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, 11, 12, 15, 16, 17, 18 AND 19, 1971

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CONTENTS

ORAL STATEMENTS BY GOVERNMENT WITNESSES

ORAL STATEMENTS BY PUBLIC WITNESSES

MATERIAL SUBMITTED FOR THE RECORD BY THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MATERIAL SUBMITTED FOR THE RECORD BY THE PUBLIC

NATIONAL HEALTH INSURANCE PROPOSALS

FRIDAY, OCTOBER 29, 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. Sam M. Gibbons presiding.

Mr. GIBBONS. Good morning. The meeting will come to order, and we will continue the hearings concerning health care legislation and health insurance.

Our first witness this morning will be Msgr. Harrold Murray and he has some other witnesses with him.

Monsignor Murray, please identify yourself for the record, and those who accompany you. You may proceed as you wish. We will be glad to place your written statement in the record as it is written.

STATEMENT OF MONSIGNOR HARROLD A. MURRAY, DIRECTOR, DEPARTMENT OF HEALTH AFFAIRS, UNITED STATES CATHOLIC CONFERENCE; ACCOMPANIED BY SISTER MARY MAURITA SENGELAUB, R.S.M., EXECUTIVE DIRECTOR, CATHOLIC HOSPITAL ASSOCIATION; MONSIGNOR LAWRENCE J. CORCORAN, EXECUTIVE SECRETARY, NATIONAL CONFERENCE OF CATHOLIC CHARITIES; EDWARD J. KRILL, ASSISTANT DIRECTOR FOR GOVERNMENT RELATIONS PROGRAMS, U.S. CATHOLIC CONFERENCE; AND SISTER MARIE LENAHAN, ASSISTANT TO THE DIRECTOR, DEPARTMENT OF HEALTH AFFAIRS, U.S. CATHOLIC CONFERENCE

Monsignor MURRAY. Thank you very much, Mr. Chairman.

I am Msgr. Harrold A. Murray, director of the department of health affairs of the U.S. Catholic Conference.

With me is Sister Mary Maurita, executive director of the Catholic Hospital Association and Msgr. Lawrence J. Corcoran, executive secretary of the National Conference of Catholic Charities. Also with us today for these hearings:

On my far left is Sister Marie Lenahan, assistant to the director of the department of health affairs, and on my far right Mr. Edward J. Krill, assistant director for government relations of the department of health affairs.

(Msgr. Murray's prepared statement follows:)

STATEMENT OF THE UNITED STATES CATHOLIC CONFERENCE

PRESENTED BY

MONSIGNOR HARROLD A. MURRAY AND SISTER MARY MAURITA SENGELAUB, R.S.M.
AND MONSIGNOR LAWRENCE J. CORCORAN

INTODUCTION

It seems clear enough that substantial changes are needed in the way Americans finance, organize and deliver health care. President Nixon, in his Health Message of February 18, 1971, recognized that while there is much that is right with health care in America, there is also much that is wrong. Other responsible observers have almost universally cited the same problems, and have documented them far beyond the need to do more than summarize and restate them here. While there is great agreement about the problems we face, there is less agreement concerning their causes, and still less agreement concerning steps we must take toward their solution. Today, we would be pleased to make some recommendations toward the solution of some of these problems and the development of a more effective health care system.

We would note at the outset that we claim no ability to assess the detailed fiscal or operation aspects of some of our recommendations. We cannot project the final dollar cost nor the precise management and administrative system that might be required to meet our recommendations. We are convinced, however, that in the debate over the Nation's health care policy, there must be openness to a consideration of the non-technical, the non-actuarial and the nonstatistical viewpoint.

The Need for Health Care

The innate human desire for good health prompts the related desire to find the means to preserve good health if a person possesses it or to regain it if it has been lost. Far more effective methods for preserving health and treating illness exist today than at any period in history. Public awareness of this fact has accentuated the desire to benefit from these advanced methods.

Such health care is expensive and relatively few persons can afford optimum care. Private insurance plans have been developed to facilitate prepayment and to "spread the risk." The concept of a public insurance program has been debated for a quarter of a century. Medicare was a beginning step in this direction. Medicaid, though not an insurance program, was a recognition and assumption of public responsibility for the support of health care for those too poor to pay for this themselves.

Much of the advocacy of a national health insurance program, and the development of programs like Medicare and Medicaid has arisen from the feeling that good health care should be a fundamental right of every citizen. Considering the intimate connection between good health and life itself, good health and satisfying functioning as a human person, it is difficult to defend the limitation of good health care only to those who have the financial means to pay for it. Pope John XXIII identifies it as a human right:

"Beginning our discussion of the rights of man, we see that every man has the right to life, to bodily integrity, and to the means which are suitable for the proper development of life; these are primarily food, clothing, shelter, rest, medical care, and finally the necessary social services."

—(*Pacem in Terris*).

The Right to Health Care

The first issue to be decided about health care is whether it is a right of man, because this fundamentally determines the role of government in the provision of health care. We support the position that it is a basic human right, that the responsibility for fulfilling this right rests with both the individual and society, and government as an instrument of society must assure an adequate response to this right.

We favor a national health insurance program under governmental auspices, which will bring into reality the rights of individuals and the responsibility of society.

Public Policy

The question of health care as a basic human right is being faced by this Nation. Pragmatic considerations of fiscal and administrative feasibility are

essential to any discussion concerning the manner of making such rights, once recognized, truly meaningful and operative. But we have not yet taken those steps necessary to make health care a recognized right of the citizens of America. We are seeking the development of a broad consensus on the part of this Committee and the entire Congress that health care is a basic human right, akin to the right to life guaranteed by our Constitution. We make our recommendations with a firm conviction that social justice demands that this Congress approach the problems in health care not as a philanthropist, "doing what it can for the people," but as a principal avenue for doing what must be done.

We must affirm the dignity of man and assure adequate health care to all Americans as a necessary outgrowth of this belief, and design a system of health care on this premise.

Equality of Right

Viewing health care as a right, we cannot support any proposal or policy which would not provide or encourage the delivery of health care on an equal basis to all, regardless of race, religion, national origin, or ability to pay. Other factors such as the fact of employment, size or source of income, residence, age or family situation, could influence the financing of health care or its mode of delivery, but they should not serve as a basis for advantage or impediment of a substantial nature in obtaining health care. Just as in employment, education and civil rights we are eliminating obstacles to equality, so in health care what obstacles of this nature exist must be eliminated.

In too many governmental programs a type of second class citizenship has been fostered, developing problems far more divisive for our social fabric than mere neglect. We cannot solve our health problems without an understanding of American society today as painfully divided in many ways according to these nonessential characteristics of men. We will not accomplish anything for health care or for society in the broader sense, if our solutions are not based on an equal right to health care for all Americans.

Considerations of a fiscal, administrative and technical nature are all clearly relevant but should not overshadow or compromise this basic principle. Even though proposals may seem more convenient from the point of view of fiscal predictability or actuarial certainty, we cannot support them if their effect, even on a short term basis, is to deny an equal right to health care to any class of citizens. We do recognize, however, that the goal we seek—an equal and effective right to health care for all Americans—cannot be accomplished overnight. Many steps must be taken in a broad program toward this goal. But in the process of reshaping the health care system we are convinced that further inequities, however temporary or supported as "feasible," do not serve the goal of equal health care as a public policy and moral commitment of this Nation.

Eligibility

We support those proposals which will move us closer to the standard of adequate equal health care for all Americans. Those qualifications and eligibility criteria which tend to place various members of society at greater advantage or disadvantage vis-a-vis access to necessary health care fall outside this standard. There are many bases upon which governmental programs have been made available to certain segments of the population, and not others, which may have operated fairly for those programs. In health care, viewed as a right, there is no place for these kinds of factors. We, therefore, support national health insurance and service delivery programs which would provide universal coverage for all United States residents.

Health care should be rapidly made available without regard to whether a person is a taxpayer, employee, poor or wealthy; in a region served by a hospital or even a physician. Where these obstacles exist, they must be removed.

Equal access to the means of maintaining health does not exist in America today. Certain individuals enjoy the ability to spend whatever is necessary for their health care; while others cannot afford preventive care, a routine (preventive) physical examination, or even emergency care. Other hindrances and inequality are the result of geographic factors and urbanization. In many rural areas there is no physician, no system of health care and no hospital. For some this means travel which is inconvenient; for others this means travel which they cannot afford. Inconvenient hours, long waiting periods, unpleasant sur-

roundings, psychological or language barriers, and complex qualification procedures all constitute factors which deter persons from seeking health care and must be considered in the context of eligibility. It is one thing to provide a right on paper, and altogether another thing to insure that the right exists in effective measure. If enough of these deterrants are operative, it is meaningless to be technically "eligible" for benefits.

Unless we remove the serious obstacles to obtaining services necessary to maintain a decent norm of health, economic advantage will continue to play an unacceptable role in determining who shall get care and who shall not. We urge that this Committee explore ways to minimize those factors which are serious obstacles to obtaining health care, and to look beyond the mere availability of payment for care as a sufficient entitlement or eligibility under a national health program.

Health Education

At this point, we would stress the need for health education as a necessary component of any national health program. There are several well known efforts of the federal government in this area; its anti-smoking campaign is possibly the best known. There is evidence that the anti-smoking efforts have had a significant impact on the smoking habits of the nation. National health organizations have produced material for newspapers and television, with good appeal. We urge that these rather limited examples be broadened and better coordinated both by the government and by the voluntary health sector.

Any national health program should include reimbursement for approved health education efforts by providers of care, particularly comprehensive health care providers, toward better health habits on the part of the general population. This would include public messages which encourage individuals to maintain a proper diet, have a regular physical exam, avoid excessive or inappropriate use of drugs and alcohol, and how to recognize the warning signs of various diseases. This would include many of messages that are now transmitted by media. It should also include organized classroom health education of enrollees of health organizations and members of the general public.

A large part of pre-natal care consists of counselling in personal nutrition, proper exercise and weight control and is accompanied by occasionally outstanding aids in motivation and psychological preparation for maternity and child care. Most industries urge an annual physical and encourage exercise by their employees. But apart from infrequent and scattered exposures, the majority of the population simply does not have reliable personal health maintenance information conveniently available.

Help with health maintenance and personal health care would be welcomed by all of us. It is efficient, sparing the physician's time. It is desired by a large portion of the reading public, if the contents of popular magazines are any indication. A number of "family" or "women's" publications have a regular column on personal health, answering readers' questions and featuring articles on diets, exercise and "how to live longer." This advice, while it fills a need, is not systematized and is frequently unrelated to what an individual wants to know about his personal health situation.

Some very promising efforts are being made by physicians in primary care, family medicine or related practice who present formal classes in health education for their patients, occasionally as a requirement to continued care of the whole family. Hospitals are presenting health education classes on the broad subjects of how to take care of yourself and how to know when you need care. Public health efforts in this area have been widespread, but directed at limited population groups.

In summary, we urge that as a supplement to any national health program, federal support for the following types of health education programs:

(*a*) Continued and broadened use of media to encourage good health habits, and proper use of health care services.

(*b*) Support for organized public and patient education by health providers in a "classroom" situation.

(*c*) Support for research, publication and wide distribution of personal health education materials of professional and popular usefulness and acceptance.

President Nixon in his Health Message of February 18, 1971, announced the creation of the National Health Education Foundation. What the role of this organization might be in health education efforts remains to be seen. The President's action does, however, demonstrate the kind of recognition necessary for health education as part of our national health policy.

Without adequate tools, through an organized and continuing health education program, personal responsibility for maintaining health is an illusory concept. If individuals are expected to accept their obligations for their health and the health of their families, health agencies must reach out and create the kind of understanding that will promote sound individual action.

Benefits

As part of a national health program, services should be made available over a broad range that is designed to promote and maintain health, not merely treat disease. Any national health insurance program should also include provisions for payment for direct health services plus the supportive activities which have been demonstrated necessary for effectively serving the poor, the aged, the disabled and those with special health problems such as alcoholism and drug abuse.

A multiplicity of independent providers now offer these various services to some degree. Some of the essential preventive and diagnostic services are not available in anything approaching an adequate supply. The range of services which should constitute the health care available to all Americans, includes services that are available; these must be more equally and effectively used. We also include services which our system must commit itself to developing. Each citizen should have available:

1. Physician care with emphasis on a freely chosen, responsible physician for every family, properly supported by paramedical personnel and as part of a multi-specialty arrangement among physicians organized to permit and facilitate referrals and consultation as necessary.
2. Emergency care with follow-up under the primary care physician's supervision.
3. Hospital inpatient, outpatient and clinic services, as effective in the provision of preventive, diagnostic and acute short term care, including psychiatric care.
4. Long term hospitalization and long term health related care in facilities which provide nursing care, therapeutic or rehabilitative services.
5. Dental care.
6. Prescribed drugs.
7. Home health services, outreach and intake service, including transportation, nutritional consultation, personal and family health education, medical-social services and physical therapy services.

The present system does not deliver this comprehensive range of services to every American. What can be seen from the listing of benefits is that health manpower must be trained in a different manner, providers, including physicians, must adjust to different service patterns and additional service techniques now largely experimental will have to be perfected.

The health care system within itself, has both the means and the latent ability to delivery many of the health care services we have described. Just as H.E.W. was recently able to fund over $5 million for the development of experimental HMO's by 52 interested organizations on a voluntary basis, the will to change the mode of delivery and possibly the nature of services delivered can be found within the present system. However, estimates for funding a single HMO through the planning, development and initial operating phase are up around that $5 million figure. Therefore, it does seem necessary to use federal programs which purchase health services to influence the delivery system. To rely on grants and federal capital alone, even with the other external influences such as health planning, would constitute a more expensive approach toward improving the delivery system than we care to estimate.

Changing the Delivery System

The question of what kind of health services shall be delivered is not nearly so difficult as questions of how to deliver and finance it. However, there has been strong correlation between the availability of funds, insurance payments typically, for certain types of care and the long term production or availability of that type of care. In the opinion of many, the health care system in the United States has overemphasized episodic acute care principally because financing it has been the primary goal of prepayment or reimbursement mechanisms. Therefore, even if we had an organizationally sound health care system, this system would not deliver comprehensive, preventive or primary care. We would have a highly efficient system for curing illness, but not preventing it.

