an expanding capability and is more responsive to the needs of a wide variety of patients—who some day might not be solely veterans".

This system of socialized medicine, the VA Hospital system that Senator Kennedy and the Veterans Affairs Sub-Committee have denounced as "holding back on giving first-class treatment when they are brought home in wheelchairs and stretchers", will be expanded to the private sector.

The Journal of the American Hospital Association of August 1970 shows the average stay in a private community short-term general hospital was 8.3 days in 1969. The average stay in a government hospital of the same type was 19.9 days. A major factor in this is certainly the fact that the appropriations for the VA Hospitals are strongly dependent upon the number of patient days of the year before, and since the hospitals are not one hundred percent utilized, patients are kept in the hospital longer for the same operation or illness than in a private hospital. When the length of stay is multiplied by the cost per day and compared for identical operations or disease, the cost for a particular operation in a government hospital far exceeds that in a private community hospital.

A special committee on municipal hospital services appointed by Mayor James Tate to study the future of Philadelphia General Hospital (a city-owned service which received \$30,961,946 for fiscal 1970) reported on April 20, 1970: "The present PGH is obsolete and beyond economic renovation. This manner of allocating money deals with health problems too late, costs the most and does little to prevent illness. Administrative and management inefficiencies were found in present operations of city personnel health programs". Per-diem charges in the Philadelphia General Hospital on June 17, 1970 were: in-patients \$68.00, clinic visits \$25.00, receiving ward visit \$20.00. The average private physician office visit charge is less than \$10.00.

Joseph T. English, M.D., president of the New York City Health and Hospitals Corporation, warned Mayor John Lindsay in a letter in April 1971 that as many as eight of New York's municipal hospitals may have to be closed in wake of financial difficulties.

Similar reports can be made for Massachusetts General, Cook County General and other city and county-owned hospitals.

While stationed at Portsmouth Naval Hospital as a general surgeon, I frequently was assigned to the walk-in clinic to see the ambulatory ill. These people might have colds, gastroenteritis, allergies, etc. When they would return for their next visit they usually saw another physician who was a specialist in another field such as urology or psychiatry, and on a subsequent visit they probably saw a third physician.

The U.S. Public Health Service is another completely socialized system with physicians and all personnel being paid by the government, all facilities owned by the government, and patients receiving free care. HEW Secretary L. A. Richardson testified before Merchant Marine & Fisheries Committee that eight U.S. Public Health Service Hospitals and thirty Clinics may have to be closed because of "our inability to continue to provide medical care of high quality . . . through an increasingly ineffective and outmoded system".

Thus, in the government systems we have already experienced we have found no panacea for the health problem but actually a type of care which is inferior to that provided by the private sector.

Let us be quite candid, as Senator Kennedy stated in his speech on January 25, 1971 in the Senate: "Financial, professional and other incentives are built into the program to move the health care system toward organized arrangements for patient care". This will consist mainly of having a Board set fees for private physicians and allocating the amount of money for this type of practice as the residual of money not used for capitation payments. Let there be no mistake, most of these plans presented are either directly or indirectly aimed at eliminating the private physician fee-for-service practice of medicine and establishing a per-capita prepaid system similar to the Kaiser-Permanente system: What will this mean? Dr. Sidney R. Garfield, the founder of the Kaiser-Permanente system, has stated: "In our experience a removal of the fee-for-service overloads the system and, since the well and the worried-well people are a considerable portion of our entry mix, the usurping of available doctors' time by healthy people actually interferes with the care of the sick". While non-medical people are espousing the great advantages of the pre-paid per-capita system, Dr. Clifford H. Keene, president and chief administrative officer of the Kaiser Health Plan Hospitals, who should be in a position to know better than anyone else the effect of this plan, when asked what effect prepaid clinics had on the quality of care to patients stated: "I do not know".

Statements are made that more surgery is done on a fee-for-service basis than in pre-paid per-capita systems, with allegations that this is for financial reasons—that the surgeries are unnecessary. However, in the pre-paid per capita system it is to the doctor's advantage not to operate. In other words, he is being paid much like welfare recipients, i.e. for not doing something. Who can say whether you need to have your hernia fixed this month or next year, or you need to have your veins stripped this month or next year, when there is an incentive financially not to do it. If you are willing to accept the premise that there are surgeons who will operate unnecessarily for fees, you must then accept the premise that there would be surgeons who would not operate in order to have a greater profit. Similarly, it is not to the advantage of the Kaiser system physician to have less than 100% hospital occupancy. In an extensive study of the Kaiser system, Greer Williams, in *Modern Hospital*, Feb. 1971, states that in 1970 certain Kaiser hospitals in the Los Angeles and San Diego areas reported occupancy rates between 100-110%. "This comes about by the patient being scheduled for major surgery without an available empty bed. He is prepared as in ambulatory patient, goes to the recovery room after surgery, and waits there for a hospital bed assignment. If a bed does not become available the administrative and nursing staff review the patient list to see who can be sent home, to another hospital, or to an extended care facility. If the backup is too large, the staff reviews the elective surgery schedule and postpones operations that 'will keep'."

When schedules become crowded they exercise their own priority system, based not on "health care as a human right", "a meaningful doctor/patient relationship", or "first come first serve", but on "sickest first".

To have more beds available for the sick would mean building more hospitals and decreasing the profit.

A fundamental principle of the Kaiser Health Plan has been "to insist that all subscribers shall have, upon joining or upon periodic renewal of contract, the opportunity to choose from two or more alternative health plans. This policy not only insures that enrollment will be voluntary within the employee group, but introduces open-market competition into a quasimonopolistic tradition of partially insured doctor and hospital bills paid through a plan imposed on the group by an employer arrangement with a single carrier supporting a fee-for-service system". This has been felt absolutely necessary to maintain the quality of the closed panel system.

Senator Kennedy has said "patients everywhere face a bewildering array of health personnel who know more and more about one disease or organ, but less and about the whole patient". Yet these plans propose to eliminate the private physician/patient relationship and promote systems in which the patient/doctor relationship is further destroyed. Patients for these plans are told they will receive the same or better quality care and attention than they would receive from a private physician.

However, a surgeon in Los Angeles told me when he was a resident in surgery, not Board-eligible, not Board-certified, in a Kaiser Hospital, he did twelve ap-

pendectomies one night himself. He also stated that if there was a major case to be done, the staff man would come in and help him. However, the staff men usually did not like to come in during the night (it should be noted there is no financial incentive for them to do so). If a patient had a bowel obstruction the staff man frequently would instruct the resident to put down a Levine tube, give IV fluids and get the patient in shape to be operated in the morning. When I asked this surgeon if this was the way he wanted to be treated, he said "no". When I asked him if that was the way he practiced now that he is in private practice, he said "no".

James V. Maloney, M.D., in the presidential address at the 31st annual meeting of the Society of University Surgeons, gave a "Report on the Role of Economic Motivation in the Performance of Medical School Faculty". He compared "the effect of intellectual motivation and economic motivation on patient care and teaching and on the extent to which individual faculty members in institutions were meeting the needs of society in the field of medical education". After an extensive survey he concluded, "without economic incentive, clinical faculty of medical schools will not accept personal involvement in the care of the sick if they have any reasonable alternative which permits them to maintain their self respect".

Rashi Fein, Professor of Economics of Medicine at Harvard School of Medicine and a member of the faculty of the John Fitzgerald Kennedy School of Government and a vociferous proponent of national health insurance stated in *Technology Review* of April 1970, "A right to quality of care? A right to what amenities that accompany care? A right to how short a waiting period in a physician's office? Available how close to a person's residence? Available in what quantity?"

In the Kaiser-Permanente system waiting times for appointments commonly run from "three to six weeks", and in one large Kaiser-Permanente group, as high as fifty-five days. Each group has its cut-off point, beyond which appointments are not made. Dr. Cecil Cutting, executive director of the Permanente Medical Group in north California states, "one of our big problems is developing an appointment system that will screen members so that sick can get in for service and yet the well and the worried-well can appropriately be taken care of without swamping our physicians".

Since 1966 the Kaiser plan rates have increased an average of 11-14%. Prior to that they had increased an average of 6-8% annually. Private physician fees only rose 8.1% last year, yet the private physician is still blamed for the rising cost of medical care although the Social Security Administration's own data showed that only 15% of the total cost of medical care of those over 65 was due to the physician's fees. Stated another way, if the physician had worked for nothing there would only have been a 15% savings in the cost of Medicare for 1969.

What other catastrophic events are we witnessing since the advent of Medicare-Medicaid intervention into medicine in 1966? MEDI-CAL is in serious financial difficulties. Thomas Bryant, M.D., Medical Affairs Director of the O.E.O. declared that Medicaid is an "unmitigated disaster". These pieces of legislation were passed when the medical profession warned that they would be disasters.

Above and beyond these problems, however, the loss of the fee-for-service, private physician/patient relationship will strike at the very core of the foundations of medicine, and here lies the true medical crisis and the true disaster that lies ahead.

Again I turn to Mr. Rashi Fein, one of the main proponents for national health insurance on a pre-paid per-capita basis. In his testimony September 24, 1970 before the Committee on Labor and Public Welfare of the U.S. Senate, he said: "One of the deficiencies in the production of health services is that the individual providers, institutions and people, do not really see themselves—or function as if they were—part of a larger system. They are concerned with those patients that come through their doors but often seem less aware of the large number of people who do not find their way of entry into the system". In his testimony before the Sub-Committee on Health of the U.S. Labor and Public Welfare Committee February 23, 1971 he stated: "A traditional financing approach will maintain the traditional delivery system organization—and we need change".

Hippocrates Oath has guided and maintained the ethics of the medical profession for centuries. It states: "I will use that regimen which, according to my ability and judgment, shall be for the welfare of the sick, and I will refrain from that which shall be baneful and injurious. If any shall ask of me a drug to produce

death, I will not give it. Nor will I suggest such counsel. In like manner I will not give a woman a destructive pessary".

When a private physician has a patient, his only concern is, and must be, the welfare of that patient. When you are ill and go to a physician, you do not want him to be concerned about the overall welfare of the masses or whether the money spent to keep an old patient alive would be better utilized elsewhere. I treat mentally retarded children, and we operate on them and treat them medically with the same zeal, care and attention that we would treat you, although we know that even if they get well from their acute illness they will be wards of the state, still will have to be maintained in institutions, still will have to be fed and looked after, and still will be a drain on the financial resources of society. If we let this overwhelming obligation to the patient be destroyed we will be destroying one of the few remaining fundamental moral principles left in this country.

What indication do we have that this can be destroyed by government intervention? Already another fundamental principle in medicine is being destroyed. Again from Hippocrates, "Whatever in the life of men I shall see or hear, in my practice or without my practice, which should not be made public, this will I hold in silence, believing that such things should not be spoken".

It has always been considered a necessity and a right that the patient who has tried to commit suicide, the girl who has had an illegitimate pregnancy, a woman who has had cancer, a man who has had syphilis, know that what transpires between him and his physician is absolutely confidential. Right now, today, under Medicare and Blue Cross this privacy is being invaded without the patient or physician knowing it. When the patient enters a hospital he is required to sign an authorization for release of information. Following his discharge, Blue Cross or Medicare carriers merely write to the medical records section of the hospital for a complete copy of progress notes or the complete chart of that patient, and it is being forwarded. The patient knows nothing of this, the physician knows nothing of this. Thus, even though the Medicare guide states that the history and physical and other information are not to be solicited, it is being done. Therefore, anyone who enters the hospital can have his personal history and physical examination reviewed by persons unknown.

In Louisiana a hospital refused to violate the patient's trust and refused to comply with these requests for complete chart copies, and had its Medicare and Medicaid funds cut off summarily. Why is it now necessary when it never has been necessary before, for third party insurance firms to have complete copies of charts? Why should the patient's personal history become the property of the government? Why should the government be able to use economic force to invade the privacy of its citizens? Most patients do not realize when they accept Medicare and Blue Cross of central Ohio that they automatically waive these rights.

Thus we already have government invasion of the individual's privacy, and the idea is being promoted that the physician must consider the welfare of society in general above the welfare of the individual.

In 1910 the Flexner Report maintained that we had too many "fly-by-night" medical schools and too many people practicing medicine who are unqualified. The answer to this problem was the creation of higher standards and more stringent requirements to be a practitioner of medicine.

Hippocrates Oath states: "... and to teach his art if they shall wish to learn it, without fear or stipulation; to impart a knowledge by precept, by lecture, and by every other mode of instruction to my sons, to the sons of my teacher, and to pupils who are bound by stipulation and oath, according to the law of medicine, but to no other".

Today we are coming 180° around from 1910. We are told the quality of medicine is poor, and we must improve this by developing a vast body of lay paramedical personnel. There are radiologists proposing that x-rays be surveyed by trained personnel; proctologists suggesting routine sigmoidoscopies be performed by para-medical technicians; corpsmen being trained to make housecalls to the extent that the patient "waves goodbye and says 'so-long Doc'"; the nursing profession has abandoned the scrub-nurse to the operating room technician.

Here is the true medical crisis: the loss of the private physician patient relationship, where the physician reaches his responsible decision not by considering the economics, nor by considering the influence an action might have on the rest of society, but on the basis of what is best for this individual patient; the destruction of the private physician/patient confidentiality; the move from quality medical care to homogeneous mediocrity.

OLYMPIA, WASH., November 19, 1971.

Mr. JOHN MARTIN,
Chief Counsel, Ways and Means Committee, U.S. Congress,
Washington, D.C.

DEAR MR. MARTIN: This letter is being written to express my views on the current proposals for a national health insurance program.

I am a psychiatrist in private practice and am also president-elect of the Northern Pacific Branch of the American Psychiatric Association and of the Thurston-Mason Medical Society.

I would first like to urge you to consider individual freedom of selection of physician and making as much allowance for freedom of medical practice as possible. I certainly hope that we can maintain this while working toward trying to make medical care more economical and more freely and readily available to all people.

My principle concern in writing this to you is that I believe very strongly that psychiatric insurance coverage should be included on an equal basis with all other types of medical care. In the past, as I am sure you are aware, psychiatric care has often been excluded entirely, severely limited, or at least dealt with in some specifically biased manner. Much of this has been due to misunderstanding or prejudice, although some of it has arisen from a realistic concern about the costs or of the difficulties in predicting costs of psychiatric service. I would like to comment specifically on these points.

First, private psychiatric practice is relatively new and therefore is often not well understood. Many insurers regard it as relatively unproven in terms of actuarial data. In this respect I would like to point out that in recent years there are available very good figures concerning psychiatric hospitalization. This is important and I am sure should be included on the same basis as other medical coverage. Actually, psychiatric hospital care is much less expensive than general medical care and there is no reason to consider it as a greater financial risk.

Next, as far as outpatient coverage is concerned, this is somewhat more complex. The cost of psychiatric service certainly does not exceed comparable hourly costs in other medical specialties. Certainly for the average and ordinary type of psychiatric care there would be no reason to be concerned about costs since these are not excessive. I believe that the only reason for concern about this is due to the impact of some forms of very intensive and long continued treatment, particularly psychoanalysis.

This type of treatment often involves several consultations weekly and may extend into several years. Psychoanalysis is declining in popularity and is gradually being used primarily in research and training. Thus, the future demand for such service will not be great and probably will not even be increased by having a national health insurance plan. There is a limited number of psychoanalysts. Their time is already well occupied; this time can not be stretched very much by increasing demands by patients due to a national health insurance plan.

It should be easy to predict what the overall demands on a national health plan would be. You can simply take the number of psychiatrists, multiple this by the number of hours a psychiatrist can work in a week and that will be your demand. This could be done only very gradually and slowly. Therefore, why should we have a health plan that discriminates in any way against psychiatry. This important specialty needs to be encouraged.

Another important point is that mental illness is our number one health problem; it contributes in so many ways to disability at work, to problems in society such as drugs, violence, various types of criminal behavior, physical illness, (which raises the cost of other medical services), and many other types of morbidity and infirmity which I will not even try to enumerate. I can only say that where psychiatry is concerned an ounce of prevention is truly worth a pound or probably a ton of cure.

Please, therefore, give your support to including psychiatric insurance coverage at full parity with other medical insurance. Thank you very much for your consideration of my comments.

Sincerely,

J. D. BREMNER, M.D.

KNOXVILLE, TENN., October 23, 1971.

HON. WILBUR D. MILLS,
Chairman, Ways and Means Committee,
U.S. House of Representatives,
Washington, D.C.

DEAR MR. MILLS: As a practicing physician with several years of experience including the problems associated in treating patients covered by government financed medical care programs (Medicare and Medicaid), I would like to make some comments and suggestions for the consideration of your committee.

It would seem that one of the major problems in developing a medical insurance program (the term health insurance is probably better), is how to encourage people to get needed preventive and medical care without asking for unnecessary or excessive services from physicians and other health personnel.

Practicing physicians have struggled with this dilemma for years, but particularly in the last 5 years since government funds and the demand for medical care by those covered has risen rapidly while the supply of health personnel has not kept pace.

I am not familiar with all the details of the several proposals now being studied which would provide some type of universal health insurance, but I have read several articles about them. It seems to me that they all share a common flaw—they lump together health or preventive services with illness or treatment medical services.

From talking to patients over the years, I think there is a basic difference in the motivation for and utilization of preventive services as opposed to medical services. When a patient feels well, he has many interests and duties to keep him busy which interfere with seeing a physician for preventive care—he may feel there is no reason to go or that it can be safely put off until later.

Therefore, these services are usually under utilized (except for obstetrical care and well-child care in the well-educated upper middleclasses which are already the population at lowest risk for serious illness). There should be a positive incentive to encourage the use of preventive services, not a negative one such as a deductible payment which the patient must make before insurance coverage begins.

On the other hand, when a person is ill or feels he is ill, his symptoms are usually sufficient incentive to get him to the physician. Since some people tend to go for minor symptoms which really do not always require skilled professional services, it is probable that medical or illness services are somewhat over utilized (although ideally this type patient could be gradually helped through education and supportive psychotherapy to become more objective and self-reliant about his complaints if there were an adequate supply of comprehensively trained medical personnel). Therefore, I think there should be a mild deterrent such as a yearly deductible payment before insurance coverage begins for illness care.

Another major problem occasionally faces patients, physicians and hospitals. This is the unusual or rare illness that is very prolonged and expensive, i.e., "catastrophic". Usually the entire resources of the patient and family may be exhausted by such an illness and their future welfare permanently affected by their debts. It would seem desirable that an insurance program should cover almost all expenses in such a situation so that this family could return to their usual standard of living and productivity.

With the above ideas in mind, I would like to suggest an outline for a national health and medical insurance program with three divisions.

I. "Preventicare"—to provide needed examinations testing and immunizations at regular intervals, at no cost to the patient or possibly with a small credit or reduction in insurance premium for each year in which they obtain all recommended preventive services.

There will obviously be wide variations among physicians as to what services should be provided. I am enclosing copies of our current recommendations to our patients as a suggestion. I think it would be desirable for different levels of minimum standards to be developed in different areas of the country by consultation between state medical societies and the insurance carrier in their area to see if long-term results might differ depending on the extent of preventive services provided. It should also be possible for individual physicians to recommend a higher or more complex level of preventive care to their own patients and to negotiate with them individually on the extra cost if the patient desires this.

II. "Medicare"—for all ages to provide needed illness care both outpatient and in-hospital, with a deductible payment to be made by the patient which would vary with the family income level. Usual and customary fee schedules would have to be worked out between medical societies and insurance carriers (and probably should vary somewhat in different parts of the country). Again an individual physician should be allowed to charge more than this schedule to those patients who agree that his particular quality of care is worth more and who were willing to pay the extra charge for it.

In practice, I think there would be relatively few physicians or patients who would wish this additional agreement but there would be some.

III. "Catastrophecare"—to pay for all expenses above the Medicare level coverage for the rare catastrophic illness. To prevent abuse in charges of physicians and hospitals, agreed upon "usual and customary" schedules of charges would be used, or all charges in such a case could be reviewed by the medical society "peer review" committee if questioned by the insurance carrier.

I would like to make one other general suggestion based on my experience as a Family Physician. I understand that several of the plans under consideration make a sharp distinction between physical illness and mental illness and do not provide comprehensive coverage for the latter. I think the time has come in our society when we realize that emotional problems are equally painful and disabling as physical problems and I think should be treated on the same basis. Certainly a large part of the people seen in the practicing physician's office have some degree of emotional discomfort. I also feel that as young physicians become better trained in dealing with the patient in a comprehensive fashion that these problems can be dealt with efficiently and economically outside the hospital and with relatively less cost to society.

Before I close, I would like to make one strong request! In any plan your committee recommends, try to reduce the amount of paperwork for patient, physician and insurance company in some way. The amount of time our office girls must spend filling out claims for small charges covered by Medicare and Medicaid patients is appalling and discouraging—we often feel we should just stop treating these people altogether because of the amount of time spent in paperwork!

Surely you can develop some type of credit card which could identify the patient and another to identify the physician and his services provided which will cut down on the typing time and the additional overhead which the government financed programs have required.

I am sure that your committee is receiving much mail and many conflicting suggestions on this important and controversial subject. I hope that my thoughts and suggestions will be helpful in some small way in your deliberations.

Yours very truly,

JAMES A. BURDETTE, M.D.

Enclosure.

HOW OFTEN DO YOU NEED A CHECKUP

In recent years, much has been written about this problem and physicians have varied widely in their recommendations.

We have tried to adopt a moderate position for our recommendations, considering the frequency of development of common illnesses, overall cost of routine examinations and age of the patient.

With these things in mind, our *present* recommendations for healthy adults follow. (You will find our recommendations for children posted elsewhere).

Age 17-19—A complete physical for both males and females, including a female cancer smear, a TB skin test, a tetanus booster if needed and probably a smallpox booster.

Age 20-40—A complete physical *about every 5 years* if you are healthy. Of course, all females get a careful checkup with each pregnancy, so they probably get more attention than the men during these ages. In addition, all women should have a breast exam and Pap test for cancer every one or two years.

Age 40-55—A complete physical *about every 2 years* if your health is good. Female cancer tests should be continued on a 1-2 year basis.

After 55—We encourage a physical checkup on a yearly basis.

Of course, if you have any unusual symptoms or a chronic illness you will need to be seen more often.

What about special tests and X-rays? Again, we are moderate in our recommendations compared to many physicians.

1. Chest X-ray every 5 years except yearly for regular cigarette smokers.
2. EKG—once at age 35-40 for men and 45-50 for women so we know what is normal for you—then repeat whenever symptoms suggest heart disease.
3. Sigmoidoscopy—once at age 35-40.
4. Blood Sugar and Cholesterol—About every 5 years unless your family history suggests diabetes or heart disease.
5. Tetanus Booster—About every 7-10 years.
6. Flu shots—We advise them for those with recurrent chest infections and regularly after age 55 and are glad to give them to anyone else who wishes to have them.

RECOMMENDATIONS FOR ROUTINE WELL-CHILD CARE DOCTORS BURDETTE AND ERICKSON

THE FIRST TWO YEARS OF LIFE

I. Immunizations:

- Age 3 months—DPT (diphtheria, whooping cough, tetanus) and Oral Polio.
- 4 (or 5) months—DPT and Oral Polio.
- 6 months—DPT and Oral Polio.
- 9 months—TBC (tuberculosis) Tine Test.
- 1 year—Measles (Rubeola or Red Measles) Vaccine.
- 15 months—Smallpox Vaccination.
- 18 months—DPT and Oral Polio Boosters.
- 2 years—TBC Tine Test.

II. Routine Exams—Growth and Development, Feeding, and General Physical Condition:

- 2 weeks for P.K.U. test if not done in hospital.
- 6 weeks
- 3 months
- 9 months
- 1 year
- 18 months
- 2 years

III. Exams and Booster Immunization for Older Children:

- 5-6 years—Physical examination, DPT, Oral Polio, smallpox and TBC Tine.
- 10-12 years—Physical examination, D.T. and TBC Tine. Mumps for Boys who haven't had mumps.
- 6-12 years—German Measles for children (especially girls) who haven't had German Measles.
- Alternate recommendation at one year, combination Rubella, Rubeola and Mumps vaccination.

A NOTICE TO OUR PATIENTS

In this office, we feel that our specialized medical training and main interest lies in providing primary, regular and comprehensive medical care for all members of the family. We also feel that worries and family problems often play a part in making people feel badly and that helping with such problems is an important part of the care provided by the Family Physician.

We understand that some patients prefer to go to several different doctors for different members of the family or for different parts of the body.

However, if you and your family prefer a Family Physician with the training and interest which we have, please mention it to one of us so we will be aware of it and available when you need us.

Obviously, we are going to need assistance from and will call on other specialists from time to time in dealing with complicated and unusual surgical and medical problems. We also encourage all our patients to ask for consultation with any other physician at any time you are in doubt about or are not satisfied with your condition.

Housecalls? They are very time consuming and it is often more difficult to take a diagnosis at home than in the office—but we do make necessary housecalls for our regular family patients.

We also understand that medical expenses can be a burden at times. Any time this is true in your family, please mention it to us. We can always work out an agreement where you can continue to receive the medical care you need and pay for it as you are able.

WEST ORANGE, N.J., December 15, 1971.

JOHN M. MARTIN, Jr.,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives,
Washington, D.C.

DEAR MR. MARTIN: I am grateful for your diligent reply to my previous letter, requesting the opportunity to appear as a witness before the Committee. In accordance with your instructions I am enclosing a statement, which I hope the Committee will have time to consider in its deliberations, and which I hope may prove useful to them.

Sincerely yours,

J. CHERNUS, M.D.

Enclosure.

STATEMENT OF DR. JACK CHERNUS, WEST ORANGE, N.J.

This is a personal statement, and does not represent any medical or non-medical group.

It is entirely proper for Congress to enact legislation affecting medical practice, even if such legislation contains features coercive upon doctors, and even in the face of opposition by a majority of them. This right derives from the over-riding importance of public welfare. Nevertheless, Congress must obviously construct such legislation with great care, so that the public welfare will indeed be enhanced, and further, to avoid needless sacrifice by physicians, whose personal interests might be inveighed upon, without corresponding benefit to the population at large. While I am reassured by newspaper reports as to the Congress's diligence in this matter, in the holding of extensive hearings, I am deeply troubled by the conviction that the testimony offered the committee to date, has not been complete, and that action based on it may lead to dangerous, though well-meaning and unintentional consequences.

The philosophical cornerstone of national health insurance is that health care is a *right*, to be guaranteed to every citizen. I have no quarrel with this precept. But has there been testimony clearly defining, in pragmatic terms, what health care is? The simple definition that health care is what doctors now do (but in unequal distribution) is woefully inadequate.

The truth is that doctors practice and deliver two broad categories of health service. For the sake of simplicity I would call them curative and non-curative. Curative means effective, decisive in life or death, decisive in restoring to significant improvement in functioning. Included in this category is truly preventive care, such as proven preventive inoculations. Non-curative care is often referred to as "management of the disease," such as repeated examinations of the chronic patient, with minor variations of the regimen, which didn't significantly improve the condition in the first place, nor is at all likely to improve it with these minor changes. The reason for this is the "state of the art" of medicine. We do not yet have the knowledge to give curative care in these cases.

The truth is, further, that doctors spend more time in non-curative health care (and derive more than half their income from it), than in curative care. The point might well be made that patients' morale is improved, at the least; that they appreciate and are willing to pay for non-curative care; and that the doctor doesn't mind providing it, for both humanitarian and financial reasons. Therefore, it would seem to be a moot point.

If we return to the problem of health care for all, however, it is not a moot point. Non-curative health care is not nearly so self-evident a right, to be guaranteed to all, as curative. In one way, it may be regarded as a "luxury," no more to be vouchsafed to all, than luxury housing, food, or clothing—basic needs which are approached with the idea of supplying at a minimum acceptable level. The idea of a luxury derives further from the fact that many people with adequate ability to pay for, and ready availability of physicians to supply it, nevertheless choose not to avail themselves of such care, deeming it non-essential. From the more practical viewpoint, non-curative care, apart from not being essential, may be impossible to deliver to all, no matter what the system, because we have neither sufficient manpower nor money for such a goal. (Curative care, however, in my opinion, can easily be provided for all).

What has confused the picture is not only the failure to define curative and non-curative, but the special pleading of some groups before the committee. These groups have knowingly (with malice aforethought), or unknowingly, demanded unlimited care for all, based on statistics which reflect only the deficiencies in

curative care. They have, in effect, condemned the entire house and demanded a costly new one, on the basis of disrepair of only one wing of the house.

I trust that even this general statement, of necessity brief, may prove to be of value to the committee in its deliberations. However, I have much more information, in support of my statement, should you desire to enquire further into it.

Respectfully,

J. CHERNUS, M.D.

UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE,
Haverford, Pa., October 29, 1971.

Hon. WILBUR D. MILLS,
Chairman, Ways and Means Committee,
House of Representatives,
Washington, D.C.

DEAR MR. MILLS: In your hearings on various bills designed to modify existing ways of paying for medical care services, I urge you to keep in mind the need for caution that mechanisms adopted do not limit the physician's usefulness. Understanding the medical process, as delineated in the enclosed article, will lead to recognition of dangers inherent in certain financial and administrative mechanisms.

Yours very truly,

KATHARINE O. ELSOM, M.D.,
Emeritus Associate Professor of Community Medicine.

Enclosure.

[From the Journal of the American Medical Association, Aug. 30, 1971]

ELEMENTS OF THE MEDICAL PROCESS

THEIR PLACE IN MEDICAL CARE PLANNING

By Katharine O. Elsom, MD

Efforts to improve the structure of medical care services through revisions in financing and administration are increasingly attracting persons from outside the medical profession with previous training in finance, insurance, engineering, and administration. Because such persons are unfamiliar with the nature of the medical process, their expectations of what medicine can achieve are often unrealistic. Knowledge of the nature of the component parts of the medical process, diagnosis, treatment, and prevention, discloses that while in each instance there are objective data that can be utilized effectively, important limitations exist. Furthermore, at each point in the medical process the physician's clinical judgment is crucial. Future planning for the financing and organization of medical care must provide for this element in order to be successful.

Currently the major trend in efforts to plan for improved delivery of medical services is toward revisions in financing and in administrative mechanisms. To achieve these ends persons from insurance, economics, engineering, and administration are increasingly being relied on to outline reforms in the medical care structure. While such persons bring with them skill in their respective areas, they have had no training or experience in the medical process itself. Although facts concerning costs of medical care, distribution of services, and other administrative details are readily available to all who seek them, the meaning of these facts in terms of the successful care of patients requires an understanding of the medical process itself. Furthermore, whereas the financial and administrative aspects of medical care are currently receiving much attention, certain other facts are overlooked. For example, although the desirable role of preventive medicine in containing costs is recognized by all, the facts concerning the status of preventive techniques are not generally set forth, and, hence, not realistically considered in plans involving such services. Facts concerning the nature of disease itself, the procedures involved in arriving at a diagnosis, the bases of therapy, all intimately involved in the medical process, are not generally understood by persons who approach medical care planning from outside the profession. Finally, least comprehensible to persons trained in other disciplines are

the points in the medical process where the "exact science" of medicine leaves off and clinical judgment becomes profoundly important.

This communication considers various aspects of the medical process and endeavors to show how an understanding of them is essential to adequate plans for medical care services. Considered first is the fact that, in spite of all the scientific data available, the practice of medicine is ultimately rooted in an uncertainty which stems from the multiplicity of factors that produce disease. Even with the application of the best objective techniques, the very complexity of these factors and the fact that they are constantly changing make largely impossible the kind of "yes" and "no" answers which persons trained in more precise disciplines expect.

Next, the component parts of the medical process are examined: diagnosis, treatment, and prevention. In each instance, the effectiveness of the objective tools at the doctor's disposal is examined. In my experience, many persons have unrealistic expectations of what these objective tools can accomplish because they are unfamiliar with the facts concerning their use. Finally, I endeavor to show that in each step of the medical process an intuitive element supplied by the physician is crucial. It is this element which renders the planning more complicated than is commonly supposed. The factors which promote this element—medical education which enhances it, financial arrangements which reward it, administrative arrangements which provide time and space for its transfer—all require comprehension of its nature. In the absence of such comprehension there is danger that the plans adopted will rely on remuneration geared primarily to specific technical procedures and on administrative arrangements which limit contact between patient and physician. Such plans, though tidy from financial and administrative points of view, could ultimately be self-defeating, through the limitations they place on this crucial aspect of the medical process.

THE NATURE OF DISEASE: A SHIFTING PHENOMENON

Though disease has been present from earliest recorded time,¹ its prevalence and severity have fluctuated widely, often independent of medical intervention, as in the case of syphilis, scarlet fever, measles, mumps, and tuberculosis, where the prevalence and severity of these diseases decreased even before the advent of modern treatment. Changing environmental factors appear to be related to the causation of diseases such as silicosis, bronchitis, and emphysema. The vast number of new chemical compounds in industry has increased the possibility of toxic exposure. Peptic ulcer, hypertension, and other stress-related diseases are associated with the increased tempo of living.

In the last half century, clearly defined infectious disease has been replaced by atherosclerotic cardiovascular disease and malignant neoplasms as the major causes of mortality in industrialized nations. This has radically altered the physician's task. Instead of diseases of single etiology, he is now more often confronted by those of multiple and often obscure causation which are much more difficult both to identify and to treat. Change is still going on. For example, diseases such as mental disease, hypertension, and coronary artery disease in which reaction to nonobjective components of the environment plays a significant role, are increasing in prevalence. Furthermore, recent experiments have demonstrated that the frequency of both infectious and noninfectious disease can be influenced by the stress endured by the experimental animal (S. P. Martin, personal communication). Finally, the role of human perception in initiating and influencing the form of disease is just beginning to be investigated.^{2,3}

Thus, in planning for medical care, the thing which medical care is designed to deal with, human disease, is an ever-changing phenomenon. Since evidence now points to the increasing part that human perception probably will play in initiation of the diseases of tomorrow, new kinds of practitioners, differently educated, will be needed to deal with these problems. Financial arrangements will be required which take these changes into account, while imaginative new practice arrangements will be needed. Realization of these facts constitutes an important component in successful planning for future medical care services.

¹ DuBos R: *The Mirage of Health*. New York, Harper & Bros, 1959, pp 144-145.

² Hinkle LW, Wolff HG: Ecologic investigation of the relationship between illness, life experiences and the social environment. *Ann Intern Med* 49: 1373-1388, 1958.

³ Wilson C: *Introduction to the New Existentialism*. Boston, Houghton Mifflin Co, 1966.

THE HEALTH-DISEASE CONTINUUM

The definition of "health" is difficult. An abrupt invasion of the individual by a pathogenic organism produces clear evidence of illness, but today more diseases are produced by multiple factors, both internal and external, which interact over a prolonged period before the "disease" is manifest. Thus, frequently today no distinct boundary exists between health and major diseases afflicting mankind. Rather, one merges into the other. A person's place on this health-disease continuum is determined by the balance between the factors permitting effective function and those disrupting it. It is impossible to assign a value to any single factor in terms of where it places one in this continuum. Thus, although the "normality" or "abnormality" of a single factor may be determined in relation to a scale of values for that factor alone, such information cannot establish the relative place that factor occupies in the total constellation of factors determining a person's place in the continuum. This is why the results of a given test, or even a large battery of tests, do not yield clear-cut "yes" or "no" answers about a patient's "health." It is here that false expectations about medical service often arise.

The current loose use of the word "health" contributes to misunderstanding and false expectations. Thus "health center," "health examination," "health promotion," and "health insurance" are terms commonly used today. Actually, in each instance, the activities encompassed under these designations are largely concerned with problems of disease.

MEDICINE'S TOOLS

Today's planning for medical care aspires to better ways for more people equably to gain access to medical service at less cost. In my experience, these efforts have seemed to proceed on the assumption that medical service is a kind of unified "product" which might advantageously be disassembled and rearranged. Such propositions in general have appeared to be made with little understanding of the nature of the product.

In the following discussion, medical service is considered under three sections which together constitute the medical process: diagnosis, treatment, and prevention. In each section the usual procedures undertaken by a physician are outlined, the source of the data used by him is considered, and an assessment made of the possibility of change. In each instance the comparative place of objective data and subjective information about the patient is considered.

Diagnosis.—The keystone in the medical process is the diagnosis of disease. The physician's estimate of where the patient stands in the health-disease continuum must precede action for his benefit. This estimate is based on analysis of data derived from the patient by various techniques and on information which the physician secures intuitively from the patient himself.

Diagnosis consists first of the accumulation of objective data about the patient. In this part of the diagnostic process a selection must first be made of what data to collect from the vast number of possibilities. Traditionally the physician has made this selection as a result of his contact with the patient—looking at him, talking with him, and examining his body. He then draws on his medical experience to interpret the data, arrive at a diagnosis, and plan for treatment. Recently automation of the diagnostic process is being attempted at this point. The patient is given a series of questions and laboratory tests derived from a quantity of data collected from persons harboring commonly occurring diseases. The information supplied by the patient is then cross-correlated with data characteristic of various diseases and mathematical probabilities calculated for the presence or absence of those diseases in that patient. The computer's ability to store, retrieve, and cross-correlate an almost limitless number of individual pieces of information renders it a valuable aid at this point in the diagnostic process. However, before it is concluded that increasing the efficiency of diagnosis by automation is a simple problem of collating and programming data, certain problems must be recognized. Medical knowledge of various diseases is notably uneven. Thus, as pointed out by Engle and Davis⁴ in their erudite inquiry into the nature of the diagnostic process, diagnostic problems range in complexity from those of the "first order of certainty" for diseases in which the manifestations are essentially stable over time and hence the symptoms, signs, and laboratory evidences are well known, to "diagnoses of the fifth order of certainty," where the cause of disease remains obscure, the manifestations protean, and laboratory evidence equivocal. Obviously, to catalogue diagnostic criteria for the

⁴ Engle RL Jr, Davis BJ: Medical diagnosis: Present, past and future. *Arch Intern Med* 112: 512-543, 1963.

first order of certainty is simple. As the fifth order is approached, it becomes increasingly complex if not impossible and automation becomes less feasible.

Automation of the diagnostic process is also hampered by the lack of clear criteria for "abnormality" in many laboratory data. A series of studies by the Periodic Health Examination Research Group has recently disclosed a wider range of values than was commonly supposed to be associated with the presence of certain diseases.⁵ Furthermore, this Group has also shown that success in the early detection of disease varies among different diseases.⁶ Successful detection ranged from 88% for rheumatic heart disease, cardiac arrhythmias, and other commonly encountered chronic heart diseases, to only 43% for all cancers. In a study⁷ of coronary heart disease, no detection procedure discriminated correctly in more than 35% of matched pairs between persons who later died of this disease and persons also harboring the disease who survived. The electrocardiogram alone, an instrument usually relied upon in the early detection of this disease, failed to discriminate between 75% of such paired persons. Studies elsewhere⁸ have also indicated that between 23% and 57% of all cases of coronary heart disease are undetected prior to the development of symptoms. Thus, in many situations clear "yes" and "no" criteria for the presence or absence of disease are not at present possible. This fact clearly complicates the problem of automation in the diagnostic process.

Finally, one must realize that utilization of mechanical aids in diagnosis substitutes a wide-meshed screen for the discriminatory choices of the physician. For example, an automated history questionnaire applies to the patient a series of questions that encompass the symptoms associated with important diseases involving every organ system in the body. This results in the collection of a great deal of irrelevant material. In a recent study, yet to be published, we found that 62% of the information collected by a standardized history questionnaire had later to be discarded as irrelevant in the light of the final diagnoses, while only 13% of the information collected by the physician's history was found to be irrelevant. Furthermore, information about the patient secured by the physician's history led to 48% of the correct final diagnoses, compared to 38% from the automated history. Likewise, the collection of laboratory data by means of standardized procedures applied to all patients, in spite of the reduction in unit cost, may ultimately be wasteful in terms of the proportion of useful information secured on the individual. We have found,⁹ for example, that routine urinalysis, though an inexpensive test, is among the most costly of the procedures commonly employed in periodic health examinations because of the infrequency with which it provides useful diagnostic information.

Thus, in arriving at conclusions concerning the cost-efficiency of automation of medical information, many factors must be weighed and many unanswered questions must be settled.

We turn now to the intuitive aspect of the diagnostic process which is crucial to success in all but diagnoses in the highest "order of certainty," and which requires an encounter between physician and patient. This has been well described by Engle, as follows:

"The experienced clinician of good native-ability has gradually acquired the power of selecting from the mass of data accumulated by clinical analysis in a given case the features of a high unity, synthesizing them to a syndrome or a "clinical picture" in much the same way that a landscape painter on viewing nature chooses and combines, for his purpose, the elements that are necessary for his work of art. Nearly everyone can, by prolonged study under instruction, learn the technique of landscape painting, but not everyone can become a Corot or a Turner. Similarly, it is not so difficult for any industrious student to learn the technique of examining patients, but only a few ever learn

⁵ Clark TW, Elsom KO, Montgomery EH, et al: Clinical and biological observations on working men. *Arch Environ Health* 19: 700-711, 1969.

⁶ Schor SS, Clark, TW, Parkhurst LW, et al: An evaluation of the periodic health examination: The findings of 350 examinees who died. *Ann Intern Med* 61: 999-1005, 1964.

⁷ Schor SS, Elsom KA, Elsom KO, et al: An evaluation of the periodic health examination: A study of factors discriminating between survival and death from coronary heart disease. *Ann Intern Med* 61: 1006-1014, 1964.

⁸ Stokes J III, Dawber TR: The silent coronary: The frequency and clinical characteristics of unrecognized myocardial infarction in the Framingham study. *Ann Intern Med* 50: 1359-1369, 1959.

⁹ Clark, TW, Schor SS, Elsom KO, et al: The periodic health examination: Evaluation of routine tests and procedures. *Ann Intern Med* 54: 1209-1222, 1961.

to construct clinical pictures as could Sydenham or Graves. And as the clinical sciences progress, the clinical pictures that masters of the subject are able to construct grow ever richer in content."

The materials used by a physician in the intuitive part of the diagnostic process are derived from the encounter with the patient. They are compounded of a variety of almost subliminal human impressions gained by both physician and patient of one another which powerfully influence both the quality and the quantity of information that is transmitted. Involved are subtle estimates of the personality of each participant, which, in turn, determine the degree of mutual trust, or lack thereof, that develops. These are derived from tones of voice, expressions in the eyes, shifting shades of skin color, types of gestures, and choice of words. From all these things, which cannot be catalogued, which change from moment to moment, and which vary from situation to situation, a physician derives the subtle clues which, if he is able to receive them, he largely unconsciously places in his hopper of information. Obviously, physicians differ in the degree to which these clues are received and also in the use made of them. It is here that the wise and sensitive physician is separated from the technician. It is here, too, that the inspired diagnosis is derived and, later, the considered decision with respect to action taken on the patient's behalf.

This part of the diagnostic process cannot be objectively analyzed and hence its existence is often overlooked. It is, however, a large determinant in the quality of the medical process. This fact explains why the usual attempts to measure the "quality of medical service" by quantitative means fall short of the mark.

Tangential evidence that physicians employ more than objective data in arriving at diagnoses was secured by us in a recent study.¹⁰ Three hundred physicians, examining 14,110 men in periodic health examinations, showed a surprising independence of standard criteria in arriving at diagnoses of diabetes, coronary heart disease, and hypertension. What elements beyond objective data were employed by these physicians were not evident in this study. That these elements are real, that any skillful physician makes use of them, that success or failure not only in the diagnostic process, but also in the management of the patient's problems, is dependent upon them, is well known by all doctors. As Engle has said, "this 'psychic shuttle' has been in the minds of all physicians since the beginning of medical thought." The future of medicine may very well hang on the nurturing and elaboration of this part of the medical process.

Treatment.—Following diagnosis, the next step in the medical process is treatment. Under the general designation of "therapy," such action may range all the way from the initiation of discrete procedures designed to alter specific processes in the patient's body, to the imaginative manipulation of factors in the interaction between the person and his environment. In general, the former requires specific information, the latter involves consideration of complex inter-relationships. Together they produce therapeutic wisdom. We need to be aware of the possibilities of both types of action in order to assess the value of medical service today.

Surgical Therapy.—The term "therapy" is generally attached to treatment which employs discrete procedures directed against specific processes. Therapies are, of course, legion, and vary depending on the cause of the disability and the body system involved. They may be divided, however, into two general categories: surgical and medical. Surgical procedures are designed to eliminate the cause of an abnormality, to be reparative, or to be palliative. The effectiveness of specific surgical procedures obviously cannot be detailed here. Suffice it to say that, as with diagnosis, the more specific, objective, and circumscribed the cause the more likely is surgical therapy to be effective, either as a curative or reparative procedure. When, however, the cause is either unknown or has multiple components, as with most of the chronic conditions today, surgery frequently is palliative and temporarily so at that. Thus, surgical repair of injuries causing gross anatomical abnormalities is usually successful. On the other hand, the record of surgical treatment in cancer, for example, is far from encouraging. In a large series of patients in health clinics in Canada¹¹ there was no evidence of superiority in survival of either early or different kinds of treatment compared with absence of treatment. The report notes that "critical clinical and pathological studies have shown that the type of cancer determines the outcome . . . It

¹⁰ Elsom KO, Ipsen, J, Clark TW, et al: Physician's use of objective data in clinical diagnoses. *JAM* 4 201: 519-526, 1967.

¹¹ McKinnon NE: Control of cancer mortality. *Lancet* 1: 251-255, 1954.

has not been proven that the survival rate of breast cancer . . . is affected by treatment at all." The report concludes: "The evidence today does not provide any encouragement that effectual control of mortality from any major cancer has been achieved . . ."

A gloomy assessment of surgical therapy for today's other major causes of mortality and morbidity must also be made. Except in the treatment of gross anatomical defects derived from rheumatic or congenital heart disease, surgery has not proved curative of heart disease in general, coronary artery disease, hypertension, atherosclerosis, emphysema, or diabetes. In some vascular conditions it constitutes an important palliative procedure. Also, in patients with duodenal ulcer and ulcerative colitis though not curative of the underlying condition, surgery can be life-saving in repair of the presenting lesion. The reason for limitation in surgical therapy undoubtedly is the "ecological complexity" of most human disease problems of the present, which places their solution out of reach of any circumscribed therapeutic procedure.

Medical Therapy.—The same general situation prevails with the other large divisions of therapy, namely medical. Modern chemotherapy has produced dramatic results in conditions in which causes are circumscribed and identifiable, as in previously fatal infectious diseases such as subacute bacterial endocarditis and meningitis, and in acute streptococcal infectious pneumococcal pneumonia, bacillary dysentery, gonorrhoea, and syphilis. However, in the chronic conditions of multiple, obscure etiologies, drugs cannot, in the nature of things, be more than palliative. The relationship of insulin to the treatment of diabetes is a good example of such a situation. Insulin replaces a key metabolic component that is in insufficient supply within the diabetic patient due to a complex, incompletely understood metabolic derangement. Insulin has enabled millions of diabetics to lead long, useful lives although it is now recognized to be only one link in a complicated chain of events; the underlying derangement is unaffected. This is demonstrated in diabetic patients by the development over time of vascular complications which are related to the underlying process in some way not yet fully understood.

Drug therapy is limited similarly in all instances where such compounds only replace a missing component but do not alter the complicated underlying processes. Examples are¹² the use of cortisone in rheumatoid arthritis, thyroid analogues in hypothyroidism, tranquilizers in mental afflictions, antihypertensive drugs in hypertension, diphenylhydantoin in epilepsy, and levodopa in Parkinson's disease. This is not to gainsay the remarkable degree to which scientific research has unravelled enough of the mysteries of complex metabolic phenomena to provide compounds capable of being inserted profitably at various points in the chain of events. Continued research will undoubtedly provide additional understanding of these events, and produce more compounds that can be administered to influence function. That ultimate solutions can be expected by this route is, however, unrealistic. When this is understood, the expectation of instant solutions from medical service by means of medical therapy is widely tempered.

Other Therapeutic Action.—The physician, having exhausted available therapies, must now decide whether any other kind of action may help the patient. How he proceeds depends more on the degree of his perception of intangibles than on a catalogue of objective facts. Now he needs to understand the non-visible parts of the person before him. It will help if he knows some objective facts about the patient's life: his occupation, his education, his culture, his personal habits, his family constellation. But these will be mere facts unless the physician grasps their contribution to the person's self perception: his goals, his interpretation of the events of his life, his concept of its meaning. Only then can the physician determine how to help the patient understand his own life situation and what he can do to alter it for the benefit of his health.

We have seen how the quality of the diagnostic process is influenced by the art of medicine. This same sort of wisdom determines the action now taken by the physician. It determines the reliance he places on specific therapeutic remedies and thus whether or not he recognizes the need to comprehend the human characteristics of his patient. The physician's performance of his task at this point is probably the determining factor in the satisfaction the patient gains from his encounter with medical service, whether or not a "cure" is effected. The requirement is, in the words of René DuBos, "a kind of wisdom and vision which transcends specialized knowledge of remedies and treatments and

¹² Ingelfinger FJ, Relman AS, Finland M (eds): *Controversy in Internal Medicine*. Philadelphia, WB Saunders, 1966.

which apprehends in all their complexities and subtleties the relation between living things and their total environment."

How does the physician acquire the comprehension necessary to meet this challenge? His preparation is compounded of many things. How he himself started out in life is the beginning: his genetic inheritance, the cultural influences in his early environment, his early educational opportunities. Later, the quality of his medical training determines not only his storehouse of facts but also his attitudes and perceptions. Here the quality of environment supplied by his instructors and his peers is paramount. Finally, and most importantly for this discussion, the type of financial and organizational surroundings in which he confronts his patient will have a profound effect on his ability to comprehend the patient's problems. This will be discussed further later in this communication.

Prevention.—The obvious ideal answer to the high cost of medical care is to achieve a relatively disease-free population and hence to reduce the need for expensive services. To what degree can medical service be expected to contribute to this end by the prevention of disease? We have already seen that, in both the diagnosis and the treatment of disease, the medical process becomes progressively more uncertain as causation diffuses and multiplies. The same situation prevails with respect to prevention. Just as no single therapeutic modality can be expected to cure the major diseases of multiple, interlocking causation, so no discrete and circumscribed method of prevention can be anticipated.

In the absence of knowledge of specific causation, the best that medical service at present can do in "prevention" is to identify evidence of disease as early as possible in the hope that its progress can thereby be attenuated. The single most important instrument at present for the early detection of chronic disease is the periodic health examination. The effectiveness of this instrument is still uncertain because of epidemiologic problems inherent in studying the results of its application. That some beneficial effect is achieved has been indicated in two recent studies (unpublished data)¹⁸ in which the age-specific mortality of persons remaining in periodic health examination programs over time was found to be significantly lower than that among persons who left such programs or among persons who presumably never had been part of such programs. Just how the observed beneficial effect is attained is still uncertain, since few specific tests yielded reliable information of the presence of those diseases which later caused death. The hope that a few key tests can be selected for use on a massive scale in so-called multiphasic screening programs appears to be based on insufficient evidence. That the accumulation of massive quantities of data, as yet largely uninterpretable, will be a worthwhile public investment, or that the availability of such data will significantly affect either the burden on the medical care system or the total prevalence of disease in the population have yet to be demonstrated.

Thus, although many technical procedures with which the physician may "test" the patient are available as part of medical service, the weight of evidence at present suggests that they are of limited value to him in determining where the patient stands in the health-disease continuum, and hence whether anything can be done to prevent further progress of disease. For those concerned with arriving at solutions for containing the cost of medical care, understanding this part of the medical process is of the utmost importance.

THE MEDICAL PROCESS AND PLANNING FOR MEDICAL SERVICES

We have seen that the medical process is compounded of a mixture of facts based on scientific inquiry, on application of these facts through technology, and additionally on the physician's intuitive synthesis of the information he derives directly from the patient. The medical process is neither complete nor effective without any of these elements. The problem in planning for future medical care service is to devise a system which will provide *all* these elements at a cost that society can afford.

Because the technical apparatus for the acquisition and application of scientific facts is highly visible and its costs readily ascertained, there is a tendency for those not adequately informed of the full nature of the medical process to expect that by increasing the efficient utilization of this equipment, the major problems of cost, distribution, and organization of medical care will be solved. The fact that the intuitive element in the medical process is largely invisible, eludes definition, and is not amenable to objective measurements of quality or of

¹⁸ Roberts, N. J., Ipsen, J., Elsom, K. O., et al.: Mortality among males in periodic health examination programs. *New Eng J Med* 281: 20-24, 1969.

efficiency is puzzling and often exasperating to those who approach medical problems with engineering, financial, and organizational skills. Without an understanding of where and how in the medical process this element is crucial, there is an impulse either to deny its existence or to regard it as antiquated or superfluous. This communication has been offered in the hope that when the essential role of the intuitive part of the medical process in successful diagnosis, in successful treatment, and in the prevention of disease is understood, its place in future planning will be not only preserved but enhanced.

Ultimate defeat awaits any system of medical care that fails to recognize the crucial role of the intuitive part of the medical process. In its absence, in spite of the most efficient organization of medical services, there will eventually be a breakdown in diagnosis, in treatment, and in the medical aspects of prevention. These breakdowns will increase the cost to society of the burdens of illness of misconceived application of sophisticated technical equipment which produce data without meaning, and ultimately of facilities required to handle the end-results of unsolved illness. As has been pointed out, where causes are primarily unitary and therefore clearly defined, the scientific and technologically based aspects of medicine can be relied on with confidence. However, in diseases of more complex and obscure origin which are increasingly prevalent in a man-made world, the intuitive aspect of the medical process assumes relatively greater importance.

Just as the medical process is multiple, so the profession of medicine requires multiple components. There will always be need for members of the profession whose orientation is toward scientific research, for those whose orientation is toward the application of scientific knowledge by technical development, and for those whose skills lie in manual dexterity. In addition, however, there is a growing need for those whose strongest aptitudes are in the intuitive aspects of the medical process. Unfortunately, these persons have recently been more and more at a disadvantage. With the advent of the "scientific era" and the subsequent rush to specialization, so that 85% of physicians now limit themselves to the practice of a "specialty," the place for the more generally oriented physician has been narrowing. General practice, in the old sense of the term, is no longer possible because of the proliferation of medical knowledge. The specialty of internal medicine or, more recently the new specialty of family practice should most logically provide opportunities worthy of the special orientation of such persons. However, health insurance, with its developing requirements for the application of price tags to ever-more-sharply defined "units" of service, has gradually been forcing such persons into more and more technically-based practices, or, in the absence of such a shift, to accept remuneration at the bottom of the medical scale. Future financial mechanisms should recognize the importance of the intuitive aspect of the medical process. Organizational patterns of medical practice must supply freedom in terms of time and of actual physical space for satisfactory and enduring contact between patient and physician. It has been postulated that pre-paid group practice might provide the financial and organizational framework required. The recent emphasis within this system of automated assembly-line procedures, particularly in diagnosis, together with pressures for "productivity," cast some doubt on the future development of this system as presently constituted.

What is needed and presently so underemphasized is careful consideration of the place of, the nature of, and the requirements for the nurture of the intuitive part of the medical process. The conditions under which this part of the process flourishes need to be studied. The need for new knowledge within medical education which will extend competence in this area requires exploration. The need for recruitment into medicine of persons with the necessary aptitudes, and the need to develop ways to attract them, to encourage their development, and to utilize their skills within the medical care structure are all urgent parts of planning for medical care for the future.

To understand why comprehension of the nature of the medical process is essential for the enlightened planning of medical services one must recognize that, in the words of René DuBos,

"For [medicine] to fulfill its potentialities it may once more need the help of bold [innovators] willing to use empirical methods based on philosophical, humanitarian, and aesthetic beliefs. Medical statesmanship cannot thrive only on scientific knowledge, because exact science cannot encompass all the human factors involved in health and in disease.

"This investigation was supported in part by a grant from the Boyer Fund, University of Pennsylvania."

STATEMENT OF DR. JOHN W. EMMER, NEW IBERIA, LA.

The following is the testimony that I want to provide for your evaluation but which I was assigned too little time to testify upon at the hearing date when dental phases were to be heard.

I am Dr. John Wiltz Emmer of New Iberia, La., and I have been practicing dentistry for the past 46 years here in New Iberia. I graduated from college with an A.B. Degree at 17 years of age, and cum laude in dentistry in 1925, having apprenticed myself to my father one intervening year to be certain that I would like to be a dentist.

The first problem I ran up against was that of a mother of 13 children who wanted to have whatever teeth needed repair to have it done. After a thorough examination and figuring out the estimate and telling her about it she cried out bitterly that I could not work for poor people. I was not so impressed with the problem of getting dentistry for people until some time later when one of our good Cajun folks came by looking for dental services and while I was engaging him in conversation he said, "You know Doc, I keep havin' dem tooths fixed but I lose dem anyhow."

The combination of a bitter reaction of a mother who could not afford to have her children's teeth fixed because of the extent of the disease entities and the reply of the Cajun who told me the real truth about the value of dental services reorientated my thinking and I decided then and there to find a way to put an end to these deprivations and natural deductions about the failure of my profession to offer a chance for realistically saving of teeth.

I never realized exactly what I had decided to undertake. Failure hounded my steps until about 1949 when several mothers literally dragged their youngest children into the office seeking someone who could do something about the toothaches their children were having. Can you imagine three young children (not all at one time) having at least practically every tooth in their mouths decayed so badly that none offered a realistic chance to repair. To try to get ahead of this screaming I decided to try a mixture of a fluoride and a germicide that was on my cabinet and had given the mothers a direction to put it on three times a day for three weeks and twice a week for three weeks and one a week thereafter. After several weeks (about 5) all the pain was controlled and never after did those children ever suffer another toothache and I did not repair one of them. Only one tooth of the 60 had to be extracted before the normal time of expectancy of the second teeth to erupt.

There upon rests the toils of my life. I finally found a biochemical firm to do the research work and by 1952 I was ready with a dentifrice with safer fluorides and more effective germicides and which was tested upon laboratory animals. In each instance anyone following simple directions to brush the gum line areas but on both sides of the teeth and also on the biting surface of the teeth. None have yet to this date ever suffered a decayed area on any of the smooth surfaces of either their baby teeth nor on any of their now permanent teeth.

All this prelude is to explain why the dental profession deserves absolutely no consideration in a National Health Program until they properly evaluate the research records that I have sent and tried to send to their Council on Dental Therapeutics. We have been at loggerheads because in spite of all the various dentifrices that have conformed to their method of testing have not reduced the incidence of dental disease one iota but does enlarge upon the number of services that the dentist is called upon to render. But we are relatively so few in number that many people even those who can afford this expensive service cannot find an office open to them. This is because each child of 2½ yrs. has 88 surfaces upon which he can develop decay and 80 on which the gums can become inflamed, and each adult of 12 or more has 128 surfaces upon which they can suffer decay and 112 of those upon which gum disease can develop. A Survey of Dentistry has shown that it would take 135,000 additional dentists about five years just to catch up with the existing backlog of disease if no new ones developed in the meantime. Therefore it is easy to conclude that the demands of the C.D.T. of A.D.A. must not be what is needed since many dentifrices have conformed to this demand and have achieved nothing for the extensively suffering public. So my experience showed me that I must deviate from this or fail in my efforts to do something for the people as a whole.

So in spite of the fact that my research attracted (Butone) a manufacturer, I demanded that this product remain as a liquid.

The members of the board who had been attending my statements got up and left me with the dental director without having the courtesy of telling me they were sorry or good-by.

Now what has this product achieved in the past 19 years that no other product has ever yet achieved in the hands of the public.

(a) Whereas the national average of decayed missing or filled teeth for a child of 5 yrs is 9.8 if he eats anything at all in between meals. Not one of the users of my dentifrice has ever yet had a cavity. . . . This completely offsets the horrible happenings that are occurring amongst some child specialists of their giving the child a barbiturate suppository as well as a barbiturate by mouth to make the child amenable to all the services they need.

(b) Not a youngster using my dentifrice throughout his life has ever yet lost a tooth from dental decay. A Dr. Thaddeus Hyatt showed in 1924 that if the defective biting surface of the teeth were filled before it decayed that even in a free dental clinic which served the poor he could prevent 95% of the former loss of the child's first permanent molar—the key tooth in the dental arch just as you may easily recall the usual white plug in most arches of masonry. Pull out that plug and the whole arch collapses and so it does in dentistry and all this adds to the total overall costs of repair but still results in much earlier loss of the permanent teeth and if this is to be avoided then most expensive rehabilitations are resorted to or the patient is driven to accept false teeth with which they must, yes they must, resign themselves to about 27% of the efficiency of natural teeth.

(c) While this dentifrice is keeping the children's teeth in far better condition than the same monies which used to be used to pay for their care (mothers would sacrifice themselves for their children) now is paying for the repair of the mother's teeth and maybe even a father now and then.

It is to be noted that the men come to the dentists on but 19–21% whereas women and children come 79–81%. Is this significant that because of the greater amount of toxins absorbed from diseased gums over a longer period of time that the male is degenerating and resulting in dying 7% earlier than his supposedly weaker sex (wife).

(d) The use of the liquid form of dentifrice also eliminates the need of the dentist or his auxiliary applying topical fluorides to the teeth of the children patients as they are doing this themselves every day twice a day. Nor is there need for excessive use of the x-ray examination since in 19 years not one touching surface of teeth has suffered a decay. It is still advisable to use the x-ray about every three to five years so that any abnormality could be discovered earlier but not the extent now being used by many child specialists—every 3–5 months.

(e) The last consideration is the one dealing with the occasional case of a person who has had rheumatic fever. Before, any dentist can even clean the teeth they must have had a series of antibiotics to prevent a serious heart lining infection from developing. Within five minutes it has been shown that the system can absorb the infectious material (toxins) within the gum crevice and dump it directly into the blood stream through a drainage channel directly into a vein under the collar bone on the right side. Now if this will happen with this type of infective condition what do you think is happening all day long from other forms of bacteria which live in the gum cuffs around the four sides of every tooth for every hour of every day. Because men cannot give up the time required to treat the extent of disease that they suffer on so many teeth why could this not be the reason that their organs degenerate earlier and thus results in their earlier death.

At any rate it is my firm belief that they should be given the opportunity to have better dental health. But they too develop bad habits of brushing when they are young. Why?

Because of that g.d. flavor burn that is in toothpaste that you are led to believe is to give your mouth a good taste but in reality is in there to cover the bad taste of the detergent strength that they must use to have any kind of bactericidal action. By keeping my dentifrice as a liquid I do not need such strong flavors and thus can achieve bactericidal action with but 1:2000 %. So even the very young can brush their teeth and develop the habit so necessary if anyone is to keep their teeth indefinitely.

Remember Sirs, the mouth is the opening of the sewer of the body. How far down the tract do I need to go to prove the claim? Also in this sewer opening the bacteria have such favorable breeding grounds that they rotten both the

teeth and the supporting bone and the gums around the tooth. It has been reported that over 80 million people have some form of gum disease.

Now let us recap.

If all this disease is occurring even in spite of the supposed value of fluoridating the water systems of the nation why is it that so much disease still exists. Well take a look at the enclosed copy of a report by the Asst. Surgeon General of the Army which appeared in one of our dental journals. Just what motivation to use the supposedly effective dentifrices when youngsters still show so much disease as this. Please note well that no ad ever mentions "gum disease" and it is from this that most people lose their teeth later in life but it is the too early loss of teeth which develops conditions which favor the development of gum disease and I should know I have been a specialist in this phase of dentistry for well, since 1942.

The intervening cost to repair a mouth when the factors have been developing since childhood takes away from the economy more than it can allow any one profession to have as its share. But tell me which women would refuse to try to have her teeth first rather than have that new dress?

What America needs is the inculcation into the school system continuous informative classes on dental health and why it is needed with positive demonstrations of exactly what can be done. It is the most dramatic showing ever to show children the plaque upon their teeth and how easily it can be brushed off with my liquid fluoride dentifrice and they grasp the thing quickly as I now have up to and including a six child family who have never had a smooth surface of their teeth to suffer a decayed area not one and they do it not me and therefore the parent can save the money for college education or what have you. So from an economic standpoint dentistry cannot claim they deserve aid as they through their leadership have refused to try to evaluate something from another standpoint. Where in the hell does anyone get the idea that there is only one way to do something and arrive at the same point or possibly at a better advantage point. We have gone further in the effort to help people to curb their disease entities since it is a well known fact that one must brush after every meal and within one hour or else they just as well forget it.

So I get some technical help and we designed a portable toothbrush with a weekly replaceable cartridge of the liquid dentifrice. Now with this thing 22 working women could brush their teeth after the two meals a day that they eat away from home (or haven't any of you ever been to a commuter center). Then with so much bussing children will eventually be given breakfast upon arrival at school as they have little chance to get any breakfast and get out to bus stations especially in winter months and with the lunch also they will have had two meals without one chance to brush and none of them at that age can save their teeth with such neglect and you might even add the fact that if they get home early enough they also add a snack to the food supply of the germs and not only their teeth go to pot but so does the household budget. Even that haughty male the peacock of the species could use the brush as he travels to and from on the job as one can brush even while driving a car and has but to spit into a kleenex tissue as the dentifrice makes: no suds.