We encourage direct moves to influence the delivery system through grants and regulation when soundly conceived, but wish to suggest two additional strong influences, first, the creation of personal demand for services and second, the availability of payment for them.

The ability of the federal government to influence the health care system merely through the purchase of services has been amply demonstrated under Medicare. But we have learned that the mere infusion of revenue into the health system did not produce more or different care. Medicare revenue was absorbed in wages, improvements, and a tremendous rise in prices. Additional financing may simply be absorbed in a continued inflationary rise in "costs" as we move to a national health insurance system, which we expect to deliver more and different types of care, the delivery system will have to be restructed to create cost controls.

A decided effort to not merely pay for what is offered but to induce the production of desired services at the same time we are building the resources necessary to provide them can produce a balanced change. Conversely, as we encourage the development of comprehensive delivery systems, there should be funds available to pay for their broadened range of services on an ongoing and stable basis. This coordination need not be mathmatically precise, but the likely effect of overemphasizing either the development of new delivery systems or the creation of additional service demands through insurance should be apparent.

We are suggesting, in the description of the "benefits" which should be available under any national health program, that these benefits also be considered goals for development in a much broader program which includes:

1. Effective coordination of all governmental and private systems which effect health.
2. Stimulation of service production through availability of payment for desired services.
3. Stimulation of improved delivery systems through direct impact through sound planning and regulation of providers.
4. Stimulation of improved delivery systems through grants, contracts, capital formation and assistance.
5. Stimulation of resource production through structured aid to health professions education and facility construction.

Merely insuring acute health services would not only put unreasonable demands on the present system, it would also effectively perpetuate disease treating systems, without developing health maintaining systems.

The availability of payment, particularly from a third party, can also influence individual demand for services. Therefore, as part of any effort to encourage the health care system to produce more of a particular type of care, a national health insurance program should create personal economic incentives, or a lack of economic deterrant to obtaining preferred care, such as selective health screening. Coupled with a personal health education program, this could produce a more natural restructuring of the delivery system than other means such as required services or relationships between providers or enforced ratio of specialists to family practitioners in a federally supported medical school.

Financing Health Care

Source of Funds: The foundation of the financing mechanisms for health care should be a social insurance system. It should be an insurance system as a means of spreading the risk and of encouraging people to plan for their future needs in a provident manner, and assuring the security of contributions. It should be federally operated social insurance available to all members of society and covering all the normally necessary health maintenance services on a non-indemnity basis.

Services should be covered throughout the period required in order to distribute even the costs of a catastrophic episode throughout the widest societal base.

Contributions can be derived from employers, employees, self-employed and non-employed with independent means. For those unable to contribute in any of these ways, public funds should be made available to provide for their contributions to the insurance system.

The level of income subject to the tax for health insurance should be sufficiently high to assure that a disproportionate tax burden does not rest on those in the lower economic brackets.

The cost of total health care is very high, probably not completely insurable. There should be general revenue funds contributed to the financing of health care to compensate for those unable to contribute and for those risks which may not be strictly speaking insurable by contributions.

B. Cost Control

Methods of paying for health care which place a heavy burden on the sick, through large deductibles or coinsurance payments, distribute the responsibility for cost inequitably, and place it frequently on those least able to pay. Disease, accidents, and other occasions of the need for health care cannot in many instances be prevented. If deterrants to unnecessary utilization are desired, other mechanisms such as effective utilization review and peer review should be used. The threat of serious financial penalty attaches to those in real need of care as well as those who would abuse the system, a rather unjust method of problem-solving.

Actual utilization experience under Medicare indicates that the improved ability to pay for acute care did not overly increase the utilization of hospitals by the elderly. However, the continued increase of the Medicare deductible to $68 may have the effect of preventing hospitalization at the earliest opportunity, when illness could be treated more effectively. We are not willing to err on the side of delayed or denied care with a theoretical deterrant to unnecessary utilization as our justification.

We do believe that the principle of payment according to ability, and the sense of responsibility and right that is maintained, can support deductibles, co-payments and other cost sharing devices, provided that they are reasonable in amount and are consistent with a sharing of the cost of care according to ability to pay and not simply with the incidence of illness. The fine balance between cost sharing provisions which preserve individual responsibility and those which unproductively burden the sick cannot be struck in a vacuum.

We look to systems and incentives within the "provider" or external to them, not the patient, as principally responsible for cost control. The design of cost controlling systems, such as budgeted prepayments and peer review, is a responsibility that this Committee and the health care industry must face in the context of a demonstrated failure of cost reimbursement and personal cost deterrants to control inflation. A transfer of financial risk by budgeted prepayment to the provider may offer the incentive needed to develop these cost control systems.

The Delivery System

A principal problem of the health care system, is, to use a cliché, that it is a non-system. There are insufficient relationships between providers of health care to insure a coordinated approach to health care needs, and there are few incentives to integrate. Institutions and professionals operate, to a large extent, on autonomous bases within separately determined goals and limitations. Thus, there is an overall lack of efficiency, duplication of effort, maldistribution of facilities and professionals and a lack of coordinated care of the patient. Health planning at all levels has been ineffective in resolving these problems.

Until recent years there were few external restraints on the decisions of providers to buy equipment, or expand services if they could afford it. The initiative for a new program or capability might come from physicians, government, or individuals. Since until recent years physicians typically had little opportunity to share formally in hospital management responsibilities, they are unaccustomed to considering the financial consequences of their impact on the hospital, either in the purchase of specialized equipment or in the use of basic

services. Thus, a principal determinant over the use of hospital services by an individual patient, and over the development of the hospital's overall services were individual physicians who were motivated by considerations of personal convenience, efficiency, third party insurance coverage and the development of a specialty, among other factors.

It is possible for hospitals to blame physicians for reckless disregard of costs and efficiency; it is likewise possible for physicians to blame hospitals for never giving them meaningful opportunities to participate in the management function. Proof of accusations is of no assistance in discussing what can be done now to integrate providers, but in a sense both statements are true. There has been an insufficient sharing of responsibility by physicians and hospitals, both with each other and with representatives of the public interest.

Planning

In recent years there has been an effort to develop areawide and other health planning organizations to attune health providers to a broader-than-themselves frame of reference in dealing with decisions to build, add, expand or reduce services. The effort has been to create plans based on the health needs of the community determined on an organized basis, apart from the manner in which a particular institution might perceive these needs. Without carefully developed and respected plans, which state the needs of a community, it is difficult for one institution or professional to look beyond its own needs.

Health planning under the auspices of the Partnership for Health Act has been a limited success. In some areas it has served very well to temper the internally developed goals of hospitals, physicians and others who influence delivery system decisionmaking. The tempering has come with a requirement to justify plans, typically for major construction, in terms of professionally documented plans agreed upon by community representatives. Where the documentation of health care needs has been successfully challenged or where community representatives cannot agree on specific plans, planning activities are somewhat of an academic exercise. To some they are that anyway, since there are few sanctions available to areawide planning organizations under Section 314(b) of the Act, and sanctions under Medicare have been part of H.R. 1, before this Congress for nearly two years.

The role of the areawide and other health planning agencies must be strengthened. This is particularly important since it is likely that under any national health insurance system something of the voluntary planning activity now carried on, external to the institutions and health care system will be needed. Continuous community comment and input is required to insure continued adaptation to community needs. We will detail our view on that topic later in our testimony.

We believe that the external agencies can compensate for a lack of integration and coordination in the present system, but their role as regards to particular institutions is limited by the fact of being outsiders and being limited to rather major items, such as—whether to build a new wing. Permanent relations must be built among a large proportion of the presently unrelated providers before the system needed to produce a national health care program will be produced. The creation of these relations is better accomplished by internal negotiation and development rather than external imposition.

Delivery Level Integration

Widespread integration developed voluntarily at the level where health care is delivered, seems the best approach if health care as a right and as part of a national system is to be realized. Without it, national health insurance or some other refinancing of health care, alone, will not solve the problems of lack of access, acute care orientation, cost inflation and lack of comprehensiveness. The care provided will in no sense be comprehensive and able to be readily coordinated to meet the needs of each patient from within the system unless basic changes are made at the delivery level. Without integration, the cost controls possible with direct provider prepayment are not available.

Providers of health care, as presently organized, could adapt to a national health insurance system, as they have under Medicare. But from the outset of any such system, and actually as a needed preparation for it, substantial incentives should be made available for the voluntary development of organized comprehensive care systems. These should bring together under a unified management system all the normally necessary services and facilities to provide health

care to a given patient population. Some of these organizations are commonly known as Health Maintenance Organizations, a generic term encompassing many variations on a theme. Some represent steps along the way to integrated comprehensive care, others go far beyond the minimum. Most incorporate the principal of level prepayment for care, or "capitation".

This is not to say that we believe that all health care must be provided through this delivery mode. We do favor access to all necessary services through one contractually responsible entity as a distinct improvement over the present method. In a health system, which has only begun to look at itself, one can say with confidence that at the present time this method, or the philosophy behind it, represents a restructuring which should preserve the elements Americans expect of social institutions. However, to say that anyone has the last word, the final solution at this stage, would be irresponsible.

We are encouraged by the development, just in the past year or so, of a large number of new prepaid comprehensive health care projects. Most are only in the planning stages, a few have actually begun to see patients, all are experiencing a wide variety of problems, but there is a significant movement, and it is to a large extent purely voluntary. There is no federal legislation specifically to encourage prepaid comprehensive health care programs, although some financial support has been granted through the auspices of the Partnership for Health Program. There is no requirement under law that these plans develop. For the most part, there is little federal control over their structure, financing, benefits or quality controls. These new projects are in addition to several other well established plans. They are being put together by many people who may not have been associated with the underlying concepts of either prepayment or comprehensive service organization prior to their current efforts. Several Catholic hospitals are involved in these projects, for example—in Milwaukee and Marshfield, Wisconsin; in Washington, D.C.; and in Albuquerque, New Mexico. Some of these projects hold great promise for widespread acceptance and successful operation.

The significance of this development is that the health industry has begun to rethink some basic premises of operation, to face some of the problems and criticisms of recent years and seems to be about to begin to put its house in better order. We wish to express our hope that this Committee and this Congress will agree that many of these efforts are essentially experimental, but rest on sound economic, medical and social premises.

Whether the experience of these prepaid programs is transferrable to dissimilar population groups, areas of the nation, poor urban and rural areas, previously unassociated enrollees and the elderly are questions few would be willing to answer at this point. It is important that this Committee and the Nation objectively study these prepaid comprehensive care programs and fairly compare them with our traditional system.

Insuring Care

The present reimbursement or indemnity systems of insurance, including Medicare, have provided payment for care from a single source. This partial coordination of payment or insuring against cost has had little coordinating impact on the range of service financed, and may have tended to further fragment the system. For example, requirements as to the situs of care or previous hospitalization have tended to artificially emphasize factors which are more for the purpose of assuring the validity of claims or focusing on costly services than any other reason. Similarly, the separate part requirement for extended care facilities is for cost finding purposes, and it has disrupted continuity of care in many situations.

Admittedly, when the payor is outside the institutional and professional organization, it will attempt to simplify proof of claims and the computation of payment in order to assure that it can control its payout. Under private health insurance, this has meant emphasis on institutionally based care where outpatient or office care would suffice. Thus rather than encourage integration of care, efficiency in the use of less costly methods or permit cost savings to benefit the institution, conventional health insurance has merely paid for actuarially contrived types of care "benefits."

Prepayment for Care

Prepayment directly to the provider of care reduces the need to pay for care according to predetermined categories, and can transfer the risk from the insurer and patient to the provider. This also reverses the incentives to increase

revenues by replacing them with incentives for reducing costs and, potentially, decreasing services. This latter factor may result in subscribers seeking services outside the prepaid program.

Several of the prepaid health programs have not eliminated the insurance function entirely. They regularly pay for varying kinds of services rendered by others, at charges set by the other party. Prepaid programs may never eliminate the need to pay for some services outside their own organization. However, for the development of effective incentives toward cost control and for true comprehensiveness, a degree of control over all necessary services is essential. There are two essential components—physician services and hospitalization.

Physical Component

Most prepayment to the provider for health care includes the prepayment of physician services and an opportunity for the physician to participate in savings which result from more efficient use of hospital services and other non-physician care components. Unless physicians, for example, benefit from a reduction in unnecessary hospitalization, and if it remains more convenient to see patients in the hospital, even for testing, the most important control over the provision of hospital care continues without strong incentives toward integration and cost savings.

Decisions as to medical necessity or appropriateness must be that of the physician. No non-professional mechanism of which we are aware can compensate for a lack of incentives operating among physicians to reduce unnecessary services to provide services in a more economical setting, provide them at an earlier and more effective time, or provide them in a preventive and diagnostic effort.

Placing physicians "at risk" for the cost of care, and reversing their present lack of incentives to control costs does not mean, however, that they can be placed absolutely in control of the prepaid amount. There is really no risk if you are totally able to control your own share. Some prepaid programs place incentives in terms of additional compensation, peer review and pressure and management controls before its physicians, but they also do so within the context of a budget for professional service which must be respected. Both aspects of control over the distribution of prepaid revenue are essential to the development of incentives to control costs. Without the incentive of budget limitation over physician services, and allocation of prepayment to other service and components of a comprehensive care program, there is no meaningful risk on physicians since expenditures in other areas of non-physician services can be curtailed to compensate for an increase in physician costs.

This does not exclude fee for service as a method of compensation to the individual physician. It does require that within a system which is financed by prepayment, some limit on payment for physician's services be established as a group with incentives for efficiency and economy operative above that limit. This is also not to say that budgeted payment for physicians' services is essential to the entire delivery system in the United States, or that other delivery models could not achieve the improvements in reduced hospitalization, broader services, improved access and higher quality. Indeed, many of the newer programs and some not yet begun may prove far more able to solve our health care problems. What must be recognized is that prepayment to physicians for comprehensive care, and even prepayment to a physician-hospital complex is not the whole story, and these variations must independently prove themselves as capable of the improvements over the existing health care system.