So finally, with the extent of dental disease occurring to a greater extent than is reported and with so many surfaces of teeth per person being exposed to this high rate of disease then think what you could do to the employment problem.

In every school could be put a dental health director who not only could supervise that twice a day brushing bit could be easily trained to excite the youngsters about doing it. Going from class to class she or he could muster the fight against this most rampant of diseases and with the reduction in disease incidence that I can prove is occurring then people not only will have their teeth but they will have a few dollars to spend elsewhere and since there are so many people still with some teeth dentists would not be deprived one bit . . . not one bit. I would even venture to say that the best way to sell this or these dental preventive products by direct sales so that returning veterans could make over 6000.00 per year as he prepared himself for other work and we could even take welfarites off the roles and excite them enough to want to go out and help themselves. But Lo I cannot get off the ground because of the utter selfishness of my professional leadership. Let me ask one final question. When you finally make up your minds about a question what would you prefer to have a bit of bull or the true facts. But in spite of them except for some shenanigans at FDA I would have been off the floor already but that is neither here nor there but I am willing to show the truth in private anytime.

So why should the working people who pay the most taxes or rather whom taxes make a bigger dent, pay for peoples dental health when there is positive opportunity for them to help themselves.

When I offered to pay for an expert to examine my facts and after that if I could use the results in advertising I had offered my profession a chance to pick up over \$300,000.00 per year in my state alone just to tell people about dentistry and what it could really do if they chose to help the dentist .

You tell me two things. . . . How in the hell can anyone get a 2½ yr old child to brush thoroughly or to have his teeth brushed with that burning substance that is in toothpaste and if you want an example of what it is like put the smallest glob of it you can in the corner of your eye and a child's tissues are as sensitive as that when they are young and should be learning to brush their teeth.

Secondly they say that a fluoride is absorbed upon the tooth enamel but when they use paste dentifrice it has also been reported that the addition of that paste to the bristles of any brush increase the abrasiveness of that bristle by about several hundred times. So would not the tooth enamel be brushed away rather than any fluoride be applied to that surface? It should be the same as if you took your wife's emery board and tried to brush the teeth even with the smooth side of that board. But look at your own gum lines if you are about 40 years of age and note all the areas at the gum line where it has been eroded away by the abrasiveness of the toothpaste form of dentrifices.

Every factor favors the liquid form. There are multiple forms of deterrents in the paste form that does not allow children to develop good brushing habits and so these bad habits are carried over into adult life and each of them continues to have more and more dental disease.

Man what a job you fellows have trying to avoid people fattening up their bankrolls on plans you are trying to offer people a chance to have better health which in some instances they do not seem to want. I would be glad to offer testimony under oath and to reply to any and all questions.

Respectfully submitted.

Dr. JOHN W. EMMER.

SAN MATEO, CALIF., November 11, 1971.

HON. WILBUR D. MILLS,
Longworth House Office Building,
Washington, D.C.

DEAR SIR: I understand that you are not satisfied with any of the proposals for national health insurance now before Congress. In response to the multiple choice of opinion polls periodically sent to physicians, I also choose "other" and offer you four alternative concepts for your consideration.

I. Two plan option under one premium for the wage earner, a healthy challenge to the insurance industry.

II. Relief for the Medicaid identity crisis, a step to sidestream involvement by the American volunteer resource.

III. Protection of the family against natural medical catastrophe to the individual citizen .

IV. Availability of education to the practicing health team in the community, as well as to the university student, adding quality and priority controls to community medical practice.

Thus, I find myself siding with the National Medical Association in its choice of "other" and join its members in their reasoning that all these plans emphasize financing and cash flow rather than delivery of medical care and minority needs. They all fail to go beyond today's "mainstream" publicly financed program to reach the sidestream citizen hung up in the ghettos, back woods, and outlying areas; all threaten solo practice and its attempt to assist the medical minority, i.e., those victims of illness and impaired productivity for which medicine has yet to discover a cure.

These sidestream citizens are very much aware that their lot is worse when they are categorized as a group of a larger plan, and, indeed, prefer to be considered as individuals within the setting of their own community by the majority for the sake of harmony. Did not our constitution makers act on the concept that the majority would consider the interest of the minority for the sake of harmony (rather than set them aside) ?

I. TWO PLAN OPTION UNDER ONE PREMIUM FOR THE WAGE EARNER

The majority, the normally well wage earning citizens concerned about the family budget, want their premium to buy a two plan option: a Kaiser type plan, as well as a private plan, both covered under the same premium dollar. Of course, both coverages could not be allowed to run simultaneously for the same illness, so that when a patient seeks private care for a medical episode, the Kaiser plan will lose claim to a head count for actuarial purposes for a predetermined period, and the patient is no longer covered by the Kaiser type plan for the care of the particular medical episode for the same period so as to avoid duplication of services.

A copayment, Kaiser type plan, without balance of payment owing to the doctor, saves the family budget from unpredictable costs, and yet provides very satisfactory medical care for short term illnesses and the care of the well, e.g., maternity and newborn care, including immunization. The patient is usually willing to accept the rotating physician attendance that usually goes with this service.

For complicated illnesses, or when illness might leave residual impairment, he often desires continuity of physician attendance under a fully knowledgeable, faithful physician relationship, and is happy to volunteer, out of his pocket, the balance of the doctor's fee after payment allowance has been made by his private insurance, or accept his doctor's volunteer of this balance under situations of medical hardship, and under the status of public financing when his earning power is lost and he faces depletion of family resources.

Many citizens wish to volunteer the balance of payment on insurance allowance in exchange for the convenience of private care, even when continuity of physician attendance is not important to the illness involved. This prerogative taps a medical cost resource that the British Medical Association now seeks to tap in order to provide funds needed to revise its ailing national insurance program, funds for which parliament is unable to find priority from its existing revenue resources.

Private practitioners are also choosing "other" by entering into the insurance field through the formation of medical society foundations based upon the concept of providing "no balance" insurance coverage for the citizens of their community, as well as an allowance, in equal amount, toward care performed by nonphysician members, all under the same premium dollar.

Secretary Elliot Richardson wishes to recognize that "some impediments to life, liberty, and happiness are not to be found in the province of governmental powers". He wishes to enlarge self determination, but is hampered by Parkinson's law in the operation of his own sprawling Health, Education, and Welfare Department.

The cash flow plans on the drawing boards of the insurance industry are hardly challenged by the current proposals before Congress. Mr. Mills, sir, would you challenge the insurance industry to recruit its imagination and come up with a competitive plan to match against the health maintenance organization plan and the practicing physician's attempt to enter the insurance industry via foundations in the hope that the majority can have this key two plan option they need to balance the family budget and still have a chance for self determination?

MEDICAID IDENTITY CRISIS

Congress' "mainstream" program puts the publicly financed patient, at least those with the usual social orientation, into the private physician's waiting room along with the wage earning majority instead of the waiting room of the county hospital along side of the old fashioned "hard core" welfare patient. The incentives coming out of this "mainstream" represent the middle position between the wage earner and the citizens who President Eisenhower described as "individuals who walk the sidestreams of our American way of life." These citizens will not likely be reached by the six leading national health proposals now before Congress because they emphasize cash flow. We all know that cash alone is not the answer in this situation, but more likely the answer lies in a kind of involvement today's youth seek so devotedly.

But the step to the sidestream is through the "mainstream" program given birth by Congress in the Medicaid bill. Will it flourish? The physician's role in the Medicaid program is predicated upon private practice participation. Today this participation is threatened by an identity crisis as many physicians feel they are being readied for displacement into salaried roles. Volunteerism, the backbone of delivery for the American brand of medicine, will be the key to an effective sidestream program. Medicaid will likely survive if given another trust by Con-

gress in new legislation, a trust which embodies a recognition of the valuable resource that private practitioners contribute to the delivery of medical care (rather than the distrust that is being thrown its way today from many sources). Recognition of the private practitioner's role must be loud and clear if it is to relieve this existing identity crisis. An effective sidestream program will probably be carried largely on the shoulders of our youth. Structure and navigation will probably require involvement by seasoned practitioners. Perhaps herein we may find "new forms of democracy" requested by Pope Paul.

III. PROTECTION OF FAMILY AGAINST NATURAL MEDICAL CATASTROPHE TO THE INDIVIDUAL

The fear of the majority is the impact of catastrophic illness, not so much upon self, but upon the family as a unit. Congress has already protected his citizens against natural catastrophe due to such things as flood and civil strife, but seems to have forgotten, so far in its legislative productivity, that serious illness and extensive injury might also be classified as a natural catastrophe.

Loss of the family domicile and rapid accumulation of massive medical costs beyond insurance allowance demoralize the family of the patient if they do not undermine the victim's will to live. Massive impairment may require hospitalization in a sophisticated rehabilitation center far from home where expensive facilities and a large staff are necessary. However, the patient wishes to pick up the pieces of his life in his own community setting as soon as possible. This requires local physician attendance of a mutually faithful nature with the capacity for continuity and ongoing coverage by someone fully knowledgeable of the myriad of personal details involved, before the victim and his family can hold hope for restoring a satisfactory life. Rotating physician attendance results in a vacillating treatment program based upon inability of this physician to suddenly gain knowledge of the case, and also based upon a natural diversity of medical opinion among doctors as to which form of treatment is effective in their personal experiences. Continuity of faithful physician attendance provides the opportunity for a life, instead of an existence, for these patients with massive residual impairment when they are also in the need of ongoing medical care.

A young man with serious spinal cord injury may surmount the necessity of a wheel chair life in spite of functionless legs, and still today be denied his social security benefits if he is employed half time. He may honor his rehabilitation accomplishments by managing full time employment, however, a 40 hour week requires such an extraordinary personal effort that his life becomes a cloistered existence rather than holding a variety of avocational activities enjoyed by the normal citizen.

IV. AVAILABILITY OF EDUCATION TO THE PRACTICING HEALTH TEAM

Education of the practitioner is now vital in today's fast changing picture of newly available therapeutic techniques. Educational needs for the care of the patients who require only solo attendance, and the educational needs of the personnel in the private office workshops of patient care, may remain the financial responsibility of the practitioner.

Education of the medical team often shared by the patient who is hospitalized for complex disease or acute care requires subsidies outside of the patient's fees for service and probably outside of private community resources. In these community workshops of patient care, comparison of the work of one physician with the other demands that he update his techniques.

In view of the fact that there is only one model of the human being, one system of physiology and a common psychological response to illness and injury, the educational needs of each community can be matched across the nation. Organization of educational programs for the practicing health team will bring government responsibility deep enough into community medicine to add quality and priority controls of sufficient extent to obviate the need for concepts of mass discipline and "mandatory volunteers" designed into some of the national health proposals now before Congress.

Mr. Mills, I hope we can form a national health program with emphasis upon the delivery of care to sidestream citizens, as well as to the wage earning citizens, upon minority needs (medical minority as well as social minority), and upon victims of medical catastrophe in their families, rather than programs with emphasis upon cash flow and majority interest. Fortunately, we have con-

gressmen like you, in whom we can securely place our trust for the continuing support of legislation which is true to the nature of man.

Faithfully yours,

EDWARD C. FRONING, M.D.

Savannah, Ga., November 9, 1971.

Representative WILBUR MILLS,
House Ways and Means Committee,
House of Representatives,
Washington, D.C.

DEAR MR. MILLS: From reading the New York Times, I understand that you and your committee are considering a federally subsidized catastrophic health insurance plan. Many of the hospitalization policies place a limit on the benefits for patients suffering with mental illness. I would like to suggest for your consideration that this illness be included in the catastrophic health insurance plan without limitation of benefits.

Very truly yours,

FRANK HOFFMAN, M.D.

Ossining, N.Y., September 15, 1971.

Representative WILBUR D. MILLS,
Chairman, House Ways and Means Committee,
Capitol Building,
Washington, D.C.

DEAR REPRESENTATIVE MILLS: In the articles on national health insurance and the organizations and delivery of medical care, I am concerned that there is no connection made between what is involved in providing competent medical care for the entire nation and what is being discussed in the individual proposals. Unless some goals for competent medical care are set and unless the means to attain these goals are analyzed, how can any reasonable decisions be made concerning what should be included in a national health insurance program.

I feel it is imperative that physicians and legislators work together. There are basic concepts and goals of medical care which a good physician will apply in his practice but which a legislator may not even consider when working on a health program.

It is for these reasons that I as a practicing physician have set down some principles of health care which I sincerely hope will be considered by you as you work on a health program for this nation.

With best wishes,

Sincerely yours,

HARVEY I. HURWITZ, M.D.

Enclosure.

PREFACE

If any health care program is going to be successful in raising the level of health care throughout the country, that system must buttress the efforts of physicians to provide good medical care. Obviously no national health insurance program will train a doctor to be a competent physician, but the structure of a program can influence in a favorable or unfavorable way how a well trained physician will practice medicine.

A. HEALTH CARE AND THE PATIENT

1. A complete medical history and physical examination is essential to good preventive health care as well as to the proper evaluation of a significant medical illness.

This requires that adequate time be available to evaluate a patient. Therefore any good system of reimbursement to the physician or to the patient should not make a physician or a group of physicians (particularly an internist and a family practice physician) feel they cannot afford to spend adequate time with a patient. A thorough initial work up of a patient may well reduce the number of subsequent doctor visits and prevent complications due to hasty decisions.

2. Patient education is an integral part of good health care. Through education the patient may not only practice preventive health care but learns when

to utilize medical services. The patient learns, for example, that a strep throat can lead to rheumatic fever and rheumatic heart disease and that a sore throat should be cultured for streptococcus before any antibiotic is prescribed. A well thought out medical program will encourage physicians to educate their patients.

3. Many visits to physicians are not medically necessary, and a little extra time educating patients may prevent later visits. By reducing unnecessary office visits a physician can spend more time treating patients with acute and chronic illness and with practicing preventive health care.

4. In this era of increasing specialization it is essential that a primary physician (internist, pediatrician, family practice physician) be responsible for the overall management of a patient's illness, directing and correlating the medical consultations required. A health program should encourage patients to have a primary physician.

B. THE PHYSICIAN

1. The physician must be well trained, thorough, and motivated to continue with his postgraduate medical education. While much can be accomplished by reading and attending conferences the physician should have an opportunity to periodically return to a medical center for a length of time (maybe one to two months every one to two years and six months every five years) where he could both learn the medicine being practical at the academic center and bring to the center the questions he has raised in practice.

2. The functioning of a physician should not be impaired with too many financial concerns. Too much time should not have to be spent on worry about office expenses, collections, etc. Regardless of how he is paid the physician should receive fair financial remuneration taking into account the geographical area in which he and his family live.

3. There must be time for himself, his family, and continued medical education.

C. WHERE SHOULD THIS CARE BE GIVEN

1. If a physician is to be responsible for hospital patients (and I believe a good physician needs responsibility for hospital patients) then he must be available to provide care for acutely ill patients (both new admissions to the hospital and those patients who develop an acute problem while hospitalized). In order to be immediately available either the physician's office should be on or adjacent to the hospital grounds or one physician within a group of physicians should be designated to be at the hospital during a given period.

D. PHYSICIANS IN TEAMS

1. I believe it is best if physicians be encouraged to work in teams for the following reasons:

(a) A physician needs the intellectual stimulation of other physicians. Working in close association with other physicians tends to keep him "on the ball".

(b) In order for a physician to obtain postgraduate education other physicians must be available to continue with his medical practice.

(c) Patients become familiar with the team and accept the other physicians more readily when their own physician is away. It is very comforting for a chronically ill patient to know that his records are available and that his medical care can be continued in a manner as before.

E. LOCATING PHYSICIANS WHERE THEY ARE NEEDED

1. Many physicians leaving their residency programs have difficulty in finding a place to practice where they can best be utilized. It seems unfair both to the physician and to the nation that after so many years of training there is so little available to assist him in finding a needed and satisfying medical position. While there are some placement services, these are totally inadequate because they present medical opportunities in terms of the individual small town. The new physician has the choice between a well developed medical community and an area which may desperately need physicians but which is not medically organized to attract a physician who is well trained in his field and who does not want to practice medicine in the absence of other well trained physicians and good medical facilities.

This is an area in which a national health program could have a tremendous effect on the inequities of medical care in this nation. It should foster the

development of regional medical facilities where good medicine can be practiced as outlined and which in turn can attract new dedicated physicians.

In the preparation of this paper I am indebted to my wife, Sara, who in her critical comments has maintained the point of view of a concerned citizen.

STATEMENT OF DR. DANIEL LIEBOWITZ, F.A.C.P., ASSISTANT CLINICAL PROFESSOR, STANFORD MEDICAL CENTER, CHAIRMAN, COMMITTEE ON CONTINUING MEDICAL EDUCATION, SEQUOIA HOSPITAL MEDICAL AND DENTAL STAFF, REDWOOD CITY, CALIF.

PROPOSAL FOR NATIONAL HEALTH INSURANCE ACT, THROUGH JOINT PRIVATE AND PUBLIC PROGRAMS

ARTICLE I

Provides for the establishment of an independent National Health Insurance Agency. Medicare and a portion of Medicaid will be incorporated in this agency. Federal, State, County and City agencies now engaged in health care programs will transfer their operations to this agency. Exceptions: City, County, State; Federal and VA Hospitals now in operation whose future will be determined after the first five years of operation of the National Health Insurance Agency.

ARTICLE II

Provides for funding of the National Health Insurance Agency by means of a health tax, the health tax to be derived partly from increased social security taxes and partly from income tax. After age 65, the individual will only be responsible for the income tax portion of this health tax unless he continues to be employed. National Health Insurance Agency funds are to be kept independent of other government funds, cannot be used for loans to other public agencies and are to be used solely for payment of claims.

ARTICLE III

Provides for federal licensing of approved private insurance carriers. These carriers will draw upon National Health Insurance Agency funds and distribute funds to health providers as mentioned below. Reasonable operating profits will be specified for these carriers by the National Health Insurance Act (as is now the case for privately owned utility corporations).

ARTICLE IV

(A) Provides for the establishment or continuation of County Medical Society Foundations. Physician's claims will first be submitted to the County Medical Foundations for approval and processing. These claims in turn will be sent to the insurance carriers assigned to the particular county. Claims will be paid by the insurance carrier directly to the physician.

(B) Provides that claims from hospital and ancillary health providers (non-physicians including psychologists, physical therapists, pharmacists, medical equipment suppliers) will be submitted directly to insurance companies for processing and subsequent direct payment to these providers.

(C) Provides that review boards will be established as a function of the Foundations to act on contested claims submitted by physicians, hospitals and ancillary health services as defined above. These boards will not only prevent physician and other health provider abuse, but will also prevent patient abuse and resist undue pressures by the National Health Insurance Agency and the insurance company representatives to control professional fees, hospital charges and standards of health care. The claim review boards will consist of representative from health provider associations, insurance carriers and the National Health Insurance Agency.

ARTICLE V

Provides for the establishment of regional or county "no fault" malpractice adjudication commissions. These commissions, consisting of members of the National Health Insurance Agency, involved insurance carriers, the American Hospital Association, medical foundations and non-medical health provider associa-

tions, will judge malpractice cases and determine amounts of justified payments. Funds for these payments will come from the National Health Insurance Agency. The Agency will, in essence, be self-insuring. These adjudication commissions may absorb part of the functions of industrial accident commissions.

ARTICLE VI

Provides that deductible and coinsurance portions of health insurance costs be established and paid by the individual citizen for himself and his dependents.

ARTICLE VII

Provides that a portion of state funds now allocated to various Medicaid programs for care of the indigent will be dispersed directly to regional or county offices of licensed insurance carriers which, in turn, will pay health providers in the same manner as the non-indigent. The amount the states will be responsible for will equal the deductible and coinsurance portions of the claims. The basic portion of the claims would be paid by the National Health Insurance Agency. Minimal standards for care of indigents will be the same as for non-indigents.

ARTICLE VIII

Provides for the establishment of federal scholarships to medical students who must in turn contract to practice in federally indicated areas for a minimum of seven years following the completion of their medical training, including internship and residency. Draft exemption and low cost loans¹ to establish practice will be a part of this contract.

Military medical scholarships will be established in order to provide career medical officers for the Armed Forces. The recipients will agree to seven years of active duty upon completion of their medical training, including internship and residency.

Until the program takes effect, physician needs will be supplied by the U.S. Public Health Service.

ANALYSIS OF ARTICLES OF NATIONAL HEALTH INSURANCE ACT

ARTICLE I

Since the American people now realize that the cost of a serious illness or accident may be inadequately met by current private insurance policies, U.S. citizens are urging broader insurance coverage on a national basis to spread the risk of potentially huge medical costs for individuals requiring prolonged or specialized care. As a result of this current interest, a number of different plans are being considered by the federal government at this time. Some persons concerned with rising costs of health care feel that much of this is due to unnecessary hospitalization and over-utilization by doctors. Others feel that patient abuse would become a serious cost factor in any program without deductible and coinsurance features. Still others feel that medical care is a right which should be provided in part or in whole by the employers in large organizations for the benefit of their employees. Many of our citizens are concerned with the maldistribution and fragmentation of medical care. The rising costs of hospital care are making headlines, but little do most patients realize that hospital care has become a major industry in the United States and that the costs of such care are due to two major factors in recent medical history:

- (1) Increase in sophisticated machinery and complex medical treatment of serious illness.
- (2) The need for a highly specialized number of paramedical personnel to service modern hospitals.

A byproduct of this latter factor is that many new jobs have been created in the health field for people of varying abilities, integrating them into an organization dedicated to the preservation of life. This is not to decry waste and inefficiency. There are new developments almost every month in the field of hospital administration and instrumentation which will tend, perhaps, not to cut down on costs but to increase efficiency. A workable plan for national health insurance should encompass the best elements of the proposals which have been made, recognizing that checks and balances are necessary to prevent undue control

¹ And/or tax incentives.

by the federal government, private insurance carriers and to curtail abuses by patients and health providers. The basic concept of any plan should be simplicity and avoidance of fragmentation and duplication of medical care. The establishment of an independent National Health Insurance Agency will be necessary as the first link in the chain of health care on a national basis. Medicare will be incorporated into this agency with an estimated transfer of eight billion dollars. Though Medicaid will also be incorporated into the agency, there will be no real savings since tax money will continue to provide care for the indigent. It is estimated that considerable savings will occur by eliminating duplicate health care programs on the city, county and state levels. No attempt will be made to eliminate all public health care institutions until after the first five years of operation of the National Health Insurance Act.

ARTICLE II

Article II provides for funding of the National Health Insurance Agency by means of a health tax. This health tax is to be derived from both increased social security taxes and from federal income taxes. Despite a tax increase, there will be considerable savings in the premiums now paid for private health insurance. In the case of labor union contracts, the employer may pay all of part of the employee's health tax to the National Health Insurance Agency. It is essential to the Act that the Health Insurance Agency funds be kept independent of other government funds, budget cuts, etc., and that transfer of these funds to other government agencies be made illegal.

ARTICLE III

Article III provides for the use of experienced insurance carriers to distribute the funds to the health providers. By using already established health carriers who fit the qualifications of the program, much inefficiency and reduplication will be avoided, private enterprise will be preserved and the actuarial experience of these insurance carriers can be utilized to full effectiveness for evaluating on-going health costs.

ARTICLE IV

1. The County Medical Society Foundation consists of a board of directors and all members of the County Medical Society who choose to join the Foundation.

2. The Foundation establishes realistic fee schedules for its physician members by specialty and may engage in prepaid health plans based on these fee schedules.

3. The Foundation establishes minimum standards for health care.

4. The Foundation, in conjunction with the responsible insurance carrier, hospital and ancillary health care association representatives, maintains projected cost analyses of health care within the county. The projected yearly county health care costs become a part of and determine the national yearly health care costs which in turn determine distribution of National Health Insurance Agency funds and the amount of health tax.

5. Foundation Claims Review Boards established within the Foundation will consist of five types.

(a) Physician Peer Review Boards to consist of representatives of major medical specialties.

(b) Hospital Claim Review Boards to consist equally of the hospital administration representatives, insurance carrier representatives, physician foundation representatives and American Hospital Association representatives.

(c) Ancillary Medical Claim Review Boards to be made up of members of the associations whose claims might be reviewed (pharmacies, medical instrument suppliers, children's dentists, etc.), insurance carrier representatives and physician representatives of the Foundation.

(d) Medicaid Claims Review Boards to consist of members of the Foundation, insurance carrier and Medicaid social worker representatives in a ratio of 4-1-1. These boards will review all Medicaid claims.

(e) State appeals boards consisting equally of representatives of medical foundations, insurance carriers and the National Health Insurance Agency will hear all unresolved claims and their judgement will be final.

6. The consumers' state advisory committee, appointed by the governors will include representatives of consumer groups, union health and welfare programs,

insurance agencies, and medical foundations in a ratio of 1-1-1-4. These will advise on implementation of the Health Insurance Act within the state.

All board members will be compensated for their time.

Although the claims from the non-physicians, that is, the hospitals and ancillary health providers, are submitted directly to insurance companies in order to avoid unnecessary administrative costs, these claims, if challenged, are sent to the claims review boards in the Foundation for disposition. Because the Foundation not only regulates physician's fees but also processes physician's claims and adjudicates all health providers claims, fragmentation and reduplication of claims processing is avoided.

ARTICLE V

Article V provides for the establishment of "no fault" malpractice adjudication commissions. These would, in essence, decide malpractice claims as well as health costs of industrial accidents. They would eliminate, again, parallel commissions and costly malpractice insurance premiums which have contributed to the overall health costs of the patient, passed on the patient in the form of higher medical fees. The National Health Insurance Agency would be self-insuring. Funds for distribution of payments for accidents or malpractice to the plaintiff would come from National Health Insurance Funds.

ARTICLE VI

Article VI provides considerable savings to the National Health Insurance Agency by the establishment of deductibles and coinsurance portions of health insurance costs. These would be paid by the non-indigent patient at the time the medical service was rendered. The additional advantage of the deductible and co-insurance concept is that the patient has to personally participate and has a stake in his own health care. The fact that the coinsurance features are similar for both inpatient medical costs and outpatient services would tend to decrease the use of hospitals. The patient would no longer have the excuse of requesting hospitalization in order to have his insurance pay his bills.

Relatively inexpensive private insurance for the coinsurance portion may be provided by some private insurance carriers to encourage even the poor and near poor to take advantage of relatively complete health coverage. Outpatient and inpatient deductibles will be excluded from private co-insurance coverage.

ARTICLE VII

Article VII provides that the states will only be responsible for the deductible and coinsurance portion of the indigent's health costs, the basic portion being paid for by the federal health agency. This is merely a shifting of taxes away from state taxes to federal taxes and in no way increases the portion of taxation borne by the nonindigent for the care of the indigent. Some decrease in the costs of administering present county and state Medicaid organizations will undoubtedly occur as many of their functions will be taken over by the new National Health Insurance Agency, licensed approved insurance carriers and County Medical Foundations. State Medicaid offices, however, would have to continue to maintain regional and local qualified social workers in order to evaluate continuing fiscal insolvency of Medicaid recipients as well as their non-medical needs. These social workers would meet with Foundation committees in their areas and continually review claims of the Medicaid recipients. As long as care of the indigent remains within the province of the National Health Insurance Fund, the quality of that care will be the same for nonindigents as will the fees paid for such care.

ARTICLE VIII

Article VIII provides for the establishment of both federal scholarships to medical students and military scholarship programs for career medical officers in the Armed Forces. The purpose of this is to help improve the maldistribution of medical care as well as to maintain adequate medical care for members of the Armed Forces. There is evidence that providing scholarships for medical training and loans for establishing practice will be far less expensive than trying to establish new medical schools. There appears to be maldistribution rather than any real dearth of doctors, as they congregate in urban areas where they have certain advantages in the quality of both medical practice and personal living habits. It is hoped that those who partake of the National Medical School Scholarship

program will decide, after having spent seven years in the area, to plant roots in the community to which they are assigned. The same applies to military medical scholarship recipients since, after seven years of active duty, they may elect to stay on until retirement.

DISCUSSION

The plan utilizes the basic feature of all successful insurance programs, namely, that a relatively large number of well persons pay for the care of a smaller number of ill persons. Such a plan will, however, be basically a just one, for when young and healthy citizens reach an age where illness of a serious nature becomes more probable, they would benefit in turn from the program.

The basic outline of the financial aspect of the plan is presented in Table I. Essentially, the health care recipient pays 20% coinsurance for the first \$2000 of yearly outpatient medical expenses and yearly in-hospital medical expenses. Ancillary medical expenses include purchase of approved drugs,² prostheses, traumatic dental care, plastic surgery for accident cases and acute disease states. They also include prophylactic dental care for children under 16 years of age, acute and chronic home nursing care, physical therapy and convalescent hospital care. Psychiatric care³ is included, but all of these ancillary health services will need prior approval and authorization for limited periods of time in non-emergency situations. Similar features are now made available through Medicaid and the lessons learned from this program can be applied effectively to the new program. The patient would pay a \$50 deductible yearly for outpatient care and a \$50 deductible yearly for inpatient care. This would be less for children as seen in Table I. Adult dental care, hearing aids, false teeth, eye glasses and podiatry are excluded, at least until further experience has been gained with the program. Exception: Prior approval for indigent patients on Medicaid. The amount of coinsurance decreases with increasing health costs, thus providing almost complete coverage for catastrophic illness.

Although the costs of the program will be much greater than present federally financed programs, certain direct and indirect savings will occur. Medicare will be eliminated and Medicaid costs shifted to the new program. The .6% social security tax for Medicare funding will become a portion of the new social security tax increase. The 13.8 billion dollars (estimate) spent in 1970 for private health insurance would probably be almost completely eliminated. Private insurance for the coinsurance portion should be made available for a small additional premium.

Though actuarial studies have to be undertaken, it appears as if it will be necessary to come up with additional taxes of 14.0 billion or more. The 1970 figures for the national social security tax were 38.9 billion. Of this, 213.4 million was allocated for Medicare and therefore could be transferred to the new program. This would still result in close to a 14 billion dollar deficit. This deficit could be met by increasing the social security tax by approximately 33%. It is also conceivable that some increase in federal income tax in the form of a surtax may be necessary, unless other federal expenditures decrease.

Why deductible and coinsurance at recommended figures? By having the patient pay a higher proportion of the first few thousand dollars of care, the total plan becomes less expensive to the taxpayer, since most hospitalizations and outpatient care involve the first \$2000 of expense per year. Costs of catastrophic illness, on the other hand, are borne almost entirely by the program. The figures are based on those used for currently successful health plans, including Medicare. Adequate premium figures can only be accurately determined through the use of actuarial analyses.

The role of the physician and other health providers in the County Medical Society Foundation will undoubtedly change. At present, the foundations are attempting to compete with pre-paid wholesale supermarket health providers such as Kaiser. This will only result in decreasing the quality of medical care if realistic fee schedules are not maintained for the practicing physician. It is doubtful that any significant savings can occur through HMO's or even pre-paid foundation plans, except by controlling over-utilization by both health providers and patients. The coinsurance deductible portions of the plan and the claims review committees should help achieve this. The cheapest is not always the best

² Drug costs limited to medically indigent.

³ Psychiatric services limited to 4 visits, following which plan for further therapy to be submitted to local psychiatric peer review committee. Approval to be limited to weekly visits for 3 months, after which re-evaluation is mandatory.

and every effort should be made to prevent critics of quality private medical care from trying to wholesale it. Although rapidly increasing technology in the form of computer readouts will relieve the physician of previously inefficient activities, costs of operation will not necessarily decrease. Unless the Foundation maintains the right of collective bargaining for its members and preserves a realistic fee schedule by speciality and by region, it will become a convenient tool for exercising federal pressures on the health providers. It will have no strength of its own in challenging insurance company pressures and therefore will not serve as an essential link of checks and balances in the health care chain.

Through negotiations, labor unions will, if they desire, be able to ask management to take over part or whole of their health tax payments. This, however, will be outside the realm of the National Health Insurance Act, and therefore will not directly involve labor union politics or management pressures in the functioning of the National Health Insurance Agency. Congress may vote tax credits for small businesses who pay all or part of their employees health tax.

The National Health Insurance Act emphasizes to the citizens of the United States the concept of saving a portion of their earnings during economically productive years for use in old age and for serious illness. Every wage earner and self-employed individual should be encouraged to purchase, at a modest premium, private health insurance for the non-covered coinsurance portion.

Attached are an outline of the National Health Plan, including deductibles, coinsurance and benefits (Table I), estimated funding (Table II), estimated costs to tax payers of varied incomes who incur a serious illness (Table III) and estimated cost of Health Tax (Table IV).

Table I.—Outline of proposed deductions, coinsurance and benefits ¹

| | |
|--|-------|
| Inpatient: | |
| Yearly deductible: | |
| Child under 18..... | \$10 |
| Child under 21..... | 25 |
| Adult over 21..... | 50 |
| Coinsurance: | |
| 20 percent of the first..... | 2,000 |
| 15 percent of the next..... | 2,000 |
| 10 percent of the next..... | 6,000 |
| 5 percent of all remaining expenses..... | |
| Outpatient: | |
| Yearly deductible: | |
| Child under 18..... | 10 |
| Child under 21..... | 25 |
| Adult over 21..... | 50 |
| Coinsurance: | |
| 20 percent of the first..... | 2,000 |
| 15 percent of the next..... | 2,000 |
| 10 percent of the next..... | 6,000 |
| 5 percent of all remaining expenses..... | |

¹ The amount of coinsurance applies to all medical expenses, including physicians fees, hospital expenses and outpatient charges. The yearly deductible has to be paid for both inpatient and outpatient expenses.

ANALYSIS OF BENEFITS ¹

- A. Outpatient benefits pay for:
1. Office calls and house calls
 2. Yearly checkups
 3. Consultations
 4. Outpatient licensed laboratory services
 5. Outpatient licensed x-ray services
 6. Outpatient prenatal care by contract with Foundation or other health agency.
 7. Outpatient radiotherapy
 8. Outpatient physical therapy (prior approval) ¹
 9. Outpatient psychiatric care (emergency or prior approval) ¹
 10. Outpatient emergency care in hospital emergency room for bonafide emergencies certified by physician, diagnostic and treatment procedures that cannot be safely done in physician's office including treatment of accidents, cast application and removal, minor surgery, endoscopy, proctosigmoidoscopy, etc.²

11. Emergency outpatient care while traveling in continental U.S. or abroad includes 1-5 and 10.

B. In-hospital care includes:

1. Hospital care in four bed ward for all necessary services up to 120 days for each separate illness. Additional hospitalization for catastrophic illness must be authorized by local medical peer review with re-evaluation every 30 days. Intensive care, coronary care, isolation units and private rooms are permitted when certified as necessary by attending physician.

2. Extended care or convalescent care unit run by hospital or licensed nursing home meeting Department of Health, Education and Welfare criteria up to 120 days for any extended illness not requiring full hospital services.

3. Chronic care, home nursing care (licensed)¹

4. Physician hospital visits.

5. Consultations.

6. Special hospital procedures including cardiac monitoring in surgery, placement of temporary cardiac pacemakers, endoscopy, etc.²

7. In-hospital psychiatric care (emergency or prior approval).

8. Maternity services.

9. Hospital based outpatient laboratory, x-ray and radiotherapy services.

10. Hospital based outpatient physical therapy services (prior approval).¹

11. Emergency hospital care while traveling in continental United States includes services 1, 4, 5, 6, 9 and emergency maternity care.

C. Miscellaneous.

1. Ambulance—pays up to \$50.00 for services to and from hospital.¹

2. Servicar—pays up to \$15.00 for services to and from hospital, physician's office, laboratory, x-ray facility, radiotherapy facility and licensed physical therapy facility.¹

3. Ancillary services as outlined page 6, paragraph 2.

Table II—Estimated savings and costs¹

Savings:

Direct:

| | <i>Billion</i> |
|---|----------------|
| Elimination of medicare----- | 8.0 |
| Elimination of medicaid----- | 5.0 |
| Elimination of 0.6 percent Social Security tax----- | .2 |
| Total ----- | 13.2 |

Private health insurance:

| | |
|--------------------------------------|------------|
| Present cost ----- | 13.8 |
| Projected cost for co-insurance----- | -5.0 |
| Total ----- | 8.8 |

Total ----- **22.0**

Indirect:

The amount of indirect savings will undoubtedly be considerable but can in no way be determined at this time. It will occur, through reduction of administrative costs by eliminating duplicate federal, state, county and city health care services in part or in whole.

Cost:

| | |
|---|------|
| Medicare replacement with increased benefits----- | 11.0 |
| Medicaid with increased benefits----- | 7.0 |
| Health care under 65 exclusive of Workman's Compensation, Federal and State Hospitals----- | 18.0 |

Total ----- **36.0**

Net increase in costs----- **36.0**

-22.0

Total ----- **14.0**

¹ Costs exclude coinsurance and deductibles.

¹ Governed by County Medical Foundation fee schedule and insurance carrier contract with Foundation, or other healthy agency.

² See procedures listed in 1969 RVS.

Table III—Estimated Costs to Taxpayers with Serious Illness

Example.—The taxpayer with two dependents who makes \$6,000 annually has the following expenses to pay: For a typical serious illness of middle age, coronary thrombosis, for which the patient is hospitalized and treated by a specialist in the field, the cost might be as follows in an urban area in 1971.

| | |
|--|----------|
| (1) Outpatient costs (patient has walked into office with chest pain): | |
| (a) Initial exam (M.D. charge) | \$15.00 |
| (b) EKG (Lab charge) | 20.00 |
| (c) Patient sent immediately to hospital via ambulance (ambulance charge) | 30.00 |
| | 65.00 |
| (2) Inpatient costs: Physician: | |
| (a) History and physical | 45.00 |
| (b) Daily care (coronary care unit) 8 days—2 daily visits: 1st visit, ½ hour (\$22.50), second visit, 20 minutes (\$15.00) | 300.00 |
| (c) Daily care (ward) 20 days—1 daily visit (\$15.00) | 350.00 |
| | 695.00 |
| (3) Inpatient costs: Hospital | 3,300.00 |
| | 3,995.00 |
| (4) Cost to taxpayer patient: | |
| (a) Outpatient—First \$50 plus 20 percent of \$15 | 53.00 |
| (b) Inpatient (including physician's hospital charges)—First \$50 plus 20 percent of \$2,000 | 450.00 |
| (c) 15 percent of \$1,945.00 | 291.75 |
| | 794.75 |
| Total patient expenses | 794.75 |
| Plan pays | 3,200.25 |

If this patient has a private insurance policy, he will only have to pay his yearly coinsurance policy premiums and his deductibles.

| | |
|--|---------|
| Outpatient deductible (first) | \$50.00 |
| Inpatient deductible (first) | 50.00 |
| | 100.00 |
| Subtotal | 100.00 |
| Estimated Coinsurance Policy Premium | 100.00 |
| | 200.00 |
| Total | 200.00 |

Table IV—Estimated yearly health tax and private coinsurance costs

1. Taxpayer with two dependents with income of \$6000, federal income tax of \$800:

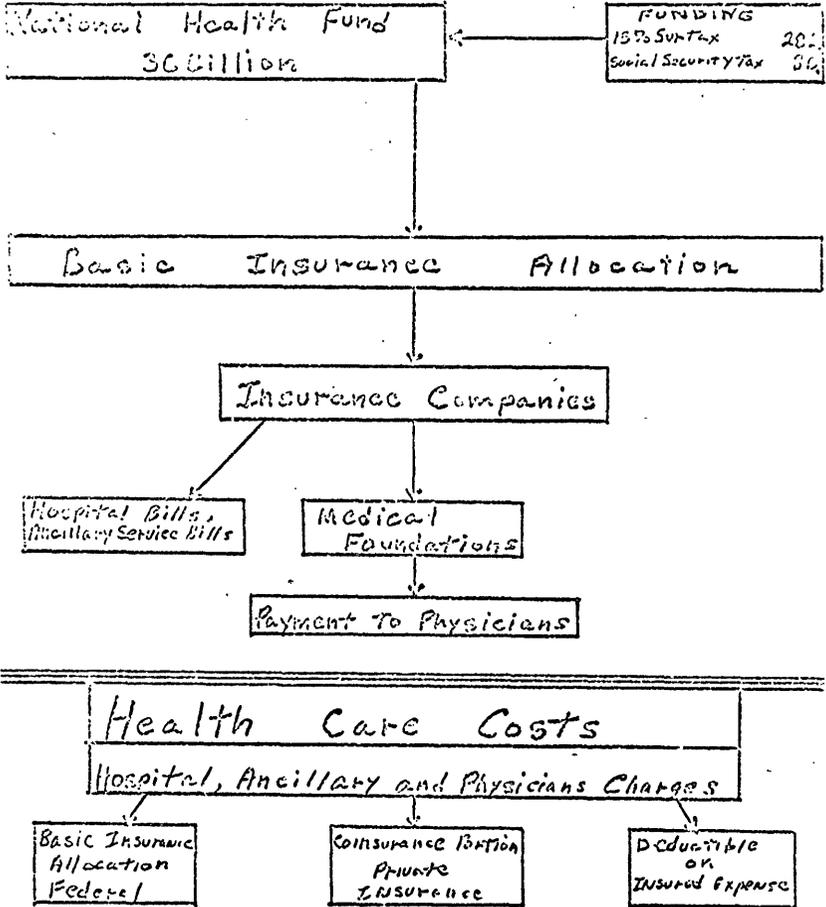
| | |
|---|----------|
| Federal Income Tax Surtax, 15 percent | \$120.00 |
| Social Security Tax Increase | 100.00 |
| | 220.00 |
| Subtotal | 220.00 |
| Estimated Yearly Coinsurance Policy Premium | 100.00 |
| | 320.00 |
| Total | 320.00 |

2. Taxpayer with two dependents with income of \$4000, federal income tax of \$400:

| | |
|---|--------|
| Federal Income Tax Surtax, 15 percent | 60.00 |
| Social Security Tax Increase | 66.00 |
| | 126.00 |
| Subtotal | 126.00 |
| Estimated Yearly Coinsurance Policy Premium | 100.00 |
| | 226.00 |
| Total | 226.00 |

3. Taxpayer with two dependents with income of \$15,000, federal income tax of \$4000:

| | |
|--|--------|
| Federal Income Tax Surtax, 15 percent..... | 600.00 |
| Social Security Tax Increase..... | 200.00 |
| <hr/> | |
| Subtotal | 800.00 |
| Estimated Yearly Coinsurance Policy Premium..... | 100.00 |
| <hr/> | |
| Total | 900.00 |



ROSLYN HEIGHTS,
LONG ISLAND, N.Y., October 15, 1971.

HON. WILBUR MILLS,
Chairman,
House Ways and Means Committee.

DEAR MR. MILLS: With regard to the hearings on governmental measures concerning health, the attached is submitted as testimony before your committee.

Sincerely yours,

GORDON R. MEYERHOFF, M.D.

Enclosure.

THE "RIGHT" TO TREATMENT

A "right" to treatment is being proposed by some in these times. Compassion for the sick has always manifested itself in a feeling that something should be done for them. Of late some would shift this into the sphere where the force of law should be used to compel it.

In the consideration of whether so to proceed, we run into a companion recommendation. What have been considered "rights" up to now were freedoms, like free speech and free assembly. The role of other people,—the companion procedure,—was to not interfere with these freedoms. The companion procedure did not require anyone to do anything. In fact, one of the main freedoms was the freedom from conscription, not to be forced to labor at anything against one's will. If we are to consider that a person now has a "right" to treatment, we are forced to consider our position towards the person who can do the treating. The companion procedure that we would be forced to introduce is that he must be compelled to provide his service. This places us in direct conflict with our established freedom from forced labor.

This conflict between our compassion for the sick and our compassion for labor freely chosen seems irreconcilable except by an arbitrary favoring of one over the other. However, a further inquiry into the basis on which the system of rights was first evolved in this country may provide us with a deeper understanding that may not only resolve this apparent conflict, but may have us favoring a higher compassion.

Alone, compassion for each other would seem to call on us indeed to do things much differently than we have been doing them in this country. Thus the Russians hardly regard themselves as tyrannical but rather as much more compassionate than we by constructing a tightly organized society to provide themselves with the goods and services that people need. The allegiance of many people to Castro is because he has provided more hospitals, more schools, and more roads.

On the basis of simply compassion for one's fellow man when he doesn't have goods and services, one can hardly raise a peep of criticism against a communist society. Why then did our forefathers not include among their list of rights the right to goods and services, especially of a basic nature. What with their experience of drastic starvations in their European background, why didn't they readily include among the rights the right not to starve.

From where, if not from compassion, did they derive the items on their list? When we go back and listen to them our hope of further understanding, we hear them say they derived their list from something that told them that there was a condition of man from which he could not be alienated.

One hears much these days about alienation. The alienation of our youth, is said by some is what the youth of this generation are particularly afflicted. Psychiatrists are reporting that early alienation and its continuation into adult life is the basis of most psychopathology. Our forefathers, too, gave this matter of alienation a very high rating.

So high that they based their philosophy of life on it declaring that there were inalienable rights—of life, liberty, and the pursuit of happiness. So high that they based their system of government on it declaring that it was the function of government to secure these inalienable rights. So high did they regard this inalienable basis that they envisaged it as coming from the highest of high, from Nature and Nature's God.

Not one word of "compassion" for those without goods and services. Rather from this flowed a plethora of subsidiary rights and liberties.

So profound was this understanding of man that, just like many people recognize the good life as having been outlined for thousands of years now in the Bible and imperfect man has still not been able to attain it, so, although we have

had the blueprint of freedom before us two hundred years now, we still have a ways to go to bring it into full fruition.

But certainly the concept of freedom has been known for thousands of years. Why then did history only contain attempts to bring it about. Prior to the establishment of our government, why did those attempts abort? What has been the obstruction to a life based on this inalienable characteristic of man? If it is so inalienable, what has prevented it from being par for the course?

History reveals another characteristic of man: an inclination to tyrannize one another and an inclination to allow ourselves to be tyrannized. The history of mankind, till the establishment of our government, was the history of the victory of our inclination to tyrannize and be tyrannized over our urge to be free. But how could this be? No man seems to consciously choose to allow himself to be tyrannized. Who except some very sick souls would have meanness perpetrated on themselves. Who would be a proponent of a government that would force such subjugations. This is where our newer psychological insights may be of some service. Man would not have himself *consciously* tyrannized, but we now know there is a definite *unconscious* inclination by which he does indeed bring this state on himself. From this we also know that it takes an extra special effort to overcome this tendency and to indeed put ourselves on the freedom road.

Our unconscious is not so easily overcome. It will attempt to play numerous tricks on us. It will find all sorts of reasons to have tyranny prevail. It has not taken new psychological insights for the wisdom to be intuitively evolved for many centuries now that "tyranny rides in on the horse of necessity." No tyrant poses as a mean, arbitrary, harmful person, but rather always sells us on the beneficence he emanates, particularly by the plentitude of goods and services which his reign will supply.

It has long since been known that we are always tempted, and many times succumb, to selling our souls for the dollar that will buy goods and services. In fancy philosophical language this has been put as the domination of the philosophy of materialism over the philosophy of spiritualism. The spirit of man, instead of being seen as nurtured from inalienable-inner-derived needs is thought of as being nourished from the goods-and-services-from-the-outside. The wisdom that knows this is not the case has become common knowledge: man does not live by bread alone. His spirit does indeed demand inalienable rights without which no goods or services have any meaning.

His spirit does indeed demand that one of the major underpinnings of his relationship with other men be on the basis of freedom. His spirit does indeed demand that the major function of government be to secure the blessings of liberty. His basic spirit does indeed demand that the force of law be used only, only, as an agent in the preservation of his freedom. That all aspirations and provisions of goods and services be done within this framework of freedom.

How then does a society dedicated to freedom take care of the starving and the sick who do not have the means to provide for themselves. It provides it by supplying the person, with the means by which all free citizens make their necessary purchases. It does not conscript anybody to supply the services or goods, nor does it dictate to the poor by giving them specific goods and services it deems desirable. It rather maintains the maximum of freedom by giving them the money with which they can freely make purchases as they regard the basics to be.

Attention to this basis from which our forefathers derived their concept of "rights", shows us clearly how the higher inalienable rights can indeed provide us with a better life, including goods and services. It shows us, too, how our compassions for the various human ills do not come in conflict. Our compassion for the sick and starving does not come in conflict with our compassion for labor freely chosen. This adherence to the underlying principle of freedom attends to both of these without such conflict.

It is well known that the freedom road is difficult. Not only are we tempted to abandon it by the numerous danglings that tyranny would offer us, but freedom may not always be the most economical way of proceeding. There are times when it costs more to maintain it than the efficiencies that an arbitrarily imposed regulated system can bring about. However those who appreciate and cherish freedom cannot purchase a more valuable commodity. The slow readjustment of goods and services so as not to usurp the acquired property rights of free men—so that they can indeed do with goods and services as they freely choose—frequently leads to temporary inequities in the distribution of goods and services. Freedom therefore calls for a modicum of patience until balance is restored.

For those who cherish freedom, one cannot have a better friend while one is waiting.

Because of all these temptations along the freedom road, the unconscious temptation to allow ourselves to be tyrannized, the temptation of the cheaper product, the temptation of a quicker delivery by a beneficent authority, freedom demands extra precautions long since expressed as "the price of freedom is eternal vigilance." The freedom road must be raised on special pillars so that it is further from the temptations that would deflect it. This is accomplished by adhering *strictly* to the principles of freedom. We already have such precautions as part of the legal structure: "due process" is a far better freedom preserving procedure than a criminal catching tool. Our feeling there is that it is better that we should suffer, *that we should suffer the loss of goods, services and even life*, by having ten criminals at large than that one innocent man shall be incarcerated.

Since one of the greatest temptations to abandon freedom is to allow tyranny in the form of beneficent government, one of the main fences is to keep down the power of government. If it becomes necessary to give government power, it must only be to preserve freedom, and even then to set up a system of checks and balances within it so that one part of government can hold to the freedom road should the other be tempted to stray. This precaution is particularly cogent in this age when the material efficiencies of industrialization have already tempted many peoples to foresake the ways of freedom and adopt regimenting and freedom-depriving governments. We, in this country, have been slipping in that direction and lately the decline has been steepening. The New York State Legislature is even now considering a recodification of its mental hygiene law which would turn over the delivery of mental health services to the State. Those who are proposing it say with all benignity, a starving man cannot be free, a sick man cannot be free. Their conclusion is, in order to feed the hungry, in order to tend the sick we must foresake our free ways. Again they are those who have not yet attended to the depths from which inalienable rights are derived and therefore *pose the problem as starvation versus freedom, as sickness versus freedom, and are not yet able to see how one can have the better life of freedom and food, the higher life of freedom and health.*

What with this nation, what with the world, in the midst of one of its gravest struggles between further refining its free way of life or turning to a more regimented existence, it does not seem wise, at this time, to consider the matter of a "right" to treatment which has with it the conscription of the treator. In light of these considerations it would seem to serve the people of this country better to table this question at this time until the struggle for the very existence of the free way of life has been surmounted.

GORDON R. MEYERHOFF, M.D.

[From the New York Times, 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 1953, 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 American 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.

JOINT STATEMENT OF ROBERT MORRIS, DIRECTOR, FRANCIS G. CARO, SENIOR POLICY ASSOCIATE, LEVINSON GERONTOLOGICAL POLICY INSTITUTE, THE FLORENCE HELLER GRADUATE SCHOOL FOR ADVANCED STUDIES IN SOCIAL WELFARE, BRANDEIS UNIVERSITY, WALTHAM, MASS.

SUMMARY

Long-term care for the chronically ill and disabled is a substantial but seriously neglected dimension of the current debate about health service delivery and financing. Both Medicare and Medicaid have important deficiencies in their approach to financing care for the severely disabled. Present proposals for national health insurance, further, are conspicuous in their failure to deal with

long-term care. Several principles and objectives for federal legislative action to address the personal care aspect of long-term care are submitted for consideration of the Committee. In addition, legislative strategies that would stimulate the development of relatively inexpensive helping services that would address the personal care needs of the severely disabled living in the community are outlined.

As an initial measure, it is recommended that a study of the service requirements of the chronically ill, such as that called for in the Kennedy-Griffiths Bill, be authorized and undertaken immediately.

INTRODUCTION

An important and seriously neglected dimension in the present debate about the financing of health services is that of long-term care of the chronically ill. The intent of this statement is to outline the scope of the problem and the limitations of present federal programs in addressing it, to examine current legislative proposals for national health insurance for their implications for the long-term care problem, and to suggest some principles and possible strategies for federal legislation concerning the organization and financing of long-term care.

THE SCOPE OF THE LONG-TERM CARE PROBLEM

Approximately six million adults presently suffer from chronic diseases to such an extent that they are unable to carry out their major activity, are severely restricted in their mobility, and are highly limited in their ability to care for themselves. A small majority of these persons are over 65 years of age, but nearly as many are aged 18-64 years. Only a minority—perhaps 20-25 percent—are presently cared for in nursing homes or in other long-term care institutions. These estimates of the prevalence of severe disability would be considerably larger if they included those whose disabilities were solely attributable to mental illness or mental retardation. Care of the severely disabled is already a considerable cost to the public. In 1970, for example, public expenditures for nursing home care amounted to nearly \$1.8 billion.

Long-term care, further, is a problem which can be expected to grow in magnitude. Population projections for the next decade indicate that substantial growth can be expected in the very old population. It is in this age group that severe disability conditions for which care is required are most likely to occur. Possible breakthrough in the treatment of cancer, stroke, and heart disease would only add to the problem. By sustaining the lives of persons suffering from chronic diseases, these advances in medical care would prolong the period in which the disabled were dependent on others for care.

LIMITATIONS OF MEDICARE AND MEDICAID

Consistent with its legislative intent to address only acute illness and its immediate consequences, Medicare provides only a limited basis for financing long-term care. Most important for the chronically ill is Medicare coverage of the costs of 100 days of nursing home care following hospitalization for treatment of an acute illness. Less use has been made of Medicare's provision of payment for a number of units of home health care. Because of the implementation of administrative measures to exclude chronically ill persons whose primary need is for custodial care, Medicare is presently playing a declining role in financing long-term care.

Medicare's bias in favor of institutional care of the chronically ill is noteworthy. When care is provided in a nursing home, Medicare is a source of payment not only for direct medical services but also for social costs of room, board, laundry, and other personal services. When the chronically ill person seeks care outside an institution, Medicare finances only more narrowly defined medical services. The costs of social services which may be required to maintain the disabled person outside of an institution are not covered.

In a number of states, Medicaid has assumed a major role in financing long-term care in nursing homes and intermediary care facilities. In Massachusetts, for example, Medicaid presently finances care in licensed nursing homes for approximately 20,000 persons at an annual cost to the public of \$100 million. A number of serious limitations are apparent in Medicaid as a vehicle for financing long-term care. Some states, of course, choose not to use Medicaid to finance long-term care or do so at such a low reimbursement rate that care of adequate

quality cannot be purchased. Because Medicaid is limited to the poor and near-poor, chronically ill persons must suffer the indignity of depleting their personal resources before they become eligible for Medicaid benefits. Medicaid patients are often placed in facilities offering more sophisticated care than required at excessive costs to the public. At the same time, the program has lacked administrative controls required to assure adequate quality of care. Further, Medicaid is also biased in favor of institutional care. At present it is much easier to use the program to finance care in an institution than to finance equivalent services at comparable or lower costs outside an institution. Medicaid often confronts families of the disabled with a cruel dilemma. Families of the disabled can either make enormous sacrifices to provide care in their own homes or they can "abandon" the disabled person in calling upon the public to finance care in an institution.

PROPOSALS FOR NATIONAL HEALTH INSURANCE

Of the current legislative proposals for national health insurance, the Kennedy-Griffiths Bill comes closest to addressing the long-term care issue. It would finance care in skilled nursing homes and extended care facilities for up to 120 days for the entire population without deductibles and without prior hospitalization. The authors of the bill recognize their failure to address the problems of those whose chronic conditions primarily require less sophisticated care. They call for a two-year study to formulate a legislative proposal for organizing and financing the social services needed by the chronically ill. The bill would leave Medicaid, at least temporarily, as the primary vehicle for public financing of long-term care.

The Administration bill, the National Health Insurance Partnership Act, would have little or no effect on long-term care. The bill does not concern itself with the over-65 population in which chronic disease problems are concentrated. Further, its coverage would be primarily for the treatment of acute illness and would offer only limited protection against costs of extended care.

Other bills for financing health care need not be reviewed here because they do not pretend to address the long-term care issue. In general, they would leave public responsibility for financing long-term care with Medicare and Medicaid.

Of considerable importance for long-term care are the provisions of H.R. 1, which would federalize public assistance for the aged, blind, and disabled and extend Medicare coverage to the disabled. What is not clear is whether responsibility for financing long-term care beyond Medicare for the severely disabled indigent would remain with the states or would be assumed by the federal government.

PRINCIPLES AND OBJECTIVES FOR LEGISLATION

Because it is an important and growing aspect of the spectrum of health services, long-term care needs to be addressed in present legislative proposals for the financing of health care. Recognition, however, must be given to some of the special characteristics of the long-term care problem which differentiate it from other aspects of health services. Care of the chronically ill is importantly different from the treatment of the acutely ill, in that much less can be expected of the contributions of physician services. For the chronically ill, recovery often is not a realistic expectation. In fact, their medical conditions are often relatively stable and their needs for medically sophisticated treatment minor. Their primary difficulties often stem from the disabling effects of their illness. Their need, then, is for assistance with some of the unsophisticated tasks of daily living—perhaps getting in and out of bed, dressing, bathing, meal preparation, and exercising. The potential expense of long-term care must be recognized. Although most services required by the long-term ill can be provided by non-professionals, the need for care may be of great duration. Extensive services are likely to be needed for the remaining years of the disabled person's life.

The following are several potential objectives for federal legislation designed to address the long-term care problem:

1. Resource should be made available to finance personal care services for the severely disabled in a context in which adequate provision is also made for income maintenance, medical care, and rehabilitation.
2. Personal care benefits for the severely disabled should be made available to the individuals according to the extent of their functional impairment, i.e., the extent to which they are unable to manage tasks of daily living and the cost of services in the area in which they live. The extent of the public benefit should *not* be dependent on the setting in which care is provided;

i.e., institutionalization, by itself, should *not* be a condition for receipt of more generous public benefits.

3. Public personal care benefits and programs should seek to strengthen the disabled person's relationship with his own family. Incentives should be provided to families to provide continuing supportive services to the severely disabled.

4. An administrative structure should be established which assures equitable and efficient procedures for reviewing claims for personal care benefits.

5. Public financing of personal care services should be set at a level which is adequate but not open-ended. Benefits should be so structured that their efficient use by both consumers and providers of services is encouraged.

LEGISLATIVE STRATEGIES

Legislative action to address the personal care requirements of the severely disabled might take the form either of a major change in the public approach to financing and organizing long-term care generally, or more modest measures to stimulate the development of personal care services in the community. Although these objectives might be accomplished through an extension of health legislation, they might also be approached through legislation primarily concerned with other issues such as income maintenance. Administratively, personal care benefits for the severely disabled might be part of a federal health insurance program, the Social Security pension system, or a federally administered public assistance program for the aged, blind, and permanently disabled.

The most ambitious approach would create a personal care benefit as part of the Social Security system paralleling federal income maintenance and health insurance programs. Federal disability evaluation boards would review claims and establish personal care benefit levels. Benefits would be made available through local personal care organizations (analogous to health maintenance organizations) which would contract on a capitation basis to provide appropriate helping services to the disabled person in the most suitable setting. Personal care organizations (P.C.O.'s) would emphasize assistance with basic tasks of daily living—dressing, meal preparation, personal grooming, house cleaning, exercising, and the like. The setting in which care would be provided might range from the disabled individual's home to an institution. Potentially, the personal care benefit could replace Medicare and Medicaid as a source of financing for the custodial aspects of care in facilities up to the level of skilled nursing homes. Relying primarily on non-professionals to provide helping services, P.C.O.'s would become a significant source of employment for older persons and perhaps even individuals with minor disabilities. Homemaker agencies, visiting nurse associations, and nursing homes are among the present organizations which might expand their scope to meet federally established professional and administrative standards for personal care organizations. Grants, loans, and training programs are among the devices that might be used to stimulate the rapid development of P.C.O.'s.

The following are among the more incremental legislative approaches that might be used to encourage the development of relatively inexpensive personal care services in the community for those disabled persons who do not require constant medical surveillance:

1. Amend Title XI of the Social Security Act by enlarging the concept of intermediate care to permit and encourage use of public assistance funds to finance long-term care provided by P.C.O.'s.

2. Establish special aid-in-attendance allowances and homebound allowances similar to those of the Veterans Administration.

3. Broaden the concept of "home health service" in Title XVIII and title XIX to include clearly non-nursing home help services for extended time periods.

We hope that the Committee will give careful consideration to the general problem of organizing and financing care for the chronically ill and will attend particularly to the long-term social service requirements of those severely disabled as a result of serious illness or injury. At a minimum, the Committee might act on the recommendation of the National Council of Senior Citizens that a study of service needs of the chronically ill as called for in the Kennedy-Griffiths Bill be authorized and undertaken immediately.

We would be happy to provide the Committee with further information about the personal care dimension of long-term care and a more detailed account of the legislative strategies outlined here.

THE GEORGE WASHINGTON UNIVERSITY.
DEPARTMENT OF HEALTH CARE ADMINISTRATION.

October 22, 1971.

HON. WILBUR MILLS,
House of Representatives,
Washington, D.C.

DEAR MR. MILLS: I would like to offer a technical suggestion which I believe could facilitate the improvement of health care delivery throughout the country if it is incorporated in the legislation implementing national health insurance. Specifically, I recommend that legislation concerning national health insurance contain an explicit requirement that health care providers be prepared to furnish (subject to safeguards of individual privacy) the data which are needed for community-level health planning.

The reports of Secretary Richardson's testimony before your committee indicate that the Administration feels there is a strong possibility that national health will create a demand which will tax the current capacity of our health system. I believe that the validity of this view is now generally accepted. In fact, Congress recognized this when it passed the Comprehensive Health Planning Act to establish one of several mechanisms designed to alleviate this particular problem.

Planning as it is now practiced under this legislation is a mixture of qualitative and quantitative considerations. However, community health decision makers have come more and more to expect the health planning agencies to provide a reasonably complete and current factual basis for the quantitative segment of the decision-making process. These legitimate demands have highlighted the lack of good health services data at the community level. This in turn has caused health planners to spend an enormous amount of time in data collection before effective planning can begin.

A substantial amount of health data will be required for effective control of any national health insurance program. Once again there seems to be widespread agreement that there must be some control, thus there must be a data collection system. Since these data will be available for one purpose, it seems logical that for a very small additional cost the same data could be used by health planners. This is true, however, only if the data are standardized so that it is possible for the health planner to take information from individual health care providers and aggregate it into a community profile. This standardization is particularly necessary when health services areas cross state boundaries as is often the case. I make particular note of this point since the newspaper reports indicate that Secretary Richardson proposes that control of health insurance be placed primarily at state level.

My suggestion would not contravene the Secretary's proposal because standardization of data does not impose uniform managerial and administrative methods. Thus, for example, even though Virginia and Maryland might apply the standardized data in different ways within their respective states, the planners could combine the data from both states to develop a rational health system for the Washington Metropolitan Area.

In view of this, I recommend that you consider including a requirement for data standardization in whatever health insurance legislation your committee develops. I have enclosed a draft of a more detailed statement of my position for review by your staff. I can be reached at my office (676-6572) if they wish additional information.

Thank you for your consideration of this suggestion.

Sincerely yours,

PHILIP N. REEVES, D.B.A.,
Assistant Professor.

Enclosure.

HEALTH INSURANCE DATA FOR HEALTH PLANNERS *

Any person who is actively involved in a planning process is painfully aware of the urgent need for relevant facts. Even the casual reader of health planning agency newsletters cannot help but be impressed by the effort which is being expended in the development of data bases to meet this need. The result seems to be that many diverse agencies are struggling independently to establish an ade-

*I am greatly indebted to Dr. Helen Chase, whose review of an earlier draft of this paper enabled me to clarify a number of points.

quate data base for the health planning process in their area of responsibility. The reasons behind these substantial investments in information gathering for health planning purposes are the inadequacies of current private and public efforts in health data collection. Private programs, such as Professional Activity Study (PAS) and Hospital Utilization Project (HUP) tend to be scattered, incomplete and incompatible with each other. For example, a planner may very well find that several of the hospitals in his area have very complete and detailed data on their patients from PAS, but that the remaining institutions in the area are incapable of furnishing similar data. Consequently, he has no way of validly using the PAS data in assessing the total population of his community.

Governmental programs have also been inadequate. The major effort in the health area is, of course, represented by the National Center for Health Statistics and its publications. These are unsatisfactory to the planner for at least three reasons:

First, timeliness. The data are generally not current. Publication often lags behind the collection of data by at least three years.

Second, geographic detail. The data deal only with large areas and are usually not truly suitable for local or state use. For example, *Census Use Study Report No. 12* indicates that aggregation of data even to the census tract may mask significant variations in the health status of a population.¹

Third, flexibility—the ability to respond to unanticipated demands by users. The published tables are designed for general purposes, mostly at national level for national planning. These data can sometimes serve state or local planners as crude first approximations or as standards to which state or local performance can be compared. Further, as Woolsey,² the Director of the Center, has pointed out publications do provide the most efficient means of satisfying the demands of a wide audience for general information. However, if the problem with which a planner is dealing requires different groupings (e.g., age categories) or different cross-tabulations (e.g., morbidity by age, sex, socioeconomic status and residence) from those published, the NCHS publications are of little value unless the user redefines his problem to fit the data. This problem of inflexibility often overlaps the geographic problem described above. The definition of "local data" will depend upon the problem addressed. Thus, the planner will frequently need to consider overlapping but not coterminous regions for ambulatory services, in-patient care and environmental problems sheds.

These are indeed difficult problems, but they are not insoluble. For example, moving from health data to demographic data and housing information, we find that the Census Bureau reports have in the past been much like the material published by the National Center for Health Statistics. However, in the most recent census a great step forward has been taken. At the present time, of course, the census data are current, or will be reasonably current as they are made available. Note however that currency is achieved not so much by publication of printed reports but rather by making available magnetic tape files. Second, and most important, the data are available on a small area basis and are structured in such manner as to permit the planner to aggregate them to fit his own specific community, and in a fashion appropriate for whatever problem he faces at that moment. The Census Use Study performed in New Haven, Connecticut clearly demonstrated that census data can be merged with health data to form a very useful data base for the health planner and the health administrator. The people who have read the reports of this experiment recognize, of course, that major problems arose in this demonstration because a substantial amount of basic health data could be obtained only by conducting a survey and that the in-patient records made available covered only two-thirds of the cases.³

These observations, however, do not lead to the conclusion that we ought to have a national health census. There are more efficient and effective ways to get complete, flexible and timely coverage of health information requirements. Specifically, we should design a health care information system based upon the data contained in the files which the providers of health care services must maintain in order to carry out their clinical, financial and administrative functions.

¹ U.S. Department of Commerce, Bureau of the Census, *Census Use Study Report No. 12, Health Information System—II*, Washington, D.C., 1971, pp. 83-89.

² Woolsey, Theodore D. "Data Banks Are Not The Answer: A Statistician's Viewpoint," *American Journal of Public Health*, October 1970, pp. 1092-93.

³ *Census Use Study, No. 12*, p. 15.

Noble⁴ describes seven major questions which must be faced by the developers of a health information system. They deal with four topics: content (questions 1 and 2), resource requirements (questions 5 and 6), participation (questions 3 and 4) and user support (question 7). National health insurance, an idea whose time is generally believed to have come, has the potential for contributing substantially to the development of satisfactory answers to the first six questions.

With regard to content, probably because of experiences with Medicare and Medicaid, there is a tendency for health insurance legislative proposals to require that health care providers be capable of furnishing data suitable for program evaluation. Ordinarily one would assume that program evaluators, operators and planners would be speaking in the same terms. In fact, unless they do, the result is likely to be an absence of implemented plans. The operator will provide services and he will have various reasons for striving to meet the expectations of the evaluator; consequently if the planner speaks in a different frame of reference, his plans are likely to be rejected as irrelevant since the incentives he can employ are typically less powerful than those of the evaluators. As Densen⁵ and others have pointed out health insurance oriented data systems generally have focused on claims rather than persons. The output of such systems may be suitable for some forms of fiscal evaluation, but are obviously inadequate for determining true quality of care or for planning epidemiology, etc.

While it undoubtedly would be impossible to satisfy all the needs of the data users who are not providers, there are a number of studies which could be used as the basis for developing a minimum feasible data set.⁶ Further, it appears that organization of these data as individual patient records as required for clinical use, would also be the best arrangement to provide the flexibility, through ad hoc aggregation, required for planners, health care services management, administration and evaluation.⁷ However, it should be noted that this arrangement would not be most suitable for all purposes. For instance, users who deal with matters which typically involve more than one person (e.g., auto accidents) would have to develop a rather elaborate scheme for cross-reference,⁸ but these seem to be a small minority in comparison to those best served by aggregation of data from records of individuals. Gerzog⁹ has even suggested that a particular type of patient record might serve as a filter to prevent overloading the information system with data.

Resources requirements can generally be translated into dollars. In this case, it might be argued that, although the data could be made available under such a system, to do so would increase the cost of delivery of health services, and thus increase the cost of national health insurance. First, we can be sure that, given the experiences with Medicare and Medicaid, a substantial amount of financial reporting will be required. Thus, there will be data systems and we need only consider the relatively small incremental costs of adding items to these data collection systems. Second, there should be no doubt that in the last analysis, national health insurance will be paid for by the general public. And for their money, the people are entitled not only to health care, *per se*, but to health care provided in an approximately optimal fashion; i.e., in accord with sound plans based upon adequate data.

In addition, this is not a call for a national health data bank comprised of individual records. Aside from the technological problems involved in maintaining such a file, this sort of data bank would be needlessly expensive. In general the people operating at local, state and federal levels have little or no

⁴ Noble, John H. Jr., "Designing Information Systems for Comprehensive Health Planning," *Inquiry*, December 1970, p. 34.

⁵ Densen, Paul M., "Some Practical and Conceptual Problems in Appraising the Outcome of Health Care Services and Programs," in Hopkins, Carl E., ed., *Outcomes Conference I-II* (Department of Health, Education, and Welfare, 1970), pp. 22-23, and Joint Center for Urban Studies of M.I.T. and Harvard University, *Problems and Perspectives in the Design of a Community Health Information System*, February 1969, pp. IV-14.

⁶ See for examples: The Public Health Conference on Records and Statistics, *Working Draft Report prepared by the Study Committee on Health Statistics for Comprehensive Health Planning and Evaluation*, Doc. No. 618.11 Rev., Feb. 2, 1970, National Center for Health Statistics; Joint Center for Urban Studies, *Design of a Community Health Information System*, Chapter III; and Murnaghan, Jane A. and White, Kerr L., M.D. (eds.), *Hospital Discharge Data* (Philadelphia: J. B. Lippincott Co., 1970), pp. 13-23.

⁷ Public Health Conference on Records and Statistics, *Working Draft Report*, p. C-4.

⁸ Pool, Ithiel de Sola, "Planning for the Future" in Joint Center for Urban Studies, *Design of a Community Health Information System*, pp. VI-15.

⁹ Gerzog, Jack, "The Changing Concept of Medical Records," *Public Health Reports*, August 1970, pp. 673-79.

occasion to concern themselves with data about specific individuals. Rather, they need aggregated data suitable for a particular problem. Aggregation implies standardization; thus the minimum data set required for health care providers participating in national health insurance would necessarily have uniform definitions and codes; however, this would not prevent individual providers from adding unique modifiers to the patient record in order to satisfy their own particular requirements. As a practical matter, McDowell and Mindlin report that standardization of data is not an insurmountable problem so long as the files of the various providers of data are comprised of individual records.¹⁰ Further, the providers involved in Medicare and Medicaid have demonstrated an ability to comply with standardized reporting requirements when this is a condition for reimbursement.

Finally, aggregation as described does not imply routine, recurring reports of all data. Rather there might be a requirement for routine reports of only a few commonly used general purpose tabulations. All other needs could be satisfied by *ad hoc* requests for specific information. Moreover, if the data users understand sampling techniques, it will seldom be necessary to require all health care providers to furnish data for any particular decision.

This raises the issue of participation by health care providers. The issue has two aspects—legal restraints and willingness.

Legal restraints are often used as a concealment for unwillingness. They have been analyzed in great detail.¹¹ Although no ultimate solution has been proposed, it appears that maintenance of individual records by individual providers, rather than in a data bank, will minimize this problem—particularly so long as restrictions similar to those imposed by the Census Bureau are observed when furnishing data to area, state or federal health agencies.

Once the legal problems have been dealt with, cooperation of providers can be obtained if: (1) this is a condition for participation in the mainstream of health services delivery and (2) they are assured of fair compensation for the effort required. As noted earlier, it would certainly be a rational decision for the general public to purchase this necessary ingredient of the health care planning process.

This leads to the final concern on Noble's list; political and financial support. National health insurance legislation may provide a vehicle for financial support of an adequate health information system, but it cannot fill the last vital requirement. Demonstration of political support by a sufficient number of potential users is a necessary condition for implementation of this concept by our legislators.

APHA, which certainly represents a substantial segment of the potential users, has endorsed the concept of health planning; surely then it should support legislation that would assure the availability of the data needed for effective implementation of the concept. At least one of the current proposals for national health insurance, the Kennedy Bill (S3)¹² contains a requirement for health data that are suitable for planning and evaluation as well as for financial management. The APHA should do everything within its power to insure that a similar proviso is incorporated in whatever national health insurance legislation emerges from the Congress, and that the legislative history makes the intent abundantly clear. In other words, we need not only legislation but a definite and unequivocal mandate for the Federal administrators of the program to implement a system for collection of data that will meet the major needs of planners, evaluators and researchers in addition to satisfying the requirements for sound fiscal management of the insurance program itself.

STATEMENT OF IRVIN P. SCHLOSS, LEGISLATIVE ANALYST, AMERICAN FOUNDATION FOR THE BLIND

Mr. Chairman and Members of the Committee, I am pleased to have this opportunity to present the views of the organizations I am representing on H.R. 11525, the Children's Catastrophic Health Care Act of 1971.

¹⁰ McDowell, Bruce D. and Mindlin, Albert. "Obtaining Metropolitan Data From Local Governments." *Journal of the American Institute of Planners*, March 1971, pp. 112-13.

¹¹ See for examples: Notman, Ralph. "Safeguards for Privacy and Confidentiality," and Curran, William J., Stearns, Barbara and Kaplan, Honora. "Legal Considerations in the Establishment of a Health Information System in Greater Boston and the State of Massachusetts" in Joint Center for Urban Studies, *Design of a Community Health Information System* and Faculty of Law and Jurisprudence, State University of New York at Buffalo, Medical Society of the County of Erie and Western New York Hospital Association, *Right of Privacy and Medical Computing*, Oct. 5, 1969.

¹² Section 130, S. 3, 92d Cong., 1st Sess.

Today I am representing the American Council of the Blind, one of the two national organizations of blind persons; the American Foundation for the Blind, the national voluntary research and consultant organization in the field of services to the blind; the American Association of Workers for the Blind, the national professional membership organization in the field; the Blinded Veterans Association, the Congressionally-chartered organization of men and women blinded in this Nation's wars; and the National Federation of the Blind, the other national organization of blind persons. All of these national organizations wholeheartedly endorse the provisions of H.R. 11525.

Title V of the Social Security Act has been far too limited in reaching and serving children with various conditions which, if not corrected in time, are seriously disabling. In particular, children with serious vision and hearing problems have not been adequately served by the existing program. Limited Federal financing, loose State plan provisions which permitted States to serve only certain types of disabled children, the term "crippled children" itself—all of these have been factors which have seriously limited the effectiveness of the present Title V in providing adequate maternal and child health as well as handicapped children's services. H.R. 11525 effectively corrects these shortcomings by assuring comprehensive health care and essential related services to mothers, infants, and children.

We particularly welcome the provisions of H.R. 11525 which would provide diagnostic services to all infants regardless of family income. As the Committee is aware, there are many conditions which are partially or totally disabling in adults, but which, if treated in early childhood, can be ameliorated or avoided altogether. We are particularly aware of two eye diseases which are correctable in children and which will illustrate the value of a nationwide screening program. Strabismus (crossed eyes) is a condition which is readily correctable through the use of prescription eye glasses or surgery. If not corrected, vision in the crossed eye is suppressed until severe sight loss results. Similarly, amblyopia ex anopsia (lazy eye) is a condition which results in severe sight loss in the suppressed eye. Both of these conditions should be detected and treated as early as possible in the pre-school years in order to prevent the serious sight loss which may then necessitate costly special education and vocational rehabilitation procedures.

In addition, we strongly support the provisions of H.R. 11525 which provide a Federal program to assist parents of handicapped children to pay the often staggering costs of special facilities and medical care for their children. We hope that these provisions will be enacted into law.

We would urge the Committee to make several changes which we believe would increase the effectiveness of the programs authorized by H.R. 11525. First, we would recommend that the title of Title V be changed to read "Comprehensive Children's Health Services and Catastrophic Disability Program" to more adequately reflect the scope of the program. Second, we would recommend liberalization of the income limitations in Section 503 to take into account the more pressing needs of families with several dependent children in contrast to using a single annual taxable income figure for every family. Families which have several children including one with a serious costly health or disability problem are more pressed financially. Third, we would recommend that Section 505(a)(4) be amended by adding at the end of the paragraph the following wording: "except that the State agency serving blind persons may be designated as the State agency administering or supervising the administration of that part of the State plan affecting services for children with visual impairments." Fourth, we would strongly urge the Committee to change the word "crippled" in the title and text of Section 511 to "handicapped" to more accurately reflect the scope of the program and to prevent exclusion of research activities on non-orthopedic handicapping conditions.

In conclusion, we should like to respectfully urge the Committee on Ways and Means to act favorably on H.R. 11525 with the amendments we have recommended. It is an excellent measure which will make a major contribution to the health of the Nation's children and to the prevention of costly lifelong disability.

AMERICAN ASSOCIATION OF DENTAL SCHOOLS,
Chicago, Ill., October 21, 1971.

Mr. JOHN M. MARTIN, Jr.,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives,
Washington, D.C.

DEAR MR. MARTIN: I am writing on behalf of the American Association of Dental Schools to thank you for the opportunity of presenting testimony on national health insurance. I regret that it will not be possible for a representative of this Association to appear on October 28. As an alternative, therefore, I am enclosing a policy statement adopted earlier this year by the Association on national health insurance plans. I would appreciate it if this policy statement could be made a part of the printed record of hearings.

Sincerely,

JOHN J. SALLEY, D.D.S.,
President.

Enclosure.

STATEMENT OF POLICY

The Executive Committee of the Association, representing 90 institutional members and more than 1500 individual members, strongly endorses the principle that total health care, including dental care, should be made available to all the citizens of the United States, without regard to economic status. The Association is prepared to support any national health insurance plan which may be developed, provided that it represents a serious and realistic attempt to improve and expand the present system of health care delivery among all health professions, including the dental profession.

The Association believes that an over-riding goal of any national health insurance plan should be to provide a single standard, quality health care service for all citizens and, to do so, any proposal should encompass the following principles:

1. Health care should be available to all, regardless of ability to pay.
2. Dental care—particularly preventive care—should be included as an integral part of the total health care.
3. Qualified health professionals and health professions' educators should retain responsibility for program design and management and peer review procedures should be used to ensure that high standards of quality care will be enforced.
4. Consumer participation should be encouraged to develop and evaluate approaches to improve health care services at the community level. Consumer participation should also be encouraged in the decisionmaking for the design and governance of the delivery system.
5. Initial emphasis should be placed on providing total care for people who cannot afford or who do not now have ready access to health care facilities and services.
6. The existing system of health care delivery, whenever possible and appropriate, should be utilized; however, and concurrently, funds should be identified to develop new and improved delivery systems.
7. The health delivery system should be structured to provide support to maintain and expand the supply of health professions' and allied health professions' manpower.
8. Evaluation and review procedures should be clearly stated and described to ensure maximum flexibility and effectiveness.
9. The intra- and extra-mural facilities of health professions' schools should be accorded vendor status to provide care and service for specific sections of the population.
10. Professionals and allied health professionals employed by schools of the health professions should be utilized in the development of new health care systems.

The Executive Committee has approved the foregoing principles which it believes will meet with the approval of its members and recommends that they constitute the basis for the Association to comment and react to any present and future proposals.

DELTA DENTAL PLAN OF UTAH,
Salt Lake City, Utah, November 1, 1971.

Subject: Health maintenance organizations.

Mr. WILBUR MILLS,
Chairman, House Ways and Means Committee,
House Office Building,
Washington, D.C.

DEAR MR. MILLS: The accompanying material is respectfully submitted for your information and consideration of the Delta Dental Plan organization and its policy formulation regarding Health Maintenance Organizations.

As a nationwide organization, the Delta Dental Plan Association is vitally concerned about the scope and directional framework within which dental prepayment will function in the future. Being a non-profit, professionally sponsored organization, the Delta system can offer cost and quality controls that are convergent with overall governmental proposals. These components are unique within Delta and cannot be obtained through any commercial carrier. Also, Delta is able to offer multistate dental care while still maintaining our basic administrative philosophy.

We think you will find the enclosed information will accurately encompass the salient features of our organization.

The Delta organization has pioneered the concept of prepaid dental care in the United States and hopes to continue its position of leadership in providing the finest care possible.

Cordially yours,

CHARLES E. PARKIN, D.D.S.,
President.

Enclosure.

POLICY OF U.S.D.A. REGARDING HEALTH MAINTENANCE ORGANIZATIONS

The material presented below is a result of a meeting held with representatives of the Utah State Dental Association Executive Committee, the presidents of the District Dental Societies and the Executive Committee of the Delta Dental Plan in regards to each organization's relationship to Health Maintenance Organizations or the philosophy that is advocated in such organizations. It is recommended that the Delta Dental Plan act as a contracting agent in the HMO philosophy in the State of Utah with the cooperation of the Utah State Dental Association and its individual members contained therein.

It is anticipated that Delta Dental Plan will act in the following manner:

1. As a fiscal agent:

(a) Delta Dental Plan is capable of contracting with various consumer groups desiring dental care on a capitation basis and is capable of contracting with individual dentists to furnish comprehensive dental care either on a fee for service basis or contracting with geographic dental groups on a prepaid capitation basis.

(b) Marketing can be undertaken by experienced staff members to introduce prepaid dental concepts to any group having interest therein.

(c) Dispersement of funds can be made directly to individual dentists in solo practice where population numbers are not great enough to warrant payment to a group of practitioners such as in large population centers. Payment can also be made to practitioners engaged in group practice in large population centers.

(d) In statewide groups it is anticipated that the principle of equalization could be used in order that no geographic group would undergo excessive profit or excessive loss. Such equalization would be based upon the equalization formula in the Delta system that would not equalize administrative costs in a group, but would equalize treatment costs.

(e) Reserves already established by Delta Dental Plan would insure fund responsibility.

(f) Actuarial experience in dental prepayment minimizes the risk in developing rates which would be sound both for the consumer group as well as the provider of care.

2. Group Practice:

(a) In cooperation with the Utah State Dental Association, Delta Dental Plan would provide groups of practicing dentists as providers of care in a

geographic area. This can be done either in group practice or in solo practices necessitated by the dispersment of the population.

(b) In cooperation with group practices, it is anticipated that preventive centers would be established wherein emphasis would be placed on disease control of both dental caries and periodontal disease.

3. Professional Supervision :

(a) Peer review which is already established would be utilized in all programs. One of the problems in a HMO is that of insuring quality control. The temptation for decreased standard or sub-quality materials in dental treatment would increase the year-end profit would be a serious problem to cope with. Without external review of preventive programs, diagnosis and treatment techniques, the HMO concept could seriously decrease the treatment quality of the nation.

(b) Claims Supervision. In the event that a solo practice were used, pre-authorization of all treatment would tend to eliminate questions in diagnosis before treatment and a professional review of patients post-operatively would be a motivating factor for quality in routine care.

(c) Continuing Education. Recurrent professional education would be a requirement for participation in the program.

4. Manpower Capabilities :

(a) The flexibility of dental manpower in the State of Utah is exhibited in the widespread distribution of dentists. The dental profession can be used either in groups or in an individual solo practice concept.

(b) The State Dental Association has offered full dental staffs to man dental facilities in areas of the state which are presently not being properly covered. This can be accomplished either by mobile units or fixed facilities located in geographical areas in cooperation with local community or governmental organizations.

(c) It is anticipated that ever-expanding use of auxiliary personnel will aid in the utilization of professional manpower.

(d) Patient Convenience :

Utilization of existing facilities are closer to the population distribution. In the more sparsely populated areas in Utah, smaller treatment centers are or can be established in close proximity to people.

(e) Central Business Management

Through the data processing facilities that have been established, Delta is capable of billing the consumer groups as well as handling any co-payment facilities that may become necessary for individual patients. We are presently studying a system which will afford cost accounting to the individual practicing dentist and have already established doctor files which will reveal treatment patterns of each individual doctor as well as patient files which give necessary information as to treatment history.

The above facilities, which are available under a Delta Dental Plan system, can provide comprehensive dental treatment in a philosophy of treatment which has been proven can reduce costs and can assure safeguards against flagrant abuse in the event either patient or practitioner becomes involved therein. Even more important, treatment under this system is designed to meet individual needs of people requiring preventative services as well as treatment expertise.

DEFINITION OF HMO

Purpose

A Health Maintenance Organization is an organization which operates or manages an organized health services delivery system on a prepaid capitation basis for enrolled population groups, designed to provide comprehensive health care economically and effectively.

The HMO concepts, either directly or through its arrangements with physician groups, to make quality health care available and accessible. The HMO provides assistance to the beneficiary in selecting a primary or managing physician (or organized physician group) who agrees to be the entry point for the beneficiary into the HMO system of health care and coordinator of his care. The HMO assures either directly, or indirectly through the physician groups, continuity of health care in the home, office, hospital, or extended care facility by making arrangements with or operating facilities and services required, assuring their adequacy in relation to the enrolled population, and assuring a unit record system applicable throughout the service system. The HMO assures quality of health care by requiring appropriate review mechanisms by all providers of service and the physician groups.

HMO Physicians

The HMO either employs directly or arranges for physician services with one or more groups of physicians. The group of physicians must be paid prospectively on a fixed aggregate sum or per capita basis. The payment may cover other non-physician health and medical services as well as salaries of auxiliary personnel employed and supervised by the physician. If only one group of physicians is involved, it assumes responsibility for providing or paying for all physicians care needed by the enrolled population. If more than one group of physicians is utilized, each group has an assigned or selected panel or enrollees for which it assumes this total responsibility. Each physician group is responsible for establishing and maintaining quality control mechanisms. Each physician group is responsible for assuring 24 hour, 365 day access to physician services by enrollees. Each physician group is responsible for assuring continuity of patient care in home, office, hospital, and ECF. The HMO requires the assurances from the physician group(s) in its contracts or agreements and requires reports of performance.

RELATIONSHIP OF HMO STRATEGY TO HSMHA PROGRAMS AND OBJECTIVES

While the words—HMO—may be new, many of the basic concepts of the HMO are consistent with HSMHA objectives and program priorities for improving the organization and delivery of health services. Among the principles that have guided HSMHA strategies in recent years are the following:

STATEMENT OF HUBERT L. CAFRITZ, D.D.S., HYATTSVILLE, Md.

"A Proper Role for the Federal Government to Play in the Financing of Health Care that Preserves All Existing Relationships Between Doctors-Patients-Hospitals-and Insurance Companies"

The scope and intensity of these hearings tells us that the time has come for broad based legislation in the area of health care. The committee, and other interested parties, are unquestionably familiar with the wide range of proposals from zero, or minimal involvement of the Federal Government to fullest involvement in a comprehensive National Health Program. Proponents of each extreme present excellent arguments against the opposite extreme; however, they are not able to defend their position against its own flaws. What is left in the middle ground? Nothing . . . but a hodge podge of partial solutions without any common principles or harmonious plan. No existing approach to health care creates any new resources; instead, all introduce an administering third party (in some cases a fourth party, too) which adds to the soaring costs of health care. The reason for our dilemma is that the proper role for the Federal Government to play in the financing of health care has never been defined until this time. The solution is so simple that it is almost unbelievable.

When one has a financing problem to whom does one turn? A bank, generally. *The solution to financing health care is to be found in banking principles.* All health dollars must be channeled under one roof, creating a huge pool from which idle dollars could be put to work for the benefit of those in need. This is how a bank works. The idle money in my account is used for a loan to you. Financing the nation's health problem is obviously far more complex. However, the United States Treasury Department could develop the necessary capability, and it would be altogether fitting and proper for the people of this country to use one of their own agencies to solve this major problem. Careful investigation, on the other hand, might reveal that it would be more feasible to create a special bank for health needs alone . . . something comparable to the many specialized banks already in existence to solve other special problems. In either case, the solution to financing health care is to be found in banking principles.

We are suggesting that all monies currently spent for health care be channeled through this selected bank. Instead of monies being withheld from wages as a tax, they should be withheld in the form of a deposit with the *ownership of the money remaining with the depositor.* This is essential. When the taxpayer controls his own money the motivation is present for economy. Doctors and patients will not gang up on some far removed third party, as many are doing with Medicare and Insurance companies. At this point we are only speaking of basic underlying forces. A sound plan must be built upon a sound foundation,

and lack of such a foundation is the reason we have no *real* solutions in sight at this time.

Let us examine what might happen when this one simple but fundamental change in ownership is effected. The role of the third party, the Federal Government, is now reduced to one of a banker only. Insurance companies can concentrate on that area of health care which lends itself best to insurance principles, i. e., unusual or catastrophic illnesses. Deposited health dollars can and should be used to purchase this type of inexpensive insurance. Patients will be free to purchase any insurance they choose—the only difference will be that there will be more dollars available for such purchases (including purchases by the poor who need it the most).

Our health care plan suddenly gets several million employees each working free, part time, to administer his own plan. We preserve all of our existing institutions, eliminating all of the expensive lobbying and public arguments now going on and likely to continue. The proponents of national health care should not object because this plan gives *everyone* the care they need. It is more comprehensive than anything suggested to date. No one is hurt and everyone benefits. Doctors are freed of mountains of paperwork; for now they practice their profession on a cash basis, cashing checks for the treatment they render at the new "Health Bank." Not one single extra form need be filled out. The doctor and his patient alone establish the treatment to be rendered. Never before have the health professions been able to practice so ideally. Needless to say, there will be problems, but these problems can be solved once we start working together in the right direction.

All right, you ask, what advantages would the system have if all existing relationships were left intact? The big over-riding advantage would be to the needy who could have loan privileges. In order to put a ceiling on any one patient's potential default in payment, we suggest that a compulsory major medical insurance feature be written into the plan. For example, if every depositor were required to purchase major medical insurance with a \$1,000 deductible feature, \$1,000 would be the greatest exposure the bank would have from an indigent, in the event he could never bring his account into balance. Our experience has been that once a man is restored to a state of health, he frequently works his way back to a state of self-sufficiency. Most of us would agree that a loan, no matter how risky, is preferable to a hand-out.

Deposits into the plan are made through the existing withholding system. The exact size and amounts of these payments must be developed through further R & D. Whether the deposits should be compulsory or voluntary is a political question and, although important, does not matter to the basic principle involved. The only thing essential is that *ownership of the funds remain with the individual*, and that all funds be directed into one giant pool so that the *full benefits of the idle money on deposit can be used for loans to those who could benefit from such loans*. Those who draft the legislation required for this type of plan must study available health statistics so that realistic but fiscally sound loan limitations can be developed. Ideally there will be enough money in the "special bank" for the full \$1,000 loan limit to apply to everyone. When this condition is reached it will mean that *any* person in the country could go to any doctor or hospital of his choice and get whatever treatment he needs. I believe the goal can be reached. Until this is proven we must either set lesser limits for everyone or have a sliding scale related to either need or income.

Bank and file depositors will have to balance and reconcile their own accounts at least annually when they file their income tax return. For many this will be the first time they consider their own health problems beyond a sickness to sickness basis. This in itself will bring better management of health dollars, particularly since money will be going into the pan during times of health as well as times of sickness. Since each patient does his own bookkeeping, he is in effect "administering" his own plan at no cost to the government. No matter how unsophisticated a patient may be, he can do a better job managing his own health needs, *when the money is available*, than a Federal agency administering one plan for everyone. *This plan would make money available to everyone.*

Bear in mind—this paper only defines a role for the Federal Government to play, i. e., a pure financing role such as a bank might play. No one has ever suggested this before. It is not only possible but, I believe, the most feasible thing suggested to date. The basic principles upon which the plan utilizing this role would be based are sound and better suited than current plans under consideration. Some people might doubt the ability of indigent patients to utilize

the plan and its loan privileges. These doubters have never heard welfare recipients arguing for their rights. This plan has educational and social redeeming factors built in to it, for a loan is better than a hand-out.

The next step is to develop a detailed prototype plan based on the principles stated above. Yes, it is late in the game. This only lights highlights however, the urgency to start as soon as possible. Who has the responsibility for initiating this effort? The position *you hold* at this time makes *you* one of those to whom this responsibility falls. If you can visualize some of the exciting possibilities that are to be found exploring this new approach to health care, pick up the telephone right now and call me at HA2-1917 or write.

BOSTON, MASS., November 8, 1971.

DEAR REPRESENTATIVE MILLS: I wish to offer the enclosed writing of mine as testimony to you and your committee concerned with national health care.

I trust that its contents will be considered. As a member of the health care profession, I much more consider myself as a consumer's advocate in the health care problem.

I should also mention that the enclosed writing has been received by Senator Ribicoff and forwarded by him to his subcommittee on government operations.

Sincerely,

FRANKLIN S. NUSBAUM, D.D.S.

Enclosure.

STATEMENT OF DR. FRANKLIN S. NUSBAUM

The charges that come about in the health care of this nation will generally be accomplished only if there is leadership that is meaningful, serious, and determined. That leadership though shared at points along the road of constructive change by government and professional, will essentially have to be provided by government through the national administration lead by the President of the United States and by the United States Congress. If effective leadership does not reach out from these sources then the American public can be assured of continued calamity and immorality in the health care aspect of American society.

While organized motivation of purpose may be a very difficult endeavor in dealing with a society concerned with such a complex problem little understood by many health professionals and certainly the lay public, the responsibility for both initial and ultimate accomplishment of the task must be assigned to, accepted by, and held accountable for by government itself. It must be this way if only by virtue of the single fact that government is held to be that single sensitive organ that responds to a nation of people and their needs.

The author's view of government's ultimate responsibility for the health care of a nation is pointed out in part of a statement that he presented to the U.S. Senate Finance Committee recently, concerned at the time with health care:

"The goals of health care in this nation should be *quality, equality, and economy*. The guidelines used to achieve these ultimate goals should be quality, equality, and economy. The main concern of the finance committee is the economy aspect of health care. And I am sure the committee realizes that the dollars involved in health care have an effect upon the other two, generally.

"The health care problem in the United States is not an under-privileged problem, exclusively; it is not an old age problem, exclusively—it is a *citizenry problem*. (Of the first degree, I may add, socially, morally, and medically.)

"What concerns me most in this issue is that there are no blueprints forthcoming from responsible individuals, groups, organizations, and associations on the health care scene (and that includes health care professionals and government representatives) that fully encompass the answers needed to remedy the health care delivery 'ills' of this society.

"I do believe the American public is entitled to this 'visionary blueprint'. Indeed, I do not know how a finance committee can perform its financial duties on either a short-range or long-range basis, without knowing where the *non-system* of health care is going in this nation. For sure, to continue along these lines that we have taken up to now, budget bankruptcy of the health care bin is assured. More important, the human being in need of health care will be the guaranteed victim.

"Medicare and Medicaid can only be looked upon as a natural social response to the needs of people in the overall history of society and medicine in this country. At the same time, it has been a growing pain in the form of a thorn for those who are trying to administer and regulate these programs. The only solace that can be offered at this time of chaos, confusion, and catastrophe in all of health care for all the people is that there are 'growing pains,' part of the growing-up process of health care delivery in a nation that has *no system*. Accompanying the 'no system' is what I personally refer to as a MEDOPOLY. (spelled M-E-D as in medicine, O-P-O-L-Y)—all together spelling, OATAS-TROPHE.

"This nation needs at this time a national overhaul—indeed, the building anew of a health care scheme that replaces the medical mess that supposedly is suppose to serve the people of this nation. Until the plans or blueprints for this future health care scheme are known, and until commitments are made to them, we can only expect the same of what we have been having—but much more of it as precious time passes.

"The Senate Finance Committee can take a leadership role in this challenging phase of society and medicine. And this challenge of a new society with new medicine is not so much in terms of dollars, as it is in terms of ingenuity and execution. While the Senate Finance Committee is not charged with creating health care concepts, it does have within its power the ability to motivate, change, curb, initiate, etc. health care currents. At this time I beseech you gentlemen to act in those ways that will bring forth a national plan from the responsible sources that are charged with the care and health of the people of this nation."

This author has recommended the formation of a National Health Service Corporation that would be charged with the administration and regulation of the national health care system of this country. Centralization of responsibility through dedication to a logical system must once and for all be accomplished. Rationality of a health care delivery system must take hold where there now exists no blueprint for an overall future plan, only piecemeal concepts with no realistic goals and no true direction.

The institutions that are directly concerned with the health care of this nation, such as hospitals, health care teaching universities, etc., would be brought into uniform purpose, function, and performance that is in common direction with the goals of its directing agency, the National Health Service Corporation. In turn, as institutions are directed and regulated by the National Health Service Corporation, so too must the individuals working in these institutions, such as doctors and allied health professionals, be responsible to necessary regulations and guidelines.

A means is needed whereby all the various groups concerned and involved in such a system have a say in its operation and feel their own integral importance in the overall system. Clearly these groups would consist of health professionals, auxiliary, the consumers of health care—the general public, and government.

The law has provided several means for organizing large enterprises concerned with decision-making. The one which has been used predominantly and which offers the best prospects here is the corporate form. The corporation consists of shareholders who have a fixed allocation of responsibility for its decisions. The Communications Satellite Act, the Public Broadcasting Corporation, and the Federal National Mortgage Association all blend public and private decision-making in their management. The most applicable here is the Communications-Satellite Corporation, Pub. L. 87-624 (1962), which provides in section 303 for the allocation of shareholding between the President, communication common carriers, and others. By explicit ratio, the President appoints three of the fifteen stockholders and no more than six of the twelve of the remainder may be from communications common carriers. By subsequent amendment, the division of the twelve non-Presidential stockholders has been allocated to a sliding-scale according to the percentage of non-government held stock owned by the communications common carriers. The statute further requires that two-thirds vote of the stockholders shall be required to make corporate decisions, thereby ensuring that at least two of the three interest groups involved, if they vote in blocs, must agree before any action is taken by the board of directors.

Similarly, the powers of a national health service corporation could be allocated between the President, the existing institutions, doctors, other system employees, and the consumers of health care. With the exception of the Presidential appointees (subject to the advice and consent of the Senate), each of

those groups would be allocated votes by ratios, similar to the sliding-scale now used in the Communications Satellite Act. However, instead of ownership used as the criteria as in the Communications Satellite Act, numbers of participants in the system would be the basis of allocating votes, with institutions getting votes according to the numbers of patients they serve during a calendar year or, perhaps, according to the monthly average number served during any given year. If, for instance, the American Medical Association puts up a slate of candidates for the doctors' positions on the Board, the individual voting doctors would not be required to assent to such a slate; indeed, no institutional or organizational affiliation should be required for any of the non-Presidential appointees; the only criterion should be the number of votes received by those eligible to vote, with a proportional representation for minority interests.

The powers of the National Health Service Corporation would cover a wide-ranging field—that being everything dealing with health care in the United States. This would include, of course, funding, wherever it may be; for hospitals, medical and dental schools, group practices, national health insurance, and so forth. Every health institution and every member of every health institution would be required to participate in the corporation and its goals before they could receive any reimbursement, as for instance from a national health insurance scheme or for institutional construction, etc. Dentists and other doctors not usually associated with hospitals would have to conform to national guidelines in order to be part of the system. The intent of such a structure is to bring all of the health caring "families" of the health complex under national regulation and guided by common national health goals. As an important part of this national plan, there would be free education for qualified students in the health care fields upon the condition that a certain number of years be spent within the system following graduation. A vast corps of health care human resource would be guaranteed to further the national goals of health care delivery in the United States.

In essence, a national health service corporation would provide the leadership and direction in the achievement of an agreed-upon blueprint for a health care system of the nation where now there is no leadership, no direction, no blueprint, and no system. It would seem logical that a country such as the United States, in the stage that it presently finds itself in relating to society and health care, would be in sight of new realistic achievable horizons with a 3 point health care program featuring:

- (1) a national health service corporation (or a form thereof)
- (2) a national health insurance scheme
- (3) a national health service corps established and encouraged by the

provision of free education for the future health professionals.

A national direction in health care in no way is meant to overlook the fact that areas of the nation have local and specific problems that are identified with that particular area and its population. Therefore, local bodies of authority would always exist for local decision-making and management within the national framework. The existence of the national directing body provides the assurance that there is a stable and effective and responsible corporate body of responsible representatives overseeing the vast "business" of health care of a nation. If the business is run well where the goals are quality product (health care) through sound economic practices, the American public stands to be a very happy and fortunate "stockholder" in the national enterprise of health care. The doctor hopefully will have found a new perspective with new incentives and a fresher meaning to his role as health carer.

The author in no way insists that his proposals as mentioned are the only means for solving the health care dilemma that exists. His ideas do attempt to get at the basic problems that can be identified as major reasons for the present situation. But certainly all should realize that whatever formulae are adopted, they should not be half-solutions when they should be total; for, it is the health care of human beings that we direct our consciences to. And since men of government will have to be making many important decisions, they should remember that nothing is politically right that is morally wrong.

STATEMENT OF THE HEARING AID INDUSTRY CONFERENCE

I. INTRODUCTION

The Hearing Aid Industry Conference is a trade association of hearing aid manufacturers and related companies whose membership includes all of the

major domestic firms engaged in the manufacture of hearing aids and components, and many of the foreign firms. The Conference has a strong interest in continuously improving the help received by users of hearing aids. Equally important, we seek out hearing handicapped Americans and encourage them to get medical, surgical or amplification assistance in order that they may return sociably and productively to the world of sound.

As a condition of membership in HAIC, each company subscribes to the Code of Ethics for the Hearing Aid Industry. This Code was drawn up after careful study by both HAIC and the National Hearing Aid Society, the retail dealers' association, in an effort to provide the best possible service to those who are hard of hearing and to the public in general. The Code closely parallels FTC's Trade Practice Rules for the industry.

II. THE NATURE OF THE HEARING LOSS PROBLEM

Various government and industry estimates as to the extent of the problem of hearing loss range from 8 to 20 million persons. Of these we estimate only 2 million now wear hearing aids. Four or five times that many would probably benefit from electronic amplification if they would identify themselves as being candidates for help. We try unceasingly to get more help to more people.

Unfortunately, most people who lose their hearing will not initiate a program to get help. The initiative in the great majority of cases thus must come from our industry.

Hearing loss is an invisible, silentcrippler. While people will seek help for almost every other human disability, they tend not to face up to a hearing loss. As a result, they become increasingly shut off from the world—they feel their friends shun them, their ability to hold onto a meaningful job is decreased, and the resultant loss to the overall economy is immense.

III. COOPERATION WITH HEW

These facts were emphasized in 1968 by the government in an agreement between the Social and Rehabilitation Services of HEW and the members of the National Hearing Aid Society. HEW noted that hearing aid dealers "are frequently the first point of inquiry from hard of hearing people and thus are strategically situated to increase the flow of referrals to the state division of vocational rehabilitation". This agreement was reaffirmed recently by Mr. John Twinn, the present administrator of Social and Rehabilitation Services.

The question of whether a national health insurance program should be instituted in the United States is beyond the scope and province of our organization. We do strongly feel, however, that if such a program is begun, and if hearing aids are included, full utilization of the existing national hearing aid dealer network would be a vital element in the success of the program.

Representatives of other organizations have adequately described the importance and complexity of hearing loss as a national health problem.

IV. HEARING AID DEALER NETWORK

Our industry's many years of creative, progressive and effective service to the hard of hearing have resulted in the building of a strong, capable network for service in four important and vital related areas—testing, fitting, selection and after-fitting assistance. Today a very large majority of all Americans throughout the country are within minutes of a competent and reliable community hearing aid dealer.

This great national resource of nearly 6,000 outlets and approximately 20,000 trained personnel is in place, ready and available at no cost to the taxpayers. Our dealers are businessmen-taxpayers, rather than institutional tax-users. No other delivery system anywhere in the world is so effective and economical.

The hearing aid dealer is eminently qualified in collaboration with the medical community, to test hearing, select and fit hearing aids and to deliver the all-important post-fitting service. He has been doing so for many decades. The dealers' association and every level of the industry are constantly engaged in building an ever-improving force of competent and reliable dealers to provide help and service to the hard of hearing.

Approximately 96% of hearing aid users benefit from the services of a dealer.

The success of the dealer delivery system is evident in the results of two surveys done on hearing aid user satisfaction. One was a U.S. Public Health Service study which revealed that 93 per cent of those who use their hearing aids

constantly, are satisfied. The other, a study conducted by a large and distinguished market research organization (Market Facts, Inc.), revealed a solid 90 per cent satisfaction rate among users.

Our Conference has prepared a position paper, which contains recommendations relative to the best, most efficient, most economical way to provide hearing aids under any government program.

The position paper, plus extensive footnotes, follows.

V. PROCUREMENT OF HEARING AIDS PURCHASED WITH GOVERNMENT FUNDS

The Hearing Aid Industry Conference shares with government agencies, medical and audiological professions, and hearing aid dealers, a mutual interest in the social and occupational well-being of the hearing handicapped. These several disciplines and interests, each with a responsibility within the total framework, contribute to the full rehabilitative process of the hearing impaired. Only through combined, interdependent efforts of the government agencies, medical, audiological and commercial fields can the impaired effectively be returned to the world of hearing (1) (2).

In the interests of furthering and enhancing service to hearing handicapped persons, the Hearing Aid Industry Conference has evaluated various methods of providing hearing aid help to beneficiaries of governmental programs. (3) The Conference now recommends a plan which affords the greatest potential for social and occupational rehabilitation of these many handicapped Americans at the lowest cost to participating agencies in all levels of government.

The Hearing Aid Industry Conference believes that it is in the best interest of the hard-of-hearing person, the government agency responsible for his welfare, the taxpayer, and the general public that all hearing aids procured with government funds should be fitted, sold, delivered, serviced and maintained by properly qualified local hearing aid dealers. (4), (5)

The following paragraphs elucidate this statement :

Hearing aids are prosthetic devices which are often essential to the personal and social well-being of handicapped persons. (6) As such, they are often procured with funds disbursed by various local, state and federal government agencies responsible for the welfare of eligible recipients. The hearing handicapped person and his overall welfare are and should be the paramount consideration of all concerned.

According to government studies, congressional hearings, independent research and the experiences of professional persons, hearing aid manufacturers and dealers, most of the hearing handicapped will not voluntarily seek help. (7) They must generally be sought out and identified by efforts of the hearing aid dealer. (8) In May, 1968, the Rehabilitation Services Administration of the U.S. Department of Health, Education and Welfare recognized this fact in a joint statement of principles of cooperation with the National Hearing Aid Society, the hearing aid dealer organization, to provide improved vocational rehabilitation services to more hard-of-hearing people by requesting dealers to identify and refer such people to the appropriate government agency. (9)

The hearing impaired individual should have easy access to a knowledgeable and trained person locally, who can provide convenient advice and counsel on hearing aid problems to insure that maximum benefits are received from the aid. (10)

There are some 5,000 hearing aid dealerships in the United States and Canada which maintain permanent, fully staffed offices. (11) In addition, many dealers operate "service center" programs under which they staff a specific location in outlying areas on the same day each month and invite hearing aid users to come in for service to their instruments or for help with respect to any hearing aid problems. (12) Dealers also employ some 10,000 trained consultants to give continuing advice and support to hearing aid users. (13) No other group working in the field of hearing rehabilitation can muster anything approaching this kind of convenience and availability for fitting and after-fitting service at the local level. (14)

Hearing aid dealers are geographically available in small towns and rural areas as well as in large urban centers. (15) They are, therefore, in a position to serve the hard-of-hearing without requiring the handicapped person to travel long distances to government facilities or clinics which are generally located in urban centers. Further, dealers are more readily available from the standpoint of promptness of service. Many clinics are crowded and overburdened,

requiring weeks or months of waiting by the hard-of-hearing person. (16), (17), (18), (27)

The hearing aid dealer, over the last ten years, has vastly improved his technical capabilities through educational efforts of the National Hearing Aid Society, the Hearing Aid Industry Conference, individual manufacturers, and programs at institutions of higher education. (4), (19) Today, states which contain more than half the population of the country and more than half the dealers have laws or regulations which require the dealer to demonstrate his capabilities by qualifying for and retaining a license. (20)

Governmental agencies responsible for the welfare of hearing impaired persons will be best served by working with and through hearing aid dealers. (21) The sale or delivery of the aid to the recipient is much more than the provision of a package of components. (10), (22) The mere provision of a fitting procedure and delivery of a hearing instrument omits an important part of the full responsibility to the hard-of-hearing consumer. The hearing aid dealer traditionally provides from 10 to 30 hours of after-fitting service, often spanning a year or more. (23) Without full utilization of the dealer in the channel of distribution the government agency must accept the important and trying responsibility for the continuing after-fitting consumer satisfaction in a problem-prone field. (24) This would require the development of large staffs of people. (25) Administrative problems would multiply and costs would rise, (26) yet fewer handicapped persons would be aided. (8), (27)

For a government agency to buy hearing aids on a lowest-bid-price basis, from whatever source, is not in the best interest of the recipient. (28) In states where this has been done, the hard-of-hearing person is short-changed the continuing after-sale service which often makes the difference between satisfactory rehabilitation with a hearing aid and a discouraged and unhappy hearing aid user. (29)

Where a hearing aid is purchased through a dealer at a fair and reasonable price the government agency and the recipient will be assured not only of a proper fitting, but also of proper performance of the instrument, proper use of the aid and continuing after-fitting service to help in the satisfactory rehabilitation. (30)

The general public interest will be served by the assurance that the social and occupational rehabilitation of the hearing impaired is proceeding at the fastest possible rate and at minimum cost. Distribution through the present dealer system will be more economical to the government and the taxpayer. (31)

The hearing aid dealer delivery system has demonstrated its effectiveness as a progressive member of the hearing health team, providing help in identification of the hearing impaired, fitting the aid and serving the after-fitting requirements. (30), (32)

Any system of distribution which fails to utilize fully the capabilities and experience of the existing hearing aid dealer facility would cause far fewer of these handicapped persons to be identified and provided with the help they need.

RECOMMENDATION

In the interests of furthering an enhancing service to the hearing handicapped, the Hearing Aid Industry Conference recommends that all government agencies involved in the rehabilitation of hearing impaired persons, and/or the disbursement of funds for the procurement of hearing aids, follow the general pattern already established in a number of states, which utilizes the local hearing aid dealers as the channel of distribution and results in the purchase of the proper hearing aid at a fair price which includes after-fitting service. This system is already functioning with a high degree of success.

Essential elements of the system are:

1. Locating and identifying hearing impaired individuals for assistance from Government funds

Some hearing impaired persons may become aware of their problem and contact a medical doctor, an audiologist, a clinic or a hearing aid dealer. More probably, they will be identified as a result of answering an advertisement or by the activity of a hearing aid dealer or consultant.

2. Certification of hearing impairment

When a hearing impaired person has been identified and is a candidate for public assistance, the dealer works with the proper agency to qualify the in-

dividual as a benefit recipient. The individual then is referred to a medical doctor for examination and determination of the proper action.

The physician may refer the hearing impaired person to a medical or audiological specialist, or he may direct the person to a hearing aid dealer of the recipient's choice, for fitting with the appropriate hearing aid.

3. *Fitting and delivery of the hearing aid*

The hearing aid dealer selects and fits a hearing aid, following proper procedures, and providing all the services which are available to "private" individual customers. This includes taking ear impressions, ordering earmolds, fulfilling warranty obligations, and providing after-fitting services. The dealer makes delivery to the user in the usual manner.

4. *Verification of delivery and effectiveness*

After the hearing impaired person has received his hearing aid, he returns to the physician who originally certified his need for the aid. After verifying the delivery, and user benefit, the medical doctor approves the hearing aid dealer's claim for payment.

5. *Payment for hearing aids and services*

The hearing aid dealer submits his claim for payment to the appropriate agency. Payment for the hearing aid is made by the agency to the hearing aid dealer.

It is the position of the Hearing Aid Industry Conference that a system of distribution based on the above outline, offers the most efficient approach to help achieve rehabilitation of the greatest number of hearing impaired persons eligible for public assistance.

It will provide greater convenience and satisfaction to the hard-of-hearing recipient and will result in more complete service. It will preserve the dignity of the recipient by giving him the freedom of choice of dealing with a qualified person in his own locality, with the added safeguard of agency supervision. It will be less of a burden on the government and the taxpayer. And it will leave the professionally trained people in the clinics more time to deal with the complex problems which require and deserve their attention, and relieve them of duties which can be handled by qualified local hearing aid dealers.

APPENDIX A

NOTE.—Indented portions are direct quotations. Portions not indented are paraphrased, describe circumstances of the quotation, or are offered as background or interpretive information.

REFERENCES

- 1.—Aram Glorig, M.D., Executive Director of the Callier Center, Dallas, Tex., and Chairman of the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology, "Hearing Loss, Hearing Aids, and the Elderly", *Hearings of Subcommittee on Consumer Interests of the Elderly of the Special Committee on Aging, U.S. Senate, Washington, D.C., July 18-19, 1968*, pp. 159-60.

During my 20-odd years of experience in otoaudiology, it has been quite evident that a team approach to the problem is essential. It is obvious that it would be to the best interest of the patient to be seen by an M.D. (preferably an otolaryngologist) prior to any attempts at wearing a hearing aid. It is also just as obvious that there are not enough specialists to do this for everyone. Therefore, some sort of criteria should be evolved to act as a guide to the initial examiner, whether he be a medical man in general practice, an audiologist who operates where there is no otolaryngologist or M.D. available, or a hearing aid dealer.

In an attempt to bring the principal groups together—American Academy of Ophthalmology and Otolaryngology, American Speech and Hearing Association, National Association of Hearing and Speech Agencies, National Hearing Aid Society (dealers' group), and the Hearing Aid Industry Conference (manufacturers' group), I proposed a so-called "Five-Man Committee." We met several times, and the name was changed to the "Inter-Society Committee on Hearing Conservation." The purpose of this group is to provide an opportunity for unofficial talks, where each society can unofficially express its opinions and criticisms through an appointed representative.

2.—Tom Coleman, Executive Director, National Association of Hearing and Speech Agencies, *Hearings*, p. 152.

You know, historically the cooperative approach of the professions, the voluntary agencies, the governmental agencies, and the industry involved in specific service activities in this country have been one of our great strengths. This combination of getting services, equipment, pharmaceuticals, prosthetics, and what have you to people via the collaboration of private and public resources has worked well over the years. I think this way of life should continue.

3.—Studies included former Veterans Administration procurement programs; present Veterans Administration procurement programs; procurement programs of various state and local health and welfare agencies; 1971 Health, Education and Welfare sponsored Institute on Services for the Hearing Handicapped child at the University of Maryland; procurement and delivery programs of various foreign nations; procedures in private and public clinics and in hearing and speech centers.

4.—The terminology "properly qualified" according to Raymond Z. Rich, President, National Hearing Aid Society, would include possession of a license in a state requiring written and practical examinations and other qualifying standards (list of states regulating hearing aid dealers: see note 20B), or certification by the National Hearing Aid Society. NHAS certification requirements: (*Hearings*, p. 180).

One of our most important activities is our certification program whereby hearing aid dealers and consultants who meet the strict standards of experience, training, competence, and character become certified. It is mandatory for each applicant to successfully complete the extensive NHAS basic course and subsequently pass the final examination.

In addition to passing the course and examination, the applicant for certification must submit an extensive application which must receive the approval of the National Board of Certification. This application requires several endorsements, including at least one by a physician, preferably an otologist; proof of experience with supervision in the fitting of hearing aids for a period of not less than 2 years; and that the applicant subscribes to our code of ethics. Also, each applicant is investigated through members, references, better business bureaus, and chambers of commerce.

5.—Raymond Z. Rich, President, National Hearing Aid Society, *Hearings*, p. 180.

Now the person who brings the benefits of the hearing aid to the public is the dealer. His is the task to select, fit, sell, and service this instrument and provide postfitting care and counselling service. I can hardly stress these last two points because seemingly as I have learned here today and learn every day everywhere this is the least known, the least appreciated fact, especially by those who themselves are not hard of hearing and do not know about the extent of the work.

6a—Edith L. R. Corliss, *Hearing Aids*, U.S. Dept. of Commerce, National Bureau of Standards Monograph 117, October, 1970, p. 1.

Loss of hearing creates a serious problem. For most of us, the spoken word is our most important channel of communication. Even slight losses can interfere with participation in public affairs, and it does not take a very high degree of loss to hamper a person in conversation within a group.

If you have difficulty in hearing speech in a group conversation, you may find that wearing a hearing aid makes it easier for you to carry on your daily affairs. Even if you are one of the many people who have difficulty only with faint speech, you may be considered as a "marginal" hearing aid user. Your hearing loss may hinder you only in public places—at lectures, meetings and the theater. A hearing aid would still be of decided assistance.

6b—Hon. Frank J. Brasco, U.S. House of Representatives (New York), *Congressional Record*, Sept. 9, 1968.

A loss of hearing can have a number of serious side effects. The individual who is hard of hearing may sustain personality damage; his mental attitude and poise can be adversely affected. He may discover also that his ability to perform on a job will be diminished, and that family relationships can suffer greatly.

6c—Lynwood Hark Rhodes, "What You Should Know About Hearing Aids," *Today's Health*, Aug. 1969.

p. 40—No one likes to admit to others, much less to himself, that he is hard of hearing. It's a common hang-up, mostly psychological, but one which more people sympathize with than you may suppose.

p. 63—To get an education, to earn a living, to be informed, amused, diverted—and even to keep from getting run over in the street—we depend upon the sense of hearing.

7a—Lynwood Mark Rhodes, *Today's Health*, Aug. 1969.

Yet, statistics also show that a surprisingly large number of people persist in tolerating their handicap, even though it likely could be lessened by the use of a hearing aid or corrected by medical or surgical means. Sixty percent of the patients at a speech and hearing clinic confessed recently that they had never been to a physician about their hearing or mentioned their hearing difficulty to their doctors. Those who had were in no particular hurry. The average person waited five years before seeking help.

7b—John J. Kojis, President, MAICO Hearing Instruments, Immediate Past President, Hearing Aid Industry Conference, *Hearings*, p. 69.

It has been established that the typical user of a hearing aid suffers a significant loss for about 5 years before taking steps to get a hearing aid. Some people suffer with a substantial hearing loss for three or four decades despite the fact that they are only marginally in touch with society because of it.

8a—John J. Kojis, *Hearings*, p. 70.

We have discovered an unmistakable truth in our field—that most people who are becoming deaf will not initiate a program to get help—to get amplification for their residual hearing. The initiative in the great majority of cases must come from our industry—the people whose products can bring many of these hard-of-hearing people back into a normal world of sound, productive work, and social participation.

8b—Raymond Z. Rich, *Hearings*, p. 178.

It is true that the hearing aid dealer in the great majority of cases has been the motivating force in encouraging these people to avail themselves of the benefits of amplification through hearing aids.

8c—John J. Kojis, *Hearings*, p. 70.

p. 92—No. 1, as an industry we have expended more in advertising probably than mass distribution industries on a percentage basis.

We have put a lot of money into trying to develop this market because it is a difficult one to develop. If the Government could give us any help, it would be to get these people to look for hearing aids and get them out to see their hearing aid dealers to see what can be done for them.

8d—Kenneth Johnson, Executive Secretary, American Speech and Hearing Association, *Hearings*, p. 142.

Judging from a recent survey of 4,000,000 deaf and hard-of-hearing people an extremely small percentage of the hearing handicapped sought the assistance of a physician or an audiologist. Almost 60% went directly to a hearing aid dealer.

9—Joint Statement of Principles of Cooperation, Rehabilitation Services Administration and National Hearing Aid Society, May 15, 1968, *Hearings*, p. 285.

10—Raymond Z. Rich, *Hearings*, pp. 179–180.

In answer to your second question, sir, about availability of services, they are readily available to all those whose hearing loss is not subject to medical or surgical reversal, to those who wish to avail themselves this type of correction, compensation. Through the phenomenal progress in hearing aid design and production, dealers can provide today a very large selection of hearing aids, different types to accommodate all degrees and types of loss which can be benefited. Seldom does the hearing aid industry, whose representatives you heard, receive credit for their energies, their devotion and engineering production skills for that progress which is unparalleled in the world.

The hearing aid dealer plays a prime role in helping his client and on his skills will hinge the success or failure of a novice user. His work does not end with the sale of the product; for years to come he will see his client. During those years he will supply batteries, cords, tubing, mechanical adjustments, and repairs. Most important, he will provide personal reinforcement in this undertaking, a very important factor, and just commonsense and understanding of the problems of those who are hard of hearing.

11—Aram Glorig, M.D., *Hearings*, p. 156.

Now when you ask the National Hearing Aid Society how many dealers there are in the country, it rounds out to about 5,000 dealers who are considered to be contributing in a significant way to the problem of selling hearing aids.

12a—Raymond Z. Rich, *Hearings*, p. 180.

Many dealers have to travel, and do travel, to homes and communities where no such services are available to people who just could not come to their offices.

| Region | Percent U.S. population ¹ | Percent total hearing aid dealers ² | Percent total NHAS membership ³ |
|-------------------|--------------------------------------|--|--|
| Northeastern..... | 30 | 30 | 20 |
| Southeastern..... | 16 | 12 | 12 |
| Midwestern..... | 17 | 18 | 17 |
| Northwestern..... | 12 | 16 | 18 |
| Southwestern..... | 10 | 9 | 10 |
| Pacific..... | 15 | 15 | 21 |

¹ Current population reports, series P-25, estimated for 1966, U.S. Bureau of the Census.

² Current Audexcel NHAS Journal circulation to hearing aid dealers, July 1968.

16—*Hearing Aids*, U.S. Dept. of Commerce, Oct., 1970, pp. 11-24.

17—National Association of Hearing and Speech Agencies, Washington, D.C., "A Challenge for NAHSA 1968," Appendix to Minutes of Board of Directors Meeting, Jan. 21-22, 1969, Chicago, Ill.

We have an increasing population without a proportionate increase in professionals within service fields. If any of the estimates of incidence of hearing and speech handicaps in the population are reasonable, we will not have available in the foreseeable future enough audiologists, speech pathologists or teachers of the deaf of professional status to take care of the case-loads. Immediate consideration must be given to using other professional disciplines and supportive personnel for the delivery of service to people.

18—Hearing and Speech News, (Journal of the National Association of Hearing and Speech Agencies), July/August, 1970, p. 3.

In the hearing and speech field, it is a tragic fact that due to a vast patient overload and an extremely limited number of practitioners, many clients are receiving no services whatsoever.

Within the United States, an estimated 10 to 20 million persons need assistance with hearing, speech and language difficulties. Yet there are only (approximately) 7,800 clinically certified speech pathologists and 1,567 certified audiologists to handle teaching, research and patient services. There is, moreover, no indication within college and university programs that there will be a favorable increase in professional/patient ratios in the near future.

19—Raymond Z. Rich, *Hearings*, p. 181.

The National Hearing Aid Society in order to advance and improve the hearing aid dealer's technical capabilities contributes these educational opportunities: The quarterly official journal *Audexcel* with contributions from researchers, teachers, engineers and hearing aid dealers; a comprehensive certification course which includes instruction in acoustics, the human ear and hearing process, types of hearing loss audiometry, and selection and fitting of hearing aids; annual, regional meetings with educational sessions, and courses at local colleges sponsored by state and local dealer associations.

20a—Aram Glorig, M.D., *Hearings*, pp. 159-160.

The first definitive task handled by the committee (Intersociety Committee on Hearing Conservation) was the problem of hearing aid dealer licensing. After two or three years' discussion (during which time several states passed licensing legislation), a so-called model bill was prepared and approved by the medical society, the hearing aid dealers and the manufacturers. The non-medical professional organizations have not, as yet, accepted the model bill for various reasons, which are not strictly related to the provisions of the bill.

20b—States which have enacted regulatory laws requiring demonstration of applicant dealers' competence and reliability: Arizona, Arkansas, California, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Maryland,

Michigan, Montana, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Oregon, South Dakota, South Carolina, Tennessee, Texas, Virginia, Wisconsin.

21a—Tom Coleman, *Hearings*, p. 151.

This leads into the role of the hearing aid dealer. Now, the best statistics I can find indicate that the dealer is providing more service to people—and I am not qualified to judge good, bad or otherwise—but that they are serving more people with hearing problems than any other group in the country. There is little doubt in mind that they will continue to do this for a long time.

Some have said that one day perhaps the hearing aid dealer may take the same role that the optician does in the eye field. Actually many communities today have only hearing aid dealers available to serve those with hearing problems and are completely void of medical hearing specialists or audiologists. Therefore, it seems that we must rely on the dealer in some ways as a provider of services—if you will permit me—as one of the technical, non-professional classes of individuals supporting the provision of services to people.

Thus, it seems only reasonable that in recognition of this—that he is serving people—we have an obligation to assist this individual by upgrading his knowledge, his education, and his ability to provide good services and continue using him as a provider of service.

21b—Lynwood Mark Rhodes, *Today's Health*, Aug., 1960, p. 5.

This is why the choice of a dealer can often be as important as choosing the right hearing aid. More than a salesman, he generally has the final responsibility for properly fitting the hearing aid, and must also offer counsel, understanding, and technical assistance if the wearer is to derive maximum benefit from his purchase.

22—S. F. Lybarger, Executive Vice President, Radioear Corp., and President, Hearing Aid Industry Conference, *Hearings*, p. 78.

Of the approximately 400,000 people who buy hearing aids each year, more than 95 percent of them enjoy the benefits of this hearing help through the efforts of a hearing aid dealer.

The hearing aid dealer has effectively persuaded the reluctant person who can truly benefit from the use of a hearing aid to take the action of buying one. The dealer has, through experience and education and with the manufacturer's capable assistance, fitted the hearing aid to provide a type of sound amplification that gives significant hearing help. He has made an earmold to comfortably fit into the user's ear to convey sound to it. He has carefully and repeatedly instructed the user in the operation of the aid. He has provided service facilities and know-how to keep the hearing aid "on the air" and often travels long distances to render service, particularly where the elderly are concerned. He provides the help, encouragement, and guidance that a new hearing aid user needs to bring him back to the world of sound. In short, the hearing aid dealer is the key to hearing aid success, not only for the elderly, but for all users . . . the agency through which successful handling of the hearing aid problems of the elderly are being and will continue to be solved.

23—California Senate Fact-Finding Committee on Public Health and Safety. Hearing: "Hearing Aid Legislation." Los Angeles, Calif., Jan. 21, 1960.

24a—Edith L. R. Corliss, *Hearing Aids*, U.S. Dept. of Commerce, October, 1970, p. 1.

A person in need of a hearing aid has a special problem for he himself must decide which instrument gives him the greatest benefit. Hearing aids cannot at present be fitted to individual hearing losses with the same exactitude as eye glasses can be fitted to the refractive imperfections of the eye. We know that one reason for this lack of precision is the variety of factors causing hearing loss. A loss in hearing can occur either because the cochlear nerve has become insensitive or because the sound vibrations are conducted inefficiently from the outer to the inner ear. Each of these conditions produces a hearing loss that behaves in a distinctive manner. Loss of hearing is often due to a combination of these causes in various proportions; it is not easy to measure the proportions.

24b—Many mechanical and human problems that develop with hearing aids are never corrected by the dealer. The hearing aid wearer should be aware of problems that do arise, recognize the limitation of the hearing aid and utilize the convenient, economical help of the hearing aid dealer.

24c—Edith L. R. Corliss, *Hearing Aids*, Oct., 1970, U.S. Dept. of Commerce.

An ear mold that fits properly is necessary for best performance from a hearing aid. The ear mold provides a speaking tube leading to the ear drum of the user from the earphone. If it is too loose, sound energy escaping may be sufficient to reach the microphone of the hearing aid. When this happens, the hearing aid will "squeal" on loud sounds, and may even squeal continuously. A hearing aid may, in fact, squeal at a frequency inaudible to the user, and he may be aware of the occurrence only because of high distortion or reduced gain.

Blurring of loud sounds may also be noticed in a hearing aid in which some part is wearing out, or when the batteries become weak. If a hearing aid that has not previously been troublesome on loud sounds begins to be so and the insertion of a new battery does not remedy the condition, the hearing aid may be in need of repair.

24d—Elizabeth Dodds and Earl Harford, Northwestern University, *Helpful Hearing Aid Hints*, 1970, pp. 8-10.

Common complaints of hearing aid users include internal feedback, continued inefficiency of hearing, wind whistle, and pressure or fullness in the ear. These difficulties can often be remedied or at least should be investigated by the hearing aid dealer.

24e—Edith L. R. Corliss, *Hearing Aids*, Dept. of Commerce, Oct. 1970, p. 8.

It has been stressed previously that the after-fitting service the dealer provides is an important aspect for the happy hearing aid user. Many of the problems hearing aid wearers experience can be corrected or explained by the dealer.