Hospital Component

Direct involvement of hospitals is also essential to a full realization of prepaid comprehensive care. Mere prepayment for care to physicians or others who then arrange for hospital services on a risk basis is an improvement over the present system; it does not go far enough. It is difficult to inject incentives to reduce hospitalization or restructure services into a hospital that stands to lose operating revenues as a result. Some prepaid programs can "arrange" for hospitalization within the meaning of, for example—Section 227 of H.R. 1, and would qualify as a prepaid provider for Medicare purposes. Yet, the significant cost savings which can result from lowered hospitalization and the overall aim of integrating health care into a more rational system are only partly realized. Hospital care is still arranged by outsiders to the hospital management and influence its decisions regarding the provision of services in competition with traditionally based and compensated physicians. This type of plan is clearly a step in the right di-

rection, as is prepaid group practice or simply multi-specialty group practice, without prepayment. But it does not represent the degree of integration which will have to be achieved if a national health insurance program is to guarantee equal and effective health care to all Americans as a matter of right. Not enough of the present problems can be solved without an integration of hospitals into the prepaid program.

Negotiation-Subscriber Representation

A third component of the preferred prepaid comprehensive health delivery organization, at this time a most promising model for improving the health care delivery system, is the concept of subscriber representation. This factor represents the vehicle which can provide a balance of competing interests among provider components to insure that the goals of the program do not get lost in professional and institutional pressures.

Prepayment to providers, whether hospitals or physicians, or a unified organization composed of both, may require the tempering of an enrollee-representative body or adequate substitute. In the existing plans these bodies vary in composition, representation and responsibility. The prepaid board contracts with subscribers for services and accepts payment of a level capitation rate, and in turn, negotiates and contracts with its hospitals and physicians, separately, for services under the program. This is not consumer control; neither is it provider control. There is a tempering and representative agency between the subscriber and the health professionals and facilities which acts to some extent the way the federal government has proposed in the negotiations of prepayment contracts under Medicare.

We would propose that in encouraging the development of vertically integrated comprehensive health care programs, that the federal government prefer those plans which establish a non-provider entity which performs the negotiating function, subscriber vis-a-vis provider, but that the negotiator be as representative of the subscriber as possible. Ideally, with subscriber-representatives doing the negotiating, much of the potential for underutilization and a sacrifice of quality for reduced costs in a simple prepaid-provider system could be mitigated.

We believe with the proper development of prepaid comprehensive health care plans covering a significant percentage of the population, the role of government could remain supportive and supervisory. Unless the changes implicit in this statement take place voluntarily, as they could, a more active, indeed dominant role, might be forced on the federal government in order to insure an equal right to health care to all Americans. The system of national health insurance we see possible at this time must recognize the imperfections as well as the healthy diversity of the present system, but move positively toward its improvement.

Administration

As we move to a health system which is increasingly financed through federal revenues of various types, we strongly recommend that the distribution of those funds be through a system which avoids the potential for development into the largest bureaucracy among all federal activities, with the problems that may imply. We are not convinced that a massive governmental administration along conventional lines would be sufficiently responsive to the varied health needs of our complex society over the long run. It is true that government can act quickly and dramatically in dealing with some problems, but as much as one might wish a quick, simple and dramatic solution to our health care problems, we know that it will take time and will not be a simple matter.

Our recommendation is based on the same premise as the requirement for consumer and voluntary involvement in the Partnership for Health Program and the Office of Economic Opportunity's Healthright programs. It is also based on the experience of many of our American institutions during the last decade. It is no longer possible to provide vital services to people, particularly under government sponsorship, and exclude them from a voice in the program. As the consumer of health care shifts his focus to the government as responsible for health care, government must prepare to cope with the almost inevitable demand for a forum. The administrative framework that we recommend could be as readily adapted to the Medicare and Medicaid programs as it could to a national health insurance system. There is nothing inherent in any federal program in health that prohibits a significant partnership with voluntary agencies and a high degree of consumer representation.

Our recommendation is to incorporate community representation at every level of administration, from the national down through the regional or state to the last local federal administrative unit. Just as the Migrant Health Act was amended to require consumer involvement after a history of unresponsive relations and services to migrants, this requirement should be in federal health service programs from the beginning. Our own hospitals have seen this need and provide community input through the mechanisms of advisory boards and representation on Board of Trustees.

Citizens, consumers and community representatives are rightfully demanding a voice in governmental and institutional programs that deeply affect their lives. Basic choices in the delivery of health services can affect the right to health care, indeed the right to life. It seems most appropriate to give recognition to a need for close attention to the needs, desires and expectations of the people for whom the program is intended to operate and benefit. To keep the health care of this Country responsive, able to meet new needs and local circumstances, and to commit it to progress from within, we should build forces for change and private input directly into the system.

CONCLUSION

It is recognized that the Nation's health care problems will not be solved overnight. Legislative and voluntary steps on a broad range of items will be required over the next years and decades. It would be realistic to admit that health care will constantly pose new problems, offer new alternatives and demand almost continual adaptation to changing conditions. That seems to be the nature of the world we live in; there simply are no solutions, programs, institutions which will meet human needs for all time. As you probably know, this is now even true of the Chruch. We are going through a period of change, and it is not always as comfortable a process as one might wish.

Social progress is a factor which must be recognized and built into the system of health care we design. Just as the best that society could do ten years ago is rapidly becoming obsolete in health, education, civil rights and the environment, among other areas, the best that we are able to provide by way of health care and health care systems today should be expected to improve, develop and reflect man's rising expectations. We recognize there may be some answers today for today's problems, some pretty good ones, but throughout our comments we urge you to remember that we are suggesting what we see as the best direction based on what we know now. We would hope that any actions taken on our recommendations and those of others would be such that health care can continue to change as needs and times demand, and that this change not become totally a matter of Congressional action at every step.

Monsignor MURRAY. I thank you for this opportunity to appear before the committee today and also for the permission granted to incorporate the testimony that we have presented to the committee so far, as well as the testimony that we will be presenting orally for the record of the committee.

We are here today to assure you that the Church and its health care facilities are deeply concerned with the state of health care in America, and we wish to take this opportunity to pledge ourselves to support the many improvements in the future as we have contributed to the health care of our Nation in the past.

However, I would like to pause a moment and inform the committee of the tremendous contribution the Church has made, not only in the health care facilities, but also recently, during the past year. The American hierarchy conducted a campaign for human development, directing funds to aid the poor in our Nation.

Through our campaign offices and its board, there have been many, many programs that have been approved, and the campaign for human development has allocated the amount of $242,564 in the area of health care for the poor of our Nation. This just further states the commitment the Church has made to the health care of our people in this country.

Sister Maurita will first present our position on the nature of society's responsibility for health care of its members. Monsignor Corcoran will follow with a statement regarding the need for special attention to the health care needs of the aging. Then, I will make some specific recommendations on how this might be accomplished, time permitting.

Let me say that Sister Maurita and Monsignor Corcoran represent a tradition of service and experience in caring for the sick and the aged. Without their combined counsel and advice, it would be difficult for us to appear here today. The two organizations and individual members of each are an extremely important source of advice from the practical point of view. As you well know, there is nothing like on-the-job commonsense, especially to those of us behind our desks in Washington.

I would also assure this committee that we are very proud of the accomplishments of individual physicians, hospitals, nurses, and administrators, as well as other paramedical personnel. While we may criticize the system in which they work, and point out the problems of that system, this should not be taken as a criticism of their performance. Our comments are in a spirit of progress, building on the past, and carrying out the spirit of their personal dedication toward better health care for all men.

Sister Maurita?

Sister MAURITA. Thank you, Monsignor.

I am Sister Mary Maurita, with the Catholic Hospital Association, located in St. Louis, Mo. Because of my involvement along with members of our staff in the development of the statement of the U.S. Catholic Conference on National Health Insurance, the concepts and principles which we subscribe to are documented in this statement for the record.

My brief appearance here, as well as presentation this morning, is to highlight the points made by Monsignor Murray and Monsignor Corcoran.

There is no question that the access to health care is a right of every person. Acceptance of this premise then leads us conclusively to the need to establish by law the relative responsibility of the various components of our society to protect and preserve that right of man. It demands further, that we describe specifically the ways in which this responsibility is fulfilled consistently with the individual's and society's concern for the dignity of the person.

> Dignity does not derive from a man's economic situation, nor from his vocation * * * it rests exclusively upon the lively faith that individuals are beings of infinite value.

Abraham Lincoln had great insight in these matters. He said:

> It is difficult to make a man miserable while he feels he is worthy of himself and claims kindred to the great God who made him. In our reconsideration of the Great Truths of the Declaration of Independence, we need to be reminded of these things, lest our perspective become distorted.

This concern for the dignity of the person goes beyond the boundaries of health insurance, obviously, and into the realm of a total health program and the quality of life.

Before these hearings are concluded, thousands of words will be spoken about health care systems, cost controls, provider reimburse-

ment, financing mechanisms, planning for health care, and similar pragmatic components of health insurance. We wish to make certain that due concern is expressed so that we can identify as priorities:

1. Preventive care programs.
2. Health education programs.
3. Health maintenance programs.
4. Systems that give people the right of choice.

Basic to these concerns, we need and would support a system that does not stifle, nor eliminate the private or voluntary component of our health delivery system for Americans. Our health system is, and should continue to be, primarily voluntary. This is not to say that we do not accept the notion of controls and regulations as long as they tend to lead to better coordination of all the components of the health care system, including physicians, and as long as there is a mandated involvement of provider representatives in the decisionmaking process.

Present debate over health care is almost totally concerned with programs of service for sick people. We maintain that a new priority must emerge, and that is a system designed for the prevention of illness through the elimination of the causes of ill health. The statistics dealing with our poor record in some areas of health care are not going to be improved solely by doctors and hospitals. In fact, the root causes—poverty, poor housing, malnutrition and the subhuman environment of certain segments of our population will have to be corrected before we in the health field can hope to change the record. In our opinion the best way to deal with the problems of infant mortality, lead poisoning, rat bites, drug dependence and the like, are not really cures, but prevention through removal of the root causes. I submit, without attempting to disavow our involvement in these programs, that the primary goal of any national health program is to promote an environment which makes good health possible, not just curing illness, and must be considered in our overall concern for the quality of life. Health and quality of life are interdependent, improvement of the Nation's health will undoubtedly improve its quality of life.

Parallel to this point, and perhaps one of the best ways to get at it, is a massive well organized and well financed program of health education. We see many benefits in the scattered, public service messages' programs aimed at smokers, drinkers, the accident prone, drug abusers and the like. However, if we are to see any substantial motivation on the part of all people to desire good health or possess physical well-being, a national program must be aimed at every age level and social component in terms which are acceptable and understandable. Furthermore, such an effort must create an awareness of personal responsibility for maintaining good health. Every medium available must be used, including the health system itself, the news media and a latent but potential medium—the churches.

I reiterate that we must get at the roots of the problems and focus on maintenance of health and quality of life, not just the myopic focus of curing illness. I am convinced that a reallocation of our resources toward prevention of disease, health education and a healthy environment, from those earmarked for cure of illness, could result in a substantial decrease in those dollars needed and absorbed in and by acute care services.

Before we become too concerned with the partnership of Government and the private sector in health, let's also make sure that we stress personal involvement, because each citizen has a basic responsibility for his own well-being, which only he can attempt to fulfill. One of the surest ways to erode this responsibility is to project and to promise a response for every illness with a system to delivery such services without priorities and constraints.

The organization of which I am the executive director, the Catholic Hospital Association, in its statement of purpose clearly mandates itself to the dignity of man through the provision of all levels of health services which contributes to the well-being of all men—hence the total good of our society. It has done so voluntarily in a spirit of dedication and spiritual motivation as reflected in services of excellence through many decades. We recognize that there are gaps in our system and the health system in general as reflected by society's still unmet and/or poorly financed health needs.

Finally, systems and programs which restrict a person's rights to choice, and which stiflle the initiative of provider, of health services to seek out and help those people will, in the long lead to total reliance on a Federal system which could be inflexible, unimaginative and insensitive to needs, and thus could hinder the common good. Great care must be taken to strike the proper balance between those matters in which Government has a role and those which are best developed privately. There must be sufficient incentive for all providers outside of Government to exercise initiative in the delivery of health care. We have inadequacies, to be sure, but they are not because of a lack of dedication, motivation or a sense of purpose. We request the opportunity to build on our individual and collective strengths, and therefore, strongly urge that we move beyond the debate of the weaknesses of our present health delivery system.

The board of our association recognized this need in an official policy statement supporting comprehensive health care when it said in 1968:

> National and local organizations of physicians, other health professionals, hospitals and related health facilities must devote a considerable share of their time and publication to joint discussion of broad community health problems and the alternate solutions to those problems, particularly those already proven successful.

It is our opinion that the personal involvement of physicians is essential since the physician's role is the key one in any attempt to restructure the health delivery system. I am cognizant that they are going to have the basic attitudinal changes on the part of many and especially physicians to achieve the health care goals that are being discussed in these hearings and across the country.

Within our Catholic hospital system comprised of 750 hospitals which make up 28 percent of the acute nongovernmental beds in the United States, and speaking on behalf of our board of trustees which represents 350,000 lay coworkers, 11,000 religious men and women, thousands of physicians, and hundreds of thousands of volunteers, we pledge ourselves to work cooperatively and constructively in the future as we have done in the past.

We urge and recognize that the health and citizens will improve when we move from an episodic health mentality to a preventative

health care oriented society. This requires an all-out continuing health education effort coupled with getting at the root causes of social and economic ills which afflict many segments of our society. We urge the development of a comprehensive health care delivery system which provides equal access for and is available to all citizens, a system which allows for a free choice of services.

We urge the continuing viability of our voluntary or private sector of health providers in a balanced partnership with Government, especially as we restructure a comprehensive health delivery system for the future. This viability and balance involves involvement of the private sector with Government in setting standards for quality service as well as reasonable controls and regulations.

Furthermore, we urge that implementation of such a system be characterized by an orderly evolutionary transition in order to insure involvement as well as maximize our strength and resources for the total common good.

We are convinced that the future of this Nation rests on the health and the quality of life for all its people. As the Arabian proverb says, "He who has health, has hope, and he who has hope, has everything."

Thank you.

Mr. GIBBONS. Thank you.

Monsignor CORCORAN. I am Msgr. Lawrence Corcoran. I welcome the opportunity to join this morning in speaking to this whole area of health care and health insurance, and it is a matter in which we have great concern, also, even though we do not primarily address ourselves to such things as hospital services and so forth, although we are involved in them, and in social service departments.

I would reiterate the things that have been said by Sister Maurita and the ones that will be said by Monsignor Murray, and also the matters contained in the total statement we have submitted.