After the hearing aid is selected, there is often the problem of indoctrination and of learning to make the best use of the hearing aid.

25—Tom Coleman, *Hearings*, p. 149.

Certainly, from experiences of the agencies out in the field, we are aware that our biggest problem in getting services to people is the shortage of personnel.

26—Average hearing aid sale in private sector is approximately \$300; cost of the Veterans Administration hearing aid program, per veteran supplied with hearing aid, is \$800-\$2,100 of public funds, according to unofficial estimates that have been brought to the attention of the Hearing Aid Industry Conference.

27—J. Dennis Ortiz, Executive Director, Michigan Association for Better Hearing and Speech, *Hearing and Speech News*, May-June, 1971, p. 19.

Hearing and speech centers exist only in some larger communities and possess widely varying levels of effectiveness and uneven geographical distribution. Many thousands of people with communication problems are too far away from the smallest service center, and even further from the more technical assistance they may need. We all recognize that no one profession or agency can provide all necessary services, and unless there is community awareness which results in special provisions for a multi-disciplinary approach to the management of human communication disorders, many omissions in service and errors will result.

28a—Whether intended or not, an outright purchase or one-time fitting and dispensing of an aid is not proper, productive or in any total sense economical. In the commercial hearing aid field a large part of the hearing aid dealers' retail price is for continuing services after the initial fitting and service of the aid. Counselling, encouragement and rehabilitative advice on the use of the hearing aid very often are the determining factors in whether an individual will become a successful hearing aid user, and thus restored as an active, productive member of society or a hearing aid failure—with his hearing aid in the dresser drawer and his realistic prospects of ever benefiting from hearing help sharply reduced. In most communities only the hearing aid dealer provides this continuing service, and it is included in the purchase price of the hearing aid. In terms of hours devoted to these after-sale services, estimates range from approximately 10 to 30 hours.

28b—S. F. Lybarger, *Hearings*, p. 73.

We (the hearing aid industry) thus have taken inventories and service locations to the people who need help, wherever they are. In most towns of any size at all the consumer has a choice of at least several different dealers and brands. Then, to receive this total service, he may select from these trained specialists in fitting and selling hearing aids, and, if he wishes, have them come right to his home for fitting and service. And, I might add, this

home service is an absolute must in many instances among aged customers, and this is an important aspect of our responsibility. These dealers provide the vital and costly after-sale guidance and service that make the hearing aid a successful device for the user, a service provided by no one else.

We are proud of the development of this vast distribution system, Mr. Chairman. We believe it is a very substantial national resource in the public and consumer interest and for the total American medical and paramedical spectrum. With continuing refinement and intensification of our coverage and marketing efforts, this resource will become an even stronger base for continuing and expanding services to the hard of hearing of all ages.

28c—Edith L. R. Corliss, *Hearing Aids*, p. 8.

After the hearing aid is selected, there is often the problem of indoctrination and of learning to make the best use of the hearing aid. This problem may be severe if the user has waited so long before purchasing a hearing aid that he has begun to forget what voices and noises really sound like and how noisy the world is.

28d—Lynwood Mark Rhodes, *Today's Health*, Aug., 1969, p. 61.

Replacements depend upon economic considerations, of course, but a hearing aid user should keep in touch with his dealer and take advantage of important improvements. Reliable dealers furnish this assistance free of charge. It's all part of the "hand-holding" that goes along with the purchase of a hearing aid.

29—In public programs in which hearing aids are purchased on a strict low-bid basis and specifically eliminate utilization of the vital services of the hearing aid dealer, the hard-of-hearing public beneficiary and the taxpayers at large suffer inconvenience, major hidden expenses, poor post-fitting services and high rate of unsuccessful use, in the judgment of the Hearing Aid Industry Conference.

30a—The type of hearing defect, the hearing aid most beneficial to the individual, warranty commitments, manufacturer's cost for the sophisticated, durable, small instrument and the hearing aid dealer's continuing assistance, counseling and maintenance and minor repair for the life of the aid are factors in the cost of the aid.

30b—Market Facts, Inc., Apr., 1971, p. 13.

Only 7% of the total number of hearing aid users felt that aids were too expensive. Of respondents who consulted a dealer only, and did not have medical or clinical advice, 6% felt that aids were too expensive.

30c—Lynwood Mark Rhodes, *Today's Health*, Aug., 1969, p. 5.

How much does a hearing aid cost? There are aids priced at less than \$100 and others that cost almost \$400. The patient with a moderate loss, whose sole desire is better hearing, may well discover that the less expensive of the good aids are as acceptable as the more expensive ones—particularly when it's realized that the actual cost of a hearing aid always includes service and such intangibles as dealer overhead.

30d—The technology manufacturing cost is considerable. Most personnel time required is of a high order of training and skill. The assembly work of hearing aids requires technical preparation, special tools and sophisticated testing equipment as well as specially trained and highly skilled technicians. Much of the assembly work on each hearing aid is done by hand under microscopic or otherwise magnified conditions.

30e—*The Hearing Aid Industry, A Survey of the Hard-of-Hearing*, Market Facts, Inc., Apr., 1971, p. 9.

LEVEL OF SATISFACTION—BY PERSON CONSULTED

| | This percent of the respondents who consulted | | |
|--|---|-------------|---------------------------|
| | Total | Dealer only | Dealer and M.D. or clinic |
| Said they were either very satisfied or somewhat satisfied with— | | | |
| The service they received while being tested..... | 94 | 95 | 91 |
| The service they received at the time of purchase..... | 91 | 90 | 86 |
| The service since the fitting of their present hearing aid (includes those who have not required service)..... | 87 | 86 | 94 |

VITAL AND HEALTH STATISTICS—DATA FROM THE NATIONAL HEALTH SURVEY
 CHARACTERISTICS OF PERSONS WITH IMPAIRED HEARING, UNITED STATES, JULY 1962—
 JUNE 1963

Demographic and other characteristics of persons with a binaural hearing impairment, classified according to amount of hearing loss.

DEGREE OF SATISFACTION WITH THE AID

The degree of satisfaction with the aid as reported by persons who are presently using a hearing aid is shown in table 13. Former users of a hearing aid were not asked to report the degree of satisfaction with their aid nor were they asked why they had stopped using it. However, it seems reasonable to assume that most of these persons stopped using their aid because it did not give them enough satisfaction. (Inability or failure to provide proper maintenance for the aid could of course result, ultimately, in dissatisfaction with the aid.) This assumption is supported by data which show that approximately 58 percent of former hearing aid users stopped wearing the aid because it caused discomfort.

Estimates shown in table G clearly indicate that the proportion of hearing aid users who expressed satisfaction with their aids increased as their hearing loss increased and, conversely, dissatisfaction with the aid increased as the ability to hear increased. This relationship of hearing aid satisfaction to hearing ability was the same for both men and women. However, females in general appeared more satisfied with their aids than did males. This is especially true for the two groups with the better hearing ability. The greater satisfaction of females with their hearing aids might reflect their use in less demanding situations, i.e., the external noise at home usually is less than that encountered at a place of business.

TABLE G.—PERCENT DISTRIBUTION OF PERSONS WITH A BINAURAL HEARING LOSS WHO HAVE EVER USED A HEARING AID, BY DEGREE OF SATISFACTION WITH THE AID ACCORDING TO SPEECH COMPREHENSION GROUP AND SEX: UNITED STATES, JULY 1962-JUNE 1963

| | Persons who have ever used an aid (percent distribution) | | | |
|---|--|---|--|---|
| | Total | Cannot hear and understand spoken words | Can hear and understand a few spoken words | Can hear and understand most spoken words |
| Sex and degree of satisfaction with aid: | | | | |
| All persons..... | 100.0 | 100.0 | 100.0 | 100.0 |
| Satisfied..... | 61.4 | 68.2 | 60.9 | 55.6 |
| Not satisfied and not using aid..... | 36.6 | 30.1 | 38.1 | 42.1 |
| Unknown..... | (2.1) | (1.7) | (1.4) | (2.3) |
| Male..... | 100.0 | 100.0 | 100.0 | 100.0 |
| Satisfied..... | 57.9 | 67.7 | 56.0 | 52.6 |
| Not satisfied and not using aid..... | 40.3 | 31.0 | 42.5 | 46.7 |
| Unknown..... | (1.8) | (1.4) | (2.2) | (1.1) |
| Female..... | 100.0 | 100.0 | 100.0 | 100.0 |
| Satisfied..... | 65.1 | 68.2 | 65.0 | 60.6 |
| Not satisfied and not using aid..... | 32.5 | 29.5 | 34.4 | 34.7 |
| Unknown..... | (2.4) | (2.3) | (0.6) | (4.1) |

AMOUNT OF USE OF HEARING AID

Respondents who reported that they were currently using their aids were asked to indicate the extent the aids were used at various places or times; i.e., at work home, school, church, the movies, and while listening to radio and television. (See question 16(b), supplementary questionnaire, Appendix IV.) The responses to these questions were pooled and classified according to the terms used in table 14—constant, moderate, and negligible. (See Appendix II—Definition of Terms—for a complete description of these terms.)

It may be seen from table 14 that about 57 percent of persons currently using a hearing aid indicated constant use of their device and approximately another 27

percent indicated moderate use, while only about 6 percent indicated a negligible amount of usage. About 11 percent of the hearing aid users did not reply to the question. In the earlier Health Interview Survey data on hearing aids, July 1958-June 1959, 65 percent of the current users of aids used the aid all or most of the time, while 35 percent reported occasional use.

The proportion reporting negligible use of the hearing aid did not differ a great deal by speech comprehension group.

TABLE H.—PERCENT DISTRIBUTION OF PERSONS WITH BINAURAL HEARING LOSS CURRENTLY USING A HEARING AID, BY DEGREE OF SATISFACTION ACCORDING TO AMOUNT OF USE: UNITED STATES, JULY 1962-JUNE 1963

| Amount of use | Degree of satisfaction | | | |
|---------------------|------------------------|-----------|---------------|---------|
| | Total | Satisfied | Not satisfied | Unknown |
| All persons..... | 100 | 84.6 | 12.6 | (2.8) |
| Constant use..... | 100 | 93.0 | (6.0) | (1.0) |
| Moderate use..... | 100 | 76.9 | (18.4) | (4.3) |
| Negligible use..... | 100 | (62.7) | (35.3) | (2.0) |
| Unknown..... | 100 | 70.5 | (21.1) | (8.4) |

The amount of satisfaction with the hearing aid and the amount of use of the hearing aid are cross-classified in table H. As might be expected, those who reported constant use of the aid also expressed satisfaction with the aid more often than did the less frequent users of an aid. Among those who reported constant use 93 percent reported satisfaction with the aid, compared with 77 percent of the moderate users and 63 percent of the "negligible" users.

STATEMENT OF DEWITT H. ROBERTS, EXECUTIVE SECRETARY, THE NATIONAL ASSOCIATION OF LIFE COMPANIES

The National Association of Life Companies is a trade association with member companies in approximately forty states, which member companies have approximately 100,000 shareholders among the stock companies, more than 55,000 employees, and more than 20 million policyholders and certificate holders. The officers of the Association are W. O. Crawford, Southern United Life, Montgomery, Alabama, President; DeWitt H. Roberts, Executive Secretary; Devereaux F. McClatchey, Esquire, General Counsel; and Peyton Ford, Esquire, Washington Counsel.

The Association recognizes that a considerable, and perhaps serious, problem exists in the field of health care in the United States. The insurance industry is painfully aware of the rising costs of medical care, which now consume more than 7% of the gross national product; almost all life insurance companies with significant amounts of group, accident and health coverage had substantial direct losses in that field during 1969 and 1970. Likewise, the individual health insurance policies were affected, because the rising costs of medical care resulted in the coverage in existing contracts being inadequate, resulting in dissatisfaction on the part of many policyholders and the creation of serious problems for the companies.

If Congress contemplates abolishing Medicare and Medicaid, and intends to create a wholly new, all embracing program for the delivery of and payment for health care, this Association is unable to offer constructive comment in the absence of seriously intended legislation of this type. The comments here made are predicated upon the assumption that the Congress will abolish neither Medicare nor Medicaid, though perhaps seeking to improve their present functioning and that the legislation developed will be somewhat less drastic and disruptive of the existing system. There are three pending measures of different types, therefore, to which this comment will be directed.

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It appears to us that these measures, or any similar system, would entail heavy additional accounting expense to small employers, completely destroy the carefully developed system of state regulation of insurance companies and impose

thereby extraordinarily wasteful additional costs to such carriers, and do little except create a new Federal bureaucracy. It would do little toward making adequate health care more available and would probably substantially increase its overall cost.

These proposals do not develop a new system, nor do they cure the defects of and reduce the costs of the existing system.

H.R. 4349

This measure is well balanced and, while it probably would not reduce the overall costs of providing health services, it probably also would not increase them. Its greatest weakness lies in the creation of "administering carrier". We feel that such a carrier should in all instances be a domestic commercial insurance company, stock or mutual, either life or casualty, and, if life, a legal reserve company within the definitions set out in the state's insurance code. The selection of any other type of administering carrier could open the door to conflict of interests or failure of the State to have adequate control over its operations.

S. 1376

Obviously less costly than any of the other systems proposed, and meeting the most pressing problems through relief to those sustaining catastrophic illness or injury, a plan of this kind would be less costly to administer and most socially productive.

While it is a cliché to say that only the rich and the very poor can afford adequate health care, the cliché has the merit of verity. All the other proposals, even including H.R. 4349, can be made to work, if at all, only through additional heavy costs to the middle income and lower income group of Americans without any corresponding advantages to them.

It is our strong feeling that health catastrophe insurance should be financed from the general revenues and not through a lien upon the earnings of the gainfully employed and the self-employed. The amount involved probably would not exceed \$2.8 billion in additional public funds and it would do much to alleviate present emergencies.

The eventual solution of the problem of delivery of adequate services at fair prices in the field of health lies altogether elsewhere than in the field of health insurance, whether by Government coverage or by private enterprise. One system might be more equitable than another in paying the total bill, but the system of payment can have no effect upon the costs, which must be reached in other ways.

STATEMENT OF GEORGE P. TOBLER, PRESIDENT, NATIONAL ASSOCIATION
OF MUTUAL INSURANCE AGENTS

Mr. Chairman and members of the Committee, I am George P. Tobler of Smithtown, New York. I am the owner of the George Tobler Insurance Agency in Smithtown. I am also the current President of the National Association of Mutual Insurance Agents, an organization of more than 18,500 independent property and casualty insurance agents with members in nearly all fifty states, and with headquarters in Washington, D.C.

Among the many forms of insurance protection which our members sell to the insuring public is accident and health insurance. While generally speaking, accident and health insurance is not the primary insurance product we sell, it does constitute a significant part of our portfolio. Thus, independent insurance agents are vitally interested in the matter of national health insurance currently before your Committee.

For at least 35 years now, the debate has raged over a national health insurance program for this country. Our Association feels the time has come for such a program. The key question, however, is what form it should take.

The National Association of Mutual Insurance Agents firmly believes the present health care system in our nation can and should be improved. As agents who daily deal with the insuring public, we are keenly aware of the shortcomings in our present system. On the other hand, our Association does not believe that we should throw aside our present system entirely—or even substantially—in favor of an untried, bureaucratic, and what we believe will be an immensely expensive system.

After careful study and consideration of all the proposals before this Committee, our Association urges the enactment of "The National Healthcare Act of 1971" (H.R. 4349). This proposal is based on the broad principles that every American should have access to quality health care regardless of income; maximum use should be made of the private sector and judicious use of government funds; comprehensive health insurance coverage should be available to all people at the earliest possible date; and the organization, delivery and financing of health care should be improved.

However, our endorsement of this measure is contingent upon several very important conditions. We feel that maximum coverage for poor and near-poor people must be provided immediately and without cost to them; that better controls over costs for both hospitals and doctors must be developed; that small businessmen must be assisted financially if they are to provide this coverage for their employees; that the present marketing system of health insurance should be retained; and, most importantly perhaps, that benefits payable under national health insurance should be "secondary" to duplicating benefits under other insurance programs, such as automobile insurance and workmen's compensation.

I would like now to outline and explain further the areas above which our Association believes would improve and strengthen the health care program under H.R. 4349:

(1) Complete health care protection should be provided for the poor and near-poor without cost to them, beginning immediately and including catastrophic coverage. It is argued that such coverage cannot be provided at once on such a broad basis; that initially it must be limited somewhat in benefits and in those to be covered. We see no reason why a country that can place a man on the moon cannot provide at once complete health care protection for all of its less fortunate citizens. What is needed is a commitment to accomplish the task, and we urge the Congress to lead the way.

(2) Adequate cost control and quality of services should be an integral part of any national health insurance program, thus assuring appropriateness of treatment, quality of health care, and reasonableness of physician and health care institution fees. Much is said about more stringent regulation of hospitals and other health institutions. But, in our opinion, not enough is said about the need to properly regulate the health care people—physicians, nurses, and other allied personnel. Accordingly, we recommend that the "State Health Care Institution Cost Commission" proposed by H.R. 4349, should be required to review all health care services rendered by health personnel as well as institutions. So-called "peer review" is seemingly not adequate. Furthermore, we believe that if an active, duly-licensed insurance agent is included on this Commission, its regulatory abilities will be strengthened. His day-to-day relations with the people who will be covered by this program qualifies him to represent their views and protect their interests on the Commission.

(3) All employers, public and private, with more than one employee, should be encouraged to provide the minimum coverage afforded by any national health insurance program. However, because of the obvious inequities between the small employer and his larger counterpart, we believe that some form of financial assistance should be provided to the small businessman with not more than 10 employees. Just what form such assistance should take is open to conjecture, but the general approach outlined in H.R. 7741 would seem to be acceptable.

(4) Any national health insurance system should include a specified marketing system which fully utilizes existing private insurance producer (agent) facilities. This nation's hundreds of thousands of health insurance agents have a long and proud record of providing the insurance-buying public with the best possible service. The agent is one of the major strengths of the present system and his vital role of dealing directly with the public should be retained in any national health insurance system that is established. In addition, the agent should be compensated at historic commission rates for the services he renders.

(5) All medical benefits payable under automobile insurance policies should be considered "primary" in relation to duplicating benefits available under any national health insurance program. It has been suggested, for example, that all medical benefits should be removed from automobile policies and transferred as such to national health insurance. This, in our opinion, would be a tragic mistake. We do not believe that the costs of providing medical benefits to motorists injured in automobile accidents should be borne by the millions of non-motoring Americans. In other words, we believe those who drive should bear

the cost of losses which they generate; conversely, we believe those who do not drive should not be expected to absorb the cost of losses from automobile accidents. The same principles can be applied to the idea of shifting workmen's compensation benefits to national health insurance. Thus, each of these insurance programs—automobile insurance, national health insurance, and workmen's compensation—should stand on its own.

In conclusion, the National Association of Mutual Insurance Agents believes the present health care system can and should be improved. Such an improved system should draw upon the innovative capacity of the health professions; the flexibility, experience, and managerial skills of the private insurance industry; the unique capacities of government—local, state, and federal—and the energies and ideas of the American consumer, all working together.

Comprehensive health insurance should be available to all citizens regardless of ability to pay. We submit that this can best be achieved most rapidly and at the lowest cost by expanding the scope of existing health insurance plans now serving over 170 million Americans under age 65. For those without resources to obtain such coverage, governmental subsidies should be provided.

Improvements in the organization and delivery of health care must go forward together with improvements in the means of financing such care. To simply provide dollars without the required manpower and services to meet the needs and increased demand will only compound the problem. We believe reforms can and should be made without imposing huge additional tax burdens upon our citizens. If maximum use is made of the private sector, and government funds are used judiciously, the nation can begin to move rapidly toward making quality health care available for all its citizens, without serious dislocations and without losing stride.

For all of these reasons, our Association respectfully urges you to enact H.R. 4349, subject to the five additional provisions I have outlined above. Attached hereto is a copy of the resolution which reaffirms our position and which was unanimously approved by our National Board of Directors at its most recent meeting on October 31, 1971, and I ask that this resolution be made part of the printed record with my statement.

Thank you for allowing us to share with you our thoughts and suggestions on the very important legislation now before you.

RESOLUTION

National Health Insurance

Whereas every American should have access to quality health care regardless of income; and

Whereas the organization, delivery and financing of health care in our nation urgently needs to be greatly improved; and

Whereas any new system of health care should make maximum use of the private sector and careful and judicious use of government funds; and

Whereas comprehensive health insurance coverage should be made available to all people at the earliest possible date; and

Whereas the Health Insurance Association of America has developed a "Health Care Program"; and

Whereas the Health Insurance Task Force and the Federal Legislative Steering Committee of the National Association of Mutual Insurance Agents have carefully studied the legislative health insurance proposals before the Congress and approve the HIAA "Program for Healthcare in the 1970's" (H.R. 4349, S. 1490) subject to the following conditions:

(1) Complete health care protection should be provided without cost for the poor and near-poor beginning immediately and including catastrophic coverage.

(2) All employers, public and private, with more than one employee, should be encouraged to provide the minimum coverage afforded by the program. However, an incentive to these employers should be included such as that in a bill (H.R. 7741) introduced by Rep. John W. Brynes (R-Wis.) which would provide financial assistance to small businessmen with not more than ten employees.

(3) Adequate cost control and quality of services should be an integral part of any national health insurance program, thus assuring appropriateness of treatment, quality of health care and reasonableness of physician and health care institution fees. The "State Health Care Institution Cost Commission" proposed by HIAA should include an active, duly-licensed health insurance producer

(agent), and the commission should be required to review all health care services rendered by physicians, nurses, and allied health personnel, as well as institutions.

(4) All medical benefits payable under automobile insurance policies should be considered "primary" in relation to duplicating benefits payable under any national health insurance program.

(5) Any national health insurance program should include a specified marketing system which utilizes existing private insurance producer (agent) facilities; and such health insurance producers should be compensated at historic commission rates; and therefore, be it

Resolved, That the Board of Directors of the National Association of Mutual Insurance Agents here assembled at its Annual Meeting in Miami Beach, Florida, on this 31st day of October, 1971, urge the Congress to enact H.R. 4349 and S. 1490 subject to the modifications put forth by the National Association of Mutual Insurance Agents.

STATEMENT OF THE NATIONAL ASSOCIATION OF INDEPENDENT INSURERS

The National Association of Independent Insurers is a voluntary national trade association of some 533 insurers* of all types, both stock and non-stock, whose membership provides a representative cross-section of the casualty and fire insurance business in America. Our companies, which have long been recognized as the most competitive and progressive segment of the fire-casualty insurance business, have continued to expand the voluntary market availability of automobile insurance at a faster rate than the rate of increase in new vehicle registration, so that currently they are serving more than half the insured motorists in the country.

Despite our overriding interest in the property and casualty insurance field, we still view the matter of National Health legislation as crucial. There can be no doubt that any programs which deal with the delivery of health care will directly affect the manner in which automobile accident victims are compensated. Thus, the interest of the NAI is a most direct and profound one.

To be most acceptable to public demands and responsive to public needs, the NAI endorses a National Health program which:

- Makes medical services available to all citizens regardless of financial status;

- Controls the cost of medical care;

- Produces the highest degree of utilization of medical facilities;

- Retains the financing of health services to the maximum extent possible through the existing private insurance industry mechanisms, under regulation;

- Eliminates wasteful duplication, inefficiencies, and inequities;

- Preserves automobile insurers as the primary carrier for the compensation of automobile accident victims.

This statement will address itself principally to the latter three objectives.

RETAIN FINANCING OF HEALTH SERVICES THROUGH EXISTING PRIVATE INSURANCE INDUSTRY MECHANISMS UNDER THE STATE REGULATORY SYSTEM

Consistent with our traditional position that the public is best served through private industry operating in a highly competitive market, we express the conviction that the private insurance segment has proved itself worthy and qualified to provide the basic financial protection required to those in need of medical care. In the final analysis the highest expertise, the available servicing and claims handling facilities, and the machinery to provide effective coordination between the provider of services and the consumer of these services reposes with the health insurance industry. Any National Health Insurance program should maximize its role and confine the role of government to responsibilities which the private insurance industry cannot assume, such as providing social welfare benefits for the medically indigent.

Also, consistent with our traditional position, we urge that responsibility for regulation of the private health insurance business should remain with the state insurance departments which possess both the staff resources and expertise to perform this function without superimposing an unnecessary and unwarranted level of federal control.

*354 members and 179 subscribers to our statistical services.

ELIMINATION OF WASTEFUL DUPLICATION, INEFFICIENCIES AND INEQUITIES

A study of the testimony before various congressional, state, and industry committees will disclose that no one seriously questions the desirability of avoiding duplication of medical benefits. Health insurers have sought to achieve this objective among themselves through the incorporation of policy language providing for the "coordination of benefits". More importantly, in several jurisdictions in which local laws would permit, many accident and health insurers have provided for and successfully pursued a right of subrogation in those instances in which the injury for which benefits have been paid resulted from the negligent conduct of a third party. To the extent that this is accomplished, the cost of the loss has been properly shifted away from the innocent victim to the responsible party, and equity has been achieved.

The desirability of achieving this equity has not eluded the U.S. Congress in its past considerations of compensation programs. Various federally-legislated programs, including Title XIX of the Social Security Act (Medicaid) and the Federal Employees Liability Act, provide for recoupment from the negligent party causing the injury for which benefits have been paid.

In connection with National Health programs and their relationship to programs providing compensation for accident victims, it has on occasion been suggested that this loss shifting creates inefficiencies within the system. Perhaps this contention would be more persuasive if total compensation evolved from one program alone. But such is not the case:

Many health insurance plans provide inside limits, specified deductibles and/or co-insurance features, which ultimately will be lost to the accident victim unless he pursues a claim against an automobile insurer;

The disability features, i.e., wage loss (and in some programs intangible first party recoveries beyond wage loss) will only be compensated from another source or sources;

Under the prevailing automobile accident reparations system and many "no-fault" proposals, the recovery for pain and suffering is retained and must be pursued under a separate system;

Damage to property and to vehicles must also be pursued from a separate source.

Thus, less confusion and greater efficiency and convenience will be actually achieved by keeping the entire cost of compensating automobile accident victims within one benefit system. A fair analysis of the characteristics of both health and automobile insurance highly favors the auto system as the most viable and effective method by which to accomplish these objectives.

Equally important, the efficiencies and equities produced through non-duplication further highlight the desirability of preserving the automobile insurer as the primary source of benefits for auto accident victims.

PRESERVATION OF AUTOMOBILE INSURERS AS THE PRIMARY CARRIER FOR
COMPENSATING ACCIDENT VICTIMS

The legislative experience in Massachusetts, Delaware, Florida, and Illinois attests to the fact that "no-fault" insurance laws, regardless of how structured are upon us. A recent study by the NAI staff, which disclosed that no less than 29 state legislatures convening in 1972 will deliberate auto reparations reforms, further attests to the fact that the laws heretofore enacted are not the exceptions but the rule. Therefore, our continued concern for efficiency and convenience is necessary. Partially for the reasons heretofore stated, retaining the automobile insurer as the primary source of these benefits is essential. But there are other reasons equally important:

(1) The no-fault laws now enacted and virtually all proposals that are being seriously considered provide for the conditions of entitlement and amount of benefits that may be recovered beyond mere economic loss. These losses involve pain and suffering and inconvenience and the amount allowed is in relation to the medical expenses incurred. With this proprietary interest that the automobile insurer has, insurers would continue to provide effective and economical medical compensation.

(2) Motoring serves a utilitarian function or a pleasure-producing function, or both, for those who engage in it. But it likewise saddles serious hazards and burdens on our society in the form of deaths, injuries, noise, traffic congestion, air pollution, and consumption of natural resources. Sound public policy dictates that to the fullest extent possible those who engage

in an inherently dangerous or socially burdensome pursuit should bear the full costs of that pursuit—including the costs of all attendant safeguards and measures necessary to minimize or underwrite the damage it inflicts on others. It would be unfair and unwise to shift the costs away from those who engage in this pursuit and thereby subsidize it through either tax dollars or health insurance premiums paid by the non-motoring citizen.

(3) Keeping the full costs of motoring squarely on the shoulders of those participating in it also provides at least one form of disincentive against unreasonable over-use. Over-use of the automobile by some citizens already creates serious problems in America—such as the worsening congestion of our inner cities and arterial highways by the glut of commuter-driven cars, which could and should be replaced by mass transportation. To shift a major portion of auto accident losses from auto accident losses from auto insurance to national health insurance is a step in the wrong direction. This would compound both the traffic congestion problem and the safety problem.

In summary, therefore, the NAIH respectfully urges the Committee to view with caution any suggestions that duplication can only be avoided through the relegation of automobile insurance to an excess or a secondary position. Not only is the avoidance of duplication possible, which retaining auto insurance as the primary source of benefit recovery, but for the reasons herein stated it is most desirable.

CONCLUSION

There are a few issues relating to social legislation exceeding the significance which Congressional action in the health care field will have on our nation. The fate of a pluralistic private financing system; the preservation of state regulation in some, if not all, insurance matters; the role of automobile insurance—its preservation or potential demise; the economic impact on the taxpayers and insurance buyers are all inexorably entwined with the final disposition of this vital question.

In the area of reparations reform we have constantly urged cautious deliberation and evaluation. With the same reasoning we urge this premise in the Committee's deliberations for a responsive and permanent health care program. Without exercising this caution, a rash decision might very well create a national crisis which is irrevocable. To safeguard against this potential, NAIH respectfully urges a coordinated program preserving the private insurance industry which would assure the highest efficiency through retention of the automobile insurers in their traditional role as primary auto injury insurer.

AMERICAN INSURANCE ASSOCIATION,
Washington, D.C., December 10, 1971.

Re Impact of national health insurance on no-fault automobile and workmen's compensation insurance.

Hon. WILBUR D. MILLS,

*Chairman, Committee on Ways and Means, U.S. House of Representatives,
Longworth House Office Building, Washington, D.C.*

DEAR MR. CHAIRMAN: Enclosed is the statement of our organization concerning the potential impact of the National Health Insurance legislation under consideration by your Committee upon the workmen's compensation insurance now being written by our members throughout the nation and upon the no-fault automobile insurance that we anticipate will become widespread in the years to come.

It is the view of our organization of more than 100 property and casualty insurers that benefits under mandatory no-fault automobile insurance laws and state workmen's compensation laws should be primary to those under any national health insurance legislation enacted by the Congress.

It is our view that the no-fault automobile insurance and workmen's compensation insurance systems would be seriously weakened, if not destroyed, if their benefits were made secondary to those under a National Health Insurance system.

We also believe that the Congress could greatly reduce the cost impact of a National Health Insurance program on the American taxpayer by making workmen's compensation and no-fault automobile insurance benefits primary to those under a National Health Insurance program.

We hope that you will give close attention to the reasons for these positions set forth in the enclosed statement, and that the statement can be made a part of the Committee's hearing record on the National Health Insurance programs.

Sincerely,

LESLIE CHEEK III, *Manager.*

Enclosure.

STATEMENT OF AMERICAN INSURANCE ASSOCIATION

Mr. Chairman and Members of the Committee on Ways and Means: The American Insurance Association, whose membership of more than 100 insurance companies writes all lines of property and casualty insurance throughout the United States, appreciates the opportunity to express its views on certain aspects and implications of the National Health Insurance proposals currently pending before the Committee.

A substantial proportion of our membership also belongs to the Health Insurance Association of America, whose testimony the Committee has already received. We support the recommendations of the HIAA on the substantive aspects of the pending legislative proposals.

We are submitting this statement because we are concerned about the possible impact of a national health insurance program on the workmen's compensation insurance now written by our membership, and on the no-fault automobile insurance that we are confident will become compulsory in an increasing number of states in the years to come.

The membership of the American Insurance Association includes many of the major writers of group health insurance; automobile bodily injury, property damage and collision insurance; workmen's compensation; and individual accident and health insurance. In addition, at least one of our member companies has served as an administrative agency for the Medicare program. Accordingly, we believe our views come from balanced, first-hand knowledge of and experience with almost all of the benefit systems we will be discussing.

INTRODUCTION

We believe that any National Health Insurance system created by the Congress should seek to take advantage of existing insurance systems to the extent that the goals of those systems are compatible with the goals of a National Health Insurance program, and to the extent that they can assure savings to the National Health Insurance system while providing the same uniformity and universality of protection.

Two such existing systems are the workmen's compensation system now in operation in every American jurisdiction, and the compulsory no-fault auto insurance system that several states already have enacted and which in the next session of Congress may become the law of the land through federal enactment.

The purpose of this statement is to recommend that workmen's compensation insurance benefits and benefits under compulsory first-party no-fault automobile insurance laws be explicitly made primary to benefits payable under a National Health Insurance program.

We believe that these private systems can achieve, in their clearly defined areas of competence, the goals of a National Health Insurance system at the same or lower cost to the consumer and with considerable savings to the federal government.

Moreover, the preservation of existing private systems for the compensation of work- and auto accident-related injuries will serve several major public policy objectives.

The goals of a National Health Insurance program and of the workmen's compensation and no-fault automobile insurance systems are the same: (1) the provision of adequate economic loss benefits for all at minimum cost; and (2) the restructuring of the framework under which these benefits are delivered in order to reduce frictional costs, eliminate waste and duplication, redirect resources to reduce the frequency and severity of losses, and encourage rehabilitation.

Making benefits under no-fault automobile insurance and workmen's compensation excess of (that is, payable after) benefits under a National Health Insurance program is not essential to the achievement of the goals common to

all three systems. Indeed, as we shall demonstrate below, the objectives of all three systems will be enhanced if benefits under no-fault automobile insurance and workmen's compensation are made primary to benefits under a national health insurance system.

NO-FAULT AUTO INSURANCE SHOULD BE PRIMARY

(1) The costs of motoring should be internalized to the activity of motoring

We think it is important for a number of reasons to internalize to motoring the cost of that activity, so that automobile accident costs will be accurately reflected in auto insurance prices.

From the point of view of auto accident victims, consumers and American society at large, it is a matter of sound economic resources allocation as well as of elementary fairness that an activity that generates costs should bear those costs.

More than one-half of the American population does not drive automobiles. The 110 million non-motoring American people should not be forced to subsidize a portion of the losses generated by the motoring segment of the American public through higher taxes for the National Health Insurance program.

For consumers generally, automobile accident costs should be internalized to the activity of motoring in a visible way, one that shows on the price tag. The accident cost of motoring can best be internalized to the activity of motoring through the no-fault auto insurance mechanism, one that makes the cost visible before, rather than after, the consumer decides whether, when and how much to engage in the activity of motoring.

From the point of view of the accident victim, it is only fair that his losses be paid for by the motoring populace through their common contributions to the no-fault auto insurance pool, rather than by society at large through its contribution to a national health insurance system.

The statistical separation of auto accident losses from other kinds of losses, which a primary no-fault automobile insurance system would assure, would demonstrate the cost of automobile transportation relative to the costs of alternative modes of transportation, for example. The public interest in the rational allocation of transportation resources would be ill-served if a portion of the true cost of motoring were hidden from scrutiny, as it would be if the auto insurance system were secondary.

(2) Motoring Accident Losses Merit Separate Treatment

Four out of every five American families own a car. More than 105 million licensed drivers use more than 100 million cars on our streets and highways. There is a 99 percent chance that in 20 years of driving, every one of these drivers will have at least one accident. Each year, motoring activity results in 56,000 deaths and 4.6 million injuries (of which half are serious and 4 percent result in permanent disability.) The economic loss to the nation from the carnage on our highways amounts to \$16.5 billion per year.

Moreover, 7.7 percent of all disabilities are attributable to automobile accidents; 21.5 percent of the overall number of days of disabilities from accidents are attributable to auto crashes; and 49 percent of all accidental deaths in America each year are attributable to auto accidents.

Although auto accident-related medical expenses constitute less than 5 percent of the total annual medical expense outlay in the United States, the types of injuries and disabilities are significantly different from non-auto related injuries to justify their treatment and compensation under a system directed exclusively to them.

For reasons attributable almost exclusively to the fault liability system of compensating auto accident victims, insufficient attention has thus far been given to the treatment of automobile accident trauma cases. In many cases, recovery under the tort system is enhanced by delaying medical treatment and rehabilitation. In addition, many accident victims have been dependent upon the other party's insurer for the funds necessary to undertake extensive rehabilitation or cosmetic surgery.

The price of automobile insurance is an integral part of the total cost of owning and operating an automobile. There should be no disparities in automobile insurance costs that are not justified by real differences in auto accident loss exposure.

It should also be noted that the variations in auto insurance prices which would result from making national health insurance benefits primary would serve to frustrate the potential of no-fault automobile insurance to reverse the existing pattern of auto insurance costs, in which those least able to afford it frequently pay the highest premiums. If national health insurance benefits are primary, the affluent driver secure in a job with good fringe benefits will continue to pay less for his auto insurance than the center city dweller whose employment typically has less tenure and fewer fringe benefits.

No-fault automobile insurance, by providing a comprehensive source of recovery for all economic losses sustained in automobile accidents, offers a unique opportunity to relieve non-motoring segments of society from the subsidy they now give to motoring activities. Any attempt to reduce the cost of no-fault auto insurance by making national health insurance or other collateral sources primary to its benefits would destroy the internalization potential of no-fault automobile insurance. This would be wrong in economic principle, however attractive it might be politically.

By internalizing the costs of automobile ownership, as a no-fault automobile insurance system primary to other benefits would, it will become possible for "economic man" to make reasonably rational economic decisions on important individual and public policy goals, such as (a) How many cars should a person own? (b) How should one vote on rapid transit issues? (c) Should a person commute by car, or is mass transportation more desirable and less expensive? and (d) What type or make of car should be purchased from the point of view of both accident avoidance and protection in the event of an accident?

The elimination of the adversary process in the compensation of auto accident victims will make it unnecessary for accident victims to postpone treatment or to hide the nature and extent of their injuries. Thus, insurers will be able to bring to bear on automobile accident injuries the expertise they have developed through the rehabilitation of trauma cases under the workmen's compensation system.

The effect of this expertise would be greatly diluted if auto accident injuries were compensated by a National Health Insurance system whose benefits are primary to those under no-fault automobile insurance. Conversely, if no-fault automobile insurance medical benefits were primary, auto insurers could make significant contributions to the medical and economic recovery of automobile accident victims. They could bring their collective experience to bear to improve the emergency care of automobile accident victims and the response speed of local ambulance services.

In addition, as has been the case in workmen's compensation, the insurance industry's private enterprise motive for reducing costs would encourage prompt emergency treatment and rehabilitation of automobile accident victims.

Finally, isolating the medical costs of automobile accidents within the no-fault automobile insurance framework will facilitate the generation of sufficient statistical evidence regarding the nature and causes of automobile accident injuries to maximize systematic approaches to automobile and highway traffic safety. This effort, too, would be substantially diluted if part of the cost of auto accident injuries were absorbed by a system separate from the no-fault auto insurance system.

(3) *No-Fault Auto Insurance Eliminates the Need for Collateral Sources*

Because the current automobile liability insurance policy is designed not to compensate the policyholder for his accident losses, but to protect him from the economic consequences of judgments against him, prudent drivers today must rely on other forms of insurance to pay their hospital and medical expenses resulting from automobile accidents in which they are either "at fault" or precluded from recovering from other parties by their "contributory negligence."

The elimination of questions of legal fault from auto accident reparations and the adoption of a compulsory first-party auto insurance system will reverse the current situation. Each driver will be able to look to his own insurer for full and immediate payment of all hospital and medical expenses and other economic losses incurred by those injured in his automobile.¹

¹ For a description of how such a system would operate see the *Report of the Special Committee to Study and Evaluate the Keeton-O'Connell Basic Protection Plan and Automobile Accident Reparations*, American Insurance Association, New York, 1968, pp. 5-7; and *Motor Vehicle Crash Losses and Their Compensation in the United States*, U.S. Dept. of Transportation, March 1971, pp. 133-37.

It has been estimated that 45 percent of the average traffic accident victim's total recovery today for personal injury and property damage is derived from sources completely outside the fault insurance system (e.g., accident and health insurance and income continuation plans) and from no-fault insurances engrafted upon the fault insurance system (e.g., medical payments and collision insurance.)

No-fault auto insurance will eliminate the waste and inefficiency inherent in a system that makes the majority of the accident victim's compensation contingent on his being found free of legal fault for the accident.

At the same time, it will unify in a single policy the benefits now payable, if at all, from a wide variety of frequently duplicative sources.

(4) No-Fault Savings Do Not Depend on Use of Collateral Sources

Making no-fault auto insurance benefits excess of other, collateral sources is not essential to achievement of the objective of compensating all auto accident victims at significant savings from present day liability insurance costs.

We believe that this objective can be achieved at savings to auto insurance consumers of between 15 and 45 percent, largely through the elimination or curtailment of legal fees and intangible damages. These savings are possible without making no-fault benefits secondary to other sources of recovery.

(5) National Health Insurance Would Not Be More Efficient Than Private No-Fault Auto Insurance

It is fallacious to assume that the ratio of expenses to losses in the operation of an insurance system provides an index to the efficiency of that system. The more complex the economic benefit afforded by the insurance, the more expensive the claim service will be. However, the fact that it is more expensive is no indication whatsoever that it is less efficient.

No-fault auto insurance encompasses not only unlimited hospital, medical and rehabilitation benefits, but also wage loss benefits of up to \$1,000 a month replacement household service benefits for injured housewives, and compensation for damage to vehicular and non-vehicular property. With this broad range of claim services to perform, the insurer's expenses naturally are higher than in lines of insurance offering less comprehensive benefits.

Shifting the administrative costs of processing automobile bodily injury claims to a National Health Insurance system would not greatly reduce the administrative burden of the no-fault automobile insurer, since any accident causing significant injury would undoubtedly be accompanied by a considerable degree of property damage. Thus, the automobile insurer would be in the act anyway, and the additional cost of processing the injury portion of the claim would be negligible. The shift of the administrative cost to the National Health Insurance system would result in the creation of unused capacity in the private no-fault auto insurance system, while imposing on the national health insurance system the cost of processing some 4.6 million auto bodily injury claims. We do not believe it would be sound to underutilize an established system in this manner while adding unnecessary costs to a new system.

It is possible that many state no-fault auto insurance plans will preserve the tort remedy for seriously injured auto accident victims or those with severe economic losses. Thus, insurers may be forced to retain to some degree the current investigatory and legal apparatus for the determination of legal fault that will be necessary in such residual liability cases. This would not be needed in a total no-fault system.

Finally, it should be noted that one of the reasons that Social Security disability benefits, statutory disability benefits and group insurance benefits are administered so efficiently today is because those systems do not undertake to investigate for duplication of benefits. As a result, although the systems themselves may operate efficiently, there is widespread redundancy in the compensation of certain losses and a concomitant waste of insurance resources.

We firmly believe that coordination of benefits among alternative sources should be explicitly dealt with by the National Health Insurance legislation. We would suggest that the most efficient coordination of benefits in the auto accident compensation area would be one which makes the more comprehensive of two mandatory systems, that is, the no-fault system, primary to the less comprehensive system, that is, National Health Insurance.

(6) Primary Health Insurance Would Be Inequitable to Motorists

If a no-fault auto insurer were forced to discover and confirm the extent of collateral benefits available to injured accident victims, an extensive adminis-

trative mechanism would have to be established which might present a threat to the victims' privacy and result in serious delays in the payment of benefits.

If, as we believe they should be, first-party, no-fault auto insurance benefit levels are high enough to cover virtually all economic losses for virtually all auto accident victims, auto insurance coverage will be the most complete and comprehensive coverage available.

In our view, it would be neither equitable or efficient to ask a seriously injured automobile accident victim to exhaust his benefits from one or more other less comprehensive sources before turning to his most comprehensive sources.

If auto insurance benefits are secondary to National Health Insurance, those benefits may be exhausted by auto-related injuries and disabilities, leaving the insured unprotected from the financial consequences of other, non-auto related disability.

WORKMEN'S COMPENSATION BENEFITS SHOULD BE PRIMARY

(1) The Workmen's Compensation System Serves American Workers and Employers Well.

For most American workers the greatest risk is the very real possibility of having to leave their employment because of an occupational disability. Even relatively nonserious injuries or illnesses may result in medical care expense while the more serious disabilities may cause a temporary or permanent loss of earning ability along with the burden of catastrophic medical expenses. Likewise, liability for such losses is an equally real threat to employers. Fortunately, this nation recognized the serious implications posed by occupational hazards at an early point and devised a system—Workmen's Compensation—to meet the needs of both employees and employers for protection from occupational disabilities.

For more than a half-century, workmen's compensation has served this nation well by providing to injured employees, or to the dependents of those killed in industry, effective medical care and other benefits—regardless of blame for the accidents.

The present system of Workmen's Compensation, operating within the framework of regulation at the state level, has proven to be a highly efficient method of protecting employees and employers against the hazards of work-connected injuries.

It is a system that is fundamentally sound; a system that today provides economic protection for almost all employed persons. State laws now provide the highest benefits and broadest protection in their history. They are flexible and are constantly being improved through the suggestions of state administrators, labor employers and insurers.

(2) The Importance of Medical Care to Workmen's Compensation

It is essential that medical care for work injuries be retained as part of the workmen's compensation system. Duplication or pre-emption of such care through another system would not only be economically unsound but would have a disastrous effect on the satisfactory operation of workmen's compensation. It could easily result in its destruction.

One of the most compelling reasons against making workmen's compensation excess to national health insurance is the fact that medical care is an integral part of the workmen's compensation system. The adequacy and quality of medical care and the prompt initiation of a rehabilitation program where necessary are of great importance to the injured man and the proper operation of the system. It is only thus that the disabling effects of an injury can be minimized and maximum earning capacity restored. Medical reports on initial treatment, periodic progress and termination of treatment are absolutely necessary to the operation of the workmen's compensation system. These reports would be difficult if not impossible to obtain if medical treatment were provided through another system. At best, serious delays would occur.

Existing federal law wisely recognizes the importance of retaining medical care for work injuries as part of the workmen's compensation system. When Medicare was first provided in 1965, duplication of workmen's compensation medical benefits was avoided. Section 1826(b) Title XVII (Medicare) of the Social Security Act provides that:

"Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be

expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State."

This subsection also provides for reimbursement to the appropriate Trust Fund in the event payment is made for an item or service covered by such law or plan.

In 1967, Paragraph 25 was added to Section 1902(a), Title XIX (Medicaid) of the Social Security Act, which lists conditions which a state plan must meet to receive federal medical assistance. In effect, that paragraph provides that the state, in administering plans for medical assistance, must take all reasonable measures to ascertain the legal liability of third parties (including obviously that under the workmen's compensation laws) to pay for care and services arising out of injury, disease, or disability. Such legal liability is to be treated as a resource of the individual on whose behalf the care and services are made available. Provision here again is also made for reimbursement in the event care is provided under the plan.

(3) Workmen's Compensation Provides Comprehensive Protection

It may be noted that neither under the Medicare program nor the Medicaid program do the extent of medical care benefits approach those provided under the workmen's compensation system. Medical protection under workmen's compensation laws provides the most comprehensive system of statutory health care in this country. Full medical, hospital and related services, unlimited in time or amount, are an essential part of the widespread protection that workmen's compensation laws in most states provide against income loss from and treatment for work injuries. Severe injuries involving large expenditures for medical care, while fortunately infrequent, are by no means unknown. Current medical payments under workmen's compensation laws exceed \$1,000,000,000 annually.

In contrast, the scope of benefits provided under the Medicare and Medicaid programs are quite limited. For example, inpatient hospital services for the aged may not exceed 150 days for any illness, and this amount is reduced if the elderly person has received prior in-hospital care. Furthermore, post hospital extended care and home health care services are limited in amount and must occur within a specified time period.

(4) National Health Insurance Could be More Costly Than Workmen's Compensation

Another factor which should weigh significantly in deciding whether national health insurance should be primary to workmen's compensation is the fact that Medicare and Medicaid have far exceeded cost estimates made prior to their enactment. There is every reason to believe that treatment of work related injuries under a primary national health insurance program would also be extremely costly. For the federal government to assume this large burden is unsound both economically and practically, in light of the fact that an effective and comprehensive medical benefit program for work injuries already exists.

CONCLUSION

For the reasons above, we strongly urge the Committee to include in its National Health Insurance legislation language making workmen's compensation benefits primary to National Health Insurance benefits and embodying the concept that mandatory first-party automobile accident insurance be the primary source of indemnity for auto accident injuries.

We also urge the Committee to specify that with the exception of Social Security and workmen's compensation, all other benefits, including National Health Insurance and statutory disability protection, be eliminated as to auto accident-incurred injury or disability or made excess of mandatory first-party no-fault automobile insurance.

The Health Insurance Association of America does not oppose an amendment that would make workmen's compensation and non-occupational hospital, medical and surgical benefits under mandatory national or state no-fault automobile insurance laws primary to National Health Insurance benefits.

We would be happy to meet with members of the Committee or the Committee Staff to discuss in further detail the recommendations contained in this statement.

STATEMENT OF JOHN L. THOMPSON, PRESIDENT, MASSACHUSETTS BLUE SHIELD, INC.

Massachusetts Blue Shield has been interested in the costs of medical services since the inception of its operations in 1942; however, with the advent of Title XVIII (Medicare) this interest intensified.

We have conducted various studies in order to determine whether the physicians in Massachusetts have charged the same fees for patients over 65 and for patients under 65, and whether our Usual and Customary Fee Program is inherently inflationary. The studies comparing charges for services rendered to senior citizens and patients under 65 have consistently shown that these changing patterns are identical; thus the fear that physicians would take advantage of the Medicare Part B program was unfounded.

Since 1967 we have been administering the medical reimbursement program known as Usual and Customary which is similar to the payment system under Title XVIII known as Customary and Prevailing. Using data derived from these programs, we have compared charges made by Massachusetts physicians with the United States Consumer Price Index (U.S. CPI) and with the Physicians' Fee Component of the U.S. CPI. As is already well known, the Physicians' Fee Component of the U.S. CPI has increased at a faster rate in the last few years than the overall U.S. CPI. However, as can be seen on Figure 1, the fees charged in Massachusetts from June 1967 through August 1971 have increased, but basically only at the same rate as the U.S. CPI.

In other words, physicians in Massachusetts have reflected the general inflation in the United States.

From Table 1, we can see that if we use June 1967 as our base period (100), the U.S. CPI rose to 122.5 by August 1971—a 22.5% increase. In contrast, the fees charged in Massachusetts rose by 24%, a statistically insignificant difference while the Physicians' Fees Component of the U.S. CPI rose, in the same period, by 31.6%. Moreover, except during the time period December 1968 to June 1969, the rate of increase between Massachusetts physicians and the general cost of living was similar and (apart from the same time period) was considerably lower than the increase in the Physicians' Fee Component of the U.S. CPI.

We believe that the degree of cooperation between Massachusetts Blue Shield and Massachusetts physicians is instrumental in holding down the increases in physicians' fees. Furthermore, not only do we obtain a 5% discount from all participating physicians, but we also pay only the lowest of a physician's charge, usual fee or customary fee, thus helping to hold down the total payments made for physicians' services.

For example, from February 1971 through November 1971, we received claims for subscribers covered under our Usual and Customary contracts for charges totalling \$33,346,287. After applying our Usual and Customary criteria, we paid \$29,788,325 before applying the 5% discount, thus paying out only \$28,298,909—84.9% of charges. This demonstrates that with the cooperation of the physicians in Massachusetts, we are saving the consumers of medical services nearly 11% through the use of our Usual and Customary Program, and an additional 5% because of our agreement for a discount.

TABLE 1

| | Massachusetts physicians fee index ¹ | U.S. Consumer Price Index ² | Physicians component of U.S. CPI ² |
|--------------------|---|---|---|
| June 1967..... | 100.0 | 100.0 | 100.0 |
| December 1968..... | 106.5 | 106.6 | 108.6 |
| June 1969..... | 112.2 | 110.0 | 113.3 |
| November 1970..... | 118.7 | 118.8 | 124.9 |
| August 1971..... | 124.0 | 122.5 | 131.6 |

¹ Massachusetts Blue Shield and Medicare, pt. B, claims data.

² U.S. Department of Labor: Bureau of Labor Statistics.

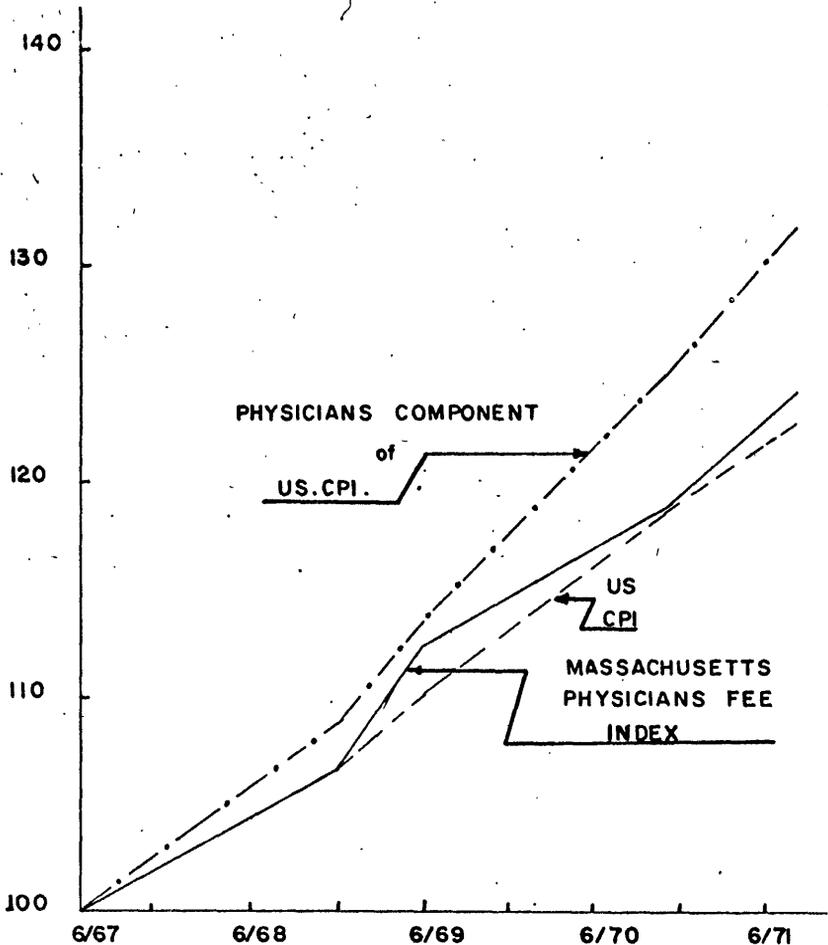


FIGURE 1

STATEMENT OF JOHN B. O'DAY, PRESIDENT-MANAGING DIRECTOR, INSURANCE ECONOMICS SOCIETY OF AMERICA

Mr. Chairman, my name is John B. O'Day and I am President-Managing Director of the Insurance Economics Society of America. The Society, founded in 1917, is an organization engaged in the continuous study of social and private insurance systems in the United States. Members of the Society consist of a select group of insurance companies who are among the pioneers in the development of health insurance and thousands of insurance agents who are engaged in marketing and servicing all types of personal insurance programs including health insurance.

The Society presents this statement to this congressional committee, now, as it has on all major social insurance legislation since 1943, with appreciation to you for your consideration of the views of our membership.

Because we solemnly believe in the superiority of private medical practice, the superiority of the private system of health insurance and the efficacy of maintaining the availability of a variety of interrelated choices to the Ameri-

can people, the Insurance Economics Society of America wishes to record its endorsement of the National Healthcare Act of 1971 (H.R. 4349), introduced by Congressman Omar Burleson.

In suing the term "superiority" to characterize the unique American system of private medical care and private health insurance which is satisfying the health care demands of the large majority of our citizens, we fully confess that we are not blind to existing deficiencies. It is the underlying genius of Congressman Burleson's bill that has singled out these deficiencies and seeks to redress each of them without deteriorating or destroying the present medical care system which has a constantly improving record of providing the best medical care the world has ever known.

CEILINGS ON FAMILY MEDICAL EXPENDITURES

This statement intentionally omits a detailed discussion of the measures contained in H.R. 4349 specifically designed to overcome existing deficiencies because these subjects have been eloquently presented to your committee by a number of previous witnesses. However, we believe it is imperative to the understanding of the Burleson Bill to re-emphasize a portion of the testimony of Mr. J. Henry Smith who appeared on October 27, 1971. He described that under H.R. 4349, no self-supporting American family would pay out of pocket more than \$1,000 per year with respect to covered health care expenses. Moreover, Mr. Smith testified that for low income families the "out of pocket limit would range from \$30 to \$120, depending on income." His statement contained two illustrations of medical bills totalling \$36,830 in one case and \$52,450 in another, whereby a maximum of only \$30 and \$1,000 respectively could be charged to the families involved.¹

STATE INSURANCE COMMISSIONERS URGE PRIVATE SYSTEM

Also, we would like to add emphasis to the testimony of the National Association of Insurance Commissioners which details that the private health insurance system in America involves \$20.1 billion annually in premium upon which is paid \$235 million in state premium taxes and \$94 million in federal income taxes along with the payment of \$45 million in daily benefits to the public.

Testifying for NAIC on October 27, 1971, the Honorable Russell E. Van Hooser, Insurance Commissioner of Michigan, endeavored to alert this committee to the undesirable consequences of replacing private health insurance with an all government program. An all government program, he stated, "would cause severe dislocation in both federal and state tax revenues as well as employment of thousands of workers." Further, he warned of the vast costs of creating a new system, and of the removal of a large segment of the economy from the private enterprise system thereby lessening political as well as economic freedom. He said:

"Until the private health insurance system demonstrates that it is either unwilling or incapable of effectively effectuating a national health insurance program, the NAIC submits that reasons such as those touched on above warrant utilizing, expanding, and improving the private health insurance mechanism as a basic element in achieving the goals of a national health care program."²

The Society submits that H.R. 4349 offers the best means to satisfy the expressed position of the state insurance commissioners who are more conversant than any other group of government officials with public attitudes, particularly consumer attitudes, concerning the private health insurance system.

The stated rejection of a monolithic government health insurance law by the NAIC is a significant commentary on the substantial progress that has been experienced in the development of private health insurance. This progress has been of an accelerative nature especially during the last three decades when the specter of socialized medicine has hung over the American health care system like the sword of Damocles. And it is from this great progress of American health insurance that H.R. 4349 has emerged—the right bill at the right time—a bill which would continue to entrust to the private sector the health

¹ Statement of the Health Insurance Association of America, American Life Convention, Life Insurance Association of America, Life Insurers Conference on National Health Insurance; Oct. 27, 1971; pp. 13, 14, 15, 16, including Chart No. 1.

² Statement of the National Association of Insurance Commissioners on National Health Insurance; Oct. 27, 1971; p. 2.

care of the majority of our people—a bill that would utilize federal help precisely where federal help is required.

AMERICAN HEALTH CARE CRISIS?

Another significant commentary is that more and more people are turning a deaf ear to those who have been crying for thirty years that there is "currently" a health care crisis in America. Mr. Robert J. Myers, renowned former Chief Actuary of the Social Security Administration implies that this crisis mania is a tactic "to scare the country into supporting a drastic change in the delivery system." He recently wrote:

"If there actually were a crisis in the true sense of the term, then it seems to me that people would be waiting in queues for days to see physicians, to get into hospitals, and to obtain medicines—as they do to a much greater extent in most other countries than here."

Mr. Myers' opposition to unwarranted government monolithic expansion into the health care and health insurance professions has received wide publication and is undoubtedly well known to this committee. Recently, however, in the October 18, 1971 issue of the Washington Insurance Newsletter, Mr. Myers details his views concerning the financial problems and new tax burdens inherent in some of the various national health insurance proposals currently before Congress. He concludes:

"Certainly, it makes much more sense to build on our present diverse, pluralistic health care delivery and financing system, which is doing such a good job for the vast majority of the populace, then to tear it down and start over again with a monolithic governmental program to provide health services."³

The Society submits this as further evidence of the aforementioned "superiority." The Burleson Bill (H.R. 4349) is the best means to build on this superior health care delivery system and thereby avoid the crushing tax burdens and financial problems Mr. Myers has articulated.

JOURNALIST DESCRIBES EFFECTS OF "CRISIS" PROPAGANDA

Another analytical observer, Mr. Harry Schwartz of the New York Times, is using very pointed language to demonstrate how an abundance of health crisis propaganda has led many eminent persons and groups to cry out for a radical change in the American health care system. In his analysis which appeared in the August 14, 1971 issue of Saturday Review Mr. Schwartz wrote:

"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 . . ."

The New York Times writer charges:

"In their righteous wrath, many of today's critics seem to feel the limits of truth, balance, or plain good sense just don't apply to their holy cause."

Mr. Schwartz further charges:

" . . . 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."⁴

CONTINUOUS CRITICISM OF PRIVATE SECTOR

Since it is so closely related to American medicine, private health insurance has been the object of a great deal of similar verbal abuse. When investigated much of this criticism has been rejected as atypical by the majority of objective observers. Had it not been so rejected the United States would have long ago adopted a system of national health insurance for the idea of monolithic health care is not new; it has been perennially introduced in Congress for three decades.

³ The Spectrum of Governmental Health Care Proposals by Robert J. Myers, F.S.A., M.A.A.A., Professor of Actuarial Science, Temple University; published Oct. 18, 1971 by Washington Insurance Newsletter, Inc., 1365 National Press Building, Washington, D.C. 20004.

⁴ Health Care in America: A Heretical Diagnosis, by Harry Schwartz published in Saturday Review; pp. 14 and 15, Aug. 14, 1971.

But the Society has observed that criticism, even that which has been grossly unfair, has had an effect, together with intense competition, of keeping the private health insurance industry from a moment of complacency. You have already heard of the many innovations in health insurance coverages that have resulted not just in response to criticism but from the competitive advantages each of hundreds of insurance companies and health care organizations must strive to maintain in order to attract and retain customers. The Society submits that it is this experience gained over the years in the many different market-places in America, by literally hundreds of thousands, that has led an otherwise highly competitive industry to act as one in urging the enactment of the Burleson Bill. We feel that under the Burleson Bill all Americans can acquire that adequate health care that the majority has already approached under the superior health care system which has evolved in America.

THE INDIVIDUAL INSURANCE QUESTION

The Burleson Bill has been questioned by some because it retains a place in the financing of health care for individual health insurance. The primary concern appears to be the higher administrative costs required for individual coverage.

In the installation and servicing of all insurance mechanisms, certain functions are essential. There has to be a means of enrolling the participants in the plan, a mechanism for dispensing information about the coverage, a process of paying claims and where continued participation is not compulsory, it is necessary to have a procedure to keep coverage in force. These functions would have to be performed even under a government plan by numerous persons, whether policemen, IRS agents, or special employees of the government body charged with responsibility for administering the plan.

These functions are performed whether the coverage is individual or group. In group insurance many of these functions and the cost thereof are absorbed by the sponsor of the group (employer) and the cost of performing these functions, though very real, are not reported as an expense of the insurance plan. Therefore, the actual cost of group insurance appears to be less than it really is because the premium is reduced by each administrative function the sponsor (employer) elects to perform at his own expense.

In individual insurance the actual cost of these functions performed by a company must be reflected in the premium and includes compensation to individual agents (numbering several hundred thousand) who must seek out the uninsured individual, explain the plan to him and enroll him in a plan for which he must pay the entire cost. This difference, and the economies of accounting which can be realized from formula rates rather than premium rates based on individual variables like age and sex, are the real economies to be found in group insurance today. But competition between companies marketing group and/or individual insurance under the Burleson Bill can be expected to be so keen that the lowest possible price of all coverages will be reached through efficiencies emanating from the many new coverages which will surely emerge.

If there is to be a continued demand for individual health insurance following the passage of the Burleson Bill it will be because a significant segment of our citizens will have elected life styles which require individual health insurance, serviced by individual agents, to satisfy their particular needs.

"We, therefore, urge this committee to allow the future of individual health insurance to be decided, not by edict, but in the marketplace by the personal choices of millions of people."

THE QUESTION OF COMPULSION

Another criticism of the Burleson Bill, Mr. Chairman, is that it is not compulsory. Some who hold this position are advocates of the other basic principles of H.R. 4349. With them, the Society is in league in opposition to an inherently compulsory monolithic government health insurance law. However, we urge that the question of compulsion be studied at great length as we believe this committee will find that, to the successful implementation of H.R. 4349, compulsion is unnecessary.

That compulsion is anathema in a free society should not be allowed to be dismissed as too philosophical, or too naive, or too self-serving, or too . . . et cetera. To those who hold that compulsion may be required we offer this recommendation:

"Congress should enact the Burleson Bill with its incentive approach and then, if ensuing events dictate, the question of adding compulsion can be considered on its individual merits. We believe that experience under the Burleson Bill will prove that the price of compulsion is inordinately high for the miniscule good that compulsion might possibly provide."