The fact that I do not repeat them does not mean that I do not adhere to them very strongly,

We just emphasize the one point of health care as a right by indicating an incident in the last couple of days. Some of our leaders of the charities movement cooperatively with those of our cohorts from the Protestant and Jewish welfare fields, and in discussing this matter, they practically charged me to say that they wholeheartedly concur from their religious convictions and from social principles that this is something that should be recognized as a right and should be established in law as such.

The reason why we say this is that if this is done, then many, many things follow from it. Practically everything that we are speaking about does follow from it, and so I want to make that point.

The matter upon which I want to focus today particularly is that which concerns the aged. This has already been mentioned, that it will be my focus. We do so because we feel that the aged have been particularly neglected, and when I say that, I am just repeating a cliche. Here everybody probably has said at one time or another, and we would hope in this whole matter of development of national health care that once again they will not—they will not once again be neglected, but they will be given the consideration which is their due.

This comes from the fact that their needs are tremendously great. They exceed, perhaps, the needs of others in this population. We

talk about this and the special needs they have and the special concern that should be attended upon these needs. The focus upon health care is particularly important, because health care is indeed increased in old age.

The ordinary physical slowdown which all of us experience is certainly experienced greatly by the elderly, and it is accompanied by and even caused by the many ailments. There is increased need for medicine, there is a need for health care of whatever kind, and this is more likely to become a permanent condition rather than one that can be quickly cured.

There are many things that point this out. The fact that the elderly represent 10 percent of the population, but 27 percent of the medical expenditures are for the medical care of the elderly.

Likewise, to repeat something that, once again, you probably have been aware of, the average aged person has more and costlier illnesses than the average young person. He is twice as likely to suffer with one or more chronic conditions, is much more likely to be limited in activity, is admitted to hospitals much more frequently and stays longer and uses physicans' services to a greater extent.

Therefore, they do have a special need of health care. This comes at a time when their financial situation has deteriorated. Income of the elderly, the median income is half of the median income of those under 65 years of age, and yet their medical expenses are more than twice, or as a matter of fact, more like three times those of the person under 65 years of age.

Therefore, any national program for health care must consider these facts. Therefore, financial assistance must be authorized, and funds appropriated which will be adequate to assure quality care for the aged, even though these are proportionately higher than funds provided for other age groups.

Another point that is especially necessary to be emphasized is the need of accessibility, because the elderly are certainly less mobile than other people, and therefore particular and special kinds of programs must be developed and emphasized in order to make up for this lack of mobility. They can't travel, they have to depend on others for such transportation, and they must await the delivery of health care to them in many instances.

Therefore, in developing a comprehensive health care system, special methods must be provided for delivering care and services to the elderly. Provision of neighborhood facilities, extension of more care to the home, inclusion of transportation assistance and other outreach efforts must be built into the health care system for the benefit of our older citizens.

Many older people will need long-term care on an inpatient basis. This is something I referred to already, that they go to hospitals more frequently and they stay longer. Therefore, this is a particularly difficult problem. It is an expensive problem, presents many more problems, but yet at the same time none of the present legislative proposals adequately provide for this.

Medicare and medicaid programs have restricted it. In the first instance, therefore, such long-term care must be made part of the health care system and adequate funding provided for it. And to as-

sure the proper quality of long-term care, Federal standards must be provided for these facilities.

I think we are all aware of the scandal of the terrible condition in nursing homes and other similar type facilities across the country. Occasionally a fire breaks out, people are killed, and people get indignant, but nothing is done. The standards must be made of the type that will take care of the needed type of facilities for these people.

We should not only attend to the basic health and residential requirements of the elderly, but also provide those auxiliary aids which are so greatly needed. Here we particularly think of rehabilitation programs, social services, and creative recreation.

Dr. Kosan, from England, in testimony before the Senate committee on long-term care, made a very pointed statement that is important. He says there is little point in organizing purely medical units for the solution of sociomedical problems. We are speaking about a sociomedical problem here, and we hope this would be very much uppermost in the minds of the committee and Congress as they address this problem.

Incorporation of long-term care into the health care system should be on the basis of the services provided rather than on location of the facility. This suggests a more flexible definition of and reimbursement of skilled nursing homes in intermediate care facilities. At times, the same type and quality of care is given in each.

What we plead for, then, is proportionate attention to the need of the elderly for health care. This may mean care that is more extensive than that given to the average adult.

Nevertheless, it must be judged in the relation to health care needs of each age group rather than quantitatively measured by the amount of care which each group receives.

We can assume no other position when we state that health care is a right, that comprehensive care must be given, and that coverage must be universal. This applies to the elderly, and we urge this committee and all of Congress to fashion the legislation which responds to their need adequately and compassionately.

Thank you.

(Monsignor Corcoran's prepared statement follows:)

STATEMENT OF MSGR. L. J. CORCORAN

I am in agreement with and fully support the presentations just made by Msgr. Murray and Sr. Maurita, as well as the complete statement which we have submitted for the record. In my observations at this time, I wish to concentrate on one very important segment of our population for whom our proposals have special significance. I refer to the aged.

The aged are faced with problems particular to their state of life which multiply and aggravate their needs. These needs must be met, and this frequently requires outside assistance—assistance over and above that required by the average adult. The net result is special consideration for the aged, and special attention to their particular problems.

Probably this special concern is nowhere more apparent than in the area of health care. The need for health care increases in old age. The ordinary physical slowing-down is accompanied by—even caused by—the many ailments which are likely to affect the aged. There is increased need for medicines. And, above all, the need for health care of whatever kind is more likely to be or become a permanent condition rather than one which can be quickly cured.

This greater need for health care on the part of the elderly comes at a time of life when their financial situation likewise has deteriorated. The median

income of the elderly is half the median income of those under 65 years of age. Yet, their medical expenses are more than twice those of persons under 65. Any national program for health care must consider these facts. Financial assistance must be authorized, and funds appropriated which will be adequate to assure quality care for the aged, even though these are proportionately higher than funds provided for other age groups.

Availability of health care means accessibility of that care. Those in need of it must be able to reach it, or it must be brought to them. This presents particular problems for the elderly, whose mobility is decreased and who are more fully dependent on others for transportation. In some instances they cannot travel and must await the delivery of health care to them, wherever they may be. In developing a comprehensive healfh care system, special methods must be provided for delivering care and services to the elderly. Provision of neighborhood facilities, extension of more care to the home, inclusion of transportation assistance and other outreach efforts must be built into the health care system for the benefit of our elder citizens.

Many older persons will need long-term care on an in-patient basis. This is most difficult and most expensive. It presents many probems yet it must be made available. None of the present legislative proposals adequately provide for this. The Medicare and Medicaid programs have restricted it. In the first instance, therefore, such long-term care must be made part of the health care system and adequate funding provided for it.

To assure the proper quality of long-term care, federal standards must be provided for these facilities. These should attend not only to the basic health and residential requirements of the elderly, but also provide those auxiliary aids which are so greatly needed. Here we particularly think of rehabilitation programs, social services, and creative recreation.

Incorporation of long-term care into the health care system should be on the basis of the services provided rather than on the location or facility in which they are provided. This suggests a more flexible definition of, and reimbursement of, skilled nursing homes and intermediate care facilities. At times, the same type and quality of care is given in each.

What we plead for is proportionate attention to the need of the elderly for health care. This may mean care that is more extensive than that given to the average adult. Nevertheless, it must be judged in relation to health care needs of each age group, rather than quantitatively measured by the amount of care which each group receives. We can assume no other position when we state that health care is a right, that comprehensive care must be given and that coverage must be universal. This applies to the elderly. We urge this Committee, and all of Congress, to fashion the legislation which responds to their needs adequately and compassionately.

SUMMARY OF WRITTEN STATEMENT

The Right to Health Care

The question of health care as a basic human right is being faced by this Nation. Pragmatic considerations of fiscal and administrative feasibility are essential to any discussion concerning the manner of making such rights, once recognized, truly meaningful and operative. But we have not yet taken those steps necesary to make health care a recognized right of the citizens of America. We are seeking the development of a broad consensus on the part of this Committee and the entire Congress that health care is a basic human right, akin to the right to life guaranteed by our Constitution.

We favor a national health insurance program under governmental auspices, which will bring into reality the rights of individuals and the responsibility of society.

Equality of Right

Viewing health care as a right, we cannot support any proposal for policy which would not provide or encourage the delivery of health care on an equal basis to all, regardless of race, religion, national origin, or ability to pay. Other factors such as the fact of employment, size or source of income, residence, age or family situation, could influence the financing of health care or its mode of delivery, but they should not serve as a basis for advantage or impediment of a substantial nature in obtaining health care. Just as in employment, education, and civil rights we are eliminating obstacles to equality, so in health care what obstacles of this nature exist must be eliminated.

ELIGIBILITY

We support those proposals which will move us closer to the standard of adequate equal health care for all Americans. Those qualifications and eligibility criteria which tend to place various members of society at greater advantage or disadvantage vis-a-vis access to necessary health care fall outside this standard. We, therefore, support national health insurance and service delivery programs which would provide universal coverage for all United States residents.

Many factors deter persons from seeking health care and must be considered in the context of eligibility. It is one thing to provide a right on paper, and altogether another thing to insure that the right exists in effective measure. If enough of these deterrants are operative, it is meaningless to be technically "eligible" for benefits.

Unless we remove these serious obstacles economic advantage will continue to play an unacceptable role in determining who shall get care and who shall not. We urge that this Committee explore ways to minimize those factors which are serious obstacles to obtaining health care.

HEALTH EDUCATION

Sister Maurita has stated the need to reorder our health system toward preventing illness. To implement this recommendation, we urge that as a supplement to any national health program, federal support for the following types of health education programs:

(*a*) Continued and broadened use of media to encourage good health habits, and proper use of health care services.

(*b*) Support for organized public and patient education by health providers in a "classroom" situation.

(*c*) Support for research, publication and wide distribution of personal health education materials of professional and popular usefulness and acceptance.

BENEFITS

The health care available to all Americans, includes services that are available; these must be more equally and effectively used. We also include services which our system must commit itself to developing. Each citizen should have available:

1. Physician care, with emphasis on a freely chosen, responsible physician for every family, properly supported by paramedical personnel and as part of a multispecialty arrangement among physicians organized to permit and facilitate referrals and consultation as necessary.
2. Emergency care with follow-up under the primary care physician's supervision.
3. Hospital inpatient, outpatient and clinic services, as effective in the provision of preventive, diagnostic and acute short term care, including psychiatric care.
4. Long term hospitalization and long term health related care in facilities which provide nursing care, therapeutic or rehabilitative services.
5. Dental care.
6. Prescribed drugs.
7. Home health services, outreach and intake service, including transportation, nutritional consultation, personal and family health education, medical-social services and physical therapy services.

The present system does not deliver this comprehensive range of services to every American. What can be seen from the listing of benefits is that health manpower must be treated in a different manner, providers, including physicians, must adjust to different service patterns and additional service techniques now largely experimental will have to be perfected.

CHANGING THE DELIVERY SYSTEM

In the opinion of many, the health care system in the United States has overemphasized episodic acute care principally because financing it has been the primary goal of prepayment or reimbursement mechanisms. Therefore, even if we had an organizationally sound health care system, this system would not deliver comprehensive, preventive or primary care. We would have a highly efficient system for curing illness, but not preventing it.

We encourage direct moves to influence the delivery system through grants and regulation when soundly conceived, but wish to suggest two additional strong influences, first, the creation of personal demand for services and second, the availability of payment for them. As we move to a national health insurance system, which we expect to deliver more and different types of care, the delivery system will have to be restructured to create cost controls. We view preventive and primary health care as goals for development in a much broader program which includes:

1. Effective coordination of all governmental and private systems which effect health.
2. Stimulation of service production through availability of payment for desired services.
3. Stimulation of improved delivery systems through direct impact through sound planning and regulation of providers.
4. Stimulation of improved delivery systems through grants, contracts, capital formation and assistance.
5. Stimulation of resource production through structured aid to health professions education and facility construction.

Merely insuring acute health services would not only put unreasonable demands on the present system, it would also effectively perpetuate disease treating systems, without developing health maintaining systems.

Financing Health Care

A. Source of Funds: The foundation of the financing mechanisms for health care should be a social insurance system. It should be an insurance system as a means of spreading the risk and of encouraging people to plan for their future needs in a provident manner, and assuring the security of contributions. It should be federally operated social insurance available to all members of society and covering all the normally necessary health maintenance services on a non-indemnity basis. Services should be covered throughout the period required in order to distribute the costs of a catastrophic episode throughout the widest societal base.

Contributions can be derived from employers, employees, self-employed and non-employed with independent means. For those unable to contribute in any of these ways, public funds should be made available to provide for their contributions to the insurance system.

B. Cost Control: Methods of paying for health care which place a heavy burden on the sick, through large deductibles or coinsurance payments, distribute the responsibility for cost inequitably, and place it frequently on those least able to pay. If deterrants to unnecessary utilization are desired, other mechanisms such as effective utilization review and peer review should be used. The threat of serious financial penalty attaches to those in real need of care as well as those who would abuse the system, a rather unjust method of problem-solving.

We do believe that the principle of payment according to ability, and the sense of responsibility and right that is maintained, can support deductibles, copayments and other cost sharing devices, provided that they are reasonable in amount.

We look to systems and incentives within the "provider" or external to them, not the patient, as principally responsible for cost control.

THE DELIVERY SYSTEM

A principal problem of the health care system, is, to use a cliché, that it is a non-system. There are insufficient relationships between providers of health care to insure a coordinated approach to health care needs, and there are few incentives to integrate. Institutions and professionals operate, to a large extent, on autonomous bases within separately determined goals and limitations. Thus, there is an overall lack of efficiency, duplication of effort, maldistribution of facilities and professionals and a lack of coordinated care of the patient. Health planning at all levels has been ineffective in resolving these problems.

Planning

In recent years there has been an effort to develop areawide and other health planning organizations to attune health providers to a broader-than-themselves frame of reference in dealing with decisions to build, add, expand or reduce services. The effort has been to create plans based on the health needs

of the community determined on an organized basis, apart from the manner in which a particular institution might perceive these needs. Without carefully developed and respected plans, which state the needs of a community, it is difficult for one institution or professional to look beyond its own needs.