DEFECTS IN NATIONALIZED MEDICINE

Compulsory health insurance does not guarantee that a person will avail himself of needed health care even where there is little or no fee to be paid for individual treatment. According to a recent column in the Chicago Tribune by Dr. T. R. Van Dellen there is a current concern in Great Britain over the number of people who are going blind because they have not sought necessary cataract surgery despite the fact that cost is no barrier.⁵

Former British Minister of Health, the Honorable J. Enoch Powell in a speech in St. Louis, Missouri, October 8, 1971, charged the British National Health Service with "damaging the relationship between the doctor and the patient." He said that Britain would have more patient satisfaction with medical care, more physicians and more hospitals if it had *not* nationalized medicine in 1948. He stated:

"Nationalization kept Britain from building any hospitals for fifteen years, giving priority to housing."⁶

Formerly practicing medicine under the British National Health Service, Dr. Donald Quinlan, now in private medicine in Chicago, has charged that a general practitioner in Great Britain is forced by governmentally imposed regulations and controls to neglect patients.

He says:

"Unfortunately for patients, doctors are paid less for taking adequate time to practice good medicine than doctors who see too many patients and collect the same amount of pay per capita for inferior service."⁷

After 23 years, Mr. Chairman, it now can be clearly demonstrated that nationalization of health care has not been the utopia promised. In fact, there is a growing number in Great Britain who are slunning the "free" British Health Service and opting for private medical care.

COMPARISON WITH OTHER COUNTRIES

For over two decades, Mr. Chairman, Congressional committees have been told time and again that American health care is inferior and needs to be replaced by a monolithic government program. Congress and the public have been inundated with international statistics with the conclusion that the United States is down the list of the world's nations ranked by such indicators as infant mortality and life expectancy. The Society believes that Congress has recognized that these conclusions, while they sound sensational from the platform, TV or printed page, are founded on what journalist Harry Schwartz has aptly termed "simple naivete in statistical matters."⁸ The American Medical Association has previously pointed out the fallacy of comparing numbers as a measure of a nation's health. Attached to this statement is an article which proves this fallaciousness even as it reports that the infant mortality rate in the U.S. has declined 50% in the last 30 years and 20% in the past 5 years.⁹

A comparison which is almost completely overlooked is the relative smallness of these countries said to be "healthier nations" when compared to the United States. Sweden, for example, is often cited as a model for the United States to follow. Apparently many fail to realize that if we were to superimpose the whole country of Sweden on the United States we would use up scarcely more territory than Arkansas, Louisiana and Missouri. In fact the whole Swedish population of 8 million is equivalent to those who live in New York City.

The Netherlands could fit into half of Indiana and Great Britain into Oregon. Only Oregon and Nevada would be needed to contain the largest country in Western Europe, France.

⁵ Cataract Surgery Can Be Sight-Saving, by Dr. T. R. Van Dellen, Chicago Tribune, Nov. 17, 1971.

⁶ AAPS Newsletter, vol. 25, No. 10, published by Association of American Physicians and Surgeons, Chicago, Ill.

⁷ Ibid.

⁸ See Footnote No. 4.

⁹ "Comparing Numbers," American Medical News, Jan. 25, 1971.

We offer the territorial comparisons, Mr. Chairman, to demonstrate that the problem of providing health care to the fourth largest nation in the world with a heterogeneous people numbering 210 million, spread over a vast territory, is of such greater magnitude as to be incomparable to the relatively small countries of Europe. Journalist Harry Schwartz writes: ". . . 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 and approximately the same life expectancy level."¹⁰

In conclusion, Mr. Chairman, the Insurance Economics Society of America endorses the Burleson Bill because it is non-compulsory while providing substantial incentives to participate. It will improve the health care delivery system for all without restricting a person to only one form of medical care. The Burleson Bill would concentrate most of the new energies and taxes to be expended on those with specific problems which have now been identified as needing the attention of Congress.

Today's Americans, Mr. Chairman, are as much in need of freedom in how each shall minister unto his own body as those who sailed into the bays of Massachusetts and Chesapeake, and those who walked to the Great Salt Lake, were in need of freedom to minister each unto his own soul. State medicine is as self-defeating as state religion. It should be so scorned.

We thank the House Committee on Ways and Means for this opportunity to present our position.

ADDENDUM

(Note: The following article is referred to in Footnote 9 on page 3188.)

COMPARING NUMBERS

The infant mortality rate in the United States has declined more than 50% in the past 30 years. In the past five years, it has dropped by about 20%.

These are not the standard statistics presented by the "reformers" of the nation's health care system, but there they are: in 1947, the infant mortality rate in the U.S. was 47.0 per 100,000 live births; in 1965, it was 24.7; in 1969, 20.7 and last year, according to estimates, fell below 20 per 100,000.

As we said, these are not the figures frequently quoted by the would-be reformers. They prefer to say that various other countries have lower infant mortality rates than the United States, clearly demonstrating (they would have us believe) the superiority of federalized health care programs.

A number of fallacies in such logic should be pointed out:

Infant mortality probably isn't the best indicator of a nation's health status: too many social factors are involved. These include poverty, malnutrition, poor housing, low educational levels, and racial and ethnic differences, which are more highly correlated with infant mortality than the number of MDs or hospitals.

It's possible that other indices may be better measures of the state of a nation's health. About 70% of the deaths in the U.S. are related to heart disease, cancer, and stroke; 2.2% are classified as infant mortality.

However, the more statistics are compared, the cloudier the picture becomes. For example, statistics for 1968 show the Netherlands with an infant mortality rate of 13.1 per 100,000 and the U.S. with a rate of 20.8. Clearly, we are told, this shows the superiority of the Netherlands' health care system. However, the Netherlands' bronchitis death rate was 12.2 per 100,000; the United States', 3.2. Another leader in the infant mortality rankings, Finland, had a rate of 13.9. But its tuberculosis death rate was 13.0, the United States', 3.5. Japan had an infant mortality rate of 15.3; its TB death rate was 17.7. Great Britain, whose National Health Services is sometimes held up as an example of what this country should adopt, had a lower infant mortality rate, 18.8, than the United States. Its death rates were higher, however, in such other categories as tuberculosis, pneumonia, bronchitis, and stomach ulcers.

What does all this prove? That it is difficult to compare statistically one nation's health with another.

Ranking nations' health care on the basis of infant mortality is particularly difficult because of several factors: the often-discussed statistical incompatibility; differences in population and area; and ethnic, economic, social and cultural differences.

¹⁰ See Footnote No. 4.

Infant mortality in the United States is higher than it should be. This is a matter of concern not only for medicine but for all those responsible for dealing with poverty, malnutrition, housing and education. However, the mortality rate has been declining, and for this physicians can share the credit with those who have worked to improve income levels, nutrition, housing and education. But the real purpose of compiling any rate of this type should not be to fix blame or to deliver praise; it should be used by those genuinely concerned with improvement as a gauge for measuring progress. (American Medical News—1-25-71).

STATEMENT OF MARSH & McLENNAN, INC., NEW YORK, N.Y.

Chairman Mills, members of the committee: The purpose of these hearings is to consider legislation providing a program of National Health Insurance. The question at hand is not whether such a program is necessary, but rather what type of program should be implemented. We feel that we are qualified to provide counsel and recommendations regarding benefit design, administration and financing, but to dwell at length on the technical aspect of such a program without defining overall objectives seems more than premature. No matter how arduous the task of incorporating numerous technical details into a legislative bill, the task shall be greatly simplified when a clear agreement on basic principles has been reached.

In his opening statement on these hearings, Chairman Mills stated the problems inherent in medical care as currently provided in this country. In the broadest generalizations they may be categorized as follows:

1. Lack of availability of quality health care for all Americans.
2. Inadequate or haphazard means of financing for health care expenditures, regardless of availability.

Nearly all comprehensive national health insurance proposals introduced into Congress are constructed to deal with these two great deficiencies in U.S. medical care; availability and financing. The text which follows details the principles we feel should be followed in drafting appropriate legislation, and specific proposals related to these principles.

The first principle is to provide adequate medical care to those Americans for whom it is not presently available, and to provide funding for medical care for those Americans who might otherwise have access to adequate medical care but can't afford it. More than 5,000 U.S. communities of some 500,000 residents have no doctor, and in the slums of many metropolitan areas the ratio of residents to doctors is so great that the unavailability of medical care is nearly as acute. In 1970, sixty percent of personal health care expenditures were met by third parties (government, private health coverage, philanthropy and industry.) But what of the other forty percent, individuals for whom third party coverage was inadequate or unavailable. Worse yet, what about those who were in need of treatment and did not receive it? In short, "Like any scarce commodity in a free market, medical care is rationed according to ability to pay. Thus the poor, who need it most, get the least of it." Two ideas presented here are crucial. Medical care is a scarce commodity and the poor are those most in need. Thus any legislation on national health insurance must make medical care a less scarce commodity, and must provide availability and funding for the poor. In economic terms, increasing the supply of medical services should keep the cost down, and by concentrating on providing care to those who have had the least access rather than increasing benefits for those who currently receive "adequate" care, we can hope to avoid overburdening our existing resources.

Specifically, we need to increase the supply of doctors and facilities, and federal funding will be required. It has been suggested that the current number of physicians should be doubled, and this could be accomplished in ten years if existing medical schools would increase the size of entering classes by 15% for each of six consecutive years. This will require additional funds, roughly \$18 billion. But this sum is only \$1.8 billion per year over ten years, only 3% of our current yearly health expenditures.

Related to the \$30 billion it cost to put a man on the moon, the total outlay seems worthwhile. As a corollary, if we are to provide more doctors, they should be required, or at least given incentives, to practice for a limited period of time in areas where the supply of doctors is inadequate or nonexistent, namely in the slums or rural areas. Similar attention should be given to increasing the

number of nurses, health technicians, and medical facilities, with the same attention given to placing them in medically deprived areas.

Given the state of medical technology in the United States, our indices of national health (infant mortality, longevity, etc.) should be among the highest in the world. They are not. Yet simply by extending the availability of medical care to more Americans, these indices should significantly improve. However, not all medical care available in the U.S. is of the highest quality, and this should be an area of great concern. Quality controls can and should be implemented. Legislation establishing medicare stipulated that hospitals receiving Medicare funds must be approved by the Joint Commission on Accreditation of Hospitals, or have approval to receive such funds by their respective states. Such hospitals must also have utilization review committees comprised of staff members. Whether these are the proper controls is debatable, but the point is that controls can be legislated. The idea of review boards comprised of members of the county medical society, or hospital staff may be ineffective. Medical personnel should be reviewed by a panel of professionals with whom they are not associated or familiar. Such panels should, however, remain strictly professional as it hardly seems likely that any consumer panel would be qualified to judge the quality of medical care rendered. Health Maintenance Organizations stressing ambulatory care and preventative medicine will also serve to improve the quality and availability of medical care. But no single, monolithic delivery system will be a panacea for present shortcomings. There must be room for experimentation in different forms of medical care delivery that will best meet the needs of the people in view of their particular environments and attitudes about personal health.

Whether private contributions from employers and employees or general revenues from the government are used in the financing of a national health scheme, cost controls must be implemented to insure that our dollars will buy an optimum amount of health care. It does not seem reasonable to expect that health care prices will return to the level of ten years ago, five years ago, or even one year ago. However, the price inflation that has occurred in the past must not continue unchecked. Specific areas of concern are the dispensation of unneeded health services (i.e., unnecessary surgeries, or hospital stays that are too long or not necessary at all), fee-splitting, and the duplication and resulting underutilization of expensive facilities. A national health plan will not provide specific controls in these areas, but will authorize competent administrators to implement such controls.

What features of a national health insurance bill do we favor? A national health insurance plan should mandate comprehensive coverage for every American at an established minimum level of benefits. No employed, irrespective of any potential tax penalties, should have the option of refusing to provide the minimum coverage or no coverage at all for his employees. No individual, whether employed or unemployed, should be allowed to avoid coverage. Financing and plan administration should be through existing private insurers and non-profit entities. Regulation of both the providers of medical services and the "insurers" should be undertaken by state agencies established under federal legislation.

Employed individuals and their dependents should be able to participate in employer-sponsored group plans. The unemployed, self-employed, poor, near-poor, and otherwise uninsurable should be covered under statewide insurance pools comprised of insurers licensed to do business in the state. Employer-sponsored plans may provide additional benefits over the statutory minimums with the employee having the option of enrolling for the additional benefits or the statutory benefits only. All contracts of health insurance whether providing the statutory minimum benefits or additional benefits should be of standard form (see proposed regulations introduced in New York State by the State Insurance Department).

A feature of any national health insurance plan which is certain to generate controversy will be the structure of premiums. The issue will be whether such premiums should be based on the class of risk and cumulative experience of the group or pool to which an individual belongs, or whether they should be based on ability to pay. Proponents of the first approach have argued that the cost of other life necessities like food, housing, or clothing is not based on the ability to pay, but such an assertion is not entirely true. School lunch programs, food stamps, and public housing for those of low and middle incomes are examples of providing the life essentials on an "ability to pay basis." With regard to personal and social well-being, health care is much like public education, and public education is provided to a large extent on an ability to pay basis.

The second question to be asked of "pay your own way" proponents is how we will fund the insurance to cover those in the state pools. Obviously such funds will have to come from general taxation. Thus wage earners able to pay their own way will still be assuming the burden for those who cannot. Then why not fund the national health insurance plan through a payroll tax, income tax surcharge, or a combination of both? The rates for such taxes would be established by the individual states, based on their own experience, and the revenues turned over to the insurers. In the event individuals received benefits outside of their own state, and to offset the imbalance between states with very high or very low per capita incomes, federal funds could be channelled accordingly. It would also be general revenues received through taxation at either the state or federal levels that would be used to finance the expansion of our health care manpower and facilities. The agency dispensing these funds must be at the federal level as it would be grossly inequitable to allow the burden for making up our health care deficiencies fall too heavily on any individual states. Only in this area does a federal agency appear necessary. In all other respects, the states should be permitted to regulate the provision of health care as they do the areas of Workmen's Compensation and Unemployment.

Why have we advocated the general form of national health insurance described above? Essentially it is for a reason the Committee has heard in support of other proposals; in this great undertaking the private and public sectors should each perform the functions for which they are best fitted. The private health insurance industry has often been criticized for failure to extend the availability of coverage, for failing to participate through investment in the expansion of our medical manpower and facilities, and for failing to curb the tremendous rate of increase in medical care costs. To an extent these criticisms are justified. But like any private corporation, an insurance company is limited in the effect it can have on a widespread social problem. Had the insurance companies participated in the activities they appeared to neglect, the health care situation in our country might be only slightly better than it is today. They could not regulate the providers of medical services, could not provide the capital to extend benefits to the poor, could not eradicate the conditions of poverty that are the root cause of many of our health care deficiencies. As a major representative of health care consumers they may have been able to exert some influence in slowing the inflation of medical care cost. However, if we consider that only 60% of personal health care expenditures are covered by third party payment, and private health insurers provide only 40% of this total, they paid only 24% of total personal health expenditures. The leverage is greater than that possessed by any one individual or group, but still not a major part of the total. If a hospital submits a bill which the insurer considers excessive, and refuses to pay the excess, there is presently no prohibition to keep the hospital from submitting a bill for the amount not paid by the insurer to the patient. In the areas of planning, regulation, and financing for the poor, the public sector must succeed where the private sector has failed.

If we say that private insurance companies have the facilities, technical competence, and professional know-how to be involved in the administration of a national health insurance program, we will point out the shortcomings I have already mentioned, and then say that private carriers are profit-hungry corporations that pay only 50%-80% of premium dollars in benefits and absorb the rest in profit or poor administration. The facts will not support this contention. It is true that as a private corporation, one of the goals of a private insurer is to make money. However, health insurance has become regarded as an unprofitable line of coverage. Last year several underwriters of group health insurance had combined losses of hundreds of millions of dollars. For example, Connecticut General lost \$38 million; the Travelers Insurance Company lost more than \$30 million. Private carriers are not, at least at the moment, writing health insurance for any great profit. Nor are they incompetent administrators. Most companies are efficient enough to pay out roughly \$.92 in benefits for every premium dollar. Thus, the remaining \$.08 is "expenses." But state premium taxes will take at least \$.02 of the \$.08 in expenses, so the real expense factor involved is roughly 6%. The federally administered Medicare program does not do nearly as well. A comparison of total revenues versus total payments for Medicare indicates an expense factor of more than 10% in 1970 and more than 15% in 1969. Coupled with the ability of the government to plan and regulate health care services, the private insurance carriers, which have demonstrated a better record of performance in benefit administration, could effectively serve the needs of a national health care plan.

One additional point should be made. What is needed is a comprehensive national health plan. Such a plan should be considered and acted upon as quickly as possible. Enactment of a stop-gap Catastrophic Illness Insurance Act is completely unresponsive to the problem. Such a bill covering catastrophic illness, if passed, would be viewed by some as a permanent solution to our problems rather than a temporary coverage. It may tend to abate the sense of urgency needed to resolve our health care deficiencies through a comprehensive national program. Finally, no amount of catastrophic illness coverage can benefit the poor who are most in need if they can't afford the first doctor's visit, or don't have a doctor available to them. A catastrophic illness act offers no solution to these problems.

We have purposely neglected any discussion of some of the technical, yet very vital aspects of a national health program. We have not discussed what the minimum benefit level should be, what type of provisions shall apply to duplication and "other insurance," what the specific duties of various state commissions may be, and a variety of other details too numerous to mention, much less analyze. That did not seem to be the purpose of the Committee hearings. Our purpose, as professional employee benefit consultants, has been to highlight what we feel are the most pressing problems in American health care, and recommend what we feel is the appropriate response.

In summary, unavailability and inadequate financing of health care in this country necessitate a national health insurance program. Such a program should be provided through the capabilities of both the public and private sector. To the greatest extent feasible the public sector should be represented at the level of state agencies.

Those most affected by lack of availability and financing of health care are the poor and near-poor. Any national health program should recognize the special needs of this group, and make adequate care for them a primary goal. This should be done before we get concerned about union demands that a plan be devised that will reimburse every single penny of personal medical expenditure. This type of plan would increase utilization of health care services so drastically that prices would soar and the burden would become so great as to threaten the system with collapse. Those working for living wages can afford to pay at least a portion of their medical expenses out of pocket.

Of the legislation on national health insurance which has thus far been introduced into Congress, we feel that none as presently written is fully responsive to the current deficiencies in our system of health care. The one bill which incorporates the basic principles we advocate is the administration plan introduced into the House of Representatives by Rep. Byrnes of Wisconsin. The administration bill will need to be amended or rewritten when all interested parties have presented their unique problems with regard to a plan of national health insurance, but the principles of the administration plan are the basis on which to build.

STATEMENT OF THE NATIONAL COUNCIL OF THE CHURCHES OF CHRIST IN THE U.S.A.

Mr. Chairman and Members of the Committee, the National Council of Churches is a cooperative agency of 33 Protestant and Orthodox Churches in the United States. The membership of these churches total about 42 million persons. One of the purposes of the Council as set forth in its constitution is "to study and speak and act on conditions and issues in the nation and the world which involves moral, ethical, and spiritual principles inherent in the Christian gospel." This statement speaks only for the National Council of the Churches of Christ in the U.S.A. based on action of its General Board on September 11, 1971. It does not purport to speak for the member communions or for their individual members.

BASIS OF CHRISTIAN CONCERN

Health and holy are words with a common origin akin to whole, sound, hale and well. Their close relationship in Christian history stems from the life and work of Jesus Christ "who went about all Galilee teaching in their synagogues, preaching the gospel of the Kingdom and healing every disease and infirmity among the people."

Through the centuries Christians have been constrained to show forth the love of God not only by preaching but also by healing. Society has frequently been alerted by the churches to meet health needs. For example, in 1960 the National

Council of Churches urged that government should protect the health of people by making possible prepayment for health services. In 1961 it urged the Congress to include adequate health care for retired aged persons in the Social Security insurance program. Churches have nurtured a large proportion of persons engaged in health professions. Extensive health services have been developed and maintained by churches in this nation and abroad. Through all their activities in the field of health, churches have led men more fully to render service to God and their fellows and have expressed the Christian faith in love.

GOALS TO BE SOUGHT IN A HEALTH CARE SYSTEM

Although one cannot expect that an ideal health care delivery system can be established quickly the National Council of Churches respectfully proposes the following as goals toward which changes in the health care system should be directed.

1. Quality health care should be universal. We believe that the nation's health policy should be based on the principle that enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social conditions. Therefore, our goal should be that each and every person receive sufficient health care of good quality *as a right*.

2. Quality care should be accessible. Everyone should have continual access to basic medical care. Routine health guidance should be available on a daily basis if needed. Emergency service should be accessible immediately, at any hour of day or night. Each person should have periodic access to diagnostic and screening procedures. Measures to assure accessibility of health services will differ as between the congested low-income neighborhood of a city and isolated rural hamlets. Whatever measures are necessary to make emergency or routine care accessible when needed should be provided for. For an isolated family or hamlet this may involve helicopter service on call for emergencies, with ambulance or automobile transportation available to the poor family that has no car available when there is need but not an emergency. In low income urban districts out-patient clinics should be accessible without long waits for service. Often the wage-earner in a low-income family must lose a day's pay in order to take her child or herself to the clinic. If service were provided by appointment, many times it would be necessary to lose only part of a day's wages. There should be no difference in the kind of care received and the respect with which the patient is treated between that accorded a well-to-do recipient and that experienced by a low-income person. This relates to accessibility because many people will suffer needless physical pain rather than subject themselves to behavior of health-care personnel which demeans them and undermines their dignity and sense of self-worth.

3. Quality care should be comprehensive. It should include the whole range of health care services which are required to maintain health as well as to treat illness or injury. There should be community programs which help to prevent illness and disability, for example, general administration of inoculations as medically indicated, adequate sanitation, and similar services. Regular physical examinations and other measures to encourage early diagnosis and treatment should be available without fees which tend to discourage their use. Educational programs both for providers of health services and for the general public are needed to alert everyone to early symptoms of disease.

Treatment resources for both serious malfunctions and diseases and for more common illnesses should be available. They should be organized in such a way that hospitals and in-patient facilities are not used when out-patient or home health care will meet essential needs. Nursing and intermediate care for chronically ill patients should be part of the service program. Extended care facilities should be available without limitation based on ability of the patient or his family to pay and without jeopardizing a family's financial security. Medicinal drugs should be available as prescribed, without restriction based on ability to pay.

Rehabilitation services to restore patients to optimum individual and social functioning after illness or injury should be available. These should include both services designed to restore a person to gainful employment and those that are designed to aid an individual toward self-fulfillment, not necessarily involving employment.

Mental health services should be available when they are needed, both on an in-patient and out-patient basis. They should range from preventive programs,

through early detection to long-term treatment. Rehabilitative services such as half-way houses, should be provided to aid in restoring mentally ill people to the community when that is feasible.

Denial care, both preventive and remedial, should be available to all regardless of ability to pay fees for service.

There should be provision in the health system for research to improve methods of prevention, diagnosis, and treatment.

A major requirement to provide for a comprehensive health care system is the development of many more health personnel through a greatly expanded program of education and training. Special emphasis should be placed on recruitment and education of black, Spanish-speaking and other minority persons. Provision should be made for recruitment, training and up-grading of para-professional as well as professional personnel.

4. There should be continuity of care. There should be no hindrances opposing ready movement of patient from out-patient to in-patient status, from hospital care to extended care, from diagnostic services to medically indicated treatment. Such obstacles might be imposed by differences in administrative jurisdiction, by fees beyond the reach of people with limited income, or by bureaucratic inefficiencies. It is essential for continuity of care that facilities and personnel required for various types of health care be available when and where they are needed. This will require national planning by communities, states, regions and the federal government.

FINANCING HEALTH SERVICES

Methods of financing the health care system must assure equal access to quality health services, without stigma or restrictions for the poor, the near poor, the middle income group, as well as for the affluent; for self-employed and unemployed persons as well as for employees of corporations covered by collective bargaining contracts. The burden of the costs of health care should be distributed in proportion to ability to pay, without instituting a means test for every person seeking service.

There is more than one system of financing and administration which could meet this objective. That portion of necessary funds which is raised by taxation should come from a tax that is not regressive, i.e. which charges the low income person a higher percentage of his income for health care than the higher income person is required to pay. Social security taxes which levy a fixed percentage on an established number of dollars and nothing beyond that is essentially regressive and inequitable when used to maintain a health care trust fund. General federal revenues are less regressive in most instances. The most inequitable of all methods of financing is a fee for service charged against persons requiring service without the moderating effect of any kind of insurance to spread the risk.

The methods of financing should encourage persons to seek health care on a prevention and health maintenance basis, rather than to postpone action until a crisis occurs. In general, prepayment plans and compensation of providers on a per capita basis rather than fees for service provides financial incentives for keeping people well. Deductibles, co-insurance, and other features which require the consumer to pay a fee for each service tends to discourage early detection and treatment of physical disabilities.

It is recognized that one factor in recent increases in cost of health care is the increase in compensation of para-medical and non-professional workers in health care institutions who for many years were paid unjustly low wages. Providers of health care should be assured payment of reasonable costs including adequate compensation for health workers, professional, para-professional, and non-professional. The delivery system should include procedures for controlling both quality and cost of health care, so as to protect the public interest.

CONSUMER PARTICIPATION

Every person in a community or the nation is, at least potentially, a consumer of health services. Those who are engaged in providing health care, however, have some different investments, personal and financial, in the delivery system than do those who merely pay for and use the products of the system. In this context the word consumer is used to designate all those who are not providers of health services. It can be reasonably assumed that, if everyone else in the community has adequate health care, doctors, nurses, orderlies, and hospital maintenance personnel will not be deprived of it.

We do not propose that the legal and professional and ethical responsibility of the physician to make decisions affecting the health of the individual patient be changed. How communities and the nation mobilize their resources of money and people to provide needed health care, how this care is paid for, and how the delivery system is organized and administered are decisions that vitally affect the public interest. Therefore, they should not be left to providers of health care alone. Consumers should be represented on planning and administrative agencies through representatives of their own choosing. Such representatives should be selected in such a way that they are responsible to organizations which are committed to the public interest in health care.

The health care system must be responsive to regional and local needs and variations and to the needs and cultural patterns of individual consumers. While health care is a national concern and will require the resources of the federal government, there should be sufficient flexibility within the national system to permit a significant measure of local self-determination. It will, of course, be necessary to maintain national fiscal and quality-control standards, but within such limits considerable local control can be maintained, to assure responsiveness to local needs.

CONCLUSION

We recognize that balancing conflicting needs and values and arriving at decisions about changes in the health care system does and should involve a legislative and political process which takes time. It is the concern of the National Council of Churches, Mr. Chairman and Members of the Committee, that you not lose sight of the goal of a really effective health care system as you negotiate necessary steps in progression toward that end.

STATEMENT OF B. R. HUTCHESON, ASSISTANT COMMISSIONER FOR CHILDREN'S SERVICES, DEPARTMENT OF MENTAL HEALTH, BOSTON, MASS.

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 39 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*. 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*. Public Funds in the U.S.A. are allocated for children on the basis of whether the child or family is eligible for this public assistance. When the acts or statutes are passed which authorize such expenditures the following questions are never clearly known:

- (a) How many will be eligible for such assistance?
- (b) How many will apply for assistance among those eligible?
- (c) At what rate will those eligible apply?

Following the passage of some new Act or statute (a), (b) and (c) above begin to become clear with the passage of time. When overall expenditures are too great for the tax payer to bear, new eligibility criteria are then promulgated to reduce the load—or taxes are increased.

At the present time a state can roughly measure its effort to cope with some social problem by comparison with the expenditure of other states. This is a very crude measure and does not answer the central question of how well the state's effort is serving itself. It is contended that eligibility for public assistance should not be the sole criterion in selecting a child or family for public assistance; an additional criterion should consider those important characteristics of the community which contributed to the need for public assistance in the first place and which in turn generated the statute or Act. Example: Two communities roughly equal by all demographic measures* have 30,000 and 60,000 children respectively in the general population. If one community has roughly twice as many eligible children (for public assistance) as the other, shouldn't this influence the distribution of public funds to these communities? In other words, shouldn't the potential need for public assistance be related to the community in which it is spent and furthermore shouldn't the characteristics of community govern to *some degree* the expenditure of these public funds?

THE PROBLEMS

Analysis of the distribution of Public Funds to various communities reveals that funds are not being distributed in relation to a community's probable or potential need, let alone its actual need for such services; to this extent it can be said that an inequity exists since some communities make unequal use of the public Funds that are available to them. Is such a state of affairs desirable? It is not clear that unequal distribution of public funds to communities was contemplated or envisaged by the architects of the Act authorizing the expenditure of such funds. Rather, it was probably their desire that those in need should receive help.

Presently, public assistance funds are distributed according to demand and eligibility. In many communities eligible people have no local office at which to apply or they may not want public assistance even if it is readily available. These factors tend to reduce utilization. The situation might be schematically diagramed as follows:

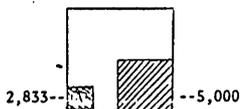
*Demographic measures to describe a community are taken by the census and include such indices as population, education, unemployment, overcrowding, per capita income, etc.

SCHEMATIC REPRESENTATION:

Present Situation
(termed inequitable due to overutilization by Service Area A and underutilization by Service Area B.)

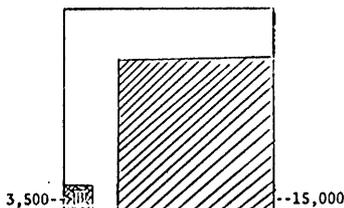
Service Area A

Child Population = 50,000



Service Area B

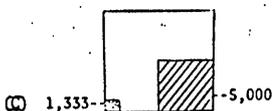
Child Population = 100,000



Proposed Situation
(termed more equitable after applying index of community need criteria)

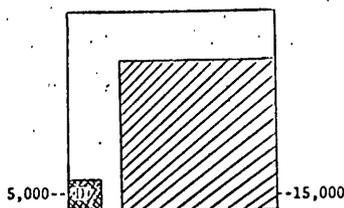
Service Area A

Child Population = 50,000



Service Area B

Child Population = 100,000



[A] + [B] = [C] + [D]

[Hatched Box] = Number receiving public assistance

[Solid Box] = Number eligible for public assistance

COMMUNITY FACTORS LEADING TO UNEQUAL USE OF PUBLIC FUNDS

Five main factors influence and lead to unequal distribution of public funds in the U.S.A. today.

1. Differential attitudes among those eligible for public assistance which in turn reflects attitudes about life.

2. Differential attitudes toward potential clients among public employees which again may reflect their outlook on life.

3. A distribution system for Public Funds which is largely unrelated to the geographic area to be served. (It is well known that clients make greater use of those services geographically close to them.)

4. A general lack of knowledge among decision makers and planners that an inequitable distribution of Public Funds is presently taking place in communities comprising the U.S.A.

5. An accountability system that is related only to eligibility per se rather than being related to eligibility plus potential community need for such services.

It appears evident that a moral issue exists: If a legislative Act defines a social need, does the U.S.A. have a responsibility to see that communities take advantage of Acts designed to relieve the social problem defined? If so, a system should be devised so that certain communities do not use public funds exces-

sively at the expense of other more needy communities. The contention is made here that public assistance is for the general use of the public and should be made evenly distributed than at present. The unit of distribution would logically be the functional geographic unit of service delivery.

A PROPOSED SOLUTION—A NEW DELIVERY SYSTEM

A more equitable distribution of public assistance funds would relate itself to the potentially existing 1800 geographic Service Areas of the U.S.A. The formula for distribution of funds would not only spell out eligibility, but would also be related to the reality of need in the individual Service Area. To accomplish this, the unit of distribution would be the 1800 Service Areas which should define service delivery. An administrative mechanism is needed in each of these Service Areas, which would distribute public assistance funds in relation to the projected need of the particular community. This would enable a finer adjustment of the expenditure of public funds, and the accountability of expenditure would be related not only to eligibility but to the reality need of the particular Service Area. Furthermore, the number eligible to receive public assistance would be constantly in the same ratio to those deemed in need of public assistance.

But what indices constitute or represent a community's true need for public assistance? A formula which could represent the reality of need might include such social indicators as number of children age 20 and below; the per capita income of the community; rate of unemployment; rate of juvenile delinquency; racial minority proportion; etc. This combined index can be thought of as an index of need, and funds would be allotted to the Service Areas in relation to the Area's overall index of need. After the allotment has taken place the mechanism at the local level would then determine individual eligibility. Such a procedure would assure that each community gets its fair share of public assistance funds. Thus, eligible people in any one community would not be deprived of services because another "richer" Service Area was consuming public funds at a higher rate per capita.

In summary: It is proposed that public assistance funds for dependent children and those with special handicaps be distributed to the potential 1800 Service Areas comprising the U.S.A. in relation to the Service Area's need as well as the eligibility of the individuals residing in that Service Area.

The assumption might be made, however, that under such a new plan high demand and consumption Service Areas would get less funds than at present. But this is, of course, not necessarily so and would depend on what index of community need was selected.

It is thus important to make a distinction between the money which a Human Services 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 formula from the federal to the 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 systems 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 it will not occur unless a true mechanism is brought into being which specifies accountability and responsibility: otherwise, 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 melange 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 of the 7 or 8 Programs should consist of the Division of Child Health Services which 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 on-going 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-CHP and the Regional Medical Program *should be integrated into one group*, and in Massachusetts should be related to the presently existing 7 regions which define service delivery. The staffs of these 2 groups could then be deployed via a visit to 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 Hu-

man 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 Service 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.

STATEMENT OF THE MASSACHUSETTS COMMITTEE FOR COMPREHENSIVE CHILDREN'S SERVICES

CHILD CARE: CHAOS AND CRISIS A PROGRAM FOR COMPREHENSIVE SERVICES

With the statement, "I have announced a commitment to the first five years of life as one of the basic pledges of this Administration," in his message to Congress on April 14, 1969, President Nixon recognized that what he called "the most dependent constituency of all" is also one of the most neglected. The care of millions of children in the United States who need public help is in chaos. This is as true in Massachusetts as it is in the other states.

The Program for comprehensive services for children, proposed by the Massachusetts Committee for Comprehensive Children's Services, outlines new methods to meet this problem.

Large numbers of Massachusetts children receive fragmented, unbalanced, incomplete and discontinuous services, despite this state's rich resources in medical technology and professional skills. The organization of the services governing the child care system is hopelessly outmoded. We must have change.

We propose a comprehensive program which will furnish the optimal health care for every child. Helen Wallace* has described such care:

"The optimal health care of a child must involve his family and must provide not only preventive, curative, and rehabilitative care on a continuing basis, but also the ancillary services which are necessary for the care to be effective. It includes the medical, dental, social, emotional, educational, vocational, recreational and nutritional aspects of care."

Meeting the problem

This program proposes to systematize the "nonsystem" we now have and form a comprehensive community program welding public and private efforts. Only in this way can a child obtain all the care he needs to grow into a mentally and physically healthy adult and a productive member of society.

The requirements for reorganization into a new child health care delivery system in Massachusetts are:

1. Passage of complementary federal and state legislation to give sanction to the creation in each community of a new nonprofit corporation combining public and private interests. Such a corporation—much like the Comsat Corporation in its public-private character—will receive all federal, state and local funds destined for the community's child care program. Such a non-profit corporate group would allocate these funds in accordance with local needs for the promo-

*American Journal of Public Health, October 1968.

tion of the welfare of all the children in its jurisdiction. The Comsat-like non-profit corporation would thus be utilized to help solve the problems of comprehensive child care as the original Comsat Corporation has solved problems of instant world-wide satellite communications.

2. Passage of complementary federal and state legislation to mandate child health insurance. A prepaid insurance plan is necessary to provide comprehensive child care services.

3. Passage of federal legislation to create tax credits encouraging industrial companies participating in the program. Such companies will view this program as a needed mechanism in their communities, they will undoubtedly want to contribute to its support as one way of assuming their social responsibilities.

4. A public decision to shift the priorities in our national budget and allocate more of our resources for child care programs. Only 10% of the \$80 billion now spent for the military industrial complex, for example, would pay for universal child health insurance.

Even if the defense budget were not increased, our growing gross national product will produce a surplus of an estimated \$38 billion by 1974. We can invest in future generations by using these funds to meet human needs at home.

5. Involvement of the public in helping to develop a rational approach to the solution of our child care problem, which is a national social problem. To bring about change, the public must create the climate for change.

What is needed, in short, is a nonprofit corporate structure to meld public and private, professional and lay interests. It will enable each community to make direct use of federal, state and local funds for its own needs, as it determines those needs. It will promote a sense of community by enabling people to feel they are controlling their own destinies and meeting their own needs.

Why a new system of comprehensive children's services is necessary

The present chaotic delivery in Massachusetts of health care for children demands a new approach to such services.

In Massachusetts there are 300,000 children in families whose incomes fall below \$3,000. More than 15 public agencies in Massachusetts now furnish them and others in need with uncoordinated services, focusing only on physical symptoms or on behavior too blatant to ignore. These agencies' failure to promote the mental health and emotional wellbeing necessary for a child's optimal growth and development is shocking. Consider this evidence, in the Commonwealth of Massachusetts and elsewhere:

1. The United States has a higher infant mortality rate than a dozen other civilized countries, due mainly to poor prenatal care and postnatal follow up services.

2. Consider the infants admitted annually to Boston Hospitals with the diagnosis "failure to thrive." They are not only underweight, but apathetic, depressed and withdrawn. Proper care has not been delivered to them.

3. "At the present time, in our own country, the evidence is becoming ever stronger that there is a reservoir of malnourished and undernourished people both in our cities and in our rural areas and that this may well explain sorry findings on I.Q. tests, etc." *

There is no doubt this stunts both physical and mental development.

4. Few very young children in Massachusetts are able to attend nurseries. There are no licensed resources for children younger than two.

5. In Massachusetts there are 500,000 working women, but only enough places in licensed all-day school centers for about 400 children. Children lacking wholesome, family-related preschool experiences are denied the crucial foundation for later formal learning. This is one reason why first graders in the Boston public schools do so poorly in reading readiness tests.

6. Some 4 million children under 18 in the United States need psychiatric help. According to a recent report of the Joint Commission on Mental Health of Children, only 10% of those in need can be served by our present services.

Last year, as an instance, some 600 Greater Boston children of school age and below suffered from emotional disturbances so severe that they had to be admitted to general hospitals.

7. Services to counteract social pathology and promote emotional growth in Massachusetts are pathetically weak and disorganized. The schools are crowded with dispirited and impulse-prone subpopulations of children, whose pathology is displayed in behavior ranging from lack of respect for authority to

**Medical Tribune and Medical News*, May 1, 1969.

drug use and crime. If the present trend in law-breaking continues, one in every ten youngsters in the United States will have appeared in juvenile court by the time he has reached the age of 18.

8. In the Commonwealth there are an estimated 60,000 emotionally disturbed and retarded children, 25,000 with handicaps such as perceptual problems and physical disabilities, 50,000 whose family life or social circumstance does not permit them proper growth and emotional development, and 117,000 whose health is at special risk, such as those receiving public welfare assistance. There is no plan to provide for a joint public and private effort in behalf of these children.

Failure of the old methods

State governments, realizing the great diversity of children's needs, have tried to cope with the problem services with two different legislative approaches.

One method has been to legislate the creation of Bureaus or Divisions of Children's and Youth Services whose function was to be the coordinating of services to children as well as the provision of only certain specific services. This fails on a local, state and federal level, since these Bureaus or Divisions are never given a mandate to provide comprehensive children's services. The mandate is withheld because other departments in the public sector have overlapping responsibility for various aspects of the needed services. This approach also fails to join the private and public sector in an overall coordinated community plan.

A second method has been to legislate local community mechanisms for the coordination of departments within the public sector. It also attempts integration with the private sector by buying services on a fee basis. This approach has always floundered at the local and top departmental levels where firm authority and responsibility for actually carrying out a coordinated program is not established with the public and private sectors merged.

Both methods are further complicated by a proliferation of public and local private advisory Boards, which in turn are responsible to various public and private agencies. Instead of having comprehensive children's services planned by a single local group representing the coordination of public and private groups, we have groups with diverse and sometimes conflicting aims and goals.

The result is that those children whose families can afford it receive good care, and other children receive care, haphazard at best. There is no reason why children, deprived economically should also be deprived of physical, mental and emotional health.

It would be hopeless as well as unwise to try merely to reform the fragmented and incomplete services with overlapping jurisdictions. Our children would just continue to suffer from the depersonalized health care symbolized by the infant in New York City who was taken to a single municipal hospital 23 times during the first nine months of its life, and was never seen twice by the same physician.

What a comprehensive services program will do

A sound early child care program provides children with a new environment, supplementing their homes, and promotes learning and growth. It is the best time to diagnose and correct physical, emotional and mental disorders, which might not otherwise be overcome or only remedied at far greater cost later in life.

(A certain amount of criticism has lately been level at Head Start, which has some elements of the program just discussed. A report claimed that children did not advance appreciably over those who did not participate. If that is so, the reason is surely that Head Start training comes too late in the child's life and it is a "one-shot" effort that lasts much too short a time.)

It is impossible to tell the cost to society of undeveloped minds, of wasted creative energy and talent. But there is no question of the crucial importance of wholesome and constructive learning experiences in the formative years. Consider this report of the National Council on the Education of Disadvantaged Children:

"There is substantial evidence that the level of intellectual capability young people will achieve at 17 is already half-determined by the age of 4 and that another 30% is predictable at 7 years.

"This is no ground for believing that a child's academic fate is sealed by his seventh birthday, but it means that a community that seriously wants to improve its children's opportunities will start them early.

"In terms of sheer economy, it can be shown that the earlier the investment in systematic intellectual development is begun, the greater will be the rate of return."

Comprehensive children's services not only provide for all aspects of physical and emotional health, but also supplies the foundation for early and vital educational processes.

How the program will work

Organization of the Comsat-like corporations into jurisdictions covering functional geographic areas of service will be the best formula for delivering comprehensive child care. Fortunately, Massachusetts already has the skeletal structure for accomplishing this in the regional system overseeing community mental health programs, which have been set up as partnerships between the state and local, private, non-profit corporations. This program, in effect since 1967, will be meshed with new ones where necessary, so that all efforts in each community will be coordinated through one source.

Like the mental health care system, the Commonwealth will be divided into 37 areas. They in turn are to be organized into seven regions, to help the community areas plan and carry out their programs. In each community, control of the non-profit corporation will be in the hands of a board of directors, representing public and private welfare agencies, business, labor and laymen—to ensure responsiveness to community needs. They will be paid, as are the directors of large private corporations, so that the best talent can be attracted to serve and so they can give the necessary time required.

The state will supply some of the professionals to the corporation, while the community will provide the facilities and upkeep. The board will appoint the director, who will have authority in his area.

Comprehensive care for children will begin at the regional centers serving three to five community areas, with an average total population of 750,000. Each center will start the development of the training, resource-sharing and professional services so necessary. It will:

1. Help the area corporations bring coordinated preventive health care and curative child care to their communities.
2. Plan family goals in relation to a child's developmental profile. The profile will be fashioned by a systematic cataloguing of his developmental and environmental liabilities and assets in his health record—something not yet done in this state.
3. Begin family-based community programs to adapt the child to group experience during his pre-school years, thus laying the foundation for formal education. Moreover, by the time he enters school, the programs will have been able to discover and deal with any physical or emotional ailments.
4. Develop community alternatives to institutionalization. Many children are now institutionalized some distance from their homes (which often compounds their problems), while they could be living at home and attending specialized day care schools. Of the 3,000 retarded children now in public institutions in Massachusetts, probably one-third could be placed in community programs.
5. Operate any child care institutions in its region.
6. Channel combined federal, state and local block grants to the community corporations in the Region.

In turn, the community corporation will develop a comprehensive child care plan for its area; initiate and carry it out; launch and oversee (through private carriers) child health insurance coverage for those children who need it; and buy services from private agencies and persons wishing to participate in the program.

Each community has a right and responsibility to define the health needs and benefits of its members. Rural towns, for example, will not have to depend upon Boston for needed services. Moreover, every community will have readily accessible services. A child should not have to travel hundreds of miles to Boston to get a specialized examination.

Financial resources for the program

The money to conduct this program will, as indicated, come mainly from the state and federal governments, as money for child care services does now, and from insurance plans. But the public funds will be much better spent, because the community system will eliminate the present wasteful duplication and lack of coordination.

Moreover, many of the children with physical and emotional problems who now require institutionalization will under the new program be treated in the community on an out-patient basis, thus saving not only the taxpayer money, but the patient money as well. There is no doubt that the preventive aspects of a comprehensive program will eventually save society untold amounts that otherwise would cost it in disorder and crime.

The federal government spends only \$190 a year per child, compared with \$2,000 per aged individual. Obviously, this amount is low considering the need. And if the reordering of national priorities spoken of earlier is undertaken, this amount can and must be raised.

A commitment we must make

There is new interest in the long-neglected subject of child welfare. The Joint Commission on Mental Health of Children, mandated by Congress in 1965, recently issued a report, which included many recommendations contained in this program.

The Department of Health, Education and Welfare has formed a panel for coping with vital problems of child health care.

A state panel has also been formed in Massachusetts based on the work of the federal panel.

The Massachusetts Office of Planning and Program Coordination, which reports to the Department of Administration and Finance, has taken the first steps in coordinating programs for children.

The United States is at a point in its posture toward the care of children similar to where it was in its attitude toward education 300 years ago. Then, the children of upper socioeconomic groups were educated as a matter of course; those of the lower socioeconomic groups were not. Compulsory health care is as much a necessity as compulsory education.

President Nixon has made a major commitment to the betterment of the first five years of life. Massachusetts must do no less.

The magnitude of the problem of children who are delinquent, retarded and have emotional disability demands public action now, and demands it immediately. Furthermore, we must bring beneficial influences to bear on children to help them grow up into productive human beings.

The task can be accomplished. *Fortune* magazine stated it well (Edmund K. Faltermayer, "We Can Afford a Better America," March 1969):

"As the U.S. moves to engage with its social and environmental shortcomings, we should keep two basic points in mind lest we be overwhelmed by the seemingly infinite commitment involved.

"The first is that during the next decade, economic growth will make available plenty of money to do what needs doing. The second: the whole undertaking will—and must—broadly benefit the entire populace."

THE MASSACHUSETTS COMMITTEE FOR COMPREHENSIVE CHILDREN'S SERVICES

The Massachusetts Committee for Comprehensive Children's Services, which presents this program to the people of Massachusetts for adoption, is a voluntary committee of concerned citizens, organized in 1969 for this purpose.

The Committee engages in public education to develop understanding for this program and for the public needs it will fulfill.

The Committee invites correspondence from groups and individuals on the broad subject it covers. Headquarters of the Committee are 91A Vernon Street, Boston, Massachusetts 02108.

The members of the steering committee are:

Dr. B. R. Hutcheson of Boston, chairman pro tem. Dr. Hutcheson is Assistant Clinical Professor of Psychiatry, Harvard Medical School; Assistant Commissioner for Children's Services, and former Director of the Division of Mental Hygiene, Massachusetts Department of Mental Health; Lecturer in Psychiatry, Tufts University Medical School.

Edward L. Bernays of Cambridge, has been called U.S. Publicist No. 1 by *Time Magazine* and other authorities and has been intimately associated with many health causes, including the American National Red Cross, Public Relations Advisory Committee member; National Multiple Sclerosis Association, a director; Arthritis and Rheumatism Foundation, N.Y., a director; National Committee on Mental Hygiene, a director; Montefiore Hospital, N.Y., a director; Hospital for Joint Diseases, N.Y., a director; Action on Smoking and Health, a spon-

sor; National Cystic Fibrosis Foundation, a trustee; National Committee on Mental Hygiene, a director; *Dietetic and Hygienic Gazette*, editor; he holds an honorary doctorate degree from Boston University.

Dr. Charles Djerf of Quincy. Dr. Djerf is a practicing pediatrician, Quincy, Massachusetts; Fellow, American Academy of Pediatrics; Instructor of Pediatrics, Tufts University Medical School; Trustee of Tufts University; a Director, Medical Foundation, Inc.; Honorary President, Quincy Symphony Orchestra; Past President, South Shore Mental Health Association, Inc.

Dr. George E. Gardner of Belmont. Dr. Gardner is Director of the Judge Baker Children's Psychiatric Clinic; Psychiatrist-in-Chief of the Children's Hospital Medical Center in Boston; and Professor of Psychiatry of the Harvard Medical School. He is a member and officer of a wide range of scientific and honorary societies.

Mr. Henry Jones. Mr. Jones is President of Massachusetts Blue Cross, Inc.; member of the Committee on Health Information Systems of the Joint Center for Urban Studies of Harvard University and M.I.T.; and also member of the Governor's Medical Assistance Advisory Council, the Health Committee Division of United Community Services, and the National Health Council.

Dr. Bernice Miller. Dr. Miller is Associate Dean of Urban Affairs at Jackson College (Tufts University); has been Vice Chairman of the Neighborhood Service Project, a board member of the Committee for Community Educational Development, and a member of the Council for Educational Development.

Mr. Paul Parks of Boston. Mr. Parks is Model City Administrator for the City of Boston; a partner of the Associated Architects & Engineers of Boston; a graduate of Purdue University, B.S. in Civil Engineering; and attended Oxford University in England, for special studies. Mr. Parks has been Committee Chairman, U.S. Civil Rights Commission, charged with conducting a study of de facto segregation in the Boston Public Schools; he has been Chairman, Education Committee and Vice President of the Boston Branch of the N.A.A.C.P.; and he also has been a member of the Massachusetts Committee of Children and Youth, along with many other organizations which he has served in an advisory capacity. Mr. Parks' awards include: Kiwanis International, "Roxbury Man of the Year," 1968, and Junior Chamber of Commerce, "One of the Ten Outstanding Young Men in Greater Boston," 1958.

STATEMENT OF CHARLES L. HUBER, NATIONAL DIRECTOR OF LEGISLATION,
DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee: The Disabled American Veterans and its Ladies Auxiliary share a deepening concern as to what effect the proposed National Health Insurance plans will have on the existing VA system of hospitals and clinics.

Legislation pending before your Committee would develop a national compulsory insurance system designed eventually to replace medicare and medicaid to be administered by HEW or state governments under HEW contract. There are also pending other varying proposals. The future role of the largest single hospital system in the world—the VA hospital system—in these new National Health Care plans is, at best, a cloudy issue. In our opinion, the great accomplishments of the system should not be overlooked as sweeping new health delivery proposals are being legislated.

There are several very important points which the DAV wants to express to this Committee as you finalize national health care legislation.

1. At the present time, the VA hospital system is taking care of about 20,000 patients daily who are eligible for medicare and medicaid benefits. A conservative estimate of the cost of treating these patients is about \$400 million annually, and under present law, the VA receives no reimbursement from medicare or medicaid funds. These patients are cared for from direct federal appropriations to VA. If VA programs are curtailed, this burden will fall on the new system.

2. The overall per diem cost of treating patients in VA hospitals currently is about \$50.00 per day, which is about one-half the average cost of private sector hospital costs. Patients cared for in the VA system will cost about twice as much under the National Health Plan.

3. Considering the above factors, it becomes clear that before a national health care plan is adopted, the future role of the VA hospital system must be clearly defined.

Recently, the Director of the Office of Management and Budget advised various members of Congress, including the Chairman of the House Veterans' Affairs Committee, that practically all plans to modernize and construct VA hospital facilities would be further delayed pending action on national health care proposals.

To quote the OMB Director in one letter to a member of Congress who inquired as to the status of a new VA hospital facility which had been announced would be built, the Director stated, "The President has recently introduced national health insurance proposals, which could have profound implications for the VA hospital systems. These initiatives are a new element that require consideration before coming to decisions on new hospital construction proposals. Therefore, we cannot move ahead with any new hospital construction proposals until there is a careful evaluation of the role, size, and geographic distribution of the VA hospital system in the light of these proposals."

Mr. Chairman, it is common knowledge that OMB officials are doing everything possible to scuttle the VA hospital system. In the 1972 budget proposal, they attempted to cut the average daily patient census in VA hospitals by 5,000 per day. Yet, it was evident that there was a sharp increase in the workload of VA hospitals because of our growing and aging veteran population; however, OMB insisted that cuts be made for the sake of budgetary savings. What happened? Waiting lists for hospital admissions skyrocketed and until Congress overrode OMB by insisting that last year's VA hospital census level be maintained, there were many veterans turned away who needed medical care. The battle is not over yet.

Subsequently, in response to an inquiry made to the Administrator of Veterans' Affairs by Chairman Teague of the House Veterans' Affairs Committee, it was learned that over \$70 million voted by Congress for FY 1972 VA medical care would not be used. These funds were vitally needed to improve VA hospital staffing; however, by OMB edict, they cannot be used even though the number of patients to be treated will be greater than ever before, and the already overworked hospital staffs will have to do more.

Mr. Chairman, the VA hospital system has too often received backhanded slaps from the Bureau of the Budget and its successor organization, the Office of Management and Budget. Accordingly, we strongly urge this Committee—before it takes final action on any national health care plan—to request from the Office of Management and Budget, a commitment as to just how the VA hospital system will fit into the legislative proposals which this Administration has laid before your Committee for consideration.

In short, Mr. Chairman, OMB cannot kill a 2½ billion dollar program that care for nearly one million Americans each year without those costs being transferred elsewhere. We submit that you cannot honestly consider the cost implications of the bills before you until OMB levels with the Congress on the future of the VA medical program.

The Disabled American Veterans recognizes that the problem of health care for the general population is swelling rapidly and that legislation is needed to deal realistically with all aspects of the health issue, including the plight of medical education. However, the DAV is unalterably opposed to any scheme which has as its object the absorption of the VA medical and hospital program into a sweeping National Health Insurance system. Conversely, we firmly advocate that the VA hospital program, as presently constituted, not only be preserved intact but also be expanded and improved for the benefit of America's war disabled.

Proposals to improve the distribution of physicians, dentists, nurses, technicians and other allied health personnel are also under consideration in the Congress. Some of these proposals have a laudable purpose because the national shortage of doctors and health professionals is severe and worsening.

The DAV, through the years, has been expressing its grateful appreciation for the support consistently given by the United States Congress to the development of the educational, medical and prosthetic research programs carried out in VA hospitals and clinics.

The long and specialized experience acquired by the VA over the years is very well placed to propose, foster and coordinate these important projects.

The DAV, by its very nature, has a deep and continuing interest in the Veterans Administration's Prosthetic and Sensory Aids program. This well-developed

discipline is currently furnishing prosthetic appliances and repair services to some half million veterans. The VA has worked out and improved this program to a point of maximum efficiency in the highest interest of these seriously disabled veterans.

The impact of the Vietnam era has brought about a greater demand for prosthetic services. In 1970, these services were provided for approximately 23,000 veterans disabled in that conflict.

To our knowledge, the VA is the only agency in the Federal Government having a specific, integrated organization devoted exclusively to the field of prosthetics. To eliminate this service or have it swallowed up by an untried, monolithic bureaucracy would, in our view, destroy one of the most vital veterans' programs now available.

We also bring to your attention, Mr. Chairman, the significant progress made in recent years by the VA in the care and treatment of patients with psychiatric disabilities. Due in large measure to the help and interest of the Congress, staffs at VA hospitals have been in the forefront in improving care for these patients. The VA has clearly demonstrated what can be done to cure and return those suffering from mental illnesses to an economically useful life. Through the efforts of the VA hospital system, the veteran psychiatric patient has fared better than his counterpart in the general population.

There is within the VA system of hospitals and clinics, a unique and unmatched resource with a tremendous potential for dealing with this problem—a potential which has proven its value in many ways. The tranquilizing and energizing drugs which revolutionized treatment in mental disorders were first demonstrated to be effective through evaluation of Veterans Administration "Cooperative Studies."

The VA has many programs in progress for the benefit of the veteran patient with a psychiatric disorder. Through its primary mission of delivering the best available treatment and care for the veteran patient, the VA system of hospitals and clinics advances the progress of medicine in the United States and, indeed, the world. The DAV feels very strongly, Mr. Chairman, that this resource must be protected and that it deserves your complete and staunch support.

The VA operates the largest chain of hospitals in the country (166). It is engaged in 5,200 research projects, covering almost every facet of medicine. It provides hospital training for over half of the nation's physicians.

The VA operates 202 outpatient clinics. Nursing home care units have been established in 63 VA hospitals, totaling 6,000 operating beds. Additionally, the VA contracts with over 3,000 community nursing homes with a total bed capacity of 250,000 beds.

The VA operates 16 domiciliaries, which provide care and treatment for aging veterans. The primary objective of this program is to establish self-reliance in the patient-member in direct accordance with his treatment and rehabilitation goals in order to assist his return to the community.

The VA has six Restoration Centers whose principal objective is to restore disabled veterans to more purposeful and independent living, with special attention to the social and economic aspects of illness and disability.

The VA operates 36 Day Treatment Centers and nine Day Hospitals, all designed to facilitate the readjustment of disabled veterans to previous normal living and work conditions.

There are currently twenty-two different types of specialized Medical Services available in VA hospitals. All are directed toward the special needs of the sick and disabled veteran.

The DAV, in accordance with a continuing national convention mandate, is constrained to oppose the closing of any VA installation in the medical field because of the well-demonstrated need for existing installations to care for disabled veterans.

Legislation (H.R. 6568) passed by the House October 4, 1971 would limit the authority of the VA and the Office of Management and Budget with respect to construction, acquisition, alteration or closing of veterans' hospitals and would prohibit the transfer of VA real property unless such transfer is first approved by the House Committee on Veterans' Affairs. This bill, if enacted, would insure that any prospective plans to close VA hospitals will be given a critical and thorough examination by the Congress. This, in our opinion, would help forestall any hasty, ill-advised plans to close VA medical facilities. As mentioned earlier, the Office of Management and Budget has already called a halt to the VA hospital construction program. The OMB in this crucial time in the history of

our country. refuses to abandon its long-range plan of trying to put as many restrictions on the operation of the Veterans Administration's medical system as it is possible to accomplish. Regrettably, this Agency has been altogether too successful.

President Nixon in his Veterans Day message, declared that "it is to our veterans that we owe the final debt for America's greatness, and we intend to pay that debt."

We believe that the welfare of the disabled war veteran and the debt his nation owes him dictate aggressive action to make certain he receives a high level of medical service as a matter of right, that he be considered apart from the general population, and that he be given total priority with respect to health care benefits. In our view, the principle of first-rate medical care for wounded and otherwise disabled war veterans is at once so just and indisputably right, that the Government is under a strong moral obligation to continue to effectively operate the VA hospital and medical care system as it is presently constituted.

The VA Administrator already has statutory authority to enter into agreements with medical schools, hospitals, medical centers and individual members of the medical profession for the free exchange of medical information and techniques. This authority was granted by Public Law 89-785, approved November 7, 1966, as one part of a comprehensive program for the sharing of medical facilities, equipment and information.

Grants to carry out these projects under this program were scheduled to expire June 30, 1971. The Congress passed Public Law 92-69 which extended this program for the next four fiscal years. It is a well-established fact that the program has proved highly beneficial, not only in the Veterans Administration's hospitals, but in the surrounding medical and scientific communities, particularly those located in remote areas. To this extent, the Disabled American Veterans would agree that the VA should link and share its resources, its talent, and its knowledge.

In closing, Mr. Chairman, I wish to emphasize again that there is a real and compelling need for maintaining the independent status of the existing VA hospital and medical care system. The transference of VA hospital functions to some unwieldy, all-encompassing National Health Insurance System would represent, in our opinion, a repudiation of the nation's commitment to provide efficient, high quality health care services for our sick and disabled veterans. We are confident that their concern will receive the sympathetic interest of your distinguished Committee.

Again, many thanks for allowing us to present the views of the Disabled American Veterans in this most important matter.

STATEMENT OF NATIONAL COUNCIL OF JEWISH WOMEN, NEW YORK, N.Y.

The National Council of Jewish Women, an organization established in 1893, and with a membership of over 100,000 in local sections throughout the United States, has concerned itself with health care for the nation for many years.

At the last biennial convention held in April of 1971, in Detroit, Michigan, the delegates adopted the following resolution:

"The National Council of Jewish Women believes that a healthy Community, sound family life and individual welfare are interdependent and thrive when barriers of poverty and discrimination are removed. It believes, therefore, that our democratic society must give priority to programs which meet the economic, social and physical needs of all the people, and that the public and the private sector must work together to help individuals function successfully and independently in a changing society.

It therefore resolves: To work for a social security program which will provide . . . Social insurance as the basic method for financing the costs of health care for all.

To work for and support a national health insurance and health care program."

These resolutions commit the National Council of Jewish Women to support a contributory health insurance system for all citizens. We believe that health care is a basic right and the benefits of modern medical science and technology should be available to all individuals on an equal basis.

At the present time many individuals are unable to secure medical care due to the inflated costs of care and the serious gaps in private health insurance coverage. The National Center for Health Statistics of the Department of Health, Edu-

cation, and Welfare, reports that of the 177 million non-institutional civilians in the United States in 1968 under 65:

| | <i>Millions</i> |
|---|-----------------|
| No Hospital insurance..... | 36.3 |
| No surgical insurance..... | 38.8 |
| No in-the-hospital medical expense insurance..... | 61.0 |
| No insurance to cover x-ray and laboratory examinations when not in the hospital..... | 89.0 |
| No insurance for visits to doctor's offices or doctor visits..... | 102.0 |
| No insurance against the cost of prescribed drugs..... | 108.0 |

Only 36.0% of consumer health expenditures were met by health insurance in 1968. One of the most serious gaps in private health insurance is that low-income people have the least coverage. A survey by the Department of Health, Education, and Welfare reveals that among:

| Families with less than— | <i>No hospital insurance</i> |
|--------------------------|------------------------------|
| \$3,000 income..... | 64 |
| \$3,000 to \$5,000..... | 43 |
| \$5,000 to \$7,000..... | 22 |
| \$7,000 to \$10,000..... | 11 |
| \$10,000 or more..... | 8 |

These statistics are a clear indication that private health insurance is not meeting the health needs of groups in our population whose needs are the most urgent.

The quality of health care in the United States is declining in spite of the fact that we spend almost \$70 billion a year, from all sources, and our record compared to that of other industrial nations is not very high. Our infant mortality rate is higher than that of 12 other nations; we rank 7th among industrial countries in percentage of mothers who die in childbirth; we are behind 17 other nations in the life expectancy of males and behind 10 for females, etc. In all instances the United States ranked better 15 or 20 years ago.

It is paradoxical that with all the excellent medical resources we have we cannot take care of the health needs of our population. Experts in medical economics have said that our resources are not used properly or efficiently and the misuse of our resources greatly increases the cost of the care. We overuse our hospital facilities for patients who should be cared for either in the out-patient facility of a hospital or in a physician's office. For these reasons hospital charges rose at an annual rate of nearly 13 percent compared with a six percent rise for all medical care prices and about three percent for all items in the consumer price index.

In view of the current situation, we believe the following are essential to a national health care program:

1. Coverage must be comprehensive and include preventive, health maintenance, diagnostic, treatment and protective services.
2. Every individual in the United States should be eligible for the complete range of services.
3. The program should be financed, like social security, with contributions from employees, employers and the Federal Government.
4. The program should provide for a free choice of physician and free choice of health delivery systems.
5. One of the principal objectives of a health security program must be the organization and delivery of health care. Additional financing alone will not guarantee that comprehensive services will be available, accessible or acceptable to all people. A more efficient delivery of health care is also imperative if current excessive costs of care are to be checked and reduced.

More care and services must be provided under a comprehensive system for the mentally and emotionally ill. It is estimated that there are some 17 million persons, ten million under the age of 25, who suffer from some form of psychological disturbance. Generally the emotionally disturbed fail to seek early treatment and are inadequately cared for when they seek it. The quality and quantity of services available has been determined largely on the basis of economic and social status of individuals. Any effective health insurance plan must provide for sufficient and comprehensive care for the millions of mentally ill individuals. An aggregate plan which will enable the nation to reduce mental illness through research and prevention and provide that individuals have access to care on an equal basis should be vigorously pursued.

Dental care is a very great need in the health field, but has not been covered extensively in any proposals, except where there is a provision to provide dental care to children. Children of medically indigent families do receive free dental care in their schools, but low income adults do not receive any free dental care, except in emergency situations. A truly comprehensive health security program should provide for dental care for all as well, since a lack of dental care often has an important effect upon the general health of an individual.

As we indicated earlier, the National Council of Jewish Women's concern for the nation's health goes back many years. In the 1940s national health insurance was one of our program priorities. We strongly supported Medicare and national health insurance proposals which were considered in Congress in 1945, 1947, and 1949. At that time there were serious differences of opinion as to whether health was a national problem. Today there is general agreement that some kind of health program must be developed which meets the acute needs of the population. The controversy is centered primarily around the methods of achieving the goal of an effective national health program. The National Council of Jewish Women strongly endorses the method of contributory national health insurance under social security.

We urge your Committee to support a comprehensive national health insurance program and alleviate the hardships suffered by millions of Americans who cannot afford health care at the highly inflated costs now prevailing.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., October 18, 1971.

HON. WILBUE MILLS,
Chairman, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am enclosing a letter and a resolution from the Board of Commissioners of Wayne County, Michigan in regard to H.R. 22.