The role of the areawide and other health planning agencies must be strengthened. This is particularly important since it is likely that under any national health insurance system something of the voluntary planning activity now carried on, external to the institutions and health care system will be needed.

Delivery level integration

Widespread integration of providers developed voluntarily at the level where health care is delivered, seems the best approach if health care as a right and as part of a national system is to be realized. Without it, national health insurance or some other refinancing of health care, alone, will not solve the problems of lack of access, acute care orientation, cost inflation and lack of comprehensiveness. Without integration, into comprehensive care organizations the cost controls possible with direct provider prepayment are not available.

This is not to say that we believe that all health care must be provided through this delivery mode. We do favor access to all necessary services through one contractually responsible entity as a distinct improvement over the present method. In a health system, which has only begun to look at itself, one can say with confidence that at the present time this method, or the philosophy behind it, represents a restructuring which should preserve the elements Americans expect of social institutions. However, to say that anyone has the last word, the final solution at this stage, would be irresponsible.

From the outset of any NHI system, and actually as a needed preparation for it, substantial incentitves should be made available for the voluntary development of organized comprehensive care systems. These should bring together under a unified management system all the normally necessary services and facilities to provide health care to a given patient population. Some of these organizations are commonly known as Health Maintenance Organizations, a generic term encompassing many variations on a theme.

Many of these efforts are essentially experimental, but rest on sound economic, medical and social premises. We hope this Committee will study these prepaid comprehensive care programs and fairly compare them with our traditional system.

We believe with the proper development of prepaid comprehensive health care plans covering a significant percentage of the population, the role of government could remain supportive and supervisory. Unless the changes implicit in this statement take place voluntarily, as they could, a more active, indeed dominant role, might be forced on the Federal Government in order to insure an equal right to health care to all Americans. The system of national health insurance we see possible at this time must recognize the imperfections as well as the healthy diversity of the present system, but move positively toward its improvement.

ADMINISTRATION

As we move to a health system which is increasingly financed through Federal revenues of various types, we strongly recommend that the distribution of those funds be through a system which avoids the potential for development into the largest bureaucracy among all Federal activities, with the problems that may imply. We are not convinced that a massive governmental administration along conventional lines would be sufficiently responsive to the varied health needs of our complex society over the long run.

Our recommendation is to incorporate community representation at every level of administration, from the national down through the regional or state to the last local Federal administrative unit.

Citizens, consumers and community representatives are rightfully demanding a voice in governmental and institutional programs that deeply affect their lives. Basic choices in the delivery of health services can affect the right to health care, indeed the right to life. It seems most appropriate to give recognition to a need for close attention to the needs, desires and expectations of the people for whom the program is intended to operate and benefit. We should build forces for change and private input directly into the system.

STATEMENT ADOPTED BY THE COMMITTEE ON HEALTH AFFAIRS, UNITED STATES CATHOLIC CONFERENCE, FEBRUARY 2, 1971

Whereas society, which is concerned for the total well-being of its members, has the responsibility to provide health care in the broadest sense which includes health education as well as preventive and environmental medicine together with curative and restorative measures;

Whereas health, as broadly defined, includes physical and mental aspects, contributes to the total well-being of and is consistent with man's personal dignity and respect for himself as well as his human condition;

Whereas physical and mental health care should be equally available to every citizen in our society as a right;

Whereas access to and availability of services which promote physical and mental well-being are essential to health maintenance; and

Whereas health services in our society are being provided and funded through the collaboration of both voluntary and governmental components of our society; therefore

We endorse and offer our support to the development of a national program for health which has as its foundation the above principles and which is designed to define and remedy deficiencies which mitigate against these principles.

Mr. GIBBONS. Monsignor Murray?

Monsignor MURRAY. Sister Maurita and Monsignor Corcoran have done a good job stating the need to improve health care, as a basic right of all citizens, and make it available in an effective way. I am convinced that the institutions that they represent are committed to a continuing role, providing health care and to the demands for leadership and cooperation in solving the broad problems before this committee. I think that the large number of Catholic hospitals is ample demonstration of the commitment to the needs of all men that the Sister has expressed, and good assurance of their continued contribution in the future. Many members of this committee will recall a Catholic hospital in their home town, and the changes in that institution over the past few years.

The special needs of the aging, is a dimension of social concern that this Nation is just beginning to address itself to. The homes and skilled care centers that Monsignor Corcoran represents can proudly say that they have served long before society recognized the responsibilities it now does toward the aged. I am proud to have this witness of the church's belief in the dignity of the individual, no matter, how infirm, with me today.

The department of health affairs of the U.S. Catholic Conference was established in 1948 to coordinate the activities of the church in health and act as the national spokesman for the bishops of the United States. We do what we can to keep Catholic programs of health care in touch with developments in legislation and public policy. Each of the bishops have appointed a diocesan coordinator for health affairs, this response to health needs dates back to 1933. These men are one of our local contact with service programs and health concerns of the church throughout the country. As you can see, we do have a great deal of help.

We try to be of assistance to government in the implementation of Federal programs of health care, and in that connection the department pledges its cooperation to this committee today, and throughout the development of legislation to implement a national health care policy.

I had intended to give a summary of our statement to point out the important things, but I note that there is a shortage of time so at his time I thank you for the opportunity to appear before you, and if you have any questions, I am sure those with us will be very happy to answer them if possible.

Mr. GIBBONS. Thank you, Monsignor, and without objection the full statements of all the witnesses will be placed in the record as if they had been delivered.

As a Presbyterian, let me thank you and your church for the fine services you rendered to my family. My father spent a great many years in one of your extended care facilities in Tampa, and all my immediate family has been nursed back to good health in the St. Joseph's Hospital there. Every time I look at a Sister, I think of Mother Maurita Mary in Tampa, and the great job she did in building the hospital there. In fact, I should say "building hospitals" there.

I won't take up any more time.

Mr. Ullman.

Mr. ULLMAN. No questions.

Mr. GIBBONS. Mr. Byrnes?

Mr. BYRNES. I just want to compliment the group on the very fine contribution to the hearing.

Mr. GIBBONS. Mr. Corman?

Mr. CORMAN. No questions.

Mr. GIBBONS. Mr. Duncan?

Mr. DUNCAN. I should also like to commend your excellent presentation. I am pleased to have an excellent Catholic hospital in my hometown of Knoxville, Tenn., which renders great service to our people.

What is the average cost per patient per day in the Catholic Hospitals? Do you have that information?

Sister MAURITA. I can not give you an exact figure, but I would say that our average cost is very comparable to the average cost for all voluntary acute, short-term hospitals in the United States. This varies according to geographic region, wherever the hospitals are located, but our hospitals would compare similarly to other hospitals.

Mr. DUNCAN. You are not referring to hospitals such as the Veterans' Administration operates?

Sister MAURITA. I would compare our costs to the other short-term care hospitals, exclusive of the Government hospitals and the Veterans' Administration hospitals.

Mr. DUNCAN. What would be a rough figure on that?

Sister MAURITA. It would average from $60 per day up to $100, depending on the geographic location.

Mr. DUNCAN. I know you give a great deal of service that you do not receive monetary compensation for. Could you tell me about what percentage that might be?

Sister MAURITA. I am sorry, sir. Would you restate the question?

Mr. DUNCAN. The services that the hospitals render, I know that you do give a lot of service that you do not receive monetary compensation for, or payment, but could you tell me about what percentage the Catholic Hospitals give for which they are not paid?

Sister MAURITA. I am sorry. I would not be able to give you the exact amount for which they do not receive reimbursement. Again, this var-

ies by locality and the number of indigent patients, and the type of reimbursement that is provided for them.

Mr. DUNCAN. Would you say it is a great deal.

Sister MAURITA. I would say there is a sufficient amount of nonreimbursement to cause concern to hospital management in continuing to provide adequate services.

As an example, I understand that in the State of Illinois because of the medicaid cutback which apparently is essential, there are several hospitals that may face financial difficulties as a result of lack of reimbursement for the care of indigent patients, which averages differently in different areas of the country.

Mr. DUNCAN. Thank you very much.

Monsignor MURRAY. Mr. Chairman, we would be very happy to supply further information for the Congressman for the record.

Mr. DUNCAN. Thank you.

(The following was received by the committee:)

We have contacted all known sources of national statistics in this area, including the American Hospital Association, and cannot supply additional information in answer to Mr. Duncan's question. The data regarding "charitable" services is not available because there is no uniform method of computing this figure, it is not always recorded and when reported it is frequently combined with other amounts such as bad debts and discounts.

Monsignor CORCORAN. I would relate what the Sister has said, just in their institutions alone last year, in just two of them, it was over $1 million. That is for two institutions alone.

Mr. GIBBONS. Let me ask one question and I think my facts are right.

Apparently in the United States we spend a very high percentage, higher than nearly any other nation, of our GNP on medical care. Yet, we have one of the highest mortality rates: male, female, and infant mortality rates of any of the major nations of the world. I don't know whether it is our statistics, or our system, or our life style that is at fault. What do you think? What does the panel think?

Monsignor MURRAY. May I be the first to try this?

Mr. GIBBONS. Give it a whirl.

Monsignor MURRAY. As far as the statistics and where the United States places in the family of nations of the world, as you are bringing out, we seem to be rather low on the totem pole.

I have a little problem accepting this. My problem is the manner in which health care is delivered in these nations can vary from our own. I think we are statistically, perhaps, better off than we would look from the charts.

You bring out a very important thing. Our cultural pattern, our methodologies, work, recreation, things of this nature, just the size of the country sometimes, all these being equal with statistics. This is my personal opinion now, if I can separate myself from the Department.

I say it is a very false thing to create a sense of depression of where we stand in the whole world. I am more depressed as we look to our country and we see the difference in the delivery of health care in different sections.

Now, the Congressman brought out a very important point here. In my home State of New Jersey, where I was active in hospitals, we would have in one hospital, one area, less than 2 percent indigents.

Yet, within 10 miles we could go and our indigent load would be over 65 percent, and once again, with individual financing, you have problems. But, once again our cultural pattern, our cities, and so forth and so on, this is why we are pushing for the health care right of individuals and for a Federal system. That is what I intended to bring out in my summary.

The Federal system is a mechanism in the delivery of care. I don't think I have answered your concern. Maybe some of the others here would have something further to say.

Mr. GIBBONS. My basic question is, is it our life style, is it our statistics, or is it our system? I think this is really the main question.

Monsignor MURRAY. I think it is a combination of those.

Monsignor CORCORAN. I think I would like to add this point to what Monsignor Murray has said: The mortality rates, the life expectancy, is less for minority groups, for instance, than it is for the average population. It is less for the poor. This reflects the fact that our total average life expectancy is made lower by reason of the much lower life expectancy of these groups, and these are precisely the groups who benefit less from our system.

In other words, our system is one which is expensive, and is particularly adapted to provide care for those who can pay for it. Therefore the kind of investigation and proposal that you are developing that would provide comprehensive care for all across the board, should definitely affect that life expectancy figure.

Now, that is not to say that I do not think life style has a lot to do with it, too, and so forth, but I won't prolong my expression, I think that the low-income groups, if they could be attended to better, would definitely improve this figure you are talking about.

Mr. CORMAN. Would the chairman yield?

Mr. GIBBONS. I believe the Sister wanted to say something.

Sister MAURITA. I would like to support what has been said. I would like to add that I do believe, though, that there is a decline in our infant mortality rate. But I would like to further emphasize that we have certain segments of our population who do not have access to the kind of health care and support, what Monsignor Corcoran said about those who can afford it seem to have better health care, are capable of purchasing it, and what we need is to make this available to all people.

Mr. CORMAN. Thank you, Mr. Chairman.

Monsignor, we are talking about comparing our own statistics to other countries, and you have indicated that, perhaps, our poor pull down our average, and yet, I think as affluent as we are, we must not have as many poor people as some of these other countries who have longer life spans. Per capita income in this country is substantially greater. Maybe some of our habits get bad when we get too much money. I am wondering if it is just because of our poor that we are pulled down. They must have poor, too, who somehow live longer.

Monsignor CORCORAN. It is my understanding that in the industrialized countries their medical care is more accessible to even the poor.

Mr. CORMAN. I am wondering how we get at the problems of the people. I suppose if we picked a range of from $7,500 to $15,000 per year of family income, that would cover a tremendous number of people in this country. We have had testimony here that comprehensive private insurance costs something in the neighborhood of $1,200 per year for a family.

Unless we move to some kind of compulsory insurance coverage, how do we get at those people? They aren't poor. They aren't the ones that our public assistance programs will reach, and yet they probably need some preventive, or at least some early medical care, early in their medical problems.

If it is voluntary, I can't imagine people in that range, very many of them, paying $1,200 a year for insurance when they are healthy, and so how do we meet their needs?

Monsignor CORCORAN. I would say this: I would put it in a sort of qualified way, because I suppose in order to avoid a real knock-down-and-drag-out argument with a lot of people. I don't know whether we should shy away from compulsory insurance. We have it for automobiles, but we don't have it for people. I think that if we recognize this as something that is necessary and for the common good, that maybe we ought to lay on the table for strong debate, shall I say, the question of whether or not it should be compulsory.

Mr. CORMAN. Thank you.

Monsignor MURRAY. Just one further comment, Mr. Corman.

About the other countries you mention, I think we see their social structure is a bit different through welfare programs and so forth. Therefore, there is accessibility of health care, but what sister brought out in her testimony is that we are not talking about the intsitutions such as the hospital, but we must talk about prevention and the whole picture that affect the statistics that the chairman brought out.

The second thing is, in our testimony we are supporting the very important concept of a national health insurance and delivery program which would provide universal coverage for all the U.S. residents, for everyone.

Mr. CORMAN. Thank you very much.

Mr. BETTS. Mr. Chairman, there is a question for clarification.

You are supporting H.R. 22, is that correct, Mrs. Griffiths' bill?

Monsignor MURRAY. We didn't specifically support any legislation.

Mr. BETTS. I see. I am sorry, I didn't hear all your testimony. My question was going to be based on that.

Your program is directed mostly to the needy, is that correct?

Monsignor MURRAY. Right, with respect to the needs and the rights of men, and our total testimony, I hope, brings this out.

Mr. BETTS. I will make it a point to read it over.

Monsignor MURRAY. We will be very happy to supply further information to the members of this committee.