I would very much appreciate having this placed in the record of hearings on this legislation.

Thank you for your attention to my request.

Sincerely yours,

JOHN D. DINGELL,
Member of Congress.

BOARD OF COMMISSIONERS,
COUNTY OF WAYNE,
October 12, 1971.

HON. JOHN D. DINGELL,
Dearborn, Mich.

DEAR CONGRESSMAN DINGELL: At its meeting of September 23, 1971, the Board of Commissioners of the County of Wayne, Michigan, adopted the attached Resolution urging the United States Congress to pass both Senate Bill No. 3 and House Bill No. 22 which would provide for national health security legislation.

The Board of Commissioners is soliciting your support in favor of this legislation.

Very truly yours,

JOSEPH V. CHAROCHAK,
Acting Assistant Committee Clerk.

RESOLUTION

(By Commissioner Rose Mary C. Robinson)

Whereas, shortages exist among physicians, nurses and other health care personnel, and we are not wisely using the manpower, facilities and other resources we have. Millions of our citizens, regardless of ability to pay, get poor and inadequate coverage, millions of people—particularly the poor—get no care at all, and

Whereas, the most recent available statistics show that the United States ranks:

14th among industrial countries in the death of infants during the first year of life

11th among industrial countries in the percentage of mothers who die in childbirth

22nd in life expectancy of males, and

Whereas, we have health personnel shortages of nearly 500,000—including 50,000 doctors, 20,000 dentists, 150,000 nurses and 280,000 other health specialists and professionals. By 1980, the shortages are expected to climb to 725,000, and

Whereas, we have immediate need for new hospitals with 250,000 hospital beds, and facilities housing another 250,000 which are in urgent need of modernization. Of the 107 medical schools, 10% face immediate closing for lack of funds, while more than half have been granted some form of emergency financial aid, and

Whereas, the Chairman of the Committee for National Health Insurance, Leonard Woodcock, has said. "No issue is more important to working people than the drive to assure quality health care at the lowest possible cost," now, therefore, be it

Resolved, That the Wayne County Board of Commissioners realizing the need for national health security legislation go on record as supporting the Kennedy, Corman, Griffith National Health Security Act and urge the United States Congress to pass both Senate Bill No. 3 and House Bill No. 22 so that all Americans may be provided with good health care.

NOTE: Information in this Resolution is from the Committee for National Health Insurance.

STATEMENT OF PETER FOSCO, GENERAL PRESIDENT, LABORERS' INTERNATIONAL UNION OF NORTH AMERICA, AFL-CIO

Mr. Chairman and Members of the Subcommittee: On behalf of more than 600,000 members of my Organization, I appreciate the opportunity to present these remarks in support of the concept of national health insurance.

There can be little doubt that the health care legislation, which Congress is presently considering, will have far reaching affect on generations of Americans yet to come, as well as help meet today's needs. And so it is imperative that we find a plan that is both responsive to today's crisis and yet still flexible enough to change with tomorrow.

We are a nation of tremendous resources. Our men have set foot on the moon and our technology has advanced and grown until we have achieved wonders beyond our farthest dreams. Despite these achievements, our health care system is disintegrating. While we are the greatest medical research nation in the world, the health of our citizenry is worse today than it was twenty years ago when placed in comparison with other industrial nations.

The United States today ranks:

(1) 13th among all industrial nations in the death of infants during the first year of life.

(2) 7th among all industrial nations in the number of others who died during childbirth.

(3) No better than 18th in the average life expectancy for males.

(4) 16th in the death rate for males still in their middle years.

To make these statistics more meaningful, the United States ranked better in all of the above categories only 15 to 20 years ago.

And while the quality of medical services has slipped, the costs for these have increased. Hospital prices have risen three times faster than the general economy while the costs of doctors' bills have risen at more than double the pace of the general economy during this same period.

We face a medical crisis, for the average American can no longer afford to pay for the escalation of fees and the padding of bills. Today, medicine is pricing itself right out of the grasp of most American families.

There were about 175,880,000 citizens in the United States who were under 65 in 1967. Of these, most found it increasingly impossible to bear the burden of medical costs. This was true even though many hold some form of insurance, which helped to cover costs. Percentage-wise, the non-carrier broke down this way: 15.5 percent had no hospital insurance; 22 percent had no surgical insurance; 37 percent had no in-the-hospital medical expense insurance; 49 percent had no insurance to cover X-ray and laboratory examinations received outside

the hospital; 60 percent had no insurance to cover visits to the doctor's office or for a doctor's visit to the home; 64 percent had no insurance to pay for the costs of prescribed medicines and drugs, and 97 percent had no insurance against dental expenses.

Private insurance plans paid only 29 percent of the total estimated medical expenses of the American public in 1969.

According to the report issued by the AFL-CIO Executive Council on the Health Security Plan, the average worker last year had to spend \$324 on medical care for himself, \$324 for his wife and for each of his children. This amounted to a 10 percent rise in the 1969 cost per individual.

Today we have more than 7,000 hospitals that service the needs of over 200 million people. And, it is estimated that there is a present need for \$16.5 billion to be spent on either new construction or the upkeep of our present facilities.

From 1965-1969, hospital charges rose at an annual rate of almost 13 percent. This compares with 6 percent rise in all medical care expenses and about a 3 percent rise for all items in the Consumer Price Index.

By the end of 1969, the average cost per day for a hospitalized patient had risen to \$67—this was an 80 percent rise in the cost since 1964.

But the hospitals alone have not caused the medical care system to rocket out of reach of so many millions of Americans. Today's doctors, the specialists, whose title have only a confused meaning and whose unavailability after closing time at 5 P.M. means so much; these specialists are expensive and removed from the average citizen.

These men, the medical practitioners of the modern age, are still very much like their predecessors in one way—they maintain one-man offices with all the drawbacks and expenses that these incur.

The office, the equipment, the personnel, the space—everything separate, everything private, nothing shared. And who is aided by this private "salon" for patients? Certainly not the patients themselves, for their bills reflect the costs of outlay and maintenance for these private offices.

Yet, the costs of the doctor's private practice are only a portion of the overall expenses which have resulted from the lack of a well-planned and viable system of health care. These expenses reached an estimated 23 percent of the health care monies spent in 1969 or \$14 billion was wasted or improperly used. The breakdown includes:

- (1) \$1.1 billion lost in the unnecessary acquisition and administration costs of private health insurance carriers.
- (2) \$700 million for failing to run full hospital services on a seven-day week.
- (3) \$1.8 billion through inappropriate design of insurance coverages and ineffective utilization of review practices.
- (4) \$1.6 billion for performing unnecessary surgery.
- (5) \$3.6 billion in physician costs by not developing group practice programs.
- (6) \$1.2 billion due to a lack of controls on physician fees, which should be held close to the same rate of growth as seen in the consumer price index.

And, added to these are the poor coordination of government programs, the inefficient selection and delivery of drugs and appliances, the failure to coordinate mental health care programs and services and several others.

The important point is that this wasted money could easily begin to pay for a comprehensive health care system that would benefit all Americans from every area of the Nation and every social and economic class.

Economists have called our present system "disjointed, inefficient, ineffective and semi-functional." They have gone into in-depth analyses trying to discover the root causes, but they have never been able to remedy the fact that millions of Americans, the poor, the migrants, the disadvantaged in both cities and in rural communities, have never received proper medical attention.

In a 1965 study performed in the upper midwest of the Nation, it was revealed that of the 1,500 cities and towns studied, 1,000 of them had no doctors and 200 had but one.

The case is not isolated. These are problems found across the Nation. People living in rural communities are running ads, building hospitals and clinics, and using a variety of means to lure doctors into their communities. But a sizable portion of these towns will be forced to do without for the doctors are not interested in places that have poor schools and very little other than hard work to offer.

The great incentives are found in the wealth of cities, the famous research laboratories, and the lucrative private practices that can be set up in suburban areas.

And so, the poor and the disadvantaged suffer. They are forced to inferior facilities where the staff is more often harassed and exhausted than it is helpful, where the waiting time is lengthy no matter what the emergency.

Perhaps the way to highlight the plight of the poor is to show how they affect the national infant mortality statistics.

There are wide variations in infant deaths both geographically and racially. In recent years, there has been a smaller reduction in the deaths of poor and minority infants than among the more affluent, middle-class Americans.

Thus, when the Nation is taken as a whole, the United States ranks thirteenth in the death rates of infants. But when the poor and disadvantaged are subtracted from the whole, the Country rises to tenth in the world. The disparity is shocking.

This crisis did not begin yesterday. As far back as 1935, there were strong proponents advocating a form of national health insurance. President Roosevelt and President Truman favored legislation in this direction. And Truman, as you well know, backed the now famous Wagner, Murray, Dingell Bill, which touched off five years of heated debate and angry argument. It was from this early forerunner of today's legislation that the term "socialized medicine" was born.

That fight was lost for the odds were weighted against change and in the direction of the status quo with most of the media, the AMA, the drug industry, Chambers of Commerce and many other groups all lobbying to defeat the legislation.

But now the years have moved the pendulum away from that status quo, and the lobby of the '50's has broken down, with many of the original detractors becoming today's strongest backers of national health insurance. It took effort and patience, but today the early leaders of the national health bill—organized labor, consumer groups, an ever-increasing number of doctors, and liberal organizations—are finding many allies.

These backers of national health insurance have come to recognize the paradox of America's health care system. Our hospitals, doctors, nurses, nursing homes, equipment—everything—is either overused, underused, or inefficiently used—and, all of this costs money. It raises the costs of doctor's fees, it makes the premiums of private health insurance soar and it increases the costs we pay for hospital facilities. Quite simply, it wastes billions of dollars a year. And, even with this waste, the present system often denies health care to those people who need it most.

Most Americans want to have the use of a family doctor, a general practitioner. This general "wizard" of medical knowledge has been part of the American myth for more than half a century.

In the 1930's three doctors out of every four were general practitioners. Today that ratio has dropped until there is only one doctor in five who still calls himself a general practitioner.

In the place of the family doctor, there are many doors, many choices and very few signposts to guide one to a competent specialist.

The National Health Insurance legislation this Committee is considering has a definite plan of action to alleviate many of the problems I have cited.

This plan is both realistic and necessary, for it provides comprehensive health coverage to anyone living in the United States as a matter of right, rich and poor alike.

It would be financed through a trust fund which would be fed by the following sources: 40 percent from general tax revenues, 35 percent from employers and 25 percent from the individuals themselves. There is a basic emphasis on preventive medicine rather than today's crisis orientation. This program would cover all necessary health care including hospital services, doctor's visits and treatment and, with some limitation, all mental home and nursing home expenses, drug care, dental care and appliances.

The fund would also have increased leverage to force the improvements in organization of medical care programs and to give doctors incentives toward joining group practices which would then practice comprehensive health care.

All private health insurance, medicare and most of the government plans would be absorbed into the Health Security Plan, and there would be a Resources Development Fund established to ease the shortage of manpower and to provide methods for better using the existing manpower.

It must be emphasized that the plan is not limited. There would be no cut-off point in the protection of every American family whether the costs are for visits alone or for a prolonged and expensive illness.

The Health Security Plan would be administered by a five-member Board appointed by the President and serving under the Secretary of Health, Education and Welfare. This Board would be assisted by an Advisory Council with representatives of the consumer holding the majority of the posts. The Board would be designated to develop policy, to formulate regulation and to administer and develop the program.

The providers for health care will be paid directly by the program so the individual will no longer be charged on a fee for service basis—all charges will be covered.

The cost of the program can only be estimated, but it is felt the program would cost in the neighborhood of \$41 billion for fiscal year 1970. This money is 70 percent of the personal health care expenses in the United States today. It is important to understand that none of the money needed to cover this plan represents "new" money. This amount has already been or is being spent, consisting of \$29.5 billion in private out-of-pocket payments and private health insurance payments, and \$11.5 billion in payments by Federal, State and Local Governments.

Importantly, the new plan would offer more health services and a better health delivery system, while reducing the inflationary rise in costs. It will do this by increasing the contributions of the Federal Government while decreasing the amounts paid by the private citizen and the State and Local Governments.

It is vital that Congress pass this legislation as quickly as possible, for after passage, there would have to be a two-year tooling up period, during which the Resource Development Fund would be preparing the ground work for the plan to function efficiently.

Congress must act for the growing crisis will not wait. Good health is the right of every American. We can no longer deny that right and that is why gentlemen I urge you today to push forward and to pass this comprehensive across-the-board health care system.

I would like also to submit to this Committee a copy of a resolution which was passed unanimously by the delegates to the 16th Convention of the Laborers' International Union of North America, on September 23, 1971. The resolution states as follows:

Whereas, the Trade Union movement has long believed that access to quality health care is the right of all citizens, not a privilege for some; and

Whereas, Unions have developed private health insurance plans for members and their families through collective bargaining contracts, at an increasing cost that is preventing development of other fringe benefit programs; and

Whereas, private health insurance plans, with their cut-off points, exclusions, and deductibles, leave large out-of-pocket expenses for our members to pay; and

Whereas, private health insurance has contributed to medical cost inflation by supporting inefficiencies and has failed to control cost or quality; and

Whereas, private insurance is unable to cover all citizens at a reasonable price, leaving millions of Americans with inadequate or no insurance coverage; and

Whereas, many Americans are denied health care because of lack of funds or insufficient medical facilities and personnel in inner city and rural areas; and

Whereas, President Nixon has declared a "crisis" in health care, yet his health insurance proposals are based on the private health insurance companies that have already proved inadequate in dealing with this nation's health care needs; and

Whereas, the national health insurance proposals of President Nixon and the insurance industry would fail to control costs, and do not provide sufficient incentives to reform the inadequacies and inequalities of the existing health care system; and

Whereas, the National Health Security Program now before Congress would offer comprehensive health benefits to all Americans; control medical cost inflation; improve the quality, efficiency and distribution of health care resources; provide for effective consumer participation in policy formulation and program development, and expand and improve medical facilities and train more personnel; and

Whereas, National Health Security would have a national contributory financing mechanism that distributes costs fairly and provides sufficient funds for comprehensive benefits; and

Whereas, the AFL-CIO supports the National Health Security program; therefore, be it

Resolved, That the Laborers' International Union of North America endorses the National Health Security Bill (H.R. 22 and S. 3) and urges immediate and favorable action on this Bill; and be it further

Resolved, That copies of this resolution be sent to the Speaker of the House, the President of the Senate, and all members of the House Ways and Means Committee.

We appreciate this opportunity to present our views on this important piece of legislation. Thank you very much.

AMERICAN NEWSPAPER GUILD,
Washington, D.C.

HEALTH PLAN

Realizing the urgent need for a comprehensive health program in the United States, the Guild strongly urges Congress to give quick approval to the Griffiths-Kennedy National Health Security bill. We oppose the Administration's Health Security legislation which shows more concern for insurance carriers than those who pay premiums, or need care.

The Kennedy-Griffiths bill would set up a health benefits system based on need, not ability to pay. Freedom from the financial horrors of serious illness is, we feel, a right not a privilege, of all citizens.

The Griffiths-Kennedy National Health Security calls for a reform of health care systems and provides for a consumer voice in planning, managing and operating the program. The Administration's strategy is based on existing private insurance plans. It would do nothing to give the average person a voice in setting rates, or quality and quantity of benefits. For those who need health protection most, the poor, it would be too expensive.

The Kennedy-Griffiths bills (H.R. 22 and S. 3) are in line with the Guild's goals of reform, consumer participation and comprehensive care for all.

Adopted by the 32nd Annual Convention of The Newspaper Guild, July 12-16, 1971, Boston, Massachusetts.

CHARLES A. PERLIK, JR., *President*.

ARKANSAS GAZETTE,
April 23, 1971.

HON. WILBUR MILLS,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN: A couple of days after I promised to write you my feelings and observations about health services generally and health insurance particularly, I read in the Arkansas Gazette where you were quoted as saying that government financing of health services would be "sheer folly" based on the experiences of Medicare and Medicaid. Since I consider health insurance a part of the health services, your statement to the embryo doctors and paramedical students gave me considerable pause.

Frankly, starting with pre-paid health insurance, I think that the only hope of providing adequate health services will be full and complete nationalization of our medical system. But this will come a step at a time and, I trust, in an orderly manner. But, for the moment let us deal with health insurance.

No matter how well prepaid hospital-health service insurance is financed, it just doesn't cut the mustard. Only the well heeled can afford to carry enough insurance to soften the blow of a major illness or surgery. The patient or the "insured" is whipsawed between the insurance carrier and the rest of the medical industry in what at first glance would appear to be collusion. Let's take my own situation—which isn't rare at all—for instance:

My wife and I are on the dark side of 60. I'm in the lower-middle income bracket of your constituency. I have three insurance policies (prepaid, if you please) which cover us. They are as follows with the monthly premiums of each listed:

| | |
|---|---------------|
| Blue Cross-Blue Shield..... | \$27. 64 |
| John Hancock (a group)..... | 12. 71 |
| 1st Pyramid of Arkansas (once a group)..... | 8. 90 |
| Total | 49. 24 |

In December 1968 and February 1969 (it was all part of the same illness) my wife had major surgery stemming from a gallbladder condition. There were four medical doctors and a syndicate of five others in on the act before I could get the little woman home. She had a private room at a Little Rock hospital. She had, considering her age and the condition of her assorted organs, a rapid recovery. I didn't argue the prices charged then by anybody. On the strength of having had a "per day in the hospital bed" insurance policy with a non-Arkansas Company, my wife and I "cleared" almost \$5.00 on this episode. (In all fairness, the rates on the Blues policy, the hospital fees and some of the doctor fees then were considerably less than now.) We'd have been happy to forego that "profit" off of premiums we'd already prepaid. But—

If that same event were to occur now, my insurance *would not* cover the costs. The non-government hospitals in Little Rock—two of which have representatives on the Board of Directors of Blue Cross-Blue Shield—have raised their rates in all categories about 23 per cent and the assorted doctors who were taking a cut out of the insurance have raised their fees from 4 to 10 percent—depending on the specialty. And Blue Cross-Blue Shield has raised its premium rates about 35 per cent and restricted the benefits it will pay if I have any other insurance.

Health care, including the insurance companies, hospitals, doctors and paramedical technicians and nurses, has become industrialized! Each is part of an assembly line that becomes more dehumanized every day. The Medical Societies, the Insurance Companies, the professional groups and the hospital associations—acting separately and in concert—have one of the most powerful and self-serving lobbying groups ever put together. I, acting solely as an individual, and a few of my friends in the legislature got clobbered in the recent session of the General Assembly. I had suggested some 10 things our state regulatory agencies could do which would be considerably short of either "state medicine" or "state insurance." I got two of them through. Only three measures touching on the 10 suggestions were even introduced—although many more had been prepared in advance of the legislature.

The average guy, whether a professional person or wage earner, simply cannot afford medical services at the present rates whether pre-paid or not. His only hope is relief from the federals. A real good place to start will be at the insurance level. I had much rather pay my government \$49.24 a month and know that I would come out even on any illness or hospitalization than pay private enterprise that same amount and know I'd still be in debt to the medical industry.

As I said before, it is much cheaper to die than to try to recover from even the most elemental illnesses. Surely there is some agency in Washington who could provide Congress with a national projection of my personal plight on this. I think it would be a popular thing politically to have a full dress look-see at this situation. I do not see how anybody making less than \$15,000 a year can pre-pay any insurance at present rates. I can't see how those of the "under-privileged" classes can even afford a doctor—much less a hospital, assuming they could get a doctor away from a hospital or a clinic.

Cordially, your friend

SAM G. HARRIS,
Director of Public Affairs.

* * * * *
MAY 3, 1971.

The only additional observation I would make would be to oppose categorically the suggestion that a National Health Insurance program be "managed" by private or existing companies. Had they not defaulted on their responsibilities we wouldn't be in quite such a mess now. It would only compound the problem to have private enterprise run a national health insurance program. Our insurance industry willingly holds still for being a "milking operation" for the rest of the medical industry. Most of the private insurance companies in Arkansas are paying out only about 55 percent of the premium dollar for benefits. The Blue Cross-Blue Shield claim—without evidence—they pay out 94 cents per premium dollar. Even the Social Security Administration does that well.

STATEMENT OF BEN LEDERMAN, MANAGER OF LOCAL 107 LABOR-MANAGEMENT TRUST FUND, AND VICE PRESIDENT OF THE METROPOLITAN CHAPTER OF THE NATIONAL HEMOPHILIA FOUNDATION

I would like the permanent record of the hearings on National Health legislation to show that support of H.R. 853, the Koch bill on blood donations, is of great importance.

(1) There is a chronic need for blood donations. This is obvious. There is an acute shortage of blood at regular periods. Blood or blood products are needed in cases of accidents and for routine or emergency surgery. Open Heart surgery requires large quantities of blood. The anemias require red cells, plasma is needed for burns or shock, platelets are used for purpura, cryoprecipitate is a coagulant for hemophiliacs, serum albumin is also used for shock or burns, fibrinogen is often used for acute hemorrhaging post-partum, gamma globulin in treating infections like measles and hepatitis, and the white cells in cases of leukemia.

(2) H.R. 853 will stimulate giving by the public at large. The purchases of blood by drug houses, blood banks or even hospitals increases the danger of spreading hepatitis. Many of those who sell are drug addicts and alcoholics and therefore, more likely to be carriers of hepatitis. Dr. August H. Groeschel estimated that 150,000 will contact hepatitis this year. He states that probably "one of the prime reasons is the source of donors to commercial blood banks". Paying for blood with money "on the barrel head" increases the risk of serum hepatitis.

(3) We are now in the enviable position of helping our fellow-countrymen who are ill or have had an accident and at the same time reducing the spread of a dangerous disease by passing H.R. 853.

(4) The greater availability of blood and blood derivatives will permit the use of these products on a home and out-patient basis and thus lower the cost of hospital charges. At present, with the shortage of lyophilized Factor VIII, many hemophiliacs have to postpone medical or surgical care. This in turn causes a prolonged hospital stay (with its increased dollar cost) when the medical care is then performed on an emergency basis.

(5) The tax incentive in H.R. 853 will not put the commercial blood banks out of business. It will, however, create a competition for clean blood. This competition will lead to a decrease in the shortage of blood, lowering the cost of blood and blood products and returning the sick citizen to productive employment quickly. A productive person will in turn be a tax payer and thus cost to our Treasury will be offset. The gain in health will be immeasurable.

(6) The donor will feel that he has participated in a common effort and will insure his family and community at the same time. His blood donations will be limited to five (5) per year, and the cost to the Treasury Department will not be more than \$125.00 per year. This is a small price to pay for medical serendipity.

STATEMENT OF HERBERT LIEBENSON, LEGISLATIVE VICE PRESIDENT, NATIONAL SMALL BUSINESS ASSOCIATION

Mr. Chairman and members of the Committee, my name is Herbert Liebenson. I am Legislative Vice President of the National Small Business Association which represents firms doing business in over five hundred different industry categories. We appreciate the Committee's giving us an opportunity to comment on national health insurance.

Your Committee has received from many sources much statistical data relating to medical coverage of the American people. We have followed for some time the various statistical programs of the Federal Government as these relate to medical care and have generally found that the Department of Labor and the Department of Health, Education and Welfare usually conduct surveys only among the larger companies which are able to provide medical and other fringe benefits either unilaterally or through collective bargaining. There is very little information that relates to depth of coverage or multiple coverage. A husband may have his family covered under an employer's group plan and his wife, who may be employed elsewhere, is also covered under a group plan. Some individuals may have coverage for medical, hospital, long-term/short-term disability while others may only have coverage for hospitalization.

We believe a logical method of computing numbers of persons covered would be to determine the amount it would take to cover the whole work force and their families and then relate that to the premiums actually being collected today. If you were to provide insurance coverage for the 85 million workers in the labor force under a basic program at a conservative cost of \$400 per family, the direct cost of coverage would be \$34 billion. (The private health insurance industry indicates their premiums approximate \$16 billion from all sources. Therefore there is a gap of at least \$18 billion for those persons not presently covered under health insurance programs.)

This would indicate that a little more than 50% of the work force is covered today under health insurance programs. Our estimate as to the number of people with multiple and comprehensive coverage is less than 50% of the work force.

If employers were required to provide coverage, it is realistic to assume that the increased cost of doing business would be passed on insofar as possible to the consumer. Since there is a 47½% cost of distribution (60% in agriculture), the cost to consumers of this basic coverage could exceed \$30 billion.

As an example, coverage for agricultural workers would increase wage costs by over 19% an hour plus an additional 60% cost of distribution, or an increased cost of 30¢ per hour at the consumer level. Based on recent statistics, the average agricultural wage which is now \$1.30 would be increased by 23%. This would be reflected in the Consumer Price Index as a 5% increase in food prices. (Food costs constitute 22% of the CPI.)

Another impact of national health insurance costs would be reflected in increases to over 3½ million workers whose wages are presently tied to the CPI and the 1.9 million civil service retirees who receive increases in wages or benefits when the CPI is increased. Under the current contract in the automobile industry, automobile workers' wages are increased 1¢ for each ¼ of 1% increase in the Index. Therefore, automobile workers who already have comprehensive health insurance benefits would receive a wage increase of 12¢ per hour or \$250.00 annually for each employee in the industry. This is before any increase in the price of automobiles which, in turn, would again be reflected in the Index, thereby continuing the spiral. In addition the Index is used as a measure for wage increases in negotiations by the highly-paid construction and other unions.

Therefore it is imperative that Congress appraise realistically what effect health insurance costs will have on consumer prices and on the ability of small business to survive.

As you are all aware, small concerns are normally more sensitive to changes in the rate of economic growth than are their larger competitors. The year 1970 proved no exception to this rule.

According to the Small Business Administration:

"The rate of growth in the total business population was roughly 30 percent below the rate experienced in recent years. Business failures were up by 17 percent over a year earlier and new incorporations down, although by only 3 percent below the all-time high recorded in 1969.

"All principal elements of business costs continued to rise at a moderated rate while sales barely kept pace with price increases. The result was a profit squeeze with a disproportionate impact on small concerns. In the manufacturing industry, after-tax earning of corporations with assets of less than \$1 million were down by 45 percent, as compared with 12 percent for corporations with assets of \$1 million and above. There was a substantial increase in the supply of funds for business loans accompanied by a marked decline in long-term interest rates and a significant drop in interest rates on short-term loans. On the other hand, the demand for loans was dampened even more by the very forces which made added funds available to business.

"The impact of the 1970 recession varied widely among and within industries. In the manufacturing sector, which recorded a fall of 20 percent in after-tax earnings in the last quarter of 1970 in comparison with the same quarter of 1969, the change over that time period varied from a fall of 87 percent for automobile and parts makers to gains of 4 percent to 23 percent for manufacturers of electrical equipment, food products and tobacco products. Among the hardest hit were small firms which supply pieces and parts for the automobile and aerospace industries. The trimming back of business investment also had a damaging impact on the tool and die and metalworking industries, which are largely comprised of small firms.

"An equally uneven impact was experienced among firms in trade and services. The lowered rate of consumer expenditures was felt most acutely by personal service establishments, clothing stores, restaurants and recreational facilities. The sluggish pace of residential construction, especially in the first half of the year, was reflected in low sales volumes for home furnishings and appliances. Similarly, business decisions to curtail capital investment and trim overhead costs resulted in a lowered demand for business services—especially for firms specializing in consulting, operations research and computer software."

The House of Representatives has passed a social security bill, a minimum wage bill, and a consumer protection agency bill—all of which will add to employer costs. There is no question that many small business firms may find it necessary to go out of business, or reduce their work force, in order to meet these additional costs. To impose additional mandatory health programs on top of those recently-added costs may well be disastrous for thousands upon thousands of small marginal firms, as well as add to consumer costs and perpetuate the inflationary spiral. We doubt whether the Price Commission or the Cost of Living Council can deny the business community additional cost increases when mandatory increases in the cost of doing business are placed in effect.

Most certainly there is recognition by NSB that the medically indigent should be taken care of by a Federal program. This would reduce hospital costs presently being charged off to the private carriers. Under the present arrangement in most hospitals the cost of care for the medically indigent is spread among the patients having the ability to pay. With the Government taking on the cost of the care of the medically indigent, hospital costs to those covered by private health insurance could be lowered.

We therefore recommend that the medically indigent be taken care of by a federal program and that service-type preventive and diagnostic clinics be established. A full re-evaluation of our health resources in terms of demand, assuming the medically indigent are provided with coverage, most certainly is in order.

Currently the government is running about \$23 billion in the red on an annual basis, and the federal fiscal situation is getting worse rather than better. A prudent Congress would not commit itself to financing a national health insurance program out of the public treasury.

We therefore see no practical alternative but to retain the health insurance programs now underwritten by private industry. In addition to cost-savings, the impact on the CPI would be reduced because employees who have contracts tied to the CPI would not receive wage increases since they already are covered under comprehensive medical programs.

If Congress does commit itself to a national health insurance program, we urge formation of a pool of private carriers for comprehensive medical coverage of those employees who do not have such insurance protection. The government should provide a health insurance program that would guarantee the pool a certain percentage of the profit over actual costs. If contributions were made on the same basis as current Social Security programs (with the employee paying half), this too would reduce the impact on consumer prices. And the smaller employer would more likely survive.

The Administration pursuant to authority granted it by Congress has launched a program of economic controls to halt inflation. Congress has the duty to refrain from enactment of new legislation such as national health insurance which cannot help but provide even more fuel to the fire of inflation. The left hand of Congress should not destroy what its right hand is attempting to do.

**STATEMENT OF ROBERT J. BOLGER, THE NATIONAL ASSOCIATION OF
CHAIN DRUG STORES**

The National Association of Chain Drug Stores represents the management of multi-unit drug store corporations. Although less than 20% or 9,000 of the nation's drug stores are part of multi-unit corporations, these pharmacies account for over 6 billion dollars of the 13 billion dollar retail drug market in 1970. Our 200 member firms operate retail pharmacies in every state of the nation providing a wide variety of pharmaceutical services, drugs and other health related products.

As government at the state and federal level has responded to the public need for prescribed drugs and pharmacy services, we have viewed with growing con-

cern the inadequacies of our present health care system. Medical and hospital care have long been recognized as major components of all government health programs; whereas, provisions for out-of-hospital drug care has remained as a separate or excluded provision.

As part of this Committee's examination of our national health program and the need for direct government involvement, there are several issues to be considered and resolved. One such issue which Congress has discussed and reviewed many times deals with the provision of drugs and pharmaceutical services as an integral part of our nation's health program. If we are to attain our national health goals, drugs and pharmacy services must be included, not as an option, but as a compulsory part of national health insurance.

For too long Americans covered by federal and state health programs have been faced with the incongruity of medical care without drug coverage. In many instances we have borne the additional expense of hospitalizing patients under these programs who may have responded to adequate out-of-hospital drug therapy. Would it not be in the patient's and public interest to provide the necessary drugs to control and cure these needy patients and thus relieve our already overburdened national health resources? Since our present system has become inflexible to the health needs and demands of the public and also very costly, there are several proposals before this Committee and Congress outlining new concepts and programs for the attainment of our national health goals.

Our comments are specifically directed to the provision for drug coverage under any national health insurance proposal. The measures under review by the Committee offer a wide range of prescription drug benefits from comprehensive coverage in such measures as H.R. 22 to almost no coverage at all as in H.R. 7741. The perfunctory notice given to the drug coverage by some of these proposals must be corrected if we are truly to provide a health benefit of any substance to the American public.

Over the past five years studies by the Department of Health, Education and Welfare and reviews by both government and private groups have consistently recommended the inclusion of prescribed drug coverage to out-patients under Medicare.

Notice of the potential cost savings to our total health program was made in 1969 by the Secretary's Review Committee on the Task Force on Prescription Drugs (The Dunlop Committee):

"Some unnecessary high cost hospital use should be reduced by the provision for out-of-hospital prescription drugs. The present inequity under Medicare between payment for in-hospital drug costs and the absence of any payments for identical out-of-hospital drug usage should be eliminated."

Unfortunately, the soaring costs of Medicare and Medicaid have frightened many Congressmen and thus deterred action on a federal drug program. But their concern was shared by NACDS, for while we believed a drug program would be of great benefit to the public, we believe in the need for administrative efficiency and cost control. For this reason we have not supported any legislation sponsoring a federal drug program. These past measures which were sponsored by Senators Long and Montoya, while providing for a necessary health service, also contained the seeds for its financial demise. In 1967, NACDS asked that Congressional action on a drug program be postponed until the HEW Task Force could complete its appointed study. In 1970, we again expressed our reservations on the proposed measures and offered our recommendations on an efficient, economically feasible drug program. We believe that a national drug program should utilize a vendor system, offer comprehensive drug coverage, require patient participation, provide fair and equitable reimbursement to the drug store and be simple to administer.

VENDOR SYSTEM

Consideration of any drug program under national health insurance must recognize the services and availability of the 50,000 retail pharmacies of this nation. For years drug stores have provided for the pharmaceutical needs of the nation. It has been estimated that over 90% of our population is within convenient access of a drug store. The development of any alternate system for distribution of drugs under a national drug program would be a wasteful expense. With the reorganization and redirection of our nation's health care resources we recognize that retail pharmacy itself will undergo change. Such changes which will improve the quality of patient care and pharmaceutical

services will be welcomed. Our hopes are to provide better service and drugs to the public through any national health insurance measure in a sound financial and professional manner. Therefore, we strongly urge that provisions be made which would require consultation by the government with business and trade organizations representing retail drug stores.

COMPREHENSIVE COVERAGE

If the full benefits of a national health program are to be realized, comprehensive coverage must be extended to the public. Otherwise, we are again faced with the inequities and shortcomings of our present health care system; that is, patients not covered for out-of-hospital drugs will eventually require extensive medical care and hospitalization. A national program cannot afford to put people in our hospitals just to insure that they receive the necessary drug therapy. Health planners must recognize that health care without out-patient drug programs is very short-sighted. Many private drug programs have already demonstrated that comprehensive drug coverage is medically necessary and financially feasible.

REIMBURSEMENT

Aside from the administrative costs involved in a drug program, the mechanism utilized for provider reimbursement will prove or devour the program. One objective of national health insurance is to provide strong incentives for the revitalization of our health delivery system. We must make certain that these same ideals and concepts follow in our reimbursement to providers for their services. We must insure that the tremendous costs associated with such a program provide the best quality of patient care at a reasonable cost.

Especially within the area of drug provider reimbursement there is a strong and desirable need to provide incentives for efficiency. At present there is no program offering a drug benefit in the United States which provides such incentives. Most programs segregate the drug "price" into two categories; the cost of the product and the charge for service.

Assuming that it is accurate and correct to separate cost of prescription drugs in such a manner, we believe that there are effective means available today to control drug costs.

One commonly proposed system is to accurately determine by audit the "actual acquisition cost" of the drug product. However, this system does not offer the retail pharmacist any incentive to purchase drugs in an efficient, fiscally responsible manner. There is absolutely no incentive for the pharmacist to purchase drugs in economic quantities, for all his expertise and effort is absorbed by the government without reward. Thus, the pharmacist will no longer concern himself with any product cost as long as this cost is covered by the program. This is the primary failing of the actual acquisition cost method. However, utilization of the average wholesale price to the retailer does provide a strong incentive to purchase efficiently. This incentive for pharmacy will result in a cost savings to the program for as the pharmacists become more efficient in their purchasing the average wholesale price must decline.

The HEW Task Force also found a great administrative disadvantage in the operation of the actually acquisition cost system:

"The acquisition cost of each covered drug furnished to a beneficiary would have to be determinable and verifiable through audit, yet it would be very difficult to determine with precision the cost incurred by the vendor in actually acquiring it."

For "under the pricing system now prevalent in the drug industry, the published wholesale price of a drug product is subject to a complex system of frequently changing discounts, including discounts based on the purchase of other drug products, and cumulative discounts based on volume that may be computed after the end of the accounting year. Thus, in many cases the pharmacist's inventory may have been purchased at several different prices, and it is possible that the costs associated with determining the actual costs of acquiring drugs would be substantial." Thus, the additional disadvantage of determining actual acquisition cost becomes apparent—a tremendous administrative burden.

We do not propose that government should subsidize an inefficient operation by utilizing inflated drug costs. However, it would seem that utilization of

the average wholesale cost system is more than justified by permitting a more simplified, more economical method of administering drug costs coupled with a positive incentive for efficiency in retail pharmacies.

The second part of the reimbursement to pharmacies may be termed the "charge for service." Again, the commonly utilized methods ignore or fail to promote any incentive for more efficient pharmacy operation. Competition among the providers in current drug benefit programs is almost non-existent. Government cannot hope to control costs within vendor systems unless adequate incentives for competition are integrated into the reimbursement mechanism.

We have supported the "reasonable charge" concept with a maximum coupled with patient participation as the system which can lower drug program costs, foster competition among providers, and thus insure responsive service and quality pharmaceutical care to the public. Recently, program administrators have noted that the fixed dispensing fee concept of reimbursement does not provide for a fair and equitable payment for pharmacy services. Variations among pharmacies must be recognized. In a study sponsored by the National Association of Chain Drug Stores and the National Association of Retail Druggists (both organizations representing over 90% of the nation's drug stores) the R. A. Gosselin Company identified thirty six factors affecting the operation of a drug store and thus the price charged for prescriptions. Attached for the Committee's review is a copy of the final report. Under the straight dispensing fee concept this variation between pharmacies goes unrecognized in the majority of drug programs today. Even so called "variable fees" to providers for pharmacy services again penalized the productive, efficient and economical providers because the reimbursement system is unresponsive to competition in the marketplace.

In attempting to cope with this problem several of the past drug coverage proposals have included an onerous reimbursement option for the government; and that is the government will reimburse for a drug based on the "reasonable charge" or "the usual and customary charge to the public" *whichever is lower*. This unique provision while insuring economy to the government will create an inequitable, if not intolerable condition, within drug stores across the nation.

Our association has opposed this provision for it penalizes the providers in two ways. On lower cost drug products the government would base its reimbursement on the "usual and customary charge to the public". While on higher price drug products the government would utilize the "reasonable charge formula." In both situations the government is reimbursing at the lowest permissible rate. But in utilizing this system a great financial burden is placed upon the private sector and the program destroys any incentive for competition.

For example, the average prescription price today is approximately \$4.00. Since the great majority of drug stores base their prescription prices on the percentage mark-up system a great majority of prescriptions are less than \$4.00. The R. A. Gosselin Company reported in 1970 that 77% of all new prescriptions were under \$4.00. Thus, to remain economically viable a drug store is forced to raise its normal prices to the public or suffer economic failure. For in a national drug program the government will certainly become the major factor in the determination of prescription prices for any incentives to competition are outweighed by the discriminatory reimbursement system.

And aside from contributing tax funds to such a national program, the public through increased personal prescription cost is again asked to indirectly subsidize the program. We believe that a national drug program should provide productive incentives for pharmacy operation to reduce program cost but not at the expense of the American public. Prescription drug costs contribute the smaller percentage of our total health care costs, because there have been meaningful incentives for efficient operation. Any government drug problem should utilize one method of reimbursement with an incentive system for pharmacies to reduce their cost for products and for services. It is our firm belief

that a system employing a controlled maximum allowable reimbursement coupled with a strong economic incentive to provide prescription products at a lower cost, offers the soundest, most efficient reimbursement system for pharmacies.

PATIENT PARTICIPATION

Closely related to pharmacy reimbursement is the need for patient participation in the clause of a national drug program. The HEW Task Force and subsequent groups all recommended patient participation as a means of a control on program cost and utilization. By the same token, patient cost sharing provides a strong incentive to providers to remain competitive in the marketplace. Either fixed dollar co-payment or co-insurance affords a good mechanism for achieving patient participation. As long as these amounts are sufficient to promote competition among providers.

ADMINISTRATION

As government expands its role in health care delivery it must cautiously and carefully examine not only the system for providing this health care but also for administering this same care. One of the reasons why the present Medicare and Medicaid programs have become inflexible to the health needs of the public as well as expensive is the administrative bureaucracy operating the program.

In drug stores the current government drug programs provide a great source of uncontrolled expense and burden. In utilizing the drug store vendor system, they have been too quick to press increasing paper work and administrative demands upon the pharmacy. As a result we have a program that needlessly ties up large amounts and may even be haphazard in its delivery of pharmaceutical services to the public.

For instance, there is a wide range of eligibility requirements under our current drug programs. It happens many times that a pharmacy in good faith dispenses a prescription to a needy patient only to find that that person has been listed as ineligible for benefits by the administrative agency. Nonetheless, the patient still continues to carry a valid agency card authorizing him to drug benefits.

With administrative entanglements and problems such as this, it is easy to see how pharmacies can become bankrupt. In a recent study the R. A. Gosselin Company found that many pharmacies were experiencing several problems in collecting funds from the government:

"Government programs fare the worst here with less than 1 out of 5 receiving payments within 30 days from Medicaid/state welfare programs which, as a general rule, is an accepted standard in the business world." The study also noted that "33% of the pharmacies must wait over 60 days for their payment; whereas 69.2% of the pharmacies were waiting over 30 days for their payment from federal programs, and a total of 80.7% of the pharmacies waited 30 days for Medicare/welfare programs payment. Some of the effect of the delayed payment can be felt in the retail drug store in that 12.2% of all pharmacies sought business loans during the past two years. It is significant that drug stores which do a mere 15% of their prescription volume in such third party business, the percentage of seeking business loans has more than doubled to 27.4%." "Clearly, the drug programs definition of reimbursement method and administration of this method is seriously affecting the viability of the nation's drug stores."

In conclusion, we do ask for serious consideration of including prescription drugs under any proposal for a national health insurance. But, in providing such drug coverage to the nation. Congress must initiate a system which has strong incentives for cost control and competition. Furthermore, we believe that these drugs and services can be efficiently provided through a vendor system utilizing the nation's drug stores in an administratively simple and efficient manner. We look forward to participating in the future of our nation's health and well being and we will provide any additional information the Committee may feel necessary.

**VARIABILITY
ANALYSIS**

**PHARMACY CHARGES
FOR PRESCRIPTION DRUGS
UNDER THIRD PARTY PROGRAMS**



R.A.GOSSELIN and COMPANY, Inc.

690 PROVIDENCE HIGHWAY · DEDHAM · MASSACHUSETTS 02026

*Summary results of a study jointly commissioned by
the National Association of Retail Druggists and
the National Association of Chain Drug Stores*

P R E F A C E

In January, 1970, the National Association of Retail Druggists and the National Association of Chain Drug Stores jointly commissioned R. A. Gosselin and Company, Inc. to conduct a comprehensive statistical study of variability in prescription charges and operating characteristics in the pharmacies of the United States.

The purpose of the study was to collect and present objective and pertinent statistical data which could be used by third party reimbursement administrators and planners and others to aid in the design of fair and equitable reimbursement policies for all pharmacies commensurate with the public interest.

Data findings in this study were obtained from a total of over 2600 retail pharmacies representative of the nation. In addition, nearly one-half million prescriptions were analysed to determine prescription charge variability.

This report is a summary of findings extracted from the 402 page technical report provided NARD/NACDS in January, 1971.

ACKNOWLEDGEMENTS

In addition to the regular research staff of R. A. Gosselin and Company, Inc., a number of individuals made major contributions to the study as consultants or advisors.

Also, during the course of the study, particularly in the early design and planning stages, numerous persons from the academic and business fields voluntarily assisted in dealing with various professional, technical and business questions which arose. To these unrecognized but unforgetten individuals, the staff of the company expresses its thanks.

In particular, we wish to acknowledge the contributions of the following individuals:

Professor Anthony J. Amadio, M.S., M.B.A., of Duquesne University School of Pharmacy who contributed significantly to the design of the large-scale mail questionnaire.

Dr. Lawrence H. Wortzel, Chairman of the Marketing Behavior and Administration Group, Boston University, C.B.A., who provided valuable assistance as a consultant on pharmacy classification.

M. M. Wolfred, Ph.D., of Beverly Hills, California, and Mrs. Helen Gouin, M.S., of the University of Oklahoma, each of whom provided technical assistance and advice on study design, protocol and planning.

We wish to especially acknowledge the work of the company's two statistical consultants, Professors John E. Bishop, Ph.D., and William B. Whiston, M.S., A.M., of the Harvard University Graduate School of Business, who, together, were responsible for developing the statistical protocols for the entire project. Professor Whiston's work in the area of Multiple Regression and Factor Analysis was a major contribution to the study.

Special recognition is given to Mr. Willard B. Simmons, Executive Secretary of the National Association of Retail Druggists, and Mr. Robert J. Bolger, Executive Vice President of the National Association of Chain Drug Stores, for their sincere and dedicated interest in the development of equitable reimbursement methods for pharmacists' services commensurate with the public interest.

We also wish to express our appreciation for the excellent cooperation given to us throughout the study by Mr. William E. Woods, Washington Representative for NARD, and Mr. Michael J. Zagorac, Director of Public Affairs, of the NACDS.

INTRODUCTION AND SUMMARY

Prescribed drugs as part of pre-paid health care programs, public or private, have been a subject of considerable controversy since the matter was first explored in depth in the HEW Task Force on Prescription Drugs during the 1960's.

The central issue has not been the question of providing needed therapy to eligible participants of one program or another, for certainly pharmacists along with their professional peers have been at least as equally desirous as program administrators to participate in the expansion and improvement of health and health care in the nation.

The issue has been fundamentally economic and fiscal in nature. Because of many misconceptions and erroneous assumptions about pharmacy practice and the systems for determining individual prescription charges by pharmacists in the more than fifty thousand retail pharmacies of the nation, program designers have tended to adopt or recommend reimbursement procedures which, at best, are foreign to the operating modes of the vast majority of pharmacy practitioners or, at worst, deprive dedicated professionals of their ability to function as important members of America's health-care team.

The causes of variability in prescription charges for identical drugs in identical quantities, so often the subject of lay press and general media "surveys," has been one of the principal misconceptions leading to restrictive reimbursement approaches to pharmacists. Not having explored and determined why such variation exists has led to the assumption that the variation should not exist to begin with. Other misconceptions and misinterpretations based upon generalizations of isolated cases or experiences or superficial reviews have helped to formulate a viewpoint that holds that low charges represent efficient pharmacy operation while higher charges represent inefficient management. Paying a "middle-ground" fixed fee to all, it has been argued, is an effective device for forcing inefficient practitioners to become efficient, even if such new efficiency means the abandonment of certain professional services required by the patrons of that pharmacy or a restriction of the scope of inventories. The fact that some dispensers of prescriptions may be overly rewarded when the fixed fee is above their normal charge is ignored.

The study which was commissioned by the National Association of Retail Druggists and the National Association of Chain Drug Stores and completed in January of 1971 has explored the matter of variations in prescription charges in well over 2000 pharmacies and has found a positive cause and effect relationship between operating characteristics and prices charged for prescriptions. It shows that prices charged by individual pharmacies reflect accurately the differences in the environmental and operating characteristics of each store. It also shows that single attributes, such as emergency service or free delivery, taken by themselves are not necessarily indicative of the cause for price variability. Other attributes may have equal or greater effect but in the opposite direction, for example - discount policy on health and beauty items. The sum total of all the significant variables, positive and negative, establishes a Professional Services Index for each pharmacy which with remarkable precision estimates what the prices charged will be for that pharmacy.

The singular importance of the findings of the study is that a realistic alternative to the fixed or variable dispensing fee plus acquisition cost method of reimbursement is indeed reasonable, feasible and economical for providing prescribed drugs via the nation's retail pharmacies.

The study provides a considerable body of facts and evidence previously lacking to show how a reimbursement system can be based upon the regular charges the pharmacist makes to the general public, while providing the program administrator with the information he needs for cost predictability and administrative control. Speed of reimbursement would be guaranteed to all pharmacies whose charges do not exceed their established statistical norms. In public programs, taxpayers could expect efficient and harmonious programs for their tax dollars.

BACKGROUND

THE PROBLEM:

Several factors, controllable and uncontrollable, have a bearing upon the individual pharmacy's ability to employ a pricing policy to entitle a fair and equitable return on investment. Each pharmacy reacts and adjusts to a unique set of circumstances, whether they be externally or internally related factors, and the operational expenses of each store vary as a result. The present reimbursement policy of paying a standard fixed fee to those pharmacies participating in third-party programs, public or private, does not take into account the unique individual differences that exist from pharmacy to pharmacy.

STUDY OBJECTIVES:

The study was intended to establish that:

Identifiable environmental factors and individual operating characteristics cause charges for identical prescriptions to vary significantly from one pharmacy to another.

Prescription charge variance is normal and expected and can be measured in a valid statistical manner.

A reimbursement system more equitable than those currently employed could be utilized for the acceptance or rejection of prescription charges submitted by individual pharmacies.

METHODOLOGY:

The study deals with source material representative of the entire nation. It is confined to retail pharmacies, both chain and independent, and specifically excludes hospital pharmacies and other non-retail outlets.

In the statistical analysis of the factors which significantly affect the final selling cost of prescription drugs, efforts are restricted to those objective factors such as hours open per week, size of store, prescription filling volume, which can be quantified in a statistically reasonable and acceptable manner. The following research sources are employed:

Pharmacy Universe Panel (PUP)

PUP is a stratified random sample of nearly 900 pharmacies routinely employed to obtain various attitudes and opinions on numerous topical questions. A mail survey was conducted in April, 1970, with this panel in order to obtain background information about the attitudes of retail pharmacists concerning third-party programs now in existence.

National Prescription Audit (NPA)

The existing data bank of the National Prescription Audit, which is recognized by industry, government and the profession as being representative of retail prescription activity in the nation, is utilized. This ongoing research study is now nearing its nineteenth year of continuous operation. Over 400,000 prescriptions collected from a nationally representative subsample of 322 pharmacies for the six-month time period ending April, 1970, serve as the base data for this analysis.

Questionnaire Survey

A questionnaire was mailed to a randomly selected list of 10,640 retail pharmacies on June 29, 1970. Pharmacists were asked to supply their usual and customary charges by whatever pricing system they routinely use, markup or fee, or a modification of either, for a list of representative prescriptions. In addition, the pharmacist was asked to provide information on the characteristics of the pharmacy, the customer, and its area served, as well as data on services rendered, purchasing and pricing policies, utilization of personnel, etc. The average price charged was correlated by statistical means with those factors, both external and internal, to each pharmacy in order to establish the relative effect of each as a contribution to price.

SUMMARY OF SPECIFIC FINDINGS:

- . There is considerable dissatisfaction among pharmacists with several factors involving the process of reimbursement now in effect under third-party pay programs and in particular the Medicaid/State Welfare Programs.
- . The factors most strongly criticized by pharmacists are those coincident with reimbursement such as the amount allowed and the method utilized.
- . Pharmacists are generally unhappy with claims processing as it concerns the administrative tasks and time required for claims submission and the length of waiting time for reimbursement.
- . The use of the actual acquisition cost as part of the reimbursement formula is almost universally found to be difficult for pharmacists to ascertain and is considered unfair.

The fixed fee component of the reimbursement formula fosters an inequitable return on investment for pharmacists due to environmental (over which they have little control) and operational influences.
- . An uncontrollable environmental influence is the varying disease patterns within the trading area served by the pharmacy. Several socio-economic factors affecting disease incidence (therapeutic category concentration) are present in different proportions in the area served by each pharmacy. The professional services required of a pharmacist vary by the type of medical environment in which he operates.
- . Beyond the pharmacist's control is the matter of drug usage patterns. Physician preference concerning length of therapy and size of prescription varies considerably. Under the fixed fee where all prescriptions, regardless of quantity dispensed and choice of therapy, each is treated identically creating disparities in return on investment between pharmacies.
- . Most pharmacists (67%) are dissatisfied with the amount of time and calculation necessary for claim form submission. In addition, slow payment forced a substantial number to seek bank loans and increase their prices to regular customers.
- . Regression analysis of 165 variables associated with pharmacy operations isolated 36 which were found to be statistically significant in causing prescription price variation in pharmacies.

- The relative presence or absence of each of the 36 variables within a pharmacy can be calculated and given a quantitative value which when added together provide an index, the Prescription Services Index (PSI), rating relative to the national average for all pharmacies.
- The index (PSI) for each pharmacy reflects an accurate calculation of costs involved in providing the drug product and pharmaceutical services to the patients served.
- The PSI method facilitates a means which would provide an equitable payment for each pharmacy based upon its own unique mode of operation and environmental conditions, matched against national parameters for similar operations in the country.
- A workable alternative reimbursement formula for third party prescription claims is proposed using Prescription Service Index as a means of establishing acceptable Rx price levels for individual prescriptions submitted by all pharmacies. It offers advantages over present methods for the program administrator, pharmacist, general public and taxpayer.

PROBLEMS WITH PRESENT REIMBURSEMENT METHODS

When pharmacists were asked to express their opinion via a mail survey in early 1970, there was found to be considerable dissatisfaction with several factors involving the process of reimbursement now in effect under third party pay programs and particularly the Medicaid/State Welfare Programs.

The factors most strongly criticized were those concerned with pricing such as:

- . the level of reimbursement allowed
- . the pricing method utilized

In addition, pharmacists were generally unhappy with claims processing as it concerned:

- . the administrative tasks required of them and time involved
- . the length of waiting time for reimbursement

PRICE DETERMINATION:

At the present time nearly every state has a reimbursement method which treats each vendor identically. The method generally involves, as part of the reimbursement formula, a component for product cost and another for dispensing cost. There is considerable dissatisfaction on the part of pharmacists that the system itself is too rigid in that allowances aren't made for individual pharmacy differences and, secondly, the formula for reimbursement is cumbersome and unduly involved.

Product Costs

An overwhelming majority of pharmacists (89%) responding to the survey did not favor the use of a formula which requires the calculation or determination of the actual acquisition cost. The main objection is the difficulty in determining actual acquisition cost for each prescription and, secondly, it penalizes those pharmacies that have been able to develop purchasing efficiency by employing good management skills.

A survey of 1933 pharmacies in the summer of 1970 shows that pharmacist purchasing of ethical drugs from the wholesaler or other source varies substantially:

| PHARMACY PURCHASING DIFFERENCES | |
|--|---------------------|
| <u>Ethical Drugs Purchased From Wholesaler</u> | <u>% Pharmacies</u> |
| Less than 20% | 12% |
| 21 - 50% | 39 |
| 51 - 80% | 26 |
| 81 - 99% | 22 |
| 100% | <u>1</u> |
| | 100% |

The table shows that not all pharmacies are alike with respect to purchasing. Secondly, it shows that within a given pharmacy the determination of actual acquisition cost can be different from item to item. The dilemma here is that the pharmacist finds this factor within the formula particularly difficult to cope with and the payer finds it an obstacle to efficient monitoring and control. Some programs using the acquisition cost have found it necessary to adopt the average wholesale price (AWP) whether the pharmacy purchased the ingredients below this price or not.

For certain products there is the added price difference based on larger quantity sizes. The decision to purchase, however, is often predicated upon product demand rates over which the pharmacist has no control as therapy is dependent upon disease incidence.

A study of new prescriptions dispensed for a typical drug within 322 pharmacies for a six-month time period showed the differences in the rate of sales to be as follows:

| SALES OF A TYPICAL DRUG | |
|-----------------------------------|-------------------------|
| <u># of Tablets Dispensed</u> | <u>% Pharmacies</u> |
| None | 13% |
| Less than 500 | 33 |
| 500 - 999 | 23 |
| 1000 - 1999 | 18 |
| 2000 or more | <u>13</u> |
| | 100% |

*National Prescription Audit,
November 1969-April 1970*

The rate of purchase discount available for this product is of benefit to some pharmacies and of no benefit to others. The profile of nearly 7000 different products, brand and generic, filled in the 322 pharmacies show similar patterns; that is, some pharmacies dispense a larger volume than others and not necessarily because of total pharmacy volume. It is also an established fact that quantity purchase discounts vary considerably by product and by supplier and are subject to change over time. Pharmacists' inventories include merchandise purchased over a period of time.

The fixed fee approach requires the calculation of the actual ingredient cost or the average wholesale price, neither of which produces a realistic cost determination with the former creating an immense burden for the pharmacist and the latter, if used, superfluous for claims purposes.

Dispensing Costs

Most pharmacists (89%) are unhappy with an inflexible reimbursement system. In addition to the basic disagreement upon the method to be used, most pharmacists (67%) believe the level of reimbursement to be inadequate. The reason for the latter is that circumstances beyond the control of the pharmacist, unique to the pharmacy and its environment, frequently are responsible for variations in return on investment. As an entrepreneur he incurs considerable business risks in fulfilling the therapeutic requirements of his patrons.

Environmental Factors:

The pharmacist has little control over the disease incidence and drug usage patterns within his geographic area. Characteristics of the pharmacy clientele vary widely from one location to another. In addition, population shifts affecting socio-economic factors such as age, family concentration and per capita income are uncontrollable. This is an important consideration since the average price for prescriptions in selected therapeutic treatment areas varies considerably. Note that the average price of an Ataraxic prescription is nearly double the price of a typical prescription for a cough/cold product, (\$5.34 vs. \$2.76).

THERAPEUTIC CATEGORY DIFFERENCES

| Therapeutic Category | % All Rx's Filled | Average Price | # Refills for Every 100 New Rx's |
|----------------------|-------------------|---------------|----------------------------------|
| Antibiotics | 21.4% | \$4.69 | 34 |
| Cough/Cold Preps | 10.8 | 2.76 | 55 |
| Analgesics | 10.0 | 3.14 | 61 |
| Hormones | 8.0 | 3.94 | 161 |
| Ataraxics | 6.3 | 5.34 | 190 |
| Sedative/Hypnotics | 4.4 | 2.47 | 225 |
| Cardiovasculars | 4.3 | 4.58 | 250 |
| Antispasmodics | 2.7 | 3.73 | 153 |
| Diuretics | 2.7 | 4.22 | 199 |
| Sulfonamides | 2.3 | 3.63 | 57 |
| All Others | 27.1 | 3.97 | 110 |
| All New Rx's | 100.0% | \$3.95 | 114 |

National Prescription Audit, November 1969 - April 1970

Also, the pharmacist can expect to fill an additional 190 prescriptions for every 100 Ataraxic Rx's filled. For cough/cold preparations, he can expect but nearly 1/3 as many refills. This again is beyond the control of the pharmacist - he does not create the "demand" for therapeutic agents.

Not only is the expected volume of total prescriptions filled, including new and refills, beyond the pharmacist's control, but the mix of therapeutic categories filled is left to the prevalence of disease patterns within the locale of the pharmacy. Based upon the refill factor alone, it is easily seen that programs allowing but one set formula for reimbursement would be difficult for the pharmacist to determine his return on investment nor exercise professional or management control in order to satisfy the demands of his clientele.

A study of the therapeutic category sales mix for a six months period found that no two stores were identical. Typically, where one pharmacy may fill more antibiotics as a proportion of the total prescription file, it would fill proportionately less for another treatment area.

To illustrate this product mix difference within a pharmacy, three typical pharmacies are shown as examples:

| Therapeutic Category | % All New Rx's Filled | | | |
|-------------------------|-----------------------|--------------|--------------|----------------|
| | Pharmacy "A" | Pharmacy "B" | Pharmacy "C" | All Pharmacies |
| Antibiotics | 9% | 22% | 34% | 21.4% |
| Analgesics | 8 | 10 | 4 | 10.0 |
| Cough/Cold Preparations | 4 | 12 | 19 | 10.8 |
| Antispasmodics | 14 | 2 | 1 | 2.7 |
| Sulfonamides | 1 | 3 | 4 | 2.3 |
| Hormones | 4 | 18 | 7 | 8.0 |
| Ataraxics | 8 | 4 | 4 | 6.3 |
| Sedative/Hypnotics | 6 | 3 | 1 | 4.4 |
| Cardiovasculars | 18 | 1 | 2 | 4.3 |
| Diuretics | 10 | 1 | 1 | 2.7 |
| All Others | 18 | 24 | 23 | 27.1 |

National Prescription Audit, November 1969 - April 1970

Although the ten therapeutic categories account for nearly the same proportion (77-82%) of the total prescription file within each pharmacy, there are distinct differences between each pharmacy in terms of selected categories. This table serves to point out that there are vast differences in types of therapeutic agents dispensed in each pharmacy. Pharmacies that fill a large proportion of their file for higher cost medication are allowed a much smaller return than those pharmacies that fill a high proportion of prescriptions in the lower priced therapeutic treatment areas.

As a professional, he is committed to serve the patients who come to him with the drugs they need available when they need them. The maintenance of the appropriate mix of inventory is a serious and costly obligation for which he should be reimbursed. To limit his trade to only a few fast turnover items for economic reasons is not in the best interests of his patients. A professional or dispensing fee developed by an individual pharmacy based upon its own historical and current experience with therapeutic agents, refill Rx and quantities it handles would be an appropriate one for that pharmacy.

A dispensing fee set arbitrarily for all pharmacies or even by arbitrary groups cannot possibly take the variations in therapy into consideration. Obviously, the pharmacist's regular charge to the general public does account for the uniqueness of his professional environment.

Another environmental factor over which the pharmacist has little control is the size of the prescription dispensed. Generally this decision is left to the discretion of the physician. Third-party program control and administration might well consider standard drug quantities rather than standard dispensing fees.

A study of prescription sizes for a six-month period shows that for a typical drug there may be as many as 50 different prescription sizes dispensed with the modal quantity size accounting for but less than half of all the prescriptions dispensed for the product.

To illustrate this point, the frequency distribution of quantity size for three typical products is presented:

| Rx Size | % Prescriptions Filled | | |
|-------------|------------------------|----------|----------|
| | Drug "A" | Drug "B" | Drug "C" |
| 9 or less | .3% | 2.9% | 2.6% |
| 10 - 19 | 4.2 | 16.1 | 12.2 |
| 20 - 29 | 11.4 | 9.1 | 14.1 |
| 30 - 39 | 30.7 | 61.5 | 39.5 |
| 40 - 49 | 7.9 | 1.5 | 2.0 |
| 50 - 99 | 30.7 | 7.9 | 21.0 |
| 100 or more | 14.8 | 1.0 | 8.5 |
| # Rx's | (3945) | (1287) | (1569) |

National Prescription Audit, November 1969-April 1970

CLAIMS PROCESSING PROBLEMS:

Claims Submission

There is considerable annoyance on the part of pharmacists with the difficulty in calculating a charge for a prescription when using a fixed fee alone or in combination with a percent markup since the average cost, whether average wholesale cost or true ingredient acquisition cost, is part of the formula and difficult to ascertain.

About two of every three (67%) pharmacists in the survey of 1933 pharmacists across the country stated that they were dissatisfied with the claim forms processing necessary for reimbursement under Federal or State supported programs. Most find it extremely time consuming.

Claims Waiting Period for Payment

Another point which creates undue financial hardship upon certain pharmacies is the matter of the length of waiting period necessary for reimbursement.

| WAITING PERIOD FOR REIMBURSEMENT UNDER MEDICAID/STATE WELFARE PROGRAMS | |
|---|-----------------------|
| <u>% of Pharmacies</u> | <u>Waiting Period</u> |
| 32.3% | Over 60 days |
| 2.5% | Over 120 days |
| .5% | Over 180 days |

Only 19% of the pharmacies indicated that they routinely received payments in 30 days.

Private insurance programs show a much better record, with 50% of the pharmacies receiving payment in 30 days or less, and all but about 10% receiving payment in under 60 days.

Forty percent (40%) of the pharmacies indicated that the amounts owed to them under Medicaid were \$1,000 or greater. Almost 6% indicated that their accounts receivable ran between \$5,000 and \$10,000. In those pharmacies that indicated a heavy Medicaid volume, that is 15% of their prescriptions or greater, 27.4% of them had to seek financial assistance from banks to meet their business obligations.

Surveys conducted in this study indicate a high degree of concern that pharmacists have with the development of third-party pay programs. Their opinions are based upon their experience with the various Medicaid programs which appear to be far less than 100% satisfactory in mode of operation and reimbursement in most states.

Perhaps the experience of Medicaid can serve the highly valuable purpose of indicating to third-party pay administrators that, if these programs are to be successful, all facets of this highly interactive system must be considered and systems developed which will recognize the needs and requirements of all pertinent factors.

A WORKABLE REIMBURSEMENT ALTERNATIVE

CONSIDERATIONS IN THE DESIGN OF A METHOD:

In the final report submitted by the Task Force on Prescription Drugs of the U. S. Department of Health Education and Welfare, specific considerations are set forth in the implementation of a drug program providing direct reimbursement to the vendor. These criteria include:

- . The level of payment submitted for reimbursement must be acceptable to the vendor (pharmacy).
- . The reimbursement technique should minimize record-keeping and time consumed in claims submission required by the vendor.
- . The method should allow the pharmacist to compute the program payment easily.
- . The method should provide prompt payment.
- . The method should permit a reasonable check on the accuracy or appropriateness of payments without resulting in very high auditing and accounting costs.

In view of the preceding, it is clear that the vendor reimbursement methods presently available have far from satisfied fully all of the above criteria.

It was with this background that a comprehensive statistical study focusing upon variability in prescription charges and pharmacy operating characteristics was conducted. Its purpose was to isolate more fully the factors which would aid in the design of an alternative reimbursement method which would satisfy the above requirements and result in other advantages.

RESEARCH BACKGROUND:

Earlier studies on the reimbursement problem concentrated upon determining the costs of filling a prescription by seeking detailed accounting and financial operating data about the prescription department. The difficulty with this approach is that the information required for analyses is not ordinarily available in the majority of pharmacies. To obtain it requires an inordinate amount of time on the part of the pharmacy owner or accountant, and adds to operating costs.

Data Description

Based upon this prior and unsatisfactory experience with studies involved with determining costs of filling a prescription, it was decided that the desired goal could be better achieved by obtaining extensive information about store environment and operations in as simple a form as possible and from as many pharmacies as possible. Over 10,000 randomly selected pharmacies in the country were sent a comprehensive questionnaire during the summer of 1970, and a 20% response was obtained on but one mailing, which was proportionate and representative of all types of pharmacies.

The owner or manager of each pharmacy was asked to provide data on specific areas involving the pharmacy's environment and operational characteristics. The areas involved were as follows:

Classification Data:

| | | |
|---|--|---|
| Location: | Trading Area Served: | Total Annual Store Sales: |
| Shopping Center (Plaza) | Mostly within 1 mile | Less than \$100,000 |
| Medical Building | Mostly within 3 miles | \$100-199,999 |
| On Main Street | Mostly within 5 miles | \$200-299,999 |
| Off Main Street | Mostly within 10 miles | \$300-499,999 |
| | Mostly beyond 10 miles | \$500-999,999 |
| | | \$1,000,000 or more |
| Area: | # Competitive Pharmacies In Trading Area: | Rx Sales As % Store Sales: |
| Downtown Business Dist. | None | Less than 25% |
| Neighborhood/Residential | 1 or 2 | 25-49% |
| Rural | 3 or 4 | 50-74% |
| | 5 to 9 | 75% or more |
| | 10 or more | |
| Type: | Size of Store: (Sq. Ft.) | Average # Rx's (new and refills) Filled Per Day: |
| Single unit | Less than 1000 sq. ft. | Less than 25 Rx's |
| Multiple (2-3 units) | 1000-1999 sq. ft. | 25- 49 Rx's |
| Multiple (4 or more) | 2000-2999 sq. ft. | 50- 74 Rx's |
| | 3000-5999 sq. ft. | 75-149 Rx's |
| | 6000-9999 sq. ft. | 150-299 Rx's |
| | 10,000 sq. ft. or more | 300 Rx's or more |
| # Years Store At Present Location: | Monthly Rent: | Ratio New To Refill Rx's: |
| Less than 5 years | (If owned, estimate rent) | More refills than new |
| 5-9 years | Less than \$250/month | New/refills about even |
| 10-24 years | \$ 250- 499/month | More new than refills |
| 25 years or more | \$ 500- 749/month | |
| | \$ 750- 999/month | |
| | \$1000-1499/month | |
| | \$1500/month or more | |
| Hours Open Per Week: | | Price Most Health & Beauty Aids At: |
| Less than 70 hours | | Mfg. Sug. Retail Price |
| 70-79 hours | | 1- 9% off list |
| 80-89 hours | | 10-19% off list |
| 90-99 hours | | 20% or more off list |
| 100 hours or more | | |

| | Rx's Covered Under Federal/State Supported Programs | Rx's Covered Under Private Insurance Programs | Rx's By Charge Customers |
|--|--|--|--|
| % All Rx's Filled: | _____ % all Rx's | _____ % all Rx's | _____ % all Rx's |
| Usual Waiting Period For Payment: | <input type="checkbox"/> Less than 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> 3-4 months <input type="checkbox"/> 5-6 months <input type="checkbox"/> 7 months or more | <input type="checkbox"/> Less than 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> 3-4 months <input type="checkbox"/> 5-6 months <input type="checkbox"/> 7 months or more | <input type="checkbox"/> Less than 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> 3-4 months <input type="checkbox"/> 5-6 months <input type="checkbox"/> 7 months or more |

% All Rx Drugs Purchased:

Direct %
 Wholesale %
 Coop. Buying Group %
 Central Warehouse %
 Other %

 ADDS TO: 100%

Those Which Apply To Store:

- Open Sundays. # Hours _____
- Open holidays. # Hours _____
- Customer waiting area
- Free vehicle Rx delivery
- Emergency after-hour on-call service
- A comprehensive drug information library
- Pharmacy accepts all Rx's requiring compounding
- Complete patient/family Rx record service
(includes drug sensitivities)

**Proportion Of Each Of The Following Activities
Performed By A Pharmacist .**

Purchasing Rx drugs
 Checking in orders
 Labeling, pricing and placing drugs into stock
 Handling recalls and returns

Receiving Rx's directly from customer
 Obtaining drugs from stock
 Typing labels
 Counting, pouring and packaging
 Instructing customer on Rx use directions

Writing up charge/sales receipts
 Preparing and sending bills
 Reconciling accounts receivable
 Selling non-legend drugs and med./surg. supplies
 Selling sundries in pharmacy

Total # Hours Spent By All Pharmacists In Store:

Maintaining a comprehensive drug info. library
 Maintaining a complete family Rx record service

Reading journals & professional publications
 Reading drug company literature
 Discussing drug & health care information with drug
 company detailmen
 Attending seminars, continuing education courses &
 professional meetings

Providing information on 3rd party pay programs to recipients
 Providing drug & health care information and Rx use
 directions to customers
 Providing drug & health care information to physicians,
 hospitals, nursing homes, ECF's
 Providing drug & health care information to civic groups,
 local gov't. officials, local community, general public

The other key element in the study was obtaining from each pharmacy the prices charged for ten identical Rx's and a description of the pricing method employed. The ten Rx's were selected after an analysis of the National Rx Audit to obtain a representative cross section of both brand name and generic items of varying volume.

In obtaining this extensive information from each pharmacy, it was possible to allow many factors to be considered in determining the relative contribution of each to variations in price. The statistical analyses necessary in the study of the interaction of the attributes and prices were achieved using two advanced and comprehensive statistical programs and large capacity computers to handle the immense amount of data collected.

One program was obtained from the National Opinion Research Center at the University of Chicago for use in the multiple correlation and regression analyses of these data. The second came from Princeton University and was utilized for factor analysis.

Regression Analysis

It was necessary to consider all of the questionnaire variables simultaneously in order to properly measure the effect of each. To do this a mathematical technique called multiple regression was used. With the high speed computers utilized in the study there was no problem in analyzing the large number of variables over a wide range of values. Each of these variables was fitted to the "Prescription Services Index" and the slope coefficient calculated.

The "Prescription Services Index" for each pharmacy in the study was calculated by assigning the value of 100.000 to represent the grand average of all prices for the ten Rx's for all stores. The average for the ten items for each pharmacy was then compared to the national value of 100.000 to determine a relative index for each pharmacy. By converting the slopes into standard units, the questionnaire variables were ranked according to their influence on the index. A minus sign indicates a decrease in index per unit and an increase in questionnaire answering units. For example, the index over store decreases as the percentage of discount on health and beauty aids increases (increase in questionnaire answering units).

Factor Analysis

Prescription prices in 19 of the 50 states were significantly different from the national average prescription price. Each member of each group was adjusted for the average price difference of the group.

The remaining 69 variables were factor analyzed to reduce these 69 variables to the smallest meaningful dimensions. The first step was to reduce all the 1933 answers on 69 questions to 14 principal components. Each of these principal components was formed by applying a calculated weight to each of the 69 original variables. Using only 14 component factors, one is able to describe every store in relation to all other stores just as precisely as if one used the original 69 questions. That is, no loss of information has occurred. The difficulty is that all 69 question variables are present in every component.

To further simplify the questionnaire results, every one of the 69 original variables is expressed in terms of the 14 new principal components. It is as if we drew a graph with principal components as the principal axis and each variable as a point on the graph. Most of the points representing our original 69 variables will be somewhere between the 14 principal component axes. The object is to twist or rotate this system of 14 axes so as to end up with each variable as close as possible to one of the 14. We wish to express each variable as a member of one of these 14 groups rather than as a point off in space by itself.

This is easy to see in two dimensions on a simple X, Y Cartesian diagram. If a variable is one-half X and one-half Y, it could be plotted as the point (1/2, 1/2) half way between X and Y axes. If we twist or rotate the axis, the point can be made to lie exactly on X or on Y, depending on which direction we rotate. This simple process generalizes directly to the fourteen principal component coordinate axes system in the survey.

Of course, all 69 variables are not directly over each of the 14 axes, but they end up very close. We know this to be true because we have already shown that the questionnaire variables have only 14 principal components. The variables are then rearranged according to the closest axis. This gives us our final factor groupings.

All of the 69 variables were regressed or fitted to price and their statistical contribution was noted. All non-significant variables were eliminated from these groupings and the identity of the variables in the final factors was established.

The interactive nature of these variables and their identity with various types of store operation was resolved into eight principal factors by factor analysis with each including a set of variables. In total, 36 different variables were isolated as significant, as shown in the following table:

FACTORS IN THE MODEL DEVELOPMENT OF PRESCRIPTION SERVICES INDEX

| | <u>Slope Coefficient</u> |
|---|------------------------------|
| I EXTERNAL FACTORS | |
| 1. REGIONAL ADJUSTMENT (State Grouping)... | |
| <u>GROUP A:</u> California, Nevada | 14.04261 |
| <u>GROUP B:</u> Rhode Island | -13.97720 |
| <u>GROUP C:</u> Connecticut, New Jersey | 3.98068 |
| <u>GROUP D:</u> New Mexico, Washington | 4.04400 |
| <u>GROUP E:</u> Arizona, Delaware, Indiana, Vermont | - 6.56598 |
| <u>GROUP F:</u> Maryland, North Carolina, North Dakota, Ohio, Oklahoma, Pennsyl- vania, Tennessee, West Virginia | - 3.25818 |
| <u>GROUP G:</u> Alabama, Arkansas, Colorado, Dist. Columbia, Florida, Georgia, Idaho Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New York, Oregon, South Carolina, South Dakota, Texas, Utah, Virginia, Wisconsin, Wyoming | - 0.76602 |

| | <u>Slope</u> <u>Coefficient</u> |
|--|------------------------------------|
| 2. URBANIZATION AND INCOME LEVEL... | |
| a. Average per capita income for city or town | 0.00073 |
| b. Trading area served in miles | - 0.58736 |
| c. Number competitive pharmacies in trading area | - 0.31024 |
| d. Average hourly wage of registered pharmacist | 0.85574 |
| e. Average hourly wage of non-pharmacist | 0.79579 |
| 3. STORE CHARACTERISTICS... | |
| a. Store under single ownership | 1.40695 |
| b. Years in present location | 0.58815 |
| c. Size in square footage | 0.22980 |
| d. Rental expense | 0.46918 |
| e. Store location (shopping center or not) | - 1.73535 |
| f. Total hours open per week | 0.50803 |
| g. Daily prescription volume | - 2.40675 |
| h. Health and Beauty Aid discount policy | - 3.31002 |
| 4. THIRD PARTY PAY PRESCRIPTION INVOLVEMENT... | |
| a. Federal/State program Rx's as % of all Rx's | 0.05585 |
| b. Private Insurance program Rx's as % of all Rx's | 0.12331 |
| c. Usual Waiting Period for payment of Third Party program prescriptions | 0.60169 |

II INTERNAL FACTORS

| | |
|--|-----------|
| 1. SPECIAL CUSTOMER SERVICES... | |
| a. Percent Rx's charged by customers | 0.07640 |
| b. Usual waiting period for charge customer payments | 0.82979 |
| c. Prescription sales as % total store sales | 1.05402 |
| d. Provide free vehicle delivery service | 2.00840 |
| e. Provide patient/family Rx record service | 1.44448 |
| f. Provide customer waiting area | 0.63150 |
| 2. SOURCE OF DRUGS PRUCHASED... | |
| a. % Rx's purchased direct | - 0.04314 |
| b. % Rx's purchased through wholesaler | 0.02497 |
| c. % Rx's obtained from central warehouse | - 0.05951 |

Slope
Coefficient

3. PERSONNEL DEPLOYMENT...

| | |
|---|-----------|
| a. % time typing of labels is done by R.Ph | - 0.05951 |
| b. % time counting, pouring & packaging is done by R.Ph. | 0.79975 |
| c. % time handling recall & returns is done by R.Ph. | - 0.26869 |
| d. % time preparing & sending bills is done by R.Ph. | - 0.29832 |
| e. % time non-legend drugs and medical/surgical supplies are sold by R.Ph. | - 0.38105 |
| f. % time the instruction of customers on Rx use direction is done by R.Ph. | 0.79421 |

4. COMMUNITY RELATIONS AND PROFESSIONAL DEVELOPMENT...

| | |
|--|-----------|
| a. Hours attending seminars, courses and professional meetings per week | 1.19288 |
| b. Hours reading journals and professional publications per week | 1.08939 |
| c. Hours reading drug company literature per week | - 0.98091 |
| d. Hours providing drug and health care information and Rx use instruction to customers per week | 0.54750 |

The factor analysis procedure has grouped the variables into sections or factors where interdependence exists. Reliance must not be placed upon the index weight associated with any single variable. But, since the entire factor group as a whole is included, this weight is reliable and the statistical significance of these factor increments to the prescription services index is impressive. The t-scores for the factors are displayed.

T-SCORES FOR THE EIGHT FACTOR GROUPINGS

| <u>Factor</u> | <u>t-score</u> |
|--|----------------|
| Regional Adjustment | 19.7 |
| Urbanization and Income Level | 7.3 |
| Store Characteristics | 18.3 |
| Third Party Pay Prescription Involvement | 5.9 |
| Special Customer Services | 11.4 |
| Source of Drugs Purchased | 6.7 |
| Personnel Deployment | 4.9 |
| Community Relations and Professional Development | 4.8 |

A t-score of 1.96 is significant at the .05 risk level. These factors are all a multiple of this threshold value. Those factors with the highest t-scores are also those with the greatest effect upon the prescription services index.

Such confidence as this illustration provides is necessary for weak factors would make interpretation difficult. Because of the very large number of respondents, the relations reported here are not only well-established statistically, but represent what are believed to be the facts of operational expenses.

For each of the variables, slope coefficient is calculated from the regression analysis. We need only multiply this slope by the score to obtain a prescription services index increment for each variable separately. The sum of all of these increments (or decrements) will be the final estimate of the prescription services index for that store.

PSI Prediction Model

The precise value for the questionnaire coding deserves discussion. In this study it is assumed that responses from 1933 pharmacies represent all the pharmacies in the country. If the average prescription services index is set at 100.00, the basis for every questionnaire variable is also the average for all stores. The advantage of this procedure is that the basic format now has a constant term of 100.00, which is incremented (or decremented) according to the pharmacy response to each question.

For instance, if a store purchases 10% direct, 90% from wholesaler and 0% from central warehouse, the following calculation would result for that store:

| <u>Variable</u> | <u>(1)</u> <u>Slope</u> <u>Coefficient</u> | <u>National</u> <u>Average</u> | <u>(2)</u> Deviation from | <u>(1) X (2)</u> <u>Increment</u> |
|-------------------------------|--|-----------------------------------|-----------------------------------|--------------------------------------|
| | | | <u>National</u> <u>Average</u> | |
| Direct Purchase | - .04314 | 36.783 | - 26.783 | 1.1554 |
| Wholesale Purchase | .02497 | 53.452 | 36.548 | .9126 |
| Central Warehouse Purchase | - .05951 | 5.949 | - 5.949 | .3540 |
| Total | | | | 2.4220 |

This pharmacy (Pharmacy A on the next page), as a result, would be expected to gain 2.4 points on its prescription services index. This, together with all other variables, would sum to the total expected prescription services index of the pharmacy.

The following pages illustrate ten typical pharmacies and the index points each would gain or lose relative to its description and activity within each of the eight groupings. The sum of the eight identifies the individual store index. Note that these ten pharmacies are quite dissimilar from one another and that one pharmacy is more than 27 points above the national average. This represented a difference of more than a \$2.00 charge on each prescription between each pharmacy (one charged 71.4% more than the other). Despite these variances, the model predicted the indices for these pharmacies within four cents or one percentage point.

**FACTORS DETERMINED TO BE
STATISTICALLY SIGNIFICANT:**

| | STORE A | STORE B | STORE C |
|--|---------------|------------------|-------------------|
| I. EXTERNAL FACTORS | | | |
| 1. Regional Adjustment (State Grouping) .. | +14.043 (Cal) | -6.566 (Ind) | -3.258 (Pa) |
| 2. Urbanization and Income Level .. | +2.851 | -1.257 | -1.662 |
| a. Average per capita income for city or town | \$3616 | \$2774 | \$2716 |
| b. Trading area served in miles | 5 miles | 10 miles | 10 miles |
| c. Number competitive pharmacies in trading area | 5 - 9 | 3 - 4 | None |
| d. Average hourly wage of registered pharmacist | \$8.00 | \$5.80 | \$5.00 |
| e. Average hourly wage of non-pharmacist | \$3.20 | \$1.80 | \$1.40 |
| 3. Store Characteristics .. | +4.986 | -9.322 | -1.601 |
| a. Store under single ownership | Yes | No | Yes |
| b. Years in present location | 10-24 yrs. | 5-9 yrs. | < 5 yrs. |
| c. Size in square footage | < 1000 sq.ft. | 6000-9999 sq.ft. | 2000-2999 sq. ft. |
| d. Rental expense | \$250-499/mo. | \$1000-1499/mo. | < \$250/mo. |
| e. Store location (shopping center or not) | No | Yes | No |
| f. Total hours open per week | < 70 hrs. | 90-99 hrs. | < 70 hrs. |
| g. Daily prescription volume | 25-49 Rx's | 150-299 Rx's | 75-149 Rx's |
| h. Health and Beauty Aid discount policy | List | 10-19% off list | List |
| 4. Third Party Pay Prescription Involvement .. | +0.190 | -0.379 | -0.238 |
| a. Federal/State program Rx's as % of all Rx's | 10% | 13% | 15% |
| b. Private insurance program Rx's as % of all Rx's | 5% | 4.5% | 1% |
| c. Usual waiting period for payment of Third Party program prescriptions | 3-4 months | 1-2 months | 3-4 months |
| II. INTERNAL FACTORS | | | |
| 1. Special Customer Services .. | +3.967 | -2.203 | -3.363 |
| a. Percent Rx's charged by customers | 50% | 25% | 5% |
| b. Usual waiting period for charge customer payments | 1-2 months | 1-2 months | < 1 month |
| c. Prescription sales as % total store sales | 75% or more | 25-43% | 50-75% |
| d. Provide free vehicle delivery service | Yes | No | No |
| e. Provide patient/family Rx record service | No | No | No |
| f. Provide customer waiting area | Yes | Yes | Yes |
| 2. Source of Drugs Purchased .. | +2.422 | -4.500 | -0.302 |
| a. % Rx's purchased direct | 10% | 0% | 50% |
| b. % Rx's purchased through wholesaler | 90% | 10% | 50% |
| c. % Rx's obtained from central warehouse | 0% | 90% | 0% |
| 3. Personnel Deployment .. | -1.627 | -0.983 | +0.194 |
| a. % time typing of labels is done by R.Ph. | 100% | 100% | 100% |
| b. % time counting, pouring & packaging is done by R.Ph. | 75% | 50% | 100% |
| c. % time handling recall & returns is done by R.Ph. | 75% | 50% | 100% |
| d. % time preparing & sending bills is done by R.Ph. | 0% | 0% | 25% |
| e. % time non-legend drugs and medical/surgical supplies are sold by R.Ph. | 50% | 25% | 50% |
| f. % time the instruction of customers on Rx use direction is done by R.Ph. | 50% | 75% | 100% |
| 4. Community Relations and Professional Development .. | +0.362 | -0.722 | -0.185 |
| a. Hours attending seminars, courses and professional meetings per week | 1-5 hours | None | 1-5 hours |
| b. Hours reading journals and professional publications per week | 1-5 hours | 6-10 hours | 1-5 hours |
| c. Hours reading drug company literature per week | 1-5 hours | 6-10 hours | 1-5 hours |
| d. Hours providing drug and health care information and Rx use instruction to customers per week | 6-10 hours | 6-10 hours | 1-5 hours |
| STORE PRESCRIPTION SERVICES INDEX: | 127.194 | 74.068 | 89.565 |
| NATIONAL INDEX:* | 100.000 | 100.000 | 100.000 |
| DEVIATION: | +27.194 | -25.932 | -10.435 |

* Based upon 1,933 pharmacies surveyed

PRESCRIPTION SERVICES INDICES FOR SELECTED STORE EXAMPLES

| STORE D | STORE E | STORE F | STORE G | STORE H | STORE I | STORE J |
|---------------------|---------------------|----------------------|----------------------|----------------------|--------------------|----------------------|
| <u>-0.766</u> (Tex) | <u>-0.766</u> (Ark) | <u>+4.084</u> (Wash) | <u>-0.766</u> (Mass) | <u>-0.766</u> (Misc) | <u>+3.980</u> (HJ) | <u>-3.258</u> (Tenn) |
| <u>-2.014</u> | <u>-1.506</u> | <u>+1.866</u> | <u>+1.095</u> | <u>-1.083</u> | <u>-0.233</u> | <u>-3.707</u> |
| \$2375 | \$2047 | \$4119 | \$2961 | \$2972 | \$3550 | \$1817 |
| 10 miles | 10 miles | 1 mile | 1 mile | 10 miles | 10 miles | Beyond 10 miles |
| 10 or more | 5 - 9 | 10 or more | 1 - 2 | 5 - 9 | 5 - 9 | 3 - 4 |
| \$5.78 | \$5.78 | \$6.00 | \$5.00 | \$6.00 | \$6.50 | \$4.50 |
| \$2.01 | \$1.85-2.15 | \$1.75-2.25 | \$1.90-2.10 | \$2.00 | \$2.05 | \$1.80-2.00 |
| <u>-0.297</u> | <u>-7.235</u> | <u>+5.245</u> | <u>+6.420</u> | <u>-2.764</u> | <u>+2.140</u> | <u>+3.307</u> |
| Yes | Yes | No | Yes | No | Yes | Yes |
| 25 yrs. or more | < 5 years | 25 yrs. or more | 25 yrs. or more | < 5 years | 5-9 yrs. | 25 yrs. or more |
| < 1000 sq.ft. | < 1000 sq.ft. | 3000-5999 sq.ft. | 1000-1999 sq.ft. | 6000-9999 sq.ft. | 1000-1999 sq.ft. | 3000-5999 sq.ft. |
| < \$250/mo. | \$500-749/mo. | \$500-749/mo. | \$250-499/mo. | \$750-999/mo. | \$250-499/mo. | < \$250/mo. |
| No | No | No | No | Yes | No | No |
| < 70 hrs. | 70-79 hrs. | 70-79 hrs. | 70-79 hrs. | 80-89 hrs. | 70-79 hrs. | 70-79 hrs. |
| 75-149 Rx's | 75-149 Rx's | 25-49 Rx's | < 25 Rx's | 50-74 Rx's | 50-74 Rx's | 50-74 Rx's |
| List | 10-19% off list | List | List | 1-9% off list | List | List |
| <u>-1.669</u> | <u>-0.350</u> | <u>-1.506</u> | <u>-1.140</u> | <u>-1.060</u> | <u>-0.320</u> | <u>+0.426</u> |
| 0% | 1% | 10% | 0% | 0% | 5% | 2% |
| 0% | 1% | 1% | 0% | 2% | 8% | 5% |
| - | 1-2 months | < 1 month | - | 1-2 months | 1-2 months | 1-2 months |
| <u>+8.532</u> | <u>-3.669</u> | <u>-2.172</u> | <u>-5.809</u> | <u>+0.247</u> | <u>+2.671</u> | <u>-1.005</u> |
| 80% | 1% | 3% | 0% | 10% | 50% | 25% |
| 3-4 months | < 1 month | < 1 month | - | 1-2 months | 1-2 months | 1-2 months |
| 75% or more | 50-74% | < 25% | < 25% | 25-49% | 25-49% | 50-74% |
| Yes | No | Yes | No | Yes | Yes | No |
| Yes | No | Yes | No | Yes | Yes | No |
| Yes | Yes | Yes | No | Yes | No | Yes |
| <u>-0.302</u> | <u>-0.719</u> | <u>+2.422</u> | <u>0.000</u> | <u>-0.302</u> | <u>+1.740</u> | <u>+0.253</u> |
| 50% | 35% | 10% | 37% | 50% | 20% | 45% |
| 50% | 65% | 90% | 57% | 50% | 80% | 55% |
| 0% | 0% | 0% | 6% | 0% | 0% | 0% |
| <u>+3.745</u> | <u>-0.700</u> | <u>+0.194</u> | <u>-0.281</u> | <u>+0.492</u> | <u>+0.492</u> | <u>-0.104</u> |
| 25. | 100. | 100. | 100. | 100. | 100. | 100. |
| 100. | 100. | 100. | 100. | 100. | 100. | 100. |
| 75. | 100. | 100. | 100. | 100. | 100. | 100. |
| 0. | 100. | 25. | 0% | 0% | 0% | 50% |
| 50. | 50. | 50% | 75. | 50% | 50% | 50% |
| 100 | 100% | 100 | 100. | 100% | 100% | 100% |
| <u>+0.362</u> | <u>-0.185</u> | <u>+0.362</u> | <u>-1.378</u> | <u>+0.367</u> | <u>+1.451</u> | <u>-1.378</u> |
| 1-5 hours | 1-5 hours | 1-5 hours | None | 1-5 hours | 1-5 hours | None |
| 1-5 hours | 1-5 hours | 1-5 hours | 1-5 hours | None | 6-10 hours | 1-5 hours |
| 1-5 hours | 1-5 hours | 1-5 hours | 1-5 hours | 1-5 hours | 1-5 hours | 1-5 hours |
| 6-10 hours | 1-5 hours | 6-10 hours | 1-5 hours | 15 hrs. or more | 6-10 hours | 1-5 hours |
| 107.721 | 86.308 | 110.455 | 98.141 | 95.131 | 111.921 | 94.534 |
| 100.000 | 100.000 | 100.000 | 100.000 | 100.000 | 100.000 | 100.000 |
| + 7.721 | -13.692 | +10.455 | - 1.859 | + 4.869 | +11.921 | - 5.466 |

Research Conclusions

- . Factors causing price variability can be identified.
- . The contribution to price for each factor can be quantified.
- . An index relative to a national average for each pharmacy can be determined based upon the varying presence of certain factors readily available.
- . The calculated index (PSI) for each pharmacy includes an accurate reflection of the costs of that pharmacy to provide the drug product and pharmaceutical services to the patients served.
- . The PSI can provide the basis for the design of a reimbursement method which would provide an equitable payment for each pharmacy based upon its environmental and operational characteristics profile.

A DESCRIPTION OF THE USE OF THE PSI METHOD IN A REIMBURSEMENT SYSTEM:

The prescription Services Index (PSI) for each pharmacy is easily calculated from information supplied by the pharmacy on an annual (or semi-annual) basis. Periodic verification and spot checking of facts supplied is left to the discretion of the administrator and would require less time and work than current audit procedures.

Secondly, the current prices charged to the general public for identical prescriptions would serve as the Rx Price Reference source. Prices charged throughout the nation for nearly one million new prescriptions at various quantity levels for approximately 7000 different products are in existence and available from the National Prescription Audit (NPA) or could be obtained from a similarly designed study.

The two sets of information, the PSI and the Rx Price Reference, allow the method to work smoothly.

For example, assume two different pharmacies (Universal Pharmacy Code numbers #999999 and #999998) submit a claim for Vilox 10mg #30 (National Drug Code number XYZ-VLOX-01). One pharmacy (#999999) with a PSI of 107.00 submits a charge of \$4.25 while the other pharmacy (#999998) with a PSI of 84.00 submits a charge for \$3.85

The average price for the nation for XYZ-VLOX-01 (#30 tablets) shows a figure of \$4.00, as shown in the National Rx Price Reference File.

An example of an acceptable claim:

$$\left(\begin{array}{c} \text{Price shown in} \\ \text{National Rx Price} \\ \text{Reference File} \end{array} \right) \text{ times } \left(\begin{array}{c} \text{Pharmacy} \\ \text{\#999999} \\ \text{PSI} \end{array} \right) \text{ equals } \left[\begin{array}{c} \text{Highest Acceptable} \\ \text{Price} \end{array} \right]$$

$$\$4.00 \quad \times \quad 107.00 \quad = \quad \$4.28$$

Charge Submitted = \$4.25 - Claim approved, payment made immediately

An example of an unacceptable claim:

$$\left(\begin{array}{c} \text{Price shown in} \\ \text{National Rx Price} \\ \text{Reference File} \end{array} \right) \text{ times } \left(\begin{array}{c} \text{Pharmacy} \\ \text{\#999998} \\ \text{PSI} \end{array} \right) \text{ equals } \left[\begin{array}{c} \text{Highest Acceptable} \\ \text{Price} \end{array} \right]$$

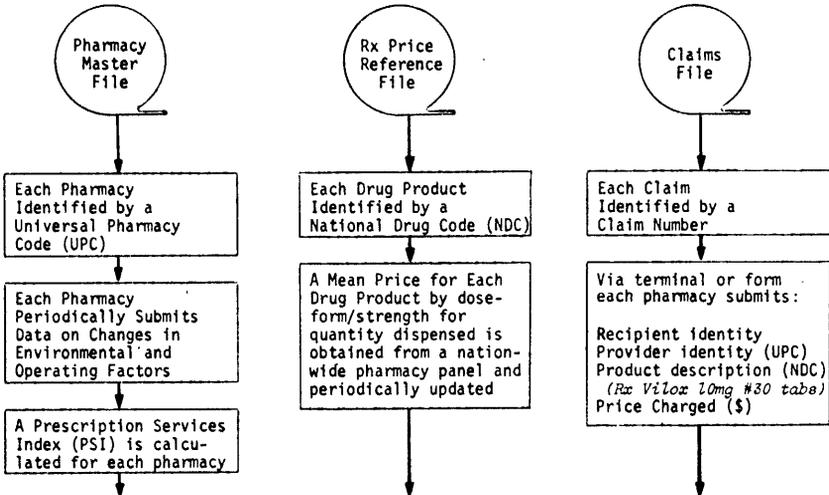
$$\$4.00 \quad \times \quad 84.00 \quad = \quad \$3.36$$

Charge Submitted = \$3.85 - Claim disapproved, price adjustment required

To allow for minor variations in prices that might occur for pharmacies with an identical PSI number, standard deviations can be applied to the Rx Price Reference figure.

PRESCRIPTION SERVICES INDEX

Third-Party-Pay Prescription Claims System



| CLAIMS PROCESSING | | |
|--|---|--|
| STEPS INVOLVED | CLAIM 1 | CLAIM 2 |
| 1 Recipient Eligibility Established | Mary Smith 000-9999-11 | John Doe 000-8888-22 |
| 2 Claim Record Identifies: Universal Pharmacy Code (UPC) Prescription Services Index (PSI) National Drug Code (NDC) Price Charged (\$) | 999999 107.00 XYZ-VLOX-01 \$4.25 | 999998 84.00 XYZ-VLOX-01 \$3.85 |
| 3 Average Price for Nation for NDC (XYZ-VLOX-01) | \$4.00 | \$4.00 |
| 4 An Acceptable Price Limit is Calculated (NDC AVG. PRICE X PSI) | \$4.28 | \$3.36 |
| 5 Price on Claim with Limit of Acceptability is Determined | Acceptable Claim Paid Promptly | Non-acceptable Price Adjustment Required |

Ongoing Research on Modal quantities, price variations, characteristics, drug utilization and review, price and quantity monitoring

Satisfaction of CriteriaSTEPS INVOLVED WITH
THE PSI METHOD:SATISFACTION OF SPECIFIC
TASK FORCE CONSIDERATIONS:

- | | |
|--|--|
| 1 Pharmacy periodically fills and submits data on changes in environmental and operating factors. | <ul style="list-style-type: none"> . Information sought is readily available or retrievable, and is not confidential. . Eliminates need for detailed P&L or other accounting data which for the most part is not available in the form needed to establish "cost of filling an Rx." |
| 2 Pharmacist fills and dispenses third party Rx as does all others and charges same price as he would to general public. | <ul style="list-style-type: none"> . Same price to all customers and patients. No double standard for professional service. . Prices respond to competitive pressures. Additional costs of 3rd party paperwork, etc., spread over full base of Rx's. . Simplified reporting for claims - only Rx price is needed - acquisition cost not essential for claim processing. AWP can be made part of computer input. |
| 3 Pharmacist submits claim to processor via terminal or form. | <ul style="list-style-type: none"> . Allows for flexibility and accommodation of all pharmacies, using terminal or not. . If form used, sight draft concept is compatible. |
| 4 Processor using national drug code and universal pharmacy code compares claim amount for quantity with national data base audit of amounts and prices and PSI for pharmacy - accepts or "rejects" claim. | <ul style="list-style-type: none"> . Simple, uncomplicated computer method for processing. . Eliminates unwieldy validation of actual acquisition cost for each Rx. . Speeds claim processing time, keeps cost at minimum. . Provides administration with realistic method for establishing limits for range of acceptable prices. |

THE ADVANTAGES OF THE PSI METHOD:

Advantage for the Program Administrator

- . Method allows the more efficient control of costs through facile review of pricing abuse.
- . Method can be easily integrated into a fully automated data processing system.
- . Method can easily be interfaced with other vendor systems.
- . Method would allow quick data retrieval by use of single comprehensive nomenclature and National Drug Code System.
- . Method works equally well with or without a scientifically designed formulary.
- . Method would provide means to implement an effective utilization review as comparisons with general public Rx's easily accomplished with National Rx Price Reference source.
- . Method is simple and easy to control.

Advantages for the Pharmacist

- . Method does not hinder dedicated pharmacist who provides service at reasonable cost.
- . Method identifies only those who are charging in excess of norm for all pharmacies operating under similar circumstances.
- . Method allows competition to work on prices in private enterprise. Low price, non-service operations are paid at usual low price.
- . Method allows for quicker payment and reduces claims submission time.
- . Method monitors those pharmacies that are consistently over-priced or under-priced.
- . Method monitors, via National Prescription Data Panel, prescription prices for all items and quantities to show shifts in price levels, up or down, allowing for constant and current revision of upper and lower limits of acceptable prices.

- . Method by use of an automated data processing system would minimize time spent in claims processing.
- . Method allows each pharmacy to use its normal pricing method whether fixed fee, variable fee, percent markup, or a combination of all and thereby eliminates any further disagreement on primary methodology.
- . Method eliminates the difficult-to-establish acquisition cost of each drug and uses the operational expenses of the pharmacy as the reimbursement criteria.
- . Method is easily implemented and simple to understand.

Advantages to the Patient and the General Public

- . Method optimizes patient care and encourages continued physician prudence in the choice of medication.
- . Method encourages participation in programs and provides incentives for pharmacists to assume new responsibilities in the health care of patients.
- . Method eliminates double standard in pricing. It uses prices to non-beneficiaries as standard reference for pricing to beneficiaries and eliminates non-beneficiary subsidization of beneficiary costs.
- . Method encourages competitive pricing and private enterprise.
- . Method satisfies the taxpayer since it minimizes program costs.

Summary

A workable alternative to the present reimbursement formulas in the processing of third party prescription claims is the use of a pharmacy prescription service index rating system and the regular prices charged to the general public. For the above reasons it offers the most equitable solution for all parties while keeping costs at a minimum and satisfying all the necessary criteria for efficient administration.

STATEMENT OF THE SOUTHERN STATES INDUSTRIAL COUNCIL

The Southern States Industrial Council is an organization of approximately 2800 business and industrial firms which together employ more than 3,600,000 people. While a majority of the Council's members are located in 16 Southern states, a substantial number are found elsewhere throughout the nation. SSIC headquarters are in Nashville, Tennessee.

Members of the SSIC share a common dedication to preserving and strengthening the private enterprise system which has made the United States of America a great nation. Proposed national health insurance programs in pending legislation raise serious questions as to their effects on the private enterprise system. The SSIC, therefore, has a deep interest in this legislation and respectfully requests that its views be considered by the Ways and Means Committee and the Congress. Council members are concerned as employers of substantial numbers of people, as taxpayers, and as individual citizens who want to assure the best possible health care for themselves, their families and fellow citizens in their communities.

Providing the highest possible quality health care for all Americans at a price they can pay is a goal which everyone shares. Great strides have been made toward that goal during the past several decades. Life expectancy has been greatly increased. Infant mortality has been sharply reduced. Diseases like tuberculosis and smallpox have been brought under control or virtually eliminated. Tremendous breakthroughs have occurred in surgical techniques such as organ transplants and in the development of new equipment and procedures to save lives. Great medical research and specialized treatment centers such as those at Houston and Boston have been developed.

To help Americans meet the costs of health care, health insurance provided by private companies has been steadily expanded until today the great majority of working men and women and their families are covered. Today only 40 percent of personal health care costs are paid directly by the patients, as compared to 70 percent in 1950. At the same time, availability of health care to the indigent, who cannot pay for either health insurance or care, and to the elderly has been greatly increased by both private and governmental action.

The American system is, by almost any standard, the best of any country in the world. Americans spend \$70 billion a year on health and health care, which is about seven percent of the gross national product and represents a larger commitment to health care than that of any other nation.

No one argues, however, that the present system of health care and health insurance in this country is perfect. It cannot be denied that the cost of medical services and hospitalization have climbed rapidly during the period of inflation that has hit the U.S., or that the rate of increase has exceeded that of most goods and services. The demand for health services is rising rapidly and appears to be outpacing the supply. There are problems, too, of unevenness in the distribution and availability of medical services and hospital care.

In considering H.R. 22 and other national health insurance legislation, there are basically two questions to be answered. First, is there a real health care "emergency" in the United States that requires drastic action by the Congress at this time? Second, can the improvements needed in the health care delivery system in the U.S. best be accomplished by massive government intervention and federal spending?

As to the first question, no real evidence has been produced of a health care emergency. On the contrary, there is abundant evidence (which we have mentioned briefly in this statement) that this nation has the finest health care of any in the world, that the advances made in this century are tremendous, and that steps are being taken to bring about further improvements.

As to the second question, the past great accomplishments in the field of health care have come about primarily through individual initiative and voluntary group action that are part of the private enterprise system. In recent years, the government has involved itself in providing health care for the elderly through Medicare and for welfare recipients and the medically indigent through Medicaid. It is estimated that through these and other government programs, about 40 percent of the nation's health bill is now financed by government.

It has been since the government began this substantial intrusion into the area of health care that the demand for medical services and hospital care has outrun the supply, and that costs have rapidly escalated. Those for whom Uncle Sam has been picking up the cost of medical care have been far less discriminating

in how often they go to see the doctor than when they paid some, or all, of the bill. Doctors have been far more prone to provide expensive treatment and longer and more frequently hospitalization when they know the government will provide the money.

As regularly happens when government intervention into operation of the private enterprise system causes disruptions and problems, there are many who think the only answer is more government intervention. The most far-reaching national health insurance plan, H.R. 22, which would provide cradle to the grave health care for virtually everyone, was developed by the Committee for National Health Insurance, created by the late Walter Reuther. Its enactment has been given major legislative priority by the AFL-CIO. These are the same forces that are in the forefront of almost every drive for legislation that injects the federal government further and further into the daily lives of all citizens and necessitates vast outlays of federal funds.

H.R. 22 and other health care proposals before the Ways and Means Committee contain the same basic faults in varying degrees; they would create additional costly and inefficient federal bureaucracy, discourage self-determination and voluntarism, erode initial initiative, and create a supine citizenry relying upon others to do what they should be able to do for themselves. They would discourage the development of innovative medical technology and tend to substitute mediocrity for standards of excellence in medical and hospital care. One has only to look at England and the other countries in which socialized systems of health care delivery have been instituted to reach this conclusion. It has been frequently said the average American would not tolerate the kind of health care he would receive in those countries.

But even if a national health insurance program were desirable, can we afford it? This is not a fashionable question in labor union-liberal circles, even though excessive government expenditures have led to an exceedingly serious economic crisis. The costs of the program that would be provided by H.R. 22 have been estimated from \$41 billion a year by its sponsors to estimates of \$70 billion and more a year by others. The costs of virtually all the programs proposed are estimated in billions. For this country, already spending at a rate so far in excess of its income that it is in the throes of an economic crisis, to consider any new multibillion dollar program, short of a national emergency, seems to be sheer folly.

The Southern States Industrial Council believes it is time that consideration be given to the ordinary, hard-working citizen who believes he has a responsibility to provide for himself and who would be asked to assume the additional heavy tax burden that a national health insurance program would entail. We also believe that the system of private health insurance and our system of health care delivery should be given the opportunity to further improve on their tremendous accomplishments, without any further government intervention.

The SSIC, therefore, urges that all proposed national health insurance and government health care programs be rejected at this time.

STATEMENT OF MAHLON Z. EURANK, DIRECTOR OF THE SOCIAL INSURANCE DEPARTMENT, COMMERCE AND INDUSTRY ASSOCIATION OF NEW YORK, INC.

Commerce and Industry Association of New York, Inc., the largest service chamber of commerce in the East, represents approximately 3,500 employers, large and small, in all branches of industrial and commercial activity, including many corporations headquartered in New York but engaged in multi-state operations. Through its Committee on Health Insurance, which includes knowledgeable executives from leading nationwide business organizations, and its Social Insurance Department, the Association studies and actively presents management thinking on significant health insurance issues at both the national and state levels. We appreciate this opportunity to present our views in connection with the proposed legislation on national health insurance. Our comments on this subject follow.

THE DILEMMA IN HEALTH CARE—RISING COST AND DEMAND

On September 13, 1971 the New York Times in an article on the above subject points out the rising cost and demand for medical services during the last decade. During this period in New York, for example, basic physical check-ups rose from \$35 to \$65; and hospital charges for the average stay for the nation as a whole rose from \$265 to \$785. They are now around \$100 a day and if the present

inflationary trend continues, could be \$1000 a day 10 years from now. Portions of the health care pie, totalling around \$80 billion this year, are divided roughly this way: 40% for hospital care; 20% for doctors' services; 10% for drugs; 6% for dentists' services; and 4% for nursing home expenses. The remaining 20% is divided among such items as medical research, construction of facilities, and administration.

A summary of the principal reasons as outlined in the Times article, why costs have increased during the last 10 years, follows:

1. Inflation, which accounts for one-half the recent rise in health care cost
2. A shift in general opinion during the decade that health care is the right of every American.
3. Increased demand for medical care resulting from a higher coverage of individuals by insurance companies, plus the medicare and medicaid programs
4. Medicare and medicaid, which accelerated the demand for services and help to drive up prices because of manpower shortages, etc.
5. More sophisticated medical techniques such as open heart surgery, that lead to better medical care but at greater cost
6. Unionization of hospital workers which gives higher salaries and more costly fringe benefits to a group that has been among the lowest paid in the nation for decades
7. Overexpansion of facilities such as hospital rooms in some areas, San Francisco for example, and a shortage of hospital beds in others as illuminated by the New York City situation
8. The flood of new money for health care has not been matched by an increase in efficiency by suppliers.
9. Premium rates for medical malpractice insurance have been soaring. One New York surgeon paid an annual premium of \$50 when he started practice in 1950 and by 1972 expects to pay \$5,050, a hundred times as much. This expense he passes along to the consumer in the form of higher fees.

THE FOUR MAJOR HEALTH PROPOSALS

To solve the present dilemma numerous legislative proposals have been introduced to correct our present health care system. The provisions of the four major health care bills currently before the House are given by a brief digest which follows:

1. National Health Insurance Partnership Act (H.R. 7741) proposed by President Nixon and introduced by Rep. John W. Byrnes.

This proposal would require employers to make group health insurance available to their employees and to contribute to its cost, except for limited subsidies to small employers; subsidizes health insurance costs and provides for a sliding scale of co-payments and deductibles for most low income families.

2. National Health Care Act (H.R. 4339) introduced by Rep. Omar Burleson and supported by the Health Insurance Association of America.

Medicaid would be replaced and the poor and near-poor would be covered by privately insured state health plans and would receive insurance subsidies financed from state and federal general revenues. Others would be covered through private health insurance programs. Those who purchased a policy meeting the minimum standards would be entitled to a greater income tax deduction. Minimum standards are set which include co-payments and deductibles.

3. Health Security Act (H.R. 22) introduced by Rep. Martha Griffiths and supported among others by the Committee of 100 for National Health Insurance (United Auto Workers) and the AFL-CIO.

This proposal would repeal medicare and provide a program of compulsory national health insurance administered by government, covering almost all medical expenses without limitations, co-payments or deductibles, for all Americans. It would be financed out of payroll taxes and general revenues. The plan also calls for a Health Resources Development Fund to be used to develop health manpower.

4. Health Care Insurance Assistance Act (the so-called "Medicredit" plan) (H.R. 4960), introduced by Rep. Richard Fulton and supported by the American Medical Association.

Medicredit would provide for 60 days hospitalization subject to a \$50 deductible, other medical services subject to 20% co-payment with certain stipulations and limitations, and catastrophic coverage of additional hospitalization subject to an income-conditioned deductible. It would be financed out of general revenues for those with no income tax liability and by means of tax credits for others.

Commerce and Industry Association does not support any specific bill but agrees in principle with H.R. 7741 (Byrnes) and H.R. 4339 (Burluson) whereby employers are required to make group health insurance available to their employees and contribute to its cost and whereby medical care is provided to the poor and near-poor through government subsidies. (An outline of our principles is set out hereafter.) We oppose both H.R. 22 (Griffiths) and H.R. 4960 (Fulton). Our reasons for opposition to each bill are set forth below.

THE "MEDICREDIT" PLAN

Our reason for opposition to the income tax credit proposed by the American Medical Association in H.R. 4960, follows:

1. A tax credit is analogous to an expenditure appropriation by the government in that it gives up revenues for an earmarked purpose. If the expenditures were made in the form of a direct appropriation, it would be subject to annual government review.

2. Integrating tax credits into the revenue structure could cause complications and create inequities between individual taxpayers.

3. It would give a windfall to individuals who are now buying health insurance without the incentive of a tax credit to pay for such insurance.

4. Tax experts fear that if any tax credit is introduced into the revenue structure, for whatever worthwhile social cause, its existence will increase the pressure for other tax credits for other worthwhile causes. Thus far the federal revenue code has been protected from tax credits designed to promote general welfare and other social objectives. Those that exist are for the purpose of preventing double taxation of income, for example, the credits for foreign taxes and state inheritance taxes.

THE HEALTH SECURITY PROPOSAL (H.R. 22)

The health security proposal which was introduced in the House by Representative Griffiths and in the Senate by Senator Kennedy gives the government a monopoly in providing health care to its citizens. By 1974 the proponents expect to put their comprehensive health care program into operation. If H.R. 22 is enacted into law we predict that at that time, or perhaps in this decade, it will fail to give our citizens the quality or quantity of medical care required for their health.

Our primary objections to H.R. 22 (not all of them), by subject, follow:

1. Elimination of Private Insurance

If H.R. 22 is enacted into law, health insurance now provided by profit and nonprofit health insurance companies would be eliminated.

Today all but a small percentage of the population have some health insurance coverage with a total premium contribution of over \$15 billion. Insurance companies have made an effort to fill in benefit gaps by a strong promotion of major medical and catastrophic insurance in addition to basic coverage. Presently this type of coverage gives protection to over 40 percent of those under 65 and has been growing rapidly.

Doing away with this multibillion-dollar industry, which has people experienced in administering health programs, would create a chaotic situation if a government plan was substituted. We fear that government employees for some period who would handle health programs, due to inexperience, would take much longer than insurance companies in approving claims and a large backlog each month would ever increase. This is what happened in New York when a new plan was put into effect under medicaid. Not only were individuals delayed in having their benefits approved but also suppliers had to wait to get paid. You cannot expect them personally to finance a government program. Insurance companies by expanding could take care of the program in a much more efficient manner.

It seems to us that throwing thousands of employees of insurance companies out of work and starting a new organization by the government would be most impractical. It could increase unemployment and at the same time cause a big jump in government expense at a time we can least afford it. Further, it would eliminate the state tax on health insurance premiums and cause a loss of much needed state revenues.

Professors Herman H. Somers and Anna R. Somers of Princeton University estimated that the United States health care bill will exceed \$100 billion before 1975. They quoted a British critic who said "Expenditure for medical care is a

bottomless pit", while the nation's resources are limited. The limits were stressed in another way by Dr. Charles L. Schultze of the Brookings Institute, who argued against trying to put the whole cost of the nation's medical care on the shoulders of the taxpayers. The nation has many other very high priority tasks—for example, rebuilding the slums of the inner city—which can only be accomplished through the tax system. So far as possible, therefore, Dr. Schultze maintained, the costs of medical care should be paid through the private sector, not loaded onto the already overburdened federal budget. About 70 percent of the nation's citizens, he argued, can afford to meet their medical costs—except for catastrophic illness—from their earnings without outside help.

2. General revenues

One of the two methods of financing health care under H.R. 22 is an appropriation from general revenues. The disadvantages of using general revenues follow:

1. To use general revenues for health care it must be shown by proponents that funds will be available. Reduction in the income tax, now passed in both Houses of Congress, would make it unlikely that funds would be forthcoming because of the competition with other worthwhile programs. A brief summary of a Brookings Institute study, released May 1, 1971, on this point follows:

"The increasing outlays under existing government programs and those proposed by President Nixon would use up the entire normal growth in federal tax revenues in the next three years. This means, according to the study, that new expanded programs would require either higher taxes or possibly inflationary deficit financing. In the absence of higher taxes the study sees no "room" in the budget for new or expanded programs through 1974. By 1976 as much as \$17 billion might be available under present tax laws. But the study warned that this figure would be mostly in the form of surpluses in the social security and other trust funds and might quickly vanish through Congressional action between now and then."

2. At the time when H.R. 22 would be fully operational (fiscal 1974) it is possible that federal programs for safety and to improve nutrition, housing, sanitation, welfare, etc. (funded out of general revenues) might have to be cut or eliminated to provide general revenue funds required by H.R. 22. Less, or no, funds under such programs could increase the cost of medical care proposed by H.R. 22 because many illnesses or accidents which could be prevented by such programs could take place. This is not as far-fetched as it might seem because the scarcity of general revenue funds can be illustrated by the Senate-House conference, on the appropriation for health, labor, welfare and education. They struck down \$25 million for hospital improvements, \$6 million for tuberculosis research, \$6 million for treatment of sickle cell anemia, a disease found primarily in blacks, and \$7.5 million for prevention of diseases caused by lead-based paint.

3. The general revenue funding technique is that taxes supporting the program become hidden within all taxes payable and are not visible in the way that premium payments or payroll taxes would be.

4. If increases in expenditures out of general revenues are to be made, other expenditures have to be cut or taxes have to be increased or borrowing increased. The first route, though possible, is not probable. The second raises the question of which taxes should be increased—income taxes, corporate taxes, or excise taxes. At least some method would have to be found to substitute tax payments for all or part of private medical payments that are now being paid. It would be inflationary if more government financing would be the solution.

3. Payroll tax

Another method of financing health care under H.R. 22 is a payroll tax on both the employer and the employee. The disadvantages of using payroll taxes follows:

1. During the last 10 years federal payroll taxes took a big jump in order to finance OASDI and medicare programs. Another big jump could take place in the next ten years if that precedent is followed. (H.R. 1, passed by the House and pending in the Senate, could result in a cumulative social security payroll tax increase of \$57 billion over the next ten years.) Tacking another payroll tax on top of an ever-increasing social security payroll tax would place a heavy tax burden on employees (some of whom are now paying more in social security taxes than income tax) and on their employers.

2. A single person would pay part of the medical expenses of a family as he does now by paying part of survivor and wife benefits under the social security system.

3. Individuals 65 or over and who are still working would have to pay a payroll tax which would be much higher for most than they now pay under medicare. This could cause many to leave employment and by drawing social security benefits the cost of the social security program could increase.

4. Unions would demand in labor negotiations that the employer pay that part of the payroll tax allocated to the employee. Where the employer now solely pays the insurance premium for health care, such a demand would be surely made. Employers generally could be expected to deny this demand, particularly when this new payroll tax would be higher than what they pay in health insurance premiums. The result would be more and more labor controversies, including strikes, and the general public itself could be hurt when such a strike involved public utilities, etc.

5. Taxes on employees' wages and salaries fall more heavily on low-middle income groups than on either the low income groups or the upper-middle income or rich who earn more than the tax base.

6. Although all payrolls are affected by a payroll tax, they are not affected equally. Some payrolls include a larger percentage of individuals receiving less than the cut-off base of the tax than others, and this percentage differs not only among industries but even among firms within the same industry. In addition, payrolls as a percent of total cost vary considerably among industries and thus the price effects of a payroll tax would also vary.

4. Disbursing Federal Funds

The basic mechanism for disbursing federal funds under H.R. 22 was explained by Senator Kennedy as follows:

"The essence of the payment mechanism and the central cost control feature of the program is that the health care system as a whole will be anchored to a budget established in advance. A given amount of money will be made available for the program each year, based on the available estimates of the needs to be met and the services to be provided, with due regard for the resources of the system. As in every area of our economic life, the health care system will be obliged to live within its budget." (Congressional Record, January 25, 1971, page S91)

In the past federal budgets established in advance are generally underestimated. Also unforeseen circumstances such as an epidemic could make the budget inadequate. If this would occur and Congress takes no action, it is questionable if the suppliers of medical care would accept "pro rata" reductions. Either the whole system would break down through a reduction in services or individuals by personal payments would have to make up the difference.

OUTLINE OF COMMERCE AND INDUSTRY ASSOCIATION PRINCIPLES FOR A NATIONAL HEALTH INSURANCE PROGRAM

If national health insurance is inevitable, Commerce and Industry Association would support a program or bill providing the following:

1. *Coverage*: The nation should require comprehensive health insurance coverage for all of its people at the earliest date consistent with the availability of health care services, including effective quality and cost controls. Coverage might also be extended to visitors from other countries where a reciprocal arrangement for medical care exists. Any coverage *solely* for major medical or catastrophic accidents or illness is opposed, primarily because it would not take care of manpower shortages, the present delivery system, etc.

2. *Benefits*: Comprehensive health care providing a minimum standard plan of benefits including full hospital care for 31 days in a semi-private room along with payment, subject to a deductible, for unlimited miscellaneous hospital costs. Scheduled allowances would be provided for surgery, diagnostic x-ray and laboratory examinations, in-hospital visits, pre-natal and well-baby care and a limited number of visits to a doctor's office or ambulatory care center. Major medical expenses would be covered subject to a deductible and co-insurance, for covered medical costs including prescription drugs, up to a stated maximum. Limited benefits would be provided for outpatient care of mental and nervous disorders. Excluded would be cosmetic services, hearing aids, dental care, custodial care, travel other than for ambulance, and charges in excess of established

guidelines. Duplication (such as workmen's compensation, payments made by insurance companies and others in negligence cases, and when the employee works for more than one employer (moonlighting), or where married individuals would covered under the policies of their spouses) should be avoided.

3. *Financing*: With the exception of the poor and aged a national health plan should be financed through private insurance with the employer and employee sharing the premium cost. Medicare should be continued as presently under the Social Security Act. The federal-state system of medicaid should be replaced with a program offering benefits for the poor and near-poor that equal those provided for everyone else, with the cost paid through general revenues by the federal government with some minimum sharing by the states. Financing should be by an insurance premium paid directly by the government to insurers. Government financing (federal-state) should be limited to those described and to planning groups and loan guarantees to initiate the restructuring of the delivery system, medical schools, training health personnel, student loans, incentives to locate or re-locate in under-served areas, and preventive programs such as sanitation, safety, etc., whose purposes are to keep people healthy. No subsidies should be provided to employers.

4. *Administration*: Any improvement in the system for delivering health care to all individuals should be accomplished by retaining the desirable elements of the present system and introducing changes necessary to increase the capacity and productivity of the system. This could be accomplished by the utilization of the private sector—the health professionals, hospitals, insurers, business and unions—in this area in which they operate best and rely on the public sector where it functions best—setting national policy, planning, stimulating development of new approaches to health care and financing by the federal government with minimum sharing by the states for medical care of the poor.

5. *Restructuring The Delivery System*: Any national health program should recommend a restructuring of the delivery system on a pluralistic basis. Such a national health program should permit the development of new forms of health care delivery with emphasis on ambulatory and primary care out of the hospital. Such systems would include medical foundation plans, health maintenance organizations and prepaid group practice as well as the development of ambulatory care centers, neighborhood health centers and home care to substitute for institutional care where feasible.

6. *Medical Personnel*: Any national health program should provide for an immediate increase in the numbers of medical and allied health personnel, through improved scholarship grant and loan programs. Emphasis should be placed on medical education and services, particularly with respect to primary care and the training of allied health personnel to work in hospitals, ambulatory care centers and outpatient clinics. Incentives should be developed for medical personnel to serve in areas of special need.

7. *Council or Board to Establish Policy*: Establish a Council or Board who would have overall responsibility to recommend all types of health care policies.

CONCLUSION

The first steps taken toward national health insurance were the enactment of the medicare and medicaid programs in 1966. In theory these programs were supposed to keep charges for regular patients from rising as rapidly as before because medicare and medicaid picked up the tab for charity patients and the elderly. Instead, charges to everyone skyrocketed, particularly due to increased price per unit of service.

One part of the rise in increased prices per unit of service, particularly in hospitals, is that these programs went into operation just when they faced and could not hold off demands for sharp wage increases from newly militant employees who in many cases had been organized by labor unions and the necessity of paying internes and residents a living wage. This alone multiplied cost because wages for labor accounts for about 60 percent of hospital cost. The major reason for spiraling cost, however, was that these new health programs created new demands on limited manpower and facilities and poured in massive amounts of money without any meaningful controls over expenditures or any effective attempt to put more efficiency into the health care system.

In formulating any comprehensive national health insurance program the mistakes made before must be corrected to preclude another uncontrolled rapid rise in health care cost.

At the time legislation is evaluated for enactment Commerce and Industry Association requests that the principles adopted and set out here by the Association be seriously considered. This could be best accomplished by retaining the desirable elements of our present system and introducing changes necessary to increase the capacity and productivity of the system and the establishment of quality and cost controls.

ROSS LABORATORIES,
Columbus, Ohio, November 12, 1971.

HON. CHALMERS P. WYLIE,
Longworth Office Building,
Washington, D.C.

DEAR MR. WYLIE: Following my discussion with you yesterday, I would like to confirm in writing some of the facts and related information which I hope will be helpful to you in evaluating the essential nature of the Children and Youth (C&Y) projects which have been authorized since 1966 under Title V of the Social Security Act.

As you know, I have some intimate knowledge of the delivery of health care to underprivileged children by virtue of my present responsibility as President of the Board of Children's Hospital of Columbus and as Founder and Past President of the Children's Hospital Research Foundation. Further, my 34 years in business and my current responsibility as President of Ross Laboratories and Vice-president of Abbott Laboratories should permit me to evaluate the benefit-to-cost ratio of any such program.

It is my considered judgment, after 5½ years of association with a C&Y project at Columbus Children's Hospital (grant cost \$1,072,000 per year) that from a business point of view, this investment represents a significantly higher benefit to the government than the dollars invested in other health programs. Our project provides comprehensive care (as compared with episodic) for approximately 7,500 children at a cost of approximately \$140 per child. This cost is comparable to the figure for the other 68 C&Y projects in the nation.

Even this reasonable cost is not a true measure of the total benefit to the government. The health services made possible by the C&Y grant allow us to supplement health programs for other indigent children in the geographic area served by the C&Y project. However, due to the restrictions and limitations of the grant, these indigent children can not be counted as patients enrolled in the project because they are provided only certain diagnostic services and acute care rather than total comprehensive care.

These projects have been effective because they focused totally on children. It has been my experience, in a 35-year association with the health care industry, that when children's programs are pooled with adult programs, they seldom get the emphasis necessary to make them effective. With limited resources for health care, priorities must be established among the 3 types of care—care for the future producers of society, intermittent medical attention to keep present producers active and custodial or maintenance care aimed at the relatively short prolongation of a given life span.

The wisdom of the government many years ago in establishing a Children's Bureau is testimonial to this point of view, as is the natural involvement of children's hospitals all over the country where groups of individuals devoted themselves to the welfare of children. Children need sponsors oriented to their special needs and requirements. These needs are easily lost when there is competition for general medical resources between programs for children and those for adults and the geriatric age population. I would, therefore, stress the fact that the C&Y project, being separate from the general medical allocations of funds, have been beneficial to the welfare of the country.

New Scientific evidence suggests serious consequences resulting from medical or nutritional neglect during gestation and the period of maturational development in the first year or two of life. Thus one can project and demonstrate great economic and sociological benefits from the prevention of malnutrition and comprehensive medical surveillance in pregnancy and early infancy.

It is my understanding that Dr. Vernon E. Weckwerth of the System Development Project of the University of Minnesota is appearing before the Ways and Means Committee to present details from the consolidated records of the C&Y projects throughout the country. This information will clearly indicate that serious acute illnesses are lessened or prevented by the comprehensive preventive care aspects of the C&Y program.

It can be demonstrated from the data that the number of hospitalizations for indigent children in the C&Y project is significantly less than for indigent children not enrolled in a project. Also the average hospital stay for the project group is shorter, probably reflecting the project's emphasis on preventive care and the early detection and treatment of illnesses requiring hospitalization.

The underprivileged families to whom C&Y care is made available are even more cooperative in obtaining their medical needs by keeping appointments, following therapies, etc., than the general public. Since motivation is considered to be one of the great difficulties in working with underprivileged groups, it seems to me that this observed cooperation is very important in pointing out to us that we can motivate underprivileged groups by offering them comprehensive medical care. Good health could undoubtedly lead to more motivation for this group in other areas such as seeking educational or work opportunities.

So far as I am aware, there is no conflict nor opposition to this program by organized medicine or the private practitioners of medicine. It is my understanding it has the endorsement of both the American Medical Association and the American Academy of Pediatrics.

While I always prefer to dwell on the positives in any situation, I would be remiss if I did not point out to you that most of the Children's Hospitals and other related pediatric institutions are in dire financial shape. The withdrawal of these C&Y projects would create a debt which would in most cases bankrupt the institutions. The alternative, of course, would be for these institutions to absolutely refuse children who need medical care because of their inability to pay. This has been an anathema to Trustees of these institutions for many years.

Approximately 500,000 children have been receiving this care for up to 6 years. If these children were turned away because of their inability to pay, hospitals and child-related organizations within the Community would suffer the ill will created by this action. It seems appropriate that these considerations should be a part of your judgment.

In summary, 1) I believe there is no expenditure of health funds by the federal government that has been more productive in raising the quality of life among our underprivileged population than the modest investment in C&Y projects since 1966. I would urge its expansion to involve more underprivileged children since rough figures indicate there are approximately 11,000,000 underprivileged children. This program is only covering $\frac{1}{2}$ million of the most needy. If it cannot be enlarged it should not be discontinued or consolidated with other general types of health care. 2) The C&Y projects tend to produce competent citizens for society and are a valid investment of health resources. 3) There is no conflict between this program and the medical organizations or the private practicing physicians. 4) This program represents one lifesaving economic link presently sustaining children's hospitals and related institutions. Even with the C&Y projects most institutions still give much free care to children who are not eligible for C&Y enrollment, for Medicaid, Crippled Children's programs or other coverage by city and county authorities. In the case of our Children's Hospital in Columbus, we still have to raise approximately \$950,000 in charity per year to cover the unpaid care for these groups.

I urge all those with authority to continue this program, to increase its financing modestly if possible and not to consolidate this highly successful program for children with any other broader health programs at this time.

Sincerely,

DAVID O. COX, *President.*

STATEMENT OF MRS. FRANK M. BARRY, DIRECTOR, HEALTH PLANNING AND DEVELOPMENT COMMISSION, THE WELFARE FEDERATION, CLEVELAND, OHIO

The Health Planning and Development Commission is a citizen's group of about 90 persons, consumers and providers, actively concerned about health problems and programs. It has identified National Health Insurance as of major public interest. It appointed a technically competent Health Issues Task Force which undertook to examine national health plans. The Task Force decided that it should develop and propose a Position as a Guide for Assessment of National Health Plans, rather than proposing a position on any specific bill at this time.

The Guide was approved by the Health Planning and Development Commission in September, and is herewith transmitted for the record of the Ways and Means Committee upon the advice of the Task Force and the authorization of the Commission.

HEALTH ISSUES TASK FORCE POSITION

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 nation-wide 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 EW 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.

TEXAS SOCIETY FOR CLINICAL SOCIAL WORK,
Houston, Tex., December 8, 1971.

Mr. JOHN M. MARTIN, Jr.,
Chief Counsel, Committee on Ways and Means,
Longworth House Office Building,
Washington, D.C.

DEAR MISTER MARTIN: The Texas Society for Clinical Social Work is submitting a position statement on its role in legislation for National health insurance. We respectfully request your earnest consideration of this statement.

We stand ready to expand or implement this statement any way you deem advisable.

Sincerely,

DAN L. DE SHAZO,
President, Texas Society.