Mr. SCHNEEBELI. May I ask a question, Mr. Chairman?

Mr. GIBBONS. Certainly.

Mr. SCHNEEBELI. In your concern for the health care of the aged, do you think the present medicare program is adequate to do the job? We have a program in being. We get the reaction generally that it is a fine program and adequate for the problem. What is your reaction regarding the aged with respect to the medicare program?

Monsignor CORCORAN. I think it is a fine program. Its adequacy, though, I think has been questioned, there has been some effort to cut back on certain things. I think that it was a tremendous step forward, and the sort of, as I would say it, provides the beginning model for the overall type of national health insurance that we are talking about.

So anything that we are saying is not particularly a criticism of medicare, but a suggestion that it does extend further.

There are many people that are not covered under medicare, even elderly people, and therefore somehow or other we have to encompass them in the total system, too.

Mr. SCHNEEBELI. Generally it has been very good start, and the reaction we get from the people who are covered is that they are very pleased, and we get little adverse reaction to the program.

Monsignor MURRAY. If I could, I would make a distinction, however. I think medicare, by and large, has been successful. It has been a good program and it is developed throughout the regulations and the interest of Congress. I see a tremendous problem with medicaid.

Mr. SCHNEEBELI. We are trying to replace medicaid with something more adequate.

Monsignor MURRAY. Yes. I wanted to be very clear on this point.

Mr. SCHNEEBELI. I think this committee would be the fisrt one to admit the weaknesses in medicaid program.

Sister MAURITA. I think as has been indicated here, medicare has been a step in the right direction. A lot of emphasis has been given to short-term care for the aged, but I think it needs to be expanded to preventive and maintenance health care for the aged beyond the acute care stage.

Mr. SCHNEEBELI. I think one of the main reasons for considering this program in total is due to the satisfaction with the success of medicare.

We were rather apprehensive to the approach on medicare, and it proved to be most successful and gave reason to consider further development.

Thank you.

Mr. GIBBONS. I want to pursue this just a little further, because we have an excellent panel here on the matter of health care for the aged. I am talking about the noncritical, the long-term health care, and as I mentioned in the beginning, I have had some experience with this in my own family. Fortunately, my father was able to pay his own bills, but I know how quickly medicare runs out when you leave the hospital, the short-term hospital, and how expensive the long-term care can be.

How do you think we ought to go about tackling this problem? What is the solution to this problem?

Monsignor MURRAY. I would say the solution is the national health insurance program.

Mr. GIBBONS. I don't believe that even this program is going to tackle the nursing home care problem.

Monsignor MURRAY. Under medicare, as I see titles 18 and 19, with A and B, it doesn't face the problem of your skilled nursing home care. As you know, the ECF is an extension of the hospital, and I think this is what Sister is referring to when she said. "What about the poor man who is leaving the hospital, but he still needs care." There are not enough outreach services in the community to come into his home, yet in all honesty you could not put him in an ECF but he does need skilled care.

I think the legislation has to face it. These people need care and assistance. In some homes they have situations where the elderly people can be taken care of adequately with their own resources. But a person who doesn't have resources or family or funds is in dire trouble, and they can be bankrupt in no time, as you well know.

Mr. CORMAN. In other words, in talking about the different kinds of resources that might be called upon to care for them and then different kinds of funding, too, it is a question of whether or not the insurance program, strictly as an insurance program, can provide all of the funding for this type of care. This is where public funds out of general revenues probably would have to come into play.

Mr. GIBBONS. Mr. Karth?

Mr. KARTH. Thank you, Mr. Chairman.

I understand that you haven't endorsed or denied endorsement to any of the particular bills before the committee. I wonder if you could tell us which one of those plans comes closest to meeting the needs, as you see it, and in consonance with the testimony you have given this morning.

Monsignor MURRAY. I would say as I reviewed personally the various plans that have been introduced, the one that I would be inclined to support at this time would be H.R. 22.

Mr. KARTH. Are the other witnesses generally in agreement with you, Monsignor Murray?

Monsignor MURRAY. I can't say that we haven't discussed that.

Sister MAURITA. If I may just say this: our position has been that we have looked at the various pieces of legislation which have been brought forth and not any one of them seems to meet the total needs, and we would hope that some kind of legislation would be developed which would take the good portions of the various pieces of legislation and make them into a comprehensive health care delivery system with insurance coverage.

Monsignor CORCORAN. I would pretty much agree, but I would add this, quickly, and though it may sound facetious, it is not meant that way, it is meant very, very seriously.

The esteemed chairman of the Ways and Means Committee has indicated that the Ways and Means Committee is going to write a bill, and I think that is the one I am going to be in agreement with [laughter]. Because he is going to take all the things we have said and put it in the bill.

Mr. KARTH. I want to thank the distinguished panel very much, and I would echo the sentiments of my colleagues, that if it were not for the fact that the Catholic Church provides health care services in my district, we would be in bad shape in St. Paul.

Mr. GIBBONS. Mr. Pettis?

Mr. PETTIS. Thank you, Mr. Chairman.

I would like to ask one question of the panel. How many medical schools are operated under the Catholic Church in this country?

Monsignor MURRAY. At this time there are four.

Mr. PETTIS. I suppose each of those has a nursing school and paramedical schools associated with it?

Monsignor MURRAY. More nursing schools than medical schools. We have over 200 schools of nursing at the various levels.

Mr. PETTIS. I suppose those schools are about in the same position as other private medical schools and church-supported medical schools are in, which is a rather desperate financial condition.

Monsignor MURRAY. Right. I have talked to officials of Georgetown on this, and other medical schools, and they would agree they still have difficulties.

Mr. PETTIS. Do you have any suggestions for this committee on how this country can help the medical schools produce high quality medical personnel considering these financial problems that you face, and the fact that we have to produce doctors through these approximately 100 medical schools of which you have some four under your auspices?

Monsignor MURRAY. First of all, I think I would like to come back to you further with some statement for the committee on this, some further information. I feel that I couldn't answer that with the expertise that I should.

Just speaking off the cuff right now, I think a realistic approach to the entire manpower needs of our medical and paramedical personnel in their health care field must be faced by the Congress if any form of national health insurance is to be enacted, that we can not deliver care unless we have personnel.

Mr. PETTIS. This is my point. We talk about a product, namely, medical services, and medical care, but I am not sure we are facing up to an even more important problem, and that is how do we produce the people who provide this care.

Monsignor MURRAY. Right. Then I would say there has to be, as it was referred to in another administartion, "creative Federalism." The partnership of the voluntary field with the government, let's say in medical education, how to effectuate this as best we can.

Looking at our forces and cutting down wherever possible, increasing classes, and maybe in a few instances increasing the number of medical schools.

Mr. PETTIS. One question has arisen here is whether we provide health through the mechanism of help to the student, or whether we provide help, say, to the medical schools.

For example, there are some church groups that have a strong feeling about maintaining a separation between church and state, and therefore they would prefer that whatever loans or grants or financial aid that is given be given to the student, and therefore you would maybe solve the problem.

So, I would like to have you put in the record the position of the Catholic Church toward this basic problem, financial support for medical education.

Monsignor MURRAY. We would be very happy to supply you with this information.

(The following was received by the committee:)

POSITION OF THE UNITED STATES CATHOLIC CONFERENCE REGARDING FINANCIAL AID TO MEDICAL EDUCATION

There is a great need to increase the overall number of physicians and other medical personnel, and to alleviate specific shortages and maldistribution of physicians. This will be brought about only with considerable assistance from government in view of the present financial condition of health education facilities and the cost of medical education. Assistance will be required in a number of ways in order to accomplish these several objectives. In our opinion, therefore, it is unrealistic to choose between aid to the school or aid to the student. Both forms of aid are needed.

Aid to the student is required to insure that students enter medicine on the basis of talent and dedication, not personal wealth. Loans, scholarships and other forms of aid to students, such as forgiveness of loans for work in physician shortage areas, are vital if economic barriers to the medical profession are to

be mitigated. If assistance is not available to the schools, several which are currently in serious financial difficulty may close. Without adequate financing the quality of education, in terms of academic and physical components, would be lowered to the detriment of medical students and ultimately the general public. Moreover, the necessary expansion of medical education facilities and programs would be seriously inhibited.

Incentives toward expanded enrollment and innovation in curricula in medical schools do not seem manageable nor potentially effective if exclusively offered by means of aid to the student. These goals seem more readily achieved through direct financial support of the school itself.

We perceive no viable issue in the area of church-state relations which would militate against our position. The decision of the United States Supreme Court in *Bradfield* v. *Roberts*, 175 U.S. 291, upholding a federal grant to Providence Hospital here, is directly in point. The decision in this case has been supported by many other favorable decisions.

Thus, our position is that governmental financial aid to medical education should be designed to meet the several needs for more and different medical personnel in a flexible manner, providing multiple forms of assistance to the students, the medical schools and to teaching programs in hospitals and other service facilities.

Monsignor HARROLD A. MURRAY,
Director, Department of Health Affairs,
U.S.C.C., December 1971.

Mr. GIBBONS. We thank this panel for your very interesting and informative testimony this morning and for your dedication to mankind.

Monsignor MURRAY. Thank you.

Monsignor CORCORAN. Thank you.

Sister MAURITA. Thank you.

Mr. GIBBONS. Our next witness is Dr. George Crawford, United Methodist Church, Board of Christian Social Concerns.

We welcome you. If you would, identify yourself for the record and then proceed.

STATEMENT OF DR. GEORGE W. CRAWFORD, PROFESSOR OF PHYSICS AND ECOLOGY, SOUTHERN METHODIST UNIVERSITY, ON BEHALF OF THE BOARD OF CHRISTIAN SOCIAL CONCERNS, UNITED METHODIST CHURCH

Dr. CRAWFORD. Thank you.

Mr. Chairman and members of the committee: My name is George W. Crawford. I am a Methodist layman, an elected member of the Board of Christian Social Concerns of the United Methodist Church and am here representing that agency. I have appended a copy of the official resolution concerning health care, adopted by the board, and a current membership list, as an appendix to this statement.

In my professional life, I am currently professor of physics and ecology at Southern Methodist University, having come to this position in 1963 following 4 years of service as chief of the physics branch at the School of Aerospace Medicine, Brooks Air Force Base, San Antonio, Tex.

On October 8, 1971, only a few weeks ago, the Board of Christian Social Concerns of the United Methodist Church adopted the statement on health care which has been placed before you in written form, to become part of my printed testimony.

Mr. GIBBONS. Without objection, we will put all of your printed testimony and your statement in the record at this point.

Dr. CRAWFORD. Thank you, sir.

(The statement and appendix follow:)

STATEMENT OF DR. GEORGE W. CRAWFORD, PROFESSOR OF PHYSICS AND ECOLOGY, SOUTHERN METHODIST UNIVERSITY, ON BEHALF OF THE BOARD OF CHRISTIAN SOCIAL CONCERNS OF THE UNITED METHODIST CHURCH

Mr. Chairman and Members of the Committee: My name is George W. Crawford. I am a Methodist layman, an elected member of the Board of Christian Social Concerns of The United Methodist Church and am here representing that agency. I have appended information concerning the Board, a copy of the official resolution concerning Health Care, adopted by the Board, and a current membership list, as an appendix to this statement.

In my professional life, I am currently professor of Physics and Ecology at Southern Methodist University, having come to this position in 1963 following four years of service as Chief of the Physics Branch at the School of Aerospace Medicine, Brooks Air Force Base, San Antonio, Texas.

On October 8, 1971, only a few weeks ago, the Board of Christian Social Concerns of the United Methodist Church adopted the statement on Health Care which has been placed before you in written form, to become part of my printed testimony. Rather than simply read the statement, I would like to point out its major features and share with you our concerns regarding health care.

We know that health care reform in this country is a matter of unusual complexity, and that the economic implications of any all-encompassing and thoroughgoing restructuring are very great. Our Board makes no claim to detailed or technical knowledge concerning any of the complex issues a meaningful reform will require. We do feel, very strongly, that certain overriding principles relevant to the health care system need to be lifted and should become truly public issues, discussed, even debated by all concerned—laymen and the public, as well as health care professionals.

We recommend the following principles to your consideration:

1. Radical revision of the existing health care system must be made, particularly of the financing, general organization and control of the health care delivery system as a whole. This rules out completely those legislative proposals before this committee which propose only palliatives, or incidental patchwork approaches to problems inherent in what is a fundamental system of disorganized health care.

2. It is our view, Mr. Chairman, that adequate health care should be established as a *right of citizenship* in the U.S.A. Health care is already recognized in other nations much less able financially to make such a right effective. All citizens should have equal access to the best available health care, including preventitve services, regardless of wealth, social status, *or any other condition.*

3. Health care should be comprehensive, including physical, dental, mental and emotional fields of practice, and should focus on *prevention* as well as treatment and rehabilitation.

4. We believe only a universal, comprehensive and prepaid financial system for health care can begin to make real and right to health care implied in the citizen's *right* to adequate health care. The costs must be controlled and kept within income.

5. National standards of health care service, including national standards of licensure, should be professionally established and kept under continual review and development.

6. A major failure of the existing system has been its inability to provide sufficient trained personnel of all types. Therefore, it is strongly urged that a major emphasis of revision be to substantially increase the number of all types of the trained Health Care personnel combined with more effective use of existing trained personnel.

7. There should be national policy making and planning, carried through in cooperation and coordination also at regional, state, area, and community levels.

8. Consumers should be represented on Boards of professionals and public officials who design and administer every level of the national health care delivery system.

I. RADICAL REVISION

We submit that the record already before the Congress overpoweringly shows that millions of Americans today still are denied reasonable access to adequate health care. The private purchase of health care by citizens on their own has failed to provide minimal health services for all citizens, particularly the poor, the elderly, the discriminated against, and those living in ghettos or in rural and remote areas. The rise in health care costs has far exceeded the increase in services with every indication that costs will continue to soar and services will be available to fewer and fewer citizens. Current practice in providing health care does not provide comprehensive coverage as requested in our point #3. The quality of health services available now is vividly revealed in the statistics which show that: in 1967, 11 industrial nations had lower infant mortality rates than did the U.S.A.; 18 advanced nations have a higher male life expectancy rate than the U.S.A.; in 1971, there is gross disparity in health between the races within the U.S.A.; in 1969, there were no physicians at all in 134 countries in 28 different states; medical facilities are overconcentrated in some areas, meager or nonexistent in some; and the medical professions are seriously undermanned.

In spite of its great technical achievements and long hours of conscientious work on the part of the majority of those in the health care professions, it is obvious that the present health care delivery system is seriously deficient in many ways that cannot be remedied without radical revision of the whole system. For all these reasons it seems clear to me that H.R. 22 alone among the bills before this Committee is a step in the right direction and comes closest to meeting the criteria of need set forth in the statement of the Board of Christian Social Concerns.

II. ADEQUATE HEALTH CARE AS A RIGHT OF CITIZENSHIP

The U.S.A. has already given the right of adequate health care to certain segments of its population, the Armed Forces for one. Many other nations have recognized this right, not only to their armed forces, but to all citizens. To those who oppose this view, we would simply point out that all other human and civil rights are of no effect if the right to life itself is not protected. Illness, with its threat to death, is indissolubly involved in any meaningful talk about a right to life. The ill person who, for whatever reason, is denied reasonable access to adequate and available health care, is a person whose right to life has been endangered if not denied. We therefore support the all-inclusive nature of Title I, Part A, Section 11 of H.R. 22.

III. HEALTH CARE SHOULD BE COMPREHENSIVE, INCLUDING PHYSICAL, DENTAL, MENTAL AND EMOTIONAL FIELDS OF PRACTICE

We support the efforts made in H.R. 22 to provide comprehensive coverage with adequate protection for the quality of care as given in Title I, Part B. We urge that the prevention aspect of health care be given equal priority with treatment and rehabilitation. Strong emphasis should be placed on outpatient services and treatment to reserve hospitalization for those truly in need of intensive hospital care.

IV. HEALTH CARE COSTS

The costs of the relatively unplanned, unmanaged, unregulated and uncontrolled health care delivery system in the U.S.A. are rising at a frightening pace. The total health bill for Americans, private and public payments, leaped from $26.4 billion in 1960 to $38.9 billion in 1965 to $67.2 billion in 1970. If the present system is continued, the Health, Education, and Welfare estimate of $105.4 billion total health costs in 1974 represents a doubling of total costs every 8 years.

The hodgepodge of governmental and private health insurance programs, the welter of inadequate health care benefits provided under different policies, the continued heavy load of private direct payments by patients because of policy exclusions, deductibles and coinsurance provisions, the distortions in the use of health care facilities arising out of arbitrary policy coverages, the extraordinary costs of individual health insurance policies (49% of benefits) as compared to group policies, the significantly higher costs of private for-profit insurance as compared to nonprofit schemes, the pyramiding of adminstrative and operational costs due to competitive insurance systems with their attendant costs of sales-

manship, advertising, and promotion, the large expense of verifying each claim—these are some of the factors that have led our Board to conclude " * * * that all basic and necessary health care should be financed entirely on a prepaid basis without deductibles and coinsurance. In view of the tremendous sums of money involved . . . as well as in view of the need for universal coverage, we believe that basic health care can be financed most effectively, equitably and inexpensively through taxation."

The basic idea of raising the necessary monies by health security taxes is supported. Since the goal is universal and equal health service for all American citizens, it is my personal suggestion that the full resources of special governmental medical services, such as those of the domestic Armed Forces and Veterans' Administration, be joined with the "civilian" resources, so that all may have equal access to adequate health care. Speaking as a combat veteran of World War II (3½ years) and as a reservist, I wish to lay before you the realization that adequate health service should not be a right reserved only for those with military service—rather it is a right based on citizenship, with all sharing equally. The extension suggested here will go far in solving some of the grave problems now facing the nation in health care.

Inherent in this presentation is a call for efficient and full use of all health care resources. We urge this Committee to study with extreme care the problems of full use of resources. The late Walter P. Reuther shocked all of us with his statement that approximately $14 billion of the $60 billion total health bill in 1969 represented wasteful and unnecessary expenditures (reported in his address to the New England Hospital Assembly, Boston, Mass., Mar. 23, 1970). Even if this is too high an estimate, it is a grim reminder that as the new health service plan is put into effect, every effort must be made to prevent unnecessary and wasteful expenditures, else it also will fail to provide adequate health care. Unnecessarily soaring costs and waste will bring the new effort to costly failure also. Even though the total cost for health care under H.R. 22 will be larger than that projected by the current system growth, the additional outlay can and should correct the grievous ommissions of the current system, raising the total coverage and quality of health care in the U.S.A. far above that obtainable by the current system or the patchwork approaches suggested in other bills.

V. INADEQUATE NUMBER OF TRAINED PERSONNEL

A major failure in the current system has been its inability to provide sufficient trained health care personnel of all types. The basic approach requiring vigorous and massive action to alleviate the shortages as outlined in H.R. 22, Title I, Part F, are supported with the urging that planned action be the keyword and that planning not be used to prevent action. New and radical approaches to this serious problem are encouraged.

VI. NATIONAL POLICYMAKING AND PLANNING

We believe Mr. Walter J. McNerney, president of Blue Cross Association, when he says: "Health systems are simply not self-regulating. They must be managed. To pour your money into the present system without changing that system, I think, would be disastrous." (Statement to the Senate Committee on Finance, Apr. 27, 1971.) Radical changes in the present system have been recommended. The new system based on "The Health Security Act" will also need to have effective and efficient managing at all levels. Particularly important is that there be genuine national policy making and planning and that these policies be carried out, not negated, on the regional and local levels.

VII. CONSUMER PARTICIPATION IN ALL LEVELS OF THE PLAN

Consumers should have effective representation at all levels in this plan. The system must be responsive to consumer needs at all levels. Therefore, it is urged that each and every board or body concerned with policy, planning, administration and evaluation have strong consumer representation and participation.

VIII. CONCLUSION

This committee has within its grasp the opportunity to replace a disorganized and inadequate health care system with one which will bring to all Americans the right and the ability to have adequate health care. We urge you to examine

health care in America in its totality, with all its problem in full view. Then seek and find new and bold solutions based on the principles we have lifted. Thank you.

HEALTH CARE

(Statement adopted by the Board of Christian Social Concerns, the United Methodist Church, Oct. 8, 1971)

We affirm that in an affluent society, unimpeded access to adequate health care is a fundamental right of all citizens, and is corollary to the right to life itself. Since quality medical care is costly, it is not surprising to find that the quality of medical science practised in the United States, the world's wealthiest nation, is unsurpassed anywhere. A majority of the American people have relatively high access to quality health care.

Therefore, it is surprising to find that health care in the U.S. is described today on every hand as in a state of crisis. The signs of crisis are clear:

1. The medical professions are seriously undermanned.
2. Medical facilities are over concentrated in some areas, underconcentrated in others, nonexistent in some.
3. In 1969 there were no physicians at all in 134 counties in 28 different States.
4. Some citizens receive more medical care than they need, many receive less.
5. In 1967, 11 industrial nations had lower infant mortality rates than did the U.S.
6. 18 advanced nations have a higher male life expectancy rate than the U.S.
7. There is gross disparity in health between the races in the U.S.; e.g., nonwhite infant mortality rates are double that for whites.
8. People in poverty have three times the chronic sickness rate of those in the middle and upper economic groups.

In spite of its great technical achievements, in spite of long hours of conscientious work on the part of the majority of those in the health care professions, it is obvious that the health care delivery system in the U.S. is seriously deficient in many ways. Meanwhile, the costs of that relatively unplanned, unmanaged, unregulated, and uncontrolled system are rising at a frightening pace. The total health bill for Americans, combining private and public payments, rose from $12.1 billion in 1950, to $26.4 billion in 1960, $38.19 billion in 1965, and $67.2 billion in 1970. If no improvements at all are made in our present system of health care delivery, Government officials estimate total health care costs for the U.S. in 1974 to reach $105.4 billion.

A significant portion of the rising costs of health care are due to increase of population, improved but costlier medical technology, wage improvements for health care workers long and grossly underpaid, and new programs of health care for the aged and the poor who previously had far too little access to care. Another significant portion of the rise in costs, however, according to health care professionals is due to inefficiencies, lack of planning, and mismanagment in the system.

We have noted the variety of current legislative proposals for providing more and better health care for Americans. The proposals range from those which would restructure the system, to those which would do little other than provide more money for the present system. We oppose such proposals as the latter, seeing profound need to effect economies and to reach greater efficiency in the methods by which health care may be planned, organized, administered, evaluated, and financed. We believe Mr. Walter J. McNerney, president of Blue Cross Association, is persuasive when he says: "Health systems are simply not self-regulating. They must be managed. To pour your money into the present system without changing that system, I think, would be disastrous." (Statement to the Senate Committee on Finance, Apr. 27, 1971.)

We believe the following represent important principles for the necessary restructuring of the health care delivery system in the U.S.:

1. All citizens should have equal access to the best available health care, including preventive services, regardless of wealth, social status, or any other condition.
2. No arbitrary limits should be set about a person's right to choose among Doctors and available facilities for medical care, nor should the Doctors be hindered from choosing the type of medical practice they wish to engage in, provided adequate medical standards of competence and responsibility are met in both cases.

3. Health care should be comprehensive, including physical, dental, mental and emotional fields of practice, and should focus on prevention as well as treatment and rehabilitation.

4. National standards of health care service, including national standards of licensure, should be professionally established and kept under continual review and development.

5. There should be national policy making and planning, carried through in cooperation and coordination also at regional, State, area and community levels.

6. Consumers should be represented on Boards of professionals and public officials to design and administer every level of the national health care delivery system.

7. State and Federal governments should increase their financial support for new medical, and nursing schools, in order to enlarge the supply of medical personnel.

8. Provision should be made for increased training and use of paramedical personnel under professional supervision and responsibility.

We believe that all basic and necessary health care should be financed entirely on a prepaid basis without deductibles and co-insurance. In view of the tremendous sums of money involved in the National Health Bill, as well as in view of the need for universal coverage, we believe that basic health care can be financed most effectively, equitably and inexpensively through taxation. The health care industry and health care professionals may be paid for services in a variety of ways. We see little value, however, in private and competitive systems of raising funds for health care, since they are costlier to those who can afford them, and useless to those who can't afford them.

As sweeping changes take place in the health and human development systems of our society, we call upon our churches to become alert to the new opportunities that are arising for worthwhile work and service in the health field. New programs in community health have the potential of extending care on a comprehensive basis to all citizens of the community. The development of new kinds of centers, together with increased cooperation between professional people, provide opportunities not only for better remedial care, but for bold new approaches in primary prevention. Opportunities are increasing for church men and women to become involved in emerging programs through community action and planning, volunteer services in centers, and innovative ministries within congregational life.

Recognizing that new biomedical technologies, such as organ transplants and control of genetic defects, while offering rich potential for enhancing health, also place stress on traditional images and values about human nature, we encourage men of ethical concern in various relevant fields together to engage in the study and direction of these developments.

Mental illness is a major health problem in all parts of the world. The Church is challenged to use its resources to make a major contribution to mental health and healing. We encourage our churches:

(1) To engage in mental health education through—
  (*a*) family life conferences;
  (*b*) workshops on parent-child communication;
  (*c*) premarital counseling;
  (*d*) education in human sexuality;
  (*e*) community development in the urban environment;

(2) To become involved in community programs for primary prevention of mental illness;

(3) To work with other agencies to develop programs and facilities for the care of the mentally disturbed and retarded;

(4) To develop pastoral counseling centers to minister to the troubled;

(5) To foster cooperative efforts between ministers, physicians, and other health professionals in the care of both the physically and mentally ill;

(6) To promote the rapid establishment of community mental health centers;

(7) To encourage the establishment or improvement of State and local mental care institutions.

Dr. CRAWFORD. Rather than simply read the statement, I would like to point out its major features and share with you our concerns regarding health care.

We know that health care reform in this country is a matter of unusual complexity, and that the economic implications of any all-encompassing and thoroughgoing restructuring are very great. Our board makes no claim to detailed or technical knowledge concerning any of the complex issues a meaningful reform will require. We do feel, very strongly, that certain overriding principles relevant to the health care system need to be lifted and should become truly public issues, discussed, even debated, by all concerned, and this certainly includes laymen and the public as well as the health care professionals.

We recommend the following principles to your consideration:

1. Radical revision of the existing health care system must be made, particularly of the financing, general organization, and control of the health care delivery system as a whole. This rules out completely those legislative proposals before this committee which propose only palliatives, or incidental patchwork approaches to problems inherent in what is a fundamental system of disorganized health care.

2. It is our view, Mr. Chairman, that adequate health care should be established as a right of citizenship in the United States of America. Health care is already recognized in other nations much less able financially to make such a right effective. All citizens should have equal access to the best available health care, including preventive services, regardless of wealth, social status, or any other condition.

3. Health care should be comprehensive, including physical, dental, mental and emotional fields of practice, and should focus on prevention as well as treatment and rehabilitation.

4. We believe only a universal, comprehensive, and prepaid financial system for health care can begin to make real this right to health care implied in the citizen's right to life. The costs must be controlled and kept within income.

5. National standards of health care service, including national standards of licensure, should be professionally established and kept under continual review and development.

6. A major failure of the existing system has been its inability to provide sufficient trained personnel of all types. Therefore, it is strongly urged that a major emphasis of revision be to substantially increase the number of all types of the trained health care personnel combined with more effective use of existing trained personnel.

7. There should be national policymaking and planning, carried through in cooperation and coordination also at regional, State, area, and community levels.

8. Consumers should be represented on boards of professionals and public officials who design and administer every level of the national health care delivery system.

Now, as to radical revision:

We submit that the record already before the Congress overpoweringly shows that millions of Americans today still are denied reasonable access to adequate health care. The private purchase of health care by citizens on their own has failed to provide minimal health services for all citizens, particularly the poor, the elderly, the discriminated against, and those living in ghettos or in rural and remote areas. The rise in health care costs has far exceeded the increase in services with every indication that costs will continue to soar and services will be unavailable to a growing number of citizens.

Current practice in providing health care does not provide comprehensive coverage as requested in our point No. 3. The quality of health services available now is vividly revealed in the statistics which show that: in 1967, 11 industrial nations had lower infant mortality rates than did the United States; 18 advanced nations have a higher male life expectancy rate than the United States; in 1971, there is gross disparity in health between the races within the United States; in 1969, there were no physicians at all in 134 counties in 28 different States; today medical facilities are overconcentrated in some areas, meager or nonexistent in some; and the medical professions are seriously undermanned.