Enclosure.

STATEMENT OF TEXAS SOCIETY FOR CLINICAL SOCIAL WORK

The Texas Society for Clinical Social Work has formulated the following position in regard to National health insurance legislation. The Texas Society is a Statewide organization, all of whose members are professional clinical social work practitioners who hold required graduate degree(s); it is affiliated with the National Federation of State Societies for Clinical Social Work. The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate, satisfying and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counseling and using applied psychotherapy of a nonmedical nature with individuals, families and groups, providing information and referral services, providing or arranging for the provision of social services, explaining and interpreting the psychosocial aspects in the situations of individuals, families or groups, helping communities to organize, to provide, or improve social and health services, and doing research related to social work.

Psychotherapy, within the meaning of this definition, is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions which affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes.

Throughout the United States in actuality clinical social work provides 75-80% of the mental health services. Community mental health clinics, child guidance centers and psychiatric hospitals and out-patient clinics are predominantly staffed by clinical social work practitioners working in conjunction with psychiatrists, psychologists and psychiatric nurses. These practitioners function as self-directing, independent professionals, frequently as directors of such services. In addition to these community agencies offering what is traditionally thought of as mental health services, clinical social work practitioners provide active preventive, diagnostic, therapeutic and rehabilitative services with respect to psychosocial dysfunction in a wide spectrum of community settings. These include family service agencies, schools, day care centers, general hospitals and child welfare agencies.

Clinical social work helped originate family therapy and group therapy processes, which are used every day to help troubled individuals, families and children with such psychosocial maladjustments as delinquency, drug addiction, divorce.

It has been common knowledge for many years that a large proportion of individuals seeking medical attention from a general practitioner have no organic defect or illness, but are suffering from an emotional or social disturbance. These individuals very often can receive most benefit from psychotherapy such as described above. To this most important consideration that distressed human beings receive the treatment of choice, the great added advantage is that thereby physicians would be freed to use their skills more exclusively with patients suffering from physical illness and conditions. Thus legal recognition of clinical social work as the existing and logical profession to deal with these psychosocial dysfunctions could also be an effective method of more equitable distribution of available health services personnel.

A large reservoir of capable, trained and dedicated clinical social work practitioners are in reality now providing much of the mental health care in this country, although not so identified by the general public. Inclusion of these practitioners as recognized, independent providers of health services is, we submit, greatly in the public interest. The almost incredible needs of manpower supply and distribution to adequately serve the optimum health care of each man, woman and child in this country requires careful study of all possible avenues. The Texas Society for Clinical Social Work is deeply committed to the belief that the above proposals are an important part of achieving this goal of optimum health care for all the people of the United States. We respectfully request your earnest consideration of our position.

STATEMENT OF THE HEALTH COUNCIL OF THE DETROIT MODEL
NEIGHBORHOOD

The Congress of the United States through its House Ways and Means Committee and the Senate Finance Committee is presently holding extensive hearings on the question of National Health Insurance. The hearings will undoubtedly be the focal point for a growing national debate on whether this nation will decide that the matter of Health care is a universal, inalienable right for all people, including the poor, ordinary working people and the deprived; or whether health care will continue to be available only to the affluent and those who can afford it.

All indications are that this issue will be one of the most important to the American people in the coming year.

The Health Council of the Detroit Model Neighborhood, a citizen-consumer organization which arranges for the provision of health services to 10,000 residents of the Detroit Model Neighborhood, wishes to make clear to the Congress that immediate enactment of a strong, comprehensive federal health program is of paramount importance to us at this time.

The Health Council's experience as sponsor of a comprehensive health plan, tells us that the services of such a plan must be expanded to all residents of the Model Neighborhood—indeed, to all people through a national health program.

President Nixon himself said, "This nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by the government and the private sector." Residents of the Detroit Model Neighborhood know full well the meaning of these words through their own experience. Many of us have suffered from the crippling medical inflation, inaccessible health facilities and fragmented and segregated health resources.

However, we are concerned that most of the proposals put forth in the name of "National Health Insurance" are, in fact devices to continue and reinforce the same fragmented and inaccessible health system. We wish to make it clear that we will not accept a national health plan that simply pours more money into a system for the benefit of insurance companies and providers of health services with little or no benefit to the consumers of health care.

We call for a program which totally eliminates all financial barriers to health care. These should be no out-of-pocket costs through deductibles or co-insurance features. We are concerned that so many proposals contain such features which are merely devices of the insurance industry to guarantee a profit. It is the poor and the sick who are hit the hardest with these charges.

We also oppose the proposal of so-called "catastrophic insurance." This appears to be at first an attractive idea to protect people against very expensive, catastrophic medical bills, but close examination shows that this is another gimmick to deprive the poor and the working people of the care they need *now* and, once again would serve to pour more money into a provider-oriented crisis ridden health system.

We call for a strong consumer voice at the policy-making level in a national health program. Consumer boards or committees should be drawn up locally to participate in such policy-making. The planning and operation of a national health program should not be in the hands of some remote government agency or appointed board, dominated by provider philosophy and inaccessible to consumers on a local level.

There must be mechanisms through which the patients can voice their opinions as to the quantity and quality of health care they are receiving under a national health system. There must be a definite break from the past which sees a health system in crisis controlled for the benefit of the wealthy and the providers of care.

One of our concerns is that a number of proposals include income tests or means tests in order to determine eligibility for benefits.

The Health Council strongly opposes any such tests in a national health scheme. Such tests only serve to isolate and segregate the poor from the main stream of health care and result in inferior care for the poor.

Health care is a right for all people regardless of income. Our own experience in the Detroit Model Neighborhood indicate there are thousands of people who would not qualify for benefits under the income tests being proposed. They are the working poor and the near poor who have no coverage or protection, or, at best a very limited coverage. Means tests are a device so that only a tiny portion of the people receive needed care while the remaining are victims to the profit-oriented private health sector.

A national health insurance program must have comprehensive benefits. It must provide total care for all consumers. Plans which, for example, limit the number of days in the hospital, exclude mental health services or dental health services or fail to pay for prescribed drugs are simply unacceptable because they exclude health care which is sorely needed.

We call for a program which not only completely covers health services for patients who are sick but preventive services to keep people well. A National Health Program must provide incentives for preventive care, such as check ups, and immunizations.

We are gratified to see that several of the major proposals for national health insurance call for support and encouragement of Health, Maintenance Organizations (HMOs). We ourselves are operating on HMO. We believe that this method of arrangement for the provision of health services is the most efficient and economical, and provides incentive for preventive care and avoids high cost facilities and resources. However, a Health Maintenance Organization is a costly and complex system to plan and operate, and, until there is a large enough network of HMOs throughout the country the government should attempt to develop linkages with primary health care units such as comprehensive health centers, group practice clinics and hospitals. It is crucial that a federal health plan finance coverage for the entire enrolled population of HMOs once they are formed.

We call on Congress to finance a federal health system through taxation from those individuals and institutions best able to pay. Most of the proposed health plans, even the Health Security Program (the Kennedy Bill) are financed on a basis of collection the bulk of the taxes from working people and the poor.

A national health program should be a program of health services for all people. We reject the insurance philosophy that health care is a commercial commodity to be bought and sold. No one should make a profit out of the illness or injury of people. We call for elimination of all financial barriers to comprehensive health care. The billions of dollars which will be poured into a new health care system must not become, for the post-part, the preserve of the private sector. We must avoid having the government's health care dollars, as in the case of nursing homes, medicare and medicaid, become a bonanza to speculators and profiteers.

The Health Council of the Detroit Model Neighborhood is particularly concerned that funds in a national health program be allocated for the training of new health personnel which are so badly needed. We specifically call for the training of low-income community people as para-professional and para-medical employees. It is our experience that this type of employee can make health services more available to the poor and the sick who traditionally have been excluded from such care. We believe a national health program should be imaginative and innovative in this area.

The time for a national health plan has arrived. Health care is a basic right for all people. We urge on Congress the immediate enactment of a national health bill which is so vitally needed for the welfare of all the American people.

STATEMENT OF ROSALIE RIECHMAN, LEGISLATIVE REPRESENTATIVE OF WOMEN'S INTERNATIONAL LEAGUE FOR PEACE AND FREEDOM

SUMMARY

The nation's present health crisis evidences an overwhelming demand for a restructuring of our health care system. Listed below are several criteria by which to evaluate the five major (i.e., most deserving and/or receiving of attention) health insurance bills, H.R. 22, H.R. 7741, H.R. 4349, H.R. 4960, and S. 1376:

1. equal access to health care for all;
2. comprehensive coverage;
3. incentives for cost and quality control;
4. financing by national progressive taxation;
5. no coinsurance or deductibles;
6. restructuring of health care systems so that there is:
 - (a) emphasis on preventive medicine
 - (b) fair regionalization
 - (c) public accountability

(d) more representative in the professional personnel of women and minority groups

(e) more manpower.

Only H.R. 22 meets criteria 1, 2, 3, and 5. None of the bills meets criterion 4. Only H.R. 22, H.R. 4349 and H.R. 7741 meet all or in part the criteria in 6, and H.R. 22 is by far the most comprehensive in this regard.

The major flaws in H.R. 22 are that it is financed by regressive taxation and it doesn't allow for sufficient public accountability.

Brief description of Rep. Ron Dellums bill currently being proposed that would create a national Cabinet of Health coordinating government and private health services in the nation in order to better service principally poor and working-class citizens.

I am Rosalie Riechman, Legislative Representative of the U.S. Section of the Women's International League for Peace and Freedom. The League was founded in 1915 by Jane Addams and has 150 branches across the country as well as sections in 19 other nations. Providing adequately for the welfare of our citizens has long been one of our priorities. In a statement before the Subcommittee on the Department of Defense, House Committee on Appropriations, in June of this year, we suggested that an alternate defense budget might in part be composed of an adequate health program for all of our citizens. We support in principle H.R. 22, the Health Security Act, and we view with great interest a bill on national health care currently being prepared by Rep. Ron Dellums of California.

The easiest part of the preparation for this testimony was ascertaining that our nation is indeed facing a health crisis and needs major revisions in order to provide adequately for its people. More than 20% of the population under 65 years of age is not covered against hospital and surgical services; more than 1/2 have no coverage for physician's home and office visits. The figures we have all heard many times are frightening and demand a response from our nation's leaders. The U.S. ranks 14th among the countries of the world in infant mortality. Our male life expectancy ranks 22nd and for females it ranks 7th among the nations of the world. The average cost for a day in the hospital in 1964 was \$37.38. In 1970 it was \$79.83. Americans are spending more than 150% as much for health care now than they were 10 years ago, while for the same period the consumer price index was increasing by less than 33%.

There are a great many bills before this Committee and the emphasis varies from bill to bill. Many important things are dealt with in these bills and this Committee has a great responsibility. We are aware of the complexity of the situation and the gravity of the need. In order to treat the many bills most fairly we have compiled a list of criteria for national health insurance, all of which are supported by both the Medical Committee for Human Rights and Congressman Dellums. We will use this criteria to measure what seems to us the five most important bills (i.e., those which either are receiving or deserve most attention). Those bills are: H.R. 22 (Griffiths) National Health Security Act; H.R. 7741 (Byrnes) National Health Insurance Partnership Act; H.R. 4349 (Burleson) National Health Care Act of 1971; H.R. 4966 (Fulton) Health Care Insurance Act of 1971; and S. 1376 (Long) Catastrophic Illness Insurance Act. We will also discuss the yet to be written Dellums bill. The criteria are:

1. equal access to health care for all;
2. comprehensive coverage;
3. incentives for cost and quality control;
4. financing by national progressive taxation;
5. no coinsurance or deductibles;
6. restructuring of health care systems so that there is:
 - (a) emphasis on preventive medicine
 - (b) fair regionalization
 - (c) public accountability
 - (d) more representative in the professional personnel of women and minority groups
 - (e) more manpower.

The first criterion, equal access to health care for all, is met in varying degrees by all the plans. In S. 1376 there is equal access for everyone under 65 currently covered under Social Security and their families, and Medicare would be unaffected for those over 65. It is important to note, however, that sizeable coinsurance and deductibles are in operation under H.R. 4349 and H.R. 4960. The coinsurance and deductibles would cause the greatest hardship to those who need

health insurance the most—the poor people—and tend to restrict their use of the insurance. S. 1376 in effect has the same restriction because benefits begin only after catastrophic costs are incurred. Under this criterion then, H.R. 22 is the most equitable of all the plans in that there is full coverage provided for all U.S. residents without the deterrents of coinsurance or deductibles.

In evaluating comprehensive coverage, the second criterion, it is again important to note coinsurance and deductibles because no matter what coverage is in theory available, if a poor man can't afford to pay the first \$50 or \$100, the coverage is as remote to him as if it weren't there at all. To this extent then, all the plans except H.R. 22 are severely limited. Beyond this, each of the other plans has limitations in coverage. Under H.R. 7741, there is limited ambulatory and institutional care (up to 30 days) under the Family Health Insurance Program part and limited ambulatory and inpatient benefits under the National Health Insurance Standards Act. Under H.R. 4349, generous but not comprehensive benefits would be achieved three to six years after the program starts. Under H.R. 4960, coverage is far from comprehensive: hospital inpatient care is limited to 60 days per year, physicians' services and laboratory and x-ray services are subject to 20% coinsurance on the first \$500 of expenses per family. No medical appliances or blood are provided. S. 1376 is set up so that benefits are limited to cover illness of a catastrophic nature. There are exclusions on drugs, nursing home care, dental and psychiatric care.

Incentives for cost and quality controls. H.R. 4960 and S. 1376 neither make provisions nor establish incentives for cost and quality control. Both H.R. 7741 and H.R. 4349 provide coverage through private insurance companies which for obvious reasons are loathe to control costs and at best are indifferent to controlling quality. H.R. 7741's only attempt at quality control is sorely inadequate—it establishes a Professional Standards Review Organization to review health insurance and Health Maintenance Organization control and quality standards. The boards of physicians set up by the PSRO to review quality and appropriateness of services necessarily presents a lopsided view. Where is the recipient of the service who can also offer valuable judgment as to the quality and appropriateness of the service he's received? H.R. 4349 uses federal tax leverage to bring insurance benefits and coverage up to new federal standards. This is fine as far as it goes, but it contains built-in limitations having to do with the profit-making nature of most insurance companies. In order to make profits, costs have to be kept at a certain level and there can't be an open-end to the degree of quality that is aimed for. In contrast to this, H.R. 22 actually provides real incentive for achieving both quality and cost control. It establishes national standards for participating professional and institutional providers. It regulates major surgery and certain other specialist services. It establishes national licensing standards and requirements for continuing education of physicians. If an organization which delivers services provides high quality services to an adequate number of people and yet saves money by lesser utilization of nursing home and hospital services, that organization is entitled to 75% of the amount that has been saved.

The fourth criterion, financing by a national progressive taxation is unfortunately not met by any of the bills under consideration. A large portion of the funds under H.R. 7741 would come from employees (65% of the cost of the employee's coverage the first 2½ years and 75% thereafter). To a large degree this money is of course coming from the employee in that his salary and/or benefits are lowered in order that he can pay his 65% to 75% and still maintain profits. It should be noted that under H.R. 22, the 36% of the revenue that comes from a 3.5% tax on an employer's payroll is about what the average employer now pays for insurance for his workers. The 12% derived from a 1% tax on the first \$15,000 of individual income is about equal to what is now being paid in Medicaid.

When considering equity of services, coinsurance and deductibles must be excluded as devices that treat the poor unfairly. A middle class man with a bank account of several thousand dollars may have no trouble in paying a small percentage in coinsurance or deductible in order to receive the benefits he wants. To a poor man, however, the initial outlay is often something he just doesn't have and therefore a deterrent to taking advantage of the benefits. This is especially ironic and costly in that it presents a deterrent to use of preventive medicine which in the long run would save him and the nation even more money. All of the plans except for H.R. 22 have sizeable deductibles. H.R. 7741 omits the very poorest from copayments and deductibles. The very poorest are those with an annual income of \$3,000 for a family of four—a family of four earning \$3,001 is subject to coinsurance and a family of 7 earning \$5,001 is subject to coinsurance.

Perhaps the most important criterion is the last one, that having to do with the restructuring of our ailing health care system. As the status and emphasis in American medicine have increasingly leaned away from care of the sick and towards research, we have suffered a severe loss in services to the sick. Today there is about 1 doctor for every 2,000 people. The Department of Health, Education and Welfare estimates there is a shortage of 50,000 doctors for family treatment. H.R. 4060 and S. 1376 propose no solution to our health crisis. H.R. 4340 touches on the tip of the iceberg; it promotes ambulatory care facilities and group practice organizations. It also provides federal subsidies to encourage health personnel to serve in deprived areas. Both H.R. 7741 and H.R. 22 encourage the development of comprehensive prepaid group practice plans which would encourage the use of preventive medicine. Both attempt to meet the manpower shortage. H.R. 7741 would establish area health education centers in areas of need as satellites of medical schools. They would be used for continuing education, teaching new health workers and delivering some services. This is a commendable idea in theory, but the practice needs to be closely watched. Medical schools receiving grants for satellites may often feel the need to use these funds for prestigious research instead of delivery services to the poor. Therefore, a system of public accountability needs to be built into this plan to make it valid. H.R. 22 would make special funds available for the training and initial utilization of new types of personnel. Attention would be paid to the hiring and training of members of minority groups and those disadvantaged by poverty. This seems to us a very realistic step in correcting one of the problems in our present system. In contrast to H.R. 7741, there is attention given to public accountability although not as much as we would like to see. The National Health Security Advisory Council, composed of 21 members, would have a majority of people who are representatives of consumers of medical services. We would like to see the Council have more than just "advisory" powers. We would also like to see the chairman elected by the Council instead of the chairman of the Health Security Board arbitrarily being the chairman of the board that administers the program. We also feel that in order to fulfill a need for an objective advisory capacity members of the Advisory Council should be elected by the people they represent rather than appointed by the Secretary of Health, Education and Welfare on the recommendation of the administering board. Finally the administering board should be empowered to review complaints and make recommendations which the Board would respond to in a meaningful way. H.R. 22 plans for the distribution of funds so that there is a just allocation of funds according to regional needs.

We are looking forward to learning more about a bill presently being prepared by Rep. Ron Dellums that would create a national Cabinet of Health that would incorporate all existing federal, state and local government programs with all private health services in an attempt at creating health care to the nation's low-income and working classes. A system of medical facilities, ultimately controlled by the community, consisting of comprehensive medical, dental, mental health and preventive health care would be created. Attention will be given to quality and cost controls. Emphasis will be given to the way medical care is delivered to insure dignity of the patient. Progressive taxation will probably be the financing mechanism.

We hope that the committee will give attention to the Dellums bill when it is introduced and to H.R. 22 for the substantial improvements they would make in our nation's health care system.

RAY ARTIGUES & ASSOCIATES,
New Orleans, La., November 1, 1971.

DEAR HONORABLE WILBUR D. MILLS: The time has come for all of us to stand up and be counted and I would certainly like to make my opinion known to you on how a national health insurance plan should be written.

The first standard of any health insurance plan to be written must be a program, which will not destroy health insurance as we know it today, but will build upon the good which we have and provide adequate medical care to everyone in the United States.

Secondly, the program must not be so expensive that it will bankrupt both employers and employees alike in financing the plan.

Thirdly, it must not destroy either the insurance carriers, who have contributed so much to the social well-being of the United States, nor should it destroy the

providers of medical care. In fact, it must not only not destroy the providers of medical care, it must provide more personnel and more facilities.

After looking over the National Healthcare Proposals, there is no question that the Burleson-McIntyre Proposal is the one that best suite the above criteria. It provides the facilities whereby doctors, dentists, and other medical personnel may be trained and many individuals who cannot afford to have such training will actually be able to be financed, providing they are willing to provide medical care in the so-called ghetto or rural areas. It preserves the insurance industry and the employer/employee relationship of providing healthcare benefits and it would be expected that service from both employers and from the insurance industry would continue at a high level.

Lastly, it would appear that the cost of this program would be well within reason and the American people would be financially able to afford it.

I urge you to vote for the Burleson-McIntyre proposal or a program of National Healthcare similar to this proposal.

Sincerely yours,

RAY ARTIGUES.

JACKSONVILLE, FLA., November 1, 1971.

Subject : National health insurance.

HON. WILBUR MILLS,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: According to information available to me, this Committee is now holding hearings on National Health Insurance.

I am a Federal employee with 28 years of tenure. I believe that our Federal program of health insurance which started in 1961 was a great step forward. As you know, this program is administered by the Civil Service Commission and there are many different Carriers of health insurance (for Federal employees) approved by the Civil Service Commission. According to my information, Blue Cross-Blue Shield is by far the largest of such Carriers.

I have been ill many, many months in the past six years. Were it not for the Federal Health Insurance which Federal employees have, my life savings would have been depleted long ago.

Therefore, I feel that your hearings could well include the opinions of Federal employees who have had to use the existing health insurance program for Federal employees.

I have one basic suggestion from my experience :

Create a health program which will not require *any paper work* (similar to the Kaiser Foundation Health Program that is available to Federal employees in California).

I firmly believe that existing hospital, clinics and other facilities pay out an inordinate amount of money for paper work which could more justifiably be used to pay for periodic tests so that eventually we will have in our Society a "preventive" medical approach to good health rather than the existing "cure" approach. I feel that the Kaiser Foundation Health Program for Federal employees does just that; help establish a preventive medical care program to keep people from getting sick and that this should be the real objective of any national health program for all citizens.

Sincerely yours,

FRANK J. BARBERA.

MEMPHIS, TENN., November 15, 1971.

HON. WILBUR MILLS,
Chairman, House Ways and Means Committee,
U.S. House of Representatives,
Washington, D.C.

- DEAR MR. MILLS: Having committed a great part of my personal life to medicine and having invested a great deal of my time in training for the health care of people, it is my personal belief that we are obligated to the personal health needs of every citizen. By "we" I do not mean my peers in medical school alone, nor do I mean the federal government, but I mean we as a nation should undertake to meet the personal health needs of our people.

Every citizen of the United States is entitled to the certain inalienable right of life, liberty, and the pursuit of happiness. Health is very central to these rights

and therefore, we are obligated to see that every American has access to quality health care. It should be and it must be our goal.

The first task before us as physicians and legislators is to establish national goals to improve health care. "National" should not be translated "federal", although much support for this move must be federal in origin. Co-ordinated effort between physician, citizen, and government must be sought and executed if substantial improvement in health care is to be realized.

The first, most basic question to be answered is where on the list of priorities is health care to be placed? This is an extremely crucial question. Without an adequate answer from the government, but even more important, without an answer from the citizenry, the physicians' role is of little significance.

If an individual does not value his health enough to restrict his diet, to stop his cigarette smoking, or to cease his drinking, there is little to be done for the three most common causes of death in this country, heart disease, cancer, and cerebrovascular accidents. This is oversimplified to be sure, but I think it is sufficiently clear that if good health is to prevail, it will of necessity require cooperation and in many cases sacrifice on the part of the patient. If good health is to become reality, individuals will have to be made aware that it will require increased effort on their part as well as more structured and altered effort on behalf of the physician and government. The individual must be made to realize that although he has access to quality health care, without his individual effort, all that the government and physicians can provide will be to no avail.

Government also must involve itself with the establishment of priority for this country's health. Is the quest for space as important as good health? Is that as significant as good health or is it even compatible with the goal of striving for a quality health care system? A high priority is in order in individual life and in communal life if a quality health care system is to become a reality in this country.

Assuming high priority for health care is made by individuals and by the government, what should be done next? Of prime importance is the development of more efficient means of delivering health care. Money from public and private sources must be invested in more research to effect more efficient modes of health care. Physicians must be encouraged to move from an acute emergency oriented health system to a health maintenance system. Perhaps the extension of present federal programs of hospital construction grants and hospital and outpatient facility loan guarantees could be used to encourage construction of comprehensive ambulatory health centers. Making available grants and loans to subsidize these ambulatory centers for the first three years would encourage physicians and patients to participate in health maintenance systems and to move away from crisis-oriented medicine.

Also involved in improving efficiency of health care systems is the establishment of health care area planning committees to insure that money is spent wisely for necessary improvement. Unfortunately, large medical centers with well endowed hospitals have in the past duplicated little used equipment and personnel merely to prevent one hospital from having an edge on another. This is a frequent and discouraging finding. Health care facilities are located many times in areas inaccessible or inconveniently accessible to the prospective patient. Effective and viable planning could reduce the above mentioned problems. The use of a health planning organization could be achieved if government loans and grants, or contracts for a health facility were granted on the approval of existing need by a comprehensive health planning agency.

A third area of change must be effected. Financial barriers to dignified access to quality health care for all citizens must be removed. The best means to accomplish this objective is to move toward a health insurance system providing coverage for all patients. To accomplish the goals set forth earlier in this letter, such coverage must be substantially different from that which currently exists. Provision must be made in health insurance to cover preventive and ambulatory care. Failure to do so will force a continuing increase in insurance costs, produce inefficient use of existing facilities and personnel, and oppose in general the shift from crisis-oriented medicine to health maintenance systems.

To provide comprehensive coverage to all citizens in an efficient manner, it is essential that we utilize existing forms of voluntary health plans. Costs for most individuals should continue to be met by individuals and employers. Public funds should be utilized for those needing total or partial support in financing their health care. Using existing structures for health insurance appears to be an adequate and appropriate means to establish total coverage. Another cen-

tralized, bureaucratic approach, like Medicare or Medicaid, is unsatisfactory. Independent decentralized administration seems to me the only viable approach.

Finally, we must provide a continuing growth of medical educational facilities concomitant with increasing need. The shortage of doctors now is a reflection of many factors. It reflects the failure of the physician to develop adequate structures to efficiently distribute his skills. It reflects the failure of government to aid in the organization and development of new and existing facilities of medical education. To rectify this situation will require rethinking and delineation of priorities and a considerable investment of funds in the establishment and operation of new medical schools.

In summary, priorities must be set for the individual and for the government because a considerable greater outlay in terms of money and effort must be made if quality health care is to be practiced in this country. We must develop more efficient means of delivering health care, and we must encourage a transition from crisis medicine to a health maintenance system. We must establish regional health care planning committees and insure their viability, and we must remove financial barriers to overall quality health care. Finally, we must insure the growth of to medical profession to continue to provide competent physicians in adequate quantity to meet the needs of the country. All of these areas must be developed if our health care system is to realize its goals. It will require the cooperation of the government, the citizens, and the physicians.

I hope these thoughts may have some influence on you as you participate in the shaping of future medical practice in this country.

Sincerely,

DAVID R. BARNES.

ALEXANDRIA, VA., October 19, 1971.

Mr. JOHN M. MARTIN, Jr.,
Longworth House Office Building,
Washington, D.C.

DEAR SIR: In regard to National Health Insurance, as stated in Congressman Bill Scott Reports, I for one will be glad to do all I can in my low-educated layman way. I can testify or present written statements.

Some experiences and details follow: I am 41 years of age, my wife is 39. I am a veteran, employed by the Government Printing Office, homeowner, with three children, will be making \$15,000 this year and can barely make it. I was just able to buy my first new car in my life and a few luxuries and this was due to an insurance settlement. We do not spend money wastefully. I have had to work a second job most of my married life just to get by.

My wife has been a patient in a hospital 38 times and well over 100 times as an outpatient. She has had 7 major operations; the rest of the times were from childbirth, miscarriages, kidney infections, bladder infections and one time a *bad operation* that left her with no thyroid or parathyroid glands. Her longest stay was over 6 weeks, several 4 weeks stays, the rest of the time one to two weeks. This is my reason for being so poor. I think we have a fairly good system, but there is room for improvement on extended illness or repeated hospital visits. We have a bill for over \$1300 on a 6-day stay at a hospital with no operation. I have Hospital and Medical Insurance, but even so I find myself paying out several hundred dollars each year. If a person goes to the hospital to get well and comes home sicker than when they went, they still have to pay top dollar. If a Doctor prescribes a medicine for an illness and it doesn't work, you still have to pay both Doctor and Drugstore. Today a bad Hospital or Doctor can make just as much money as a good Doctor or Hospital and this is not a good system. I believe the National average for a family of 5 is one hospital visit every 2½ years; if this is true it means half of the people are going more than that. We are averaging 2 times a year. I think the people under the average have a good system, but those on the other side have to have some sort of relief.

It is very bad for the people who try to work and make a go of it but due to the high cost of medical care, lose all interest in trying to get ahead. I don't think a give-away program is the answer, but there must be someone in this great land of ours that can come up with a more fair and reasonable answer.

Also, the mental health program in the State of Virginia is very poor. It definitely needs improvement. For instance, if a patient is diagnosed as well after a breakdown but has no place to stay or anyone to look after them, they

must remain in the hospital. These people need to have a chance to get back into the normal and everyday world.

I thank you for this opportunity to express my thoughts and feel free to call upon me at anything if I can be of help in my small way.

Sincerely yours,

HAROLD E. BROWN.

FARGO, N. DAK., April 7, 1971.

HON. MARK ANDREWS,
Member of Congress,
Washington, D.C.

DEAR MARK: Thanks for your prompt reply to my letter of February 17-71 but for the gravity of the situation it appeared rather indifferent to a very deplorable development.

We have just returned from a visit to warmer climates, and while away I had occasion to further become informed on what our medical fraternity is doing to our Senior Citizen brigade. A neighbor of my sister and her husband who now lives in Sun City, Arizona, was recently taken to the hospital in Del Webb's, Sun City Hospital, (He does not own same) and with just medical care no operation, but for six days his bill was \$1,600.00. Other cases where operations were performed for removal of cataracts, same hospital and a short stay, \$8,000.00, yes and you see for sale signs frequently on front lawns, while there is a steady stream of new residents in this development, but they possibly have not experienced any medical care yet or a trip to the Boston Hospital in Sun City.

To more vividly explain what I am trying to get across, I find on good authority from North Dakota Physician's Service, Fargo, that in 1970 there were 5 North Dakota M.D.'s, that grossed, \$90,000.00 from medicare payments alone, that is each M.D. This could be only a small portion of their total take, but indicates the terrible gouging they are giving the tax payer, who has deducted from his income an ever increasing tax to be gobbled up by a greedy, selfish, money mad element in our society.

As of the moment I am not suffering for want of medical attention but find that now, we have a review board to check on charges for medical attention, and that disallow charges completely for some medical care, but never question the amount of the charge the Doctor makes. I think of the burden this places on for instance my son in San Antonio, Texas with still six children at home, who will now pay tax on \$12,000.00.

In my opinion, this situation comparable to guerilla warfare, where they hit and run and their depredations cannot be stopped or no one has any desire to correct the situation. The deplorable part of this tragedy is that in our state, Blue Cross & Blue Shield are in complete control, they make the charges, with apparently no limits, pass on the legitimacy of the medical need and then we find that where medicare was required to pay 80% of the reasonable charge, because of the extortionate charges made, have now reduced payments to 50% or less.

Please note the attached exhibits, which most certainly indicate that this effort, by A.M.A. or their greedy members or associates is not relegated to any one part of our Nation, but is apparently a Nation wide conspiracy against American tax payers, whether retired, Senior Citizens or still paying for this, Social Security, Medicare monstrosity. If there ever was a case of putting the Fox in the chicken coop, this is it, and I would recommend that action be brought against the "Gougers" for recovery of their ill gotten fees, and this coupled with some prosecutions and disbarment from treating any medicare patients.

First I would like for you to review exhibit No. 1; then exhibit No. 2; exhibit No. 3 and 4.

Persons like myself are stuck with this medicare thing, you cannot buy health insurance today and at my age without investing a fortune which none of us have, unless it's based on medicare, which is being eroded away, by both Doctors and Hospitals.

I am aware that alone you are not in a position to correct this scandalous situation, but by raising your voice in the Congress and letting H.E.W. know how you stand and what you know is occurring and after a review of the material enclosed, we just may correct this situation. Good Luck.

Sincerely,

PETER J. CAREY.

P.S.—Thanks for your nice letter on the Jewel Globe. I must give most of the credit to Les Garnas, Standard Oil Mgr. here, I just got him to engineer the

matter. You are also lucky on the timing as the last Torch & Oval, adives where globes can now be secured from a fellow who has the original patterns and is going to town selling to antique collectors, you got in under the wire.

Enclosures.

EXHIBIT No. 1

MEDICARE "FREEZE" TRIGGERS HARDSHIPS

Have you used Medicare recently and believed that the amount you collected was insufficient?

Richard C. Brown of Woodford, Va., a Medicare recipient since 1966, sent in current bills amounting to \$94 and received a check for \$56 instead of the \$75 he had expected.

Henry H. Croen, White Plains, N.Y., collected only \$200 of a \$350 surgeon's bill.

Medicare is supposed to pay 80 per cent of "reasonable charges."

Six months ago, a Social Security Administration decision, never publicly announced, limited Medicare payments to the 1968 "reasonable charge"-level, ignoring rising costs of doctor fees.

As the examples above show, Medicare patients learned about it the hard way—higher costs and lower Medicare payments.

Bill S. Byrd, professional relations assistant at Medicare headquarters in Baltimore, concedes that "unquestionably, this administrative decision has been harmful to many Medicare patients."

Because of numerous complaints from Association members, Association News Bulletin reporters began investigating reports of tardy payments and inadequate reimbursements.

These facts emerged:

Because of amendments to the Social Security Act pending in the Congress that would affect the amount of medical payments, the "freeze" order was issued to prevent possible overpayment that the elderly and some physicians, would have to make.

The amendment to H.R. 17550 is now bogged down because of several controversial riders.

Clarifying the Medicare policy action, Arthur Hess, Social Security Administration Deputy Commissioner, told the News Bulletin:

"Hold the line instructions on Medicare were actually sent by the Social Security Administration to Medicare carriers as early as 1960—at a time when premiums were still \$4—because medical fees had gone up so much. This original policy was made in order to hold premium rates down as well as attempting to control inflation of medical prices. Because medical fees took quite a jump during the first two years of Medicare, we felt a catch-up time necessary and that this could only be accomplished if nothing was done for a year or two."

Is the action legal?

"Yes, it's legal. We (SSA) are charged, by the Congress, with the responsibility for instructing Medicare carriers on paying claims based on 'reasonable charges' for a particular area."

However, whether or not the pending Social Security legislation passes or doesn't pass the 91st Congress, Hess assured the News Bulletin that "the Social Security Administration will have to reconsider policy for Medicare payments shortly."

There are other examples of inconsistencies, to wit: Hartwell M. Webb, a retired foreign service officer, has his "ups and downs" with Medicare keeping records for himself, his wife and his mother-in-law.

He said that he had been unable to determine who "established reasonable charges and added: "My main quarrel with Medicare is its inconsistencies. When I've protested, I've never been answered by letter. But months later, I've received a form which says "your case has been reviewed and we are now paying you this much."

"Who reviewed it?"

Webb said that many older people "arent able to keep good books or fight for their rights as I do."

EXHIBIT No. 2

[From the New York Times Service]

BLUE CROSS IS ORDERED TO FIGHT

PHILADELPHIA, PA.—Blue Cross executives and hospital officials in Philadelphia have been jolted by a rapid-fire succession of orders from a new, consumer-oriented state insurance commissioner.

The orders were issued by Herbert S. Denenberg during five days of public hearings into a request by Blue Cross of Greater Philadelphia for an increase in rates of almost 50 percent.

The Blue Cross organization here got a 25 percent increase last August, but says it will go bankrupt if it does not increase the current rates by about 50 percent by next August. The increase would raise a typical monthly premium to \$37.70 from the present \$25.60. Blue Cross blames rising hospital costs and greater use of the insurance plan.

Denenberg, on leave from his post as insurance professor at the University of Pennsylvania, exploded when the latest request of the Philadelphia Blue Cross came in.

Since some 60 percent of the population in the area has Blue Cross coverage, he contended, hospitals depend upon Blue Cross as a major source of revenue and Blue Cross should require them to meet reasonable standards of operating efficiency rather than simply accepting higher charges and passing the cost on to subscribers in higher rates.

Oral orders followed in staccato fashion during the most extensive hearings ever held in Pennsylvania on a rate-increase request. Among the shocks Denenberg administered to Blue Cross and hospital officials were the following:

He ordered Blue Cross to reorganize its board of directors within two weeks to provide greater representation for the consumers and employers who pay the premiums.

He asked that hospital representatives and physicians be eliminated from the board. "The problems of medical care and hospital financing are too important to be left to the hospitals and doctors," he said.

He ordered Blue Cross to cancel its contracts with all 80 hospitals here at once and negotiate new ones requiring unaccustomed economies. Under the new contracts hospitals would not be allowed to defray the costs of research, education and other hospital costs of no direct benefit to patients by charging a percentage to patient services.

He suggested that doctors rather than hospitals pay the salaries of interns and residents, a major hospital cost now passed on to Blue Cross and patients as overhead. He noted that the work of student doctors was directed by physicians, not hospitals, and that the physicians benefited by collecting fees.

He ordered Blue Cross to itemize the money it spends for advertising, public relations and membership dues in hospital and other organizations engaged in lobbying and publicity activities—all reflected in premium rates.

The new commissioner believes there are some things that can be accomplished by alerting the public to what he considers cozy relationships between Blue Cross and the hospitals and to the role of doctors in decisions that raise hospital costs.

"Blue Cross and insurance companies blame the hospitals, the hospitals blame the physicians, and the physicians blame the system," he said. "It's time to improve the system rather than to attempt to palm off blame on someone else."

EXHIBIT No. 3

[From the Minneapolis Tribune, Apr. 2, 1971]

POOR MAY HAVE TO PAY PART OF MEDICAID

WASHINGTON, D.C.—Provisions for charging low-income persons part of the cost of health care under Medicaid have been tentatively written into a new welfare bill, it was learned Thursday.

Medicaid is the federal-state system for those at the poverty level or close to it. It is distinct from Medicare, the all-Federal program for those 65 and older.

The House Ways and Means Committee, putting together a complex welfare bill, is reported including in its draft a provision that reasonable charges, taking into account ability to pay, may be made for Medicaid services. The draft is still subject to review and change by the committee.

Until now, Medicaid has been free of charge to recipients and the cost of the program has increased steeply in recent years.

President Nixon's administration proposed earlier this year what it called cost sharing plans for Medicaid. Welfare Secretary Elliot L. Richardson told the committee this would make it possible "to significantly reduce the total cost—federal and state—of the Medicaid program."

The proposal, it was understood, met stiff resistance among some members of the committee, but so far opponents have not been able to muster enough votes to delete it.

Among arguments made for the cost-sharing plan is one that a sliding scale of participating payments would eliminate the abrupt dropping of a family from Medicaid benefits when its income reaches a certain level, as can occur under present law. The Medicaid eligibility level varies from state to state.

Committee members also are reported to have been told that any changes made now in the Medicaid program are only stopgap provisions, since the whole program is to be absorbed into the national health insurance system Congress is expected to enact by the end of 1972.

[From the Minneapolis Tribune, Apr. 4, 1971]

U.S. SPENDING IN STATE SET AT \$3.2 BILLION

A report by the U.S. Office of Economic Opportunity shows that federal spending in Minnesota during 1970 totaled \$3.259 billion.

The largest amount, \$950,175,184, came from the Department of Health, Education and Welfare (HEW). Minnesota ranked 17th among the states in HEW spending, according to the report.

Minnesota's lowest ranking among the states, 33rd, was in Department of Commerce spending, which totaled \$7.05 million.

Minnesota ranked third among the states in funds received from the Department of Agriculture, which spent \$637.99 million in the state.

EXHIBIT No. 4

[From the Minneapolis Tribune, Apr. 4, 1971]

U.S. STUDY UNIT URGES CHANGES IN MEDICARE

WASHINGTON, D.C.—A federal advisory council proposed Saturday that Medicare be expanded to cover partial payment of prescription drugs for the nonhospitalized elderly.

The council also proposed that the entire Medicare program, including the part for which the elderly now pay \$5.30 monthly premiums, be financed jointly by employers, employees and the federal government.

These were among the many broad changes recommended in Social Security and Medicare by an advisory council named two years ago to review the programs, as required under the Social Security Act.

The 12-member council was headed by Arthur S. Flemming, a secretary of health, education and welfare during the Eisenhower administration. The council report, released by Elliot L. Richardson, the present secretary, has been sent to congress.

The report comes at a time when the Nixon administration is pushing for legislation to curb Medicare, not expand it as the council has proposed. Thus, the report is expected to become an issue in the fight that already has broken out within the House Ways and Means Committee over planned cutbacks in Medicare benefits.

The committee rift came after tentative approval last Thursday of administration proposals to shift much of the burden of hospital bills to the elderly.

The committee chairman, Wilbur D. Mills, D-Ark., is expected to mount a drive to reverse the committee action and revamp the Medicare cutbacks to have a less adverse impact on the elderly.

But while at apparent odds with the President over whether Medicare should be curbed or expanded, the advisory council endorsed the administration's proposal that increases in Social Security benefits be geared automatically to rises in the consumer-price index.

The Flemming advisory council also proposed these changes:

The wage base on which Social Security taxes are based should be raised to \$12,000 in 1974. Congress recently raised the base to \$9,000.

Medicare should be extended to those receiving disability benefits under Social Security.

Medicare should be expanded to include prescription drugs for out-of-hospital use, with beneficiaries paying a flat \$2 for each new prescription and \$1 for each refill. Such out-of-hospital drugs are not now covered.

The number of "lifetime reserve" days for which inpatient hospital benefits may be paid should be increased from 60 to 120 days, with the patient paying a fourth of such daily costs instead of the present half. Such a lifetime reserve—designed to aid those with long illnesses—is in addition to the 90 days of hospital care available to patients.

FRAMINGHAM, MASS., October 18, 1971.

HON. WILBUR D. MILLS,
House of Representatives,
Washington, D.C.

DEAR REPRESENTATIVE MILLS: This is a suggested plan to provide hospitals with cost-control incentives.

After spending 18 years with a major industrial firm, primarily in systems design and management, I presently am manager of systems and procedures for a Boston area community hospital. I have in effect "seen the world from both sides now".

Since the product of hospitals is Care-based-on-Diagnosis, there is no reason why charges in Hospital A for an "appendectomy care" should be higher than in Hospital B (except for the possible difference in personnel or facility sophistication.)

Each hospital can be assigned a grade—say I to X—based upon the health care requirements for the geographic area. Each diagnosis can be assigned a daily charge range based upon current standards of care. Then, by creating a 2-dimensional matrix, Grade vs Diagnosis, the maximum daily charge for care in any hospital can be shown. (This is not so overwhelming a numbers game as might be anticipated. The number of hospitals in the country is quite finite, and all diagnoses are well coded by ICDA.)

This provides the hospitals with a carrot or stick. By delivering care at a cost below the allowable charge, the hospital would derive profit. Maximum daily charges could be controlled by needs rather than by costs.

The next step would be to add the dimension of length-of-stay by diagnosis, such that the matrix would indicate Total Charge rather than Charge/Day. This would truly provide cost/charge control and incentive.

This suggestion is indeed superficial. However, in view of your current hearings I think it might be appropriate. I would be happy to elaborate on this plan in detail to one of your staff members if you feel it has merit.

Respectfully submitted.

GEORGE G. PERLA.

WASHINGTON, D.C., November 6, 1971.

House Ways and Means Committee:

HONORABLE SIR: May I submit these comments relative to your hearings on National Health Insurance November 9.

My name is Marcus Rosenblum. I was employed as an editor and a writer in the Public Health Service from 1950 to 1968 and have served since as consultant to the National Commission on Product Safety, the World Health Organization, and the Regional Medical Program.

My major points are:

1. Medical care, utilizing clinics, physicians, nurses, and allied staff, does not necessarily contribute, on balance, to public health.

2. Medical care may be one of the least economic approaches to improving or protecting public health.

3. Insurance for medical care tends to provide money rather than services. The need is less for funds than for personnel and facilities.

4. In the absence of wide agreement on what is appropriate medical care, with specific standards of maximal as well as minimal treatment, the demands for medical services and funding will be insatiable.

5. Despite its political attractions, the insurance program is likely to provoke a political backlash when it proves to be a token of health services rather than

a reality, a promise rather than a performance, like so much of the social legislation.

To elaborate:

1. Medical care for all the relief it provides individual patients does nothing to satisfy the positive need of the majority for a suitable diet a vigorous regimen, a stimulating and wholesome environment, and social responsibility and stability. To state the case negatively, medical care does little to prevent malnutrition, pollution, delinquency, addiction, prostitution, or violent crime. Medical care heals the individual but does nothing for the open sores of society.

2. It costs far less to prevent most forms of illness than to treat them, when social benefits are balanced against social costs. Among the neglected possibilities for reducing the agents of disease or injury at moderate cost are: improvements in nutritional values in diets; improvements in the safety of consumer products; strict control of carcinogenic or mutagenic substances such as asbestos or radioactive wastes; sanitation of food processing establishments, including restaurants; abatement of industrial discharges to streams and the ambient air; suppression of unnecessary noise; and development of clean and safe sources of energy.

Not all the items on this truncated laundry list have been neglected. Government services have done much to control many of the obvious hazards. The past successes are a sound argument for giving still more support to preventive policies and programs.

3. On the record, insurance programs encourage medical services to increase charges to match the amount of funds available. Insurance does not necessarily increase the quantity or improve the quality of services. The insurer as a third party does little to improve the quality of service: to the contrary, the insured patient often is more likely to be treated like a charity case than the patient who pays directly. The presence of a third party tends to impair relations between patient and physician, from the point of view of both. My expectation is that the insurance bill only will delay the hour of reckoning when standards of medical care must be prescribed and when the necessary facilities and personnel must be budgeted and assured. Until then, the medical professions will play the game according to their rules, not according to national need.

If you do favor an insurance bill to meet public demands, I urge you to provide for standards of care and a rational system of assuring and operating medical services, including reasonable training and supervision of MDs in the use of pharmaceutical products, which, for most of them, is a guessing game.

4. Standards of medical care will not be easy to frame, but certainly they should not be based upon a) ability to pay, b) the indefinite prolongation of life, and c) the exercise of virtuosity in surgery or extravagant technology at the expense of patient and taxpayer. Since there must be priorities, there should be special consideration for youth, mothers, and people in their most productive years. The investment in diagnosis and treatment should bear some rational relationship to the expectancy and productivity of the patient. Personal or psychological factors in patient treatment also should receive heavy emphasis: recognition of the individual is not only good psychology, it is good therapy. A patient is not a case nor a number but a person.

Such consideration of the patient may also support a rational view of medical expenditures: it will not seem reasonable even to the patient to spend infinite amounts of care for those who have finite expectations. Unless certain limitations on care are established, it is to be expected that the medical demands will prove as voracious as the military.

5. Anyone who is ill wants a physician, not an insurance policy. It will avail little to have insurance if there are not sufficient qualified medical personnel to meet the needs of a growing and aging population. The first objective of Congress should be to reduce the need for medical care by preventive programs; the second, to assure a sufficient supply of medical services; and thereafter, if ever, to concern itself with the costs and methods of payment.

When this insurance program first was advocated, I raised some of the foregoing objections to one of its main proponents, and his answer was, "Sure, but it's what the middle classes want, and we might as well give it to them until they find out it isn't going to do them any good. Then maybe they'll let us arrange for what they need." When people find that they have been hornswoggled, their impulse is to bash the hornswoggler, not to give him another chance.

Respectfully,

MARCUS ROSENBLUM.

MONROEVILLE, PA., November 22, 1971.

WILBUR D. MILLS,
*Chairman, the House Ways and Means Committee,
 House of Representatives,
 Washington, D.C.*

DEAR CONGRESSMAN MILLS: I have been reading some of the testimony offered before your Committee on the subject of national health insurance programs. I am writing this to give my conclusions since I probably will not be invited to offer testimony.

Of course, to a large extent, the position one takes on the various bills will depend on his political philosophy—for or against a larger role of the federal government in the lives of the citizens. Beyond that we know from experience that federal legislation is expensive and unwieldy to the extent it tries to anticipate and provide for the needs of the people. Thus, Medicare/Medicaid caused sharp rises in cost and confusion in providing health care over the Kerr-Mills legislation, not without some beneficial results. However, in toto I feel that the effect of Medicare/Medicaid was detrimental to quality health care for all. In fact, isn't it due to failure that these programs must be replaced so soon?

I believe that taking everything into consideration, the best approach the federal government can make to providing quality health care to the people is to remove all federal programs, with the possible exception of one providing health insurance to be purchased by those who cannot now buy coverage because of physical conditions including age which make it unprofitable for private insurance companies to provide adequate coverage.

I am sure (at least I hope) your Committee is also studying the possibility that the most effective health care system would be that provided without any federal intervention or funding. However, if it would be of assistance, I will be happy to expound on my thesis.

Best wishes,

CHARLES A. SCHMIDT

COMMONWEALTH OF VIRGINIA,
 COUNTY OF FAIRFAX,
 BOARD OF SUPERVISORS,
 Fairfax, Va., December 10, 1971.

Hon. WILBUR MILLS,
*Chairman, Committee on Ways and Means,
 U.S. House of Representatives,*

DEAR MR. MILLS: I am transmitting with this letter copies of my statement to the Committee on Ways and Means on the subject of National Health Insurance.

I sincerely appreciate this opportunity to present my views on this very important question to your Committee.

Sincerely,

HAROLD O. MILLER,
Supervisor, Mason District.

Enclosure.

STATEMENT OF HAROLD O. MILLER

In the last several years it has been suggested with increasing frequency that the United States is facing a health care crisis. Different views have been expressed about the gravity of the crisis and about what should be done to alleviate it. There is, however, general agreement that something is wrong. As a member of the Board of Supervisors of Fairfax County, Virginia, I have had some opportunities to observe the impact of health problems at the local level and have as a result come to some conclusions about how the health care crisis should be dealt with. I am grateful for the opportunity to present my views by means of this brief statement.

The impact of the health care crisis on Northern Virginia has been uneven. Since Fairfax County is for the most part an urban metropolitan area, the majority of whose citizens are relatively prosperous, we have not experienced the severe shortages in health care resources and lack of access to medical care with which some less affluent urban and rural areas have had to cope. Perhaps in part because physicians are leaving Washington for the safer and more lucrative

suburbs we have enough doctors. We also have enough hospital beds. Indeed some experts believe we may have more than we need.

Even in a county as affluent as Fairfax, however, the people face a severe health care crisis which is out of control.

A significant minority of our citizens, especially the poor and the aged, find that they are unable to pay the cost of even their very basic health care needs. Those of us who can pay for necessary health care recognize that the cost is too high. Moreover, the vast majority of Fairfax County citizens would be hard pressed to pay the costs of health care in cases of catastrophic illness. Finally, and perhaps most important, the preventive approach to medical care is not readily available except in isolated, innovative programs. Existing evidence suggests that this approach is an effective means of keeping people healthy while reducing the need for use of high-cost health resources.

At the root of all of these deficiencies is the self-perpetuating inefficiency of our health care system. Fairfax County residents, and all Americans, are being charged unreasonable rates for inefficient services. The open-ended health insurance system serves only to encourage inefficient service and exorbitant costs, thus fueling the inflationary spiral which helped create them.

While it is not my intention to suggest that hospitals are the only contributors to health care inefficiency, a recent management study done at Fairfax Hospital provides some interesting illustrations of the problem. In Northern Virginia hospitals use 271 employees for every 100 patients. The Fairfax Hospital study suggests that inefficient utilization of staff is one factor contributing to higher than necessary costs. At Fairfax Hospital, according to the report, registered nurses are being used to perform tasks that could be carried out by licensed practical nurses, technicians or nurses' aides. Another finding of the report was that electroencephalogram technicians are being utilized only 57% of the time in productive testing procedures.

The problem with efficiency also shows itself when considering the allocation of resources to the acquisition of supplies and equipment. The Fairfax Hospital pharmacy, for example, stocks 2,700 drug products when 10% of that number accounts for 95% of all drugs dispensed. In addition, the hospital owns a machine for measuring blood alcohol costing \$5,500 which is used only 4 hours per week and a \$36,000 blood serum analyzer used only 3 to 4 hours a day.

Uneconomical regional planning or the lack of it also contributes to high costs. Although activities of this type have not progressed very far here, experiments elsewhere have shown that the cost of purchasing drugs and other hospital necessities can be reduced when nearby hospitals act as a group. Another example of inadequate planning which hits closer to home has to do with providing adequate hospital bed space. According to the Health Facilities Planning Council's projections in Northern Virginia, booming hospital construction is expected to result in more hospital beds than are needed. As a result over-all occupancy rates will be lowered and individual costs to patients will increase.

Problems such as those described above have contributed significantly to a continuing rise in the cost of obtaining medical care. In the Washington area, according to the Bureau of Labor Statistics index of medical care, the cost of hospitalization, physicians' fees and prescription drugs rose 47.7% between 1965 and 1970. This is more than 10% above the national average. What this inflationary spiral has meant for consumers of health services can be easily illustrated. The average charge to patients by three Northern Virginia hospitals for use of intensive care units jumped from \$100 to \$126 between 1969 and 1971. Delivery room charges jumped from \$83 to \$106 during the same period and charges for semi-private rooms jumped from \$49 to \$66.

In examining the factors which have contributed to the rise in health care costs and the continued inefficient organization and use of health care resources, one must also consider the part played by health insurance. Basically health insurance, whether run by the government under Medicare and Medicaid or by private firms such as Blue Cross-Blue Shield, must bear a significant share of the blame both for continued problems connected with the organization and utilization of health resources and for the unending rise in health care costs. Physicians in Washington increased their after-professional-expenses income three times as fast as the BLS consumer price index between 1965 and 1969 because they knew they could get the prices they asked. They knew this because they were aware that most people have insurance plans which pay bills without question and maintain their profit ratio by passing increased costs on to subscribers in the form

of higher premiums. The recent net increase of 34% in the Blue Cross-Blue Shield Federal Employee Benefit Plan is one of the results of this practice. Similarly, hospitals have little incentive to institute management and cost controls because they also know that insurance can be counted on to pay the bills that they submit on behalf of their customers.

In view of the failure of health insurance to play a role in reforms which would make the health care delivery system more efficient and in view of the contributions made by health insurance to spiraling health care costs, I am frankly skeptical about proposals for reform which do not include the establishment of a national health insurance system which would:

(1) Provide adequate access to care for all citizens. Available evidence has suggested that particularly for the poor and the aged a choice must often be made between obtaining adequate medical care and obtaining other necessities of life. Accordingly, a national insurance program should be structured so that all essential health care services are included. This must include provisions which encourage the development of preventive medical care programs, which are widely unavailable in the present system, and which have shown themselves to be of value in preventing illness and reducing the need for high cost hospital and other facilities.

(2) Establish effective control procedures. The failure of both insurers and the medical community to take steps to control costs and utilization of services suggests the need to bring into the picture the views of the groups which will benefit the most from effective cost controls—the consumer. Effective consumer advocacy of cost controls aided by government efforts in the same direction could do much to reduce the pressure of inflation on health care costs.

(3) Provide for regional, local and national health care planning with the objective of developing more efficient organization and utilization of health care resources. Effective national planning by the Federal government would, I believe, make it possible to include under national insurance various types of coverage which have been excluded from existing programs as being too expensive. The exclusion of outpatient prescription drug coverage under Medicare is an example of this problem. Planning could, I think, develop means by which costs of providing coverage of drugs could be reduced and this service added to existing programs. Under the existing Medicare program the purchase of drugs on a national level would actually reduce and not increase costs. At the local level planning will permit better allocation of health care resources. Groups of hospitals might, for example, plan to band together to use joint laundry facilities, to share data processing networks or even to purchase drugs.

Congress has been provided with a wide variety of proposals for dealing with the health care crisis. Some of these are better than others.

HR 4960, the Medirecredit proposal introduced by Representatives Broyhill and Fulton, should be singled out for its failure to deal effectively with the health questions before this committee and the nation. First, for the average American this bill provides great obstacles to obtaining adequate care. Faced with serious medical expenses, the average American would have to borrow money or decide not to get the care he needed because under this program he would have to wait until the end of the year before obtaining a tax refund. Second, this bill leaves cost control and reform to bring about better utilization of resources in the hands of the medical and private insurance communities which have proven themselves inadequate to the tasks. Third, this bill provides no real impetus toward effective regional or local planning of the organization and utilization of health care resources.

S-3, introduced in the Senate by Senator Kennedy and others, goes furthest of all proposals toward bringing about the innovations which our health care system so desperately needs. It addresses itself most effectively to the three areas of need which I feel are of crucial importance: the establishment of effective care/cost control procedures, the development of effective health care planning, and, most importantly, to the ultimate goal of providing adequate preventive care and medical treatment to all our citizens.

I would like to thank the Committee on Ways and Means for the opportunity to submit this statement. The problem which this committee is attempting to deal with is one which touches the lives of all of us. Paradoxically, unlike some other problems facing the United States, the question at issue today in the health care field is not alone the inadequacy of funds with which to solve the problem, but is also one in which we are spending more than we should for the health care services we get.

The need for new approaches to the problems of providing adequate health care for all our citizens has been widely documented. What is needed now is for the Congress to act resolutely to create a national health insurance system which will provide the best possible medical care.

STATEMENT OF TED SHEEDY, COUNTY SUPERVISOR, FIRST DISTRICT,
SACRAMENTO COUNTY, CALIF.

Mr. Chairman, members of the Committee, my name is Ted Sheedy, Sacramento, California, County Supervisor, First District. Since the Sacramento County Board of Supervisors has not yet taken a position on the matter of national health insurance, I offer this statement as a private citizen.

Medical Service Not Available in Many County Areas

Sacramento County has a population of just over 600,000 persons. The greatest concentration of population lies within the City of Sacramento, where many of the problems regarding the quality, availability, and cost of health care in an urban area are present. I shall return to these problems in some detail later on. Sacramento County also includes some outlying rural and semi-rural areas, where the problem of health care availability is especially acute. For example, the city of Galt, with a population of 3,200, has only minimal health care facilities, is located 20 miles from the nearest hospital, and offers no public transportation. The situation in Galt is no different than in many other small American towns—If you live there, you'd better not get seriously ill—especially if you don't own a car.

Quality Service is Costly, and Scarce

Within the primarily-urban areas of Sacramento County, the problem is not so much one of availability as of cost and, of course, quality. In one sense, Sacramento is more fortunate than cities of comparable size elsewhere in the nation. We do have one pre-paid medical group practice plan which offers excellent hospital and preventive care—the Kaiser-Permanente Medical Group and Hospital. Unfortunately, the facilities of this group are not large enough to care for the entire population, even if everyone could afford it, which they cannot. Monthly premiums for the average family are currently about \$40.00.

Number of Medically Indigent is Growing

Those Sacramentans who do not belong to the Kaiser-Permanente plan must seek medical care either at private hospitals or the county-operated Sacramento Medical Center. In either case, they do not receive preventive care. If they are lucky, they have some insurance coverage for major illnesses, such as Blue Cross. If not, they live in constant danger of having their life's savings wiped out by medical misfortune. If they have no savings and no meaningful income, they will probably be covered by Medi-Cal or Medicare.

If they fail to fit into any of these categories, they belong to the increasing number of those who are medically indigent—and they become the problem of local government.

The Sacramento Medical Center is a public health care facility operated by the County of Sacramento. It also houses the University of California Davis Campus Medical School. The total facility processes about 800 patients per day. Of these, 18% pay privately for the care they receive, 47% are covered by Medicare or Medi-Cal, and 36% are "walk-ins"—the medically indigent who are unable to pay for any or part of the care they receive.

The rolls of the medically indigent are growing. California's new welfare and Medi-Cal reforms have cut back the number of people eligible under these programs. For example, one group—the 18-21 year-olds who live away from home—are completely ineligible for any kind of care. What are they supposed to do when they become ill? Wait until they're old enough for treatment?

Medicare Costs to Patients Have Increased

The situation is not much better for those who are covered by Medicare. Part of the Medicare reform package provided that the patient would take part in fee-sharing. For example, the maintenance need of \$153.00 has been reduced to \$125.00 plus non-exemption of the first \$10.00 spent on coverage. This is a cost increase to the patient of \$43.00. For someone who must live on a severely limited income, \$43.00 is an extraordinary amount of money. In this context, fee-sharing

becomes an incentive to postpone seeking medical care until the last possible minute—when it may be too late.

Medi-Cal Services Are Now Curtailed

And, for those Medi-Cal patients who are ill and seek care, things become even more complicated. For, under the Medi-Cal reforms, there is strict regulation on the use of treatment facilities. Each eligible person is entitled to two office visits and two prescriptions per month. Any special services or prolonged treatment requires prior authorization. The process of wading through the red tape of the state bureaucracy can be extremely time consuming, of course. Obviously, the moral here is, don't get sick unless you have sought prior approval.

Taxes to Support Public Medical Facilities Are Increasing

Of course, as the overall situation grows worse, the cost of maintaining a facility such as the Sacramento Medical Center goes up. Each year some \$40 million in local, state and federal tax funds are spent on health care in the Sacramento area. Yet, for the great majority of working, tax-paying Sacramentans, not only is medical care over-priced, and quality medical care difficult to attain for themselves, but they pay taxes to provide medical care for others.

Unfortunately, under the present system, even their tax dollars aren't provided adequate care—even for those who need it most.

Health Care Reform Needed

The entire health care system cries out for reform. Of all the plans presently before Congress, it is my belief that the National Health Security program H.R. 22 and its companion measure S. 3 will most effectively reform the entire health care system for the benefit of medical care consumers.

The need for this legislation is all too obvious. For, despite the advanced state of American medicine, we still rank 14th among the world's nations in infant mortality, and 12th in maternal deaths due to childbirth. Worse, deaths among non-white mothers and infants is as much as four times the mortality rate for white mothers and infants. Quite clearly, such horrifying figures result from a medical delivery system which is inefficient, inequitable, and unnecessarily expensive—a delivery system which provides the very best medical care only to those who can afford it. It is this delivery system that H.R. 22 would reform.

The American Medical Establishment Has Failed

There are those who oppose a national health insurance program, labeling it "socialized medicine," and charging that such legislation violates the spirit of the free enterprise system. In the face of such charges, it should be remembered that every man, woman, and child in this society has a right to life, liberty, and the pursuit of happiness. The medical establishment has no such inviolable right to reap huge profits from the illness of others. For many infants who die at birth, the right to life itself is synonymous with access to medical care. For the rest of us, a life which is happy and free from illness depends to a great degree on the quality of the medical care we receive.

It should also be pointed out that the decision to support national health insurance has not been made in haste. While other industrialized nations were establishing national health programs, the American medical profession had a free reign in developing a system of medical care in this country. The results speak for themselves. Not only has the medical establishment failed, but in its haste to maximize profits, it has made the situation much worse. For example, certain professional organizations, most notably the American Medical Association, adopted policies to limit the number of students admitted to and graduated from medical schools—policies which have directly contributed to our critical shortage of trained physicians. In addition, the A.M.A. was, for many years, in tacit opposition to any program of preventive medicine. I suppose it was more lucrative to treat illness than to prevent it. For the most part, our present medical system—inefficient, inequitable, and unnecessarily expensive—is the creation of our medical establishment.

It is Time for Change—To Improved Medical Care for All Citizens

Clearly, it is time for a change. Clearly, it is time to recognize that in a democratic society access to the very best medical care for all citizens is not only *not* a privilege, as the American Medical Association would have us believe, but a *right* and a *necessity*. For those of us in Sacramento County, the enactment of this legislation will have a two-fold effect. First, and most important, a large number

of Sacramentans will receive improved medical care. Second, a national health insurance system will considerably reduce the cost of medical care to the taxpayers of Sacramento County.

I respectfully urge the Committee's favorable consideration of this measure.
Thank you.

TED SHEEDY.

NOVEMBER 25, 1971.

WAYS AND MEANS COMMITTEE,
House of Representatives,
Washington, D.C.

MR. CHAIRMAN: The provisions made by the Congress of the United States to give health care for all people have been emasculated by scoundrels, venal persons, and by unethical individuals. Neither the letter nor the spirit of these laws has been nor is being observed.

PROPOSALS

1. Revision of the present applications for *Medicare*, *Medicaid*, and for all *Supplementary services* so that such applications shall no longer be signed in blank whether the patient be below or beyond age sixty-five (65). This shall apply to signatures by the patient or by others when said patient is not competent to sign.

2. Enactment of laws which will make it a criminal offense punishable by fine or imprisonment or both for any supplier to make any attempt at collection until he can prove that he has filed with all insurance companies and exhausted all relief due to the patient by reason of insurance or other protection.

3. No use shall be made of confidential information given in medical histories, hospital, admittance papers, and similar documents. No call to next of kin, attorneys, or collection agencies without written permission of and by the patient involved.

4. In the study of definitive bills before Congress in the attempt to protect the public against the low ethical standards of the medical profession in the U.S.A. against the cupidity of those now in position to bleed the people and to wax fat batten on the suffering and reputation of those whom they were sworn to protect the most stringent laws should be and must be enacted and stringent enforcement of those laws must be applied.

5. This Committee might very well consider these facts. If material to substantiate these conclusions be necessary that material can be supplied to the Committee.

EMILY ERICSSON.