In spite of its great technical achievements and long hours of conscientious work on the part of the majority of those in the health care professions, it is obvious that the present health care delivery system is seriously deficient in many ways that cannot be remedied without radical revision of the whole system. For all these reasons it seems clear to me that H.R. 22 is a step in the right direction and comes closest to meeting the criteria of need set forth in the statement of the Board of Christian Social Concerns.

ADEQUATE HEALTH CARE AS A RIGHT OF CITIZENSHIP

The United States of America has already given the right of adequate health care to certain segments of its population, the Armed Forces for one. Many other nations have recognized this right, not only to their armed forces, but to all citizens. To those who oppose this view, we would simply point out that all other human and civil rights are of no effect if the right to life itself is not protected. Illness, with its threat of death, is indissolubly involved in any meaningful talk about a right to life. The ill person who, for whatever reason, is denied reasonable access to adequate and available health care, is a person whose right to life has been endangered if not denied. We therefore support the all-inclusive nature of title I, part A, section 11 of H.R. 22.

HEALTH CARE SHOULD BE COMPREHENSIVE, INCLUDING PHYSICAL, DENTAL, MENTAL, AND EMOTIONAL FIELDS OF PRACTICE

We support the efforts made in H.R. 22 to provide comprehensive coverage with adequate protection for the quality of care as given in title 1, part B. We urge that the prevention aspect of health care be given equal priority with treatment and rehabilitation. Strong emphasis should be placed on outpatient services and treatment, to reserve hospitalization for those truly in need of intensive hospital care.

HEALTH CARE COSTS

The costs of the relatively unplanned, unmanaged, unregulated, and uncontrolled health care delivery system in the United States are rising at a frightening pace. The total health bill for Americans, including private and public payments, leaped from $26.4 billion in 1960 to $38.9 billion in 1965 to $67.2 billion in 1970. If the present system is continued, the Health, Education, and Welfare estimate of $105.4 billion total health costs in 1974 represents a doubling of total costs in 8 years.

The hodgepodge of governmental and private health insurance programs; the welter of inadequate health care benefits provided under different policies; the continued heavy load of private direct payments by patients because of policy exclusions, deductibles, and coinsurance provisions; the distortions in the use of health care facilities arising out of arbitrary policy coverages; the extraordinary costs of individual health isurance policies—49 percent of benefits—as compared to group policies; the significantly higher costs of private for-profit insurance as compared to nonprofit schemes; the pyramiding of administrative and operational costs due to competitive insurance systems with their attendant costs of salesmanship, advertising, and promotion; the large expense of verifying each claim: these are some of the factors that have led our board to conclude:

> * * * that all basis and necessary health care should be financed entirely on a prepaid basis without deductibles and coinsurance. In view of the tremendous sums of money involved * * * as well as in view of the need for universal coverage, we believe that basic health care can be financed most effectively, equitably, and inexpensively through taxation.

We support the basic idea of raising the necessary moneys by health security taxes. Since the goal is universal and equal health service for all American citizens, it is my personal suggestion that the full resources of special governmental medical services, such as those of the domestic Armed Forces and Veterans' Administration, be joined with the "civilian" resources, so that all may have equal access to adequate health care.

Speaking as a combat veteran of World War II—3½ years—and as a Reservist, I wish to lift before you the realization that adequate health service should not be a right reserved only for those with military service—rather it is a right based on citizenship, with all sharing equally. The extension suggested here will go far in solving some of the grave problems now facing the Nation in health care.

Inherent in this presentation is a call for efficient and full use of all health care resources. We urge this committee to study with extreme care the problems of full use of resources. The late Walter P. Reuther shocked all of us with his statement that approximately $14 billion of the $60 billion total health bill in 1969 represented wasteful and unnecessary expenditures.

Even if this is too high an estimate, it is a grim reminder that as this new health service plan is put into effect, every effort must be made to prevent unnecessary and wasteful expenditures, else the new plan also will fail to provide adequate health care. Unnecessarily soaring costs and waste will bring the new effort to costly failure also. Even though the total cost for health care under H.R. 22 will be larger than that projected by the current system growth, the additional outlay can and should correct the grievious omissions of the current system, raising the total coverage and quality of health care in the United States far above that obtainable by the current system or the patchwork approaches suggested in other bills.

INADEQUATE NUMBER OF TRAINED PERSONNEL

A major failure in the current system has been its inability to provide sufficient trained health care personnel of all types. The basic approach requiring vigorous and massive action to alleviate the short-

ages as outlined in H.R. 22, title I, part F, are supported with the urging that planned action be the keyword and that planning not be used to prevent action. New and radical approaches to this serious problem are encouraged.

NATIONAL POLICYMAKING AND PLANNING

We believe Mr. Walter J. McNerney, president of Blue Cross Association, when he says:

> Health systems are simply not self-regulating. They must be managed. To pour your money into the present system without changing that system, I think, would be disastrous.

Radical changes in the present system have been recommended. The new system, based on "the Health Security Act," will also need to have effective and efficient managing at all levels. Particularly important is that there be genuine national policymaking and planning, and that these policies be carried out, not negated, on the regional and local levels.

CONSUMER PARTICITATION IN ALL LEVELS OF THE PLAN

Consumers should have effective representation at all levels in this plan. The system must be responsive to consumer needs at all levels. Therefore, it is urged that each and every board or body concerned with policy, planning, administration, and evaluation have strong consumer representation and participation.

CONCLUSION

This committee has within its grasp the opportunity to replace a disorganized and inadequate health care system with one which will bring to all Americans the right and the ability to have adequate health care. We urge you to examine health care in America in its totality, with all its problems in full view. Then seek and find new and bold solutions based on the principles we have lifted. Thank you.

Mr. GIBBONS. Thank you, Dr. Crawford. Before we get into questioning, I want to say that you have delivered a very brave statement. I think that I remember back in 1950 we had this debate going on. If you had delivered that statement in the Methodist churches in my town, and if I had introduced you, we would probably both be leaving town together pretty rapidly. Maybe things have changed that much. I don't know, but you certainly have made a very challenging statement here, and let's see what kind of questions we have.

Mr. BYRNES. No questions.

Mr. GIBBONS. Any questions on the left?

Mr. Corman?

Mr. CORMAN. I want to thank Dr. Crawford. I don't think we should be surprised at this statement, because John Wesley was concerned about the conditions of the people in the slums of London. Our church has a long history of interest in this field.

Mr. GIBBONS. I know the church does. I wonder about the insurance agents and doctors in the church.

Not that they don't have concerns, but I think they might disagree markedly with the statement. That is my perception of it.

Dr. CRAWFORD. I tested my statement against a number of my friends, dentists and medical doctors, and I did not have the opposition you are referring to.

Mr. GIBBONS. I am going to get you to come down to my district and talk to the insurance agents and the doctors and the dentists.

Dr. CRAWFORD. I would be delighted to. The understanding of the needs today is quite different from the understanding of the needs in the 1950's.

Mr. GIBBONS. I think you are right there. I don't know how far we have moved, but I think you are right.

Mr. PETTIS. Mr. Chairman, may I ask a question of the witness?

Mr. GIBBONS. Yes.

Mr. PETTIS. I note, too, that he is a professor, and I ask this question seriously as it relates to medicine rather than to his own field of expertise.

Do you feel that we could get more out of existing facilities, teaching facilities and professors in the area of health than we are now getting? I noted somewhere that professors generally are spending less and less time teaching. I don't know whether this is true or not, but I would imagine that it is at least somewhat true.

When I used to be a university professor, we considered 10, 12, 14 hours a week not too tough, and now they are talking about 3 to 4 and 5 hours in the classroom.

Now, if this is true in medical schools, that the hours that a professor is spending with students, maybe we ought to look at the problem from that standpoint.

Do you see this in the institution you are associated with?

Dr. CRAWFORD. In my own field, physics and radiation biology, it is true that the professionals who are in universities are combining research and teaching, and the cutdown in the teaching hours is usually an indication of the increase in the research hours.

Now, if I may speak to the position of the medical school, if one would emphasize the teaching aspect and separate research from the functions of instruction, we certainly could take our highly qualified teachers, have them spend more time in the classroom and have them able to handle more students.

It is quite possible to increase the efficiency of the teaching aspect. It is the combination of teaching and research which has really cut down on the efficiency of the teacher, and this is what you are describing in the universities all across the United States.

Mr. PETTIS. Right, and then in addition to that, some of the most expensive things about medical education are the facilities, the laboratories, and so on. I remember in World War II when we used to use these facilities at night, because we had such a great need for medical personnel, and no one thought that that was an undue hardship, and in many of these schools we were able to get a medical doctor out of medical school in 3 years instead of four. I have spent, now, 2 weeks listening here to testimony to the point that we need medical personnel so desperately, we need 50,000 doctors, and no one has talked about this being a crisis of such proportions that we maybe should look to using our existing facilities a little more efficiently, as we did in other crises, and maybe go on a double shift in some of these areas.

Dr. CRAWFORD. I think we cannot only double shift, but we can actually go on a sequence in which you have not only a double shift on a given day, but you actually use the facilities 6- or 7-days a week, so that your teachers are still working the same number of hours per week, but the buildings, the laboratories, the facilities you are referring to are fully occupied.

Mr. PETTIS. Right.

Dr. CRAWFORD. Furthermore, if you look at the summer activities, they are, in one sense, as far as instruction is concerned, a waste. There is no reason we have to throw away one-fourth of our calendar year in terms of efficiency of instruction.

I think it is also true that if one would expand one's concept as to where the adequate instruction could be obtained, it would be possible for us to place under fellowships, using moneys which could only be spent in the European countries, for instance, a tremendous number of persons on fellowships spending otherwise untouchable American money, and produce the cross-exchange of information by training American doctors in European schools.

We could follow the same process there, where those facilities are encouraged for maximum use.

We are not using our educational facilities to their fullest extent. We can stand a great deal of innovative thought.

Mr. PETTIS. I am glad to hear you as a professor say that. If some of us here on the congressional side of this table were to say it, I am sure we would be criticized, but having this come from you as a professor in a university situation makes it much more believable.

Thank you.

Mr. GIBBONS. Thank you, sir.

Dr. CRAWFORD. Thank you very much.

Mr. GIBBONS. The next witness this morning is Mr. C. Ross Cunningham, Christian Science Committee on Publication, First Church of Christ, Scientist.

Mr. Cunningham, we welcome you to the committee; and, if you would, please identify yourself, sir.

STATEMENT OF C. ROSS CUNNINGHAM, MANAGER, WASHINGTON, D.C., OFFICE, CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION, FIRST CHURCH OF CHRIST, SCIENTIST

SUMMARY

1. The Christian Science Church takes no position with respect to the desirability of a national health insurance program.
2. If a national health insurance law is enacted it should include:
   a. care and services in Christian Science sanatoriums to the extent that inpatient hospital services and extended care are included;
   b. services of a Christian Science visiting nurse to the extent home health services are included; and
   c. the services of a Christian Science practitioner to the extent physicians' services are recognized, but only if the program is a true insurance system administered by private carriers.

Mr. CUNNINGHAM. Thank you, Mr. Chairman and members of the committee, my name is C. Ross Cunningham, and as manager of the Washington, D.C., office, Christian Science Committee on Publication of the First Church of Christ, Scientist, in Boston, Mass., I

am making this statement on behalf of all Christian scientists in the United States. We wish to thank you for the opportunity to express the views of our denomination on the national health insurance proposals which have been introduced in Congress this year. We have the highest admiration for the deep concern expressed by this committee for the problems Americans in all walks of life are experiencing in obtaining adequate health care.

While most Americans seek health care through physicians and hospitals, there is a substantial number of people distributed throughout the country who, as Christian Scientists, rely exclusively on spiritual means through prayer for the prevention and healing of illnesses. The Christian Science Church accredits practitioners, nurses, and sanatoriums to care for our people. Our policy has always been to seek equal treatment in government programs between Christian Science care and medical care to the extent consistent with the administration and equitable operation of the programs.

As you know, Christian Science sanatoriums have been included as a part of the medicare program, being treated as both hospitals and extended care facilities. This arrangement has been proving successful from our standpoint and we believe from the standpoint of the Social Security Administration as well. Christian Science benefits under medicare are administered by the Aetna Life & Casualty Co. and our facilities and claims records are inspected generally in the same way as medical hospitals. Our sanatoriums, as well as Christian Science visiting nurses, are also included in the medicaid program.

We have also had a smooth working relationship with the administrators of two health insurance programs for Government employees, the Federal employees health benefits program and CHAMPUS, the health insurance plan for military dependents and retirees. Insurance carriers handle the administration of claims for these programs, and Christian Science practitioners' services have been covered under both of them.

The main point of our testimony is to ask that, to the extent appropriate, Christian Science health care providers be recognized in a manner as parallel as possible to providers of medical care. Christian scientists will be contributing as taxpayers, employers, employees and consumers to the support of the program. If it becomes national policy to unify in a single program all the means of furnishing care to the sick, such policy should include benefits which Christian Scientists could accept consistent with their convictions. If the program is a true insurance plan involving administration by private health insurance companies in a fashion which provides for substantially complete claims administration and payment by private carriers, it would appear just and administratively feasible to include payment for the services of Christian Science practitioners.

We do not propose to analyze here all the national health insurance bills and the varying ways in which they recognize Christian Science treatment as a benefit. It is enough to say that all the sponsors have, in one way or another, provided for Christian Science care somewhere in their programs. The administration bill, which uses private health insurance carriers as administrators, includes our practitioners, nurses, and sanatoriums. The Kennedy-Griffiths bill, H.R. 22, mentions

Christian Science sanatoriums but not our nursing services, which should be included.

We are not experts on insurance matters or questions of national scope, such as delivery of health services, and this statement is not intended to prefer any one proposal over another except as they have bearing on the equal treatment of all citizens.

Mr. Chairman, we deeply appreciate the consideration this committee has always given to the needs of adherents of our denomination and we feel sure that as you examine proposals for a system of guaranteed health care for all Americans, an extremely complex matter, you will continue to make equitable provision for Christian Scientists.

Thank you.

Mr. GIBBONS. Thank you.

Are there questions?

We thank you, sir.

Mr. CUNNINGHAM. Thank you.

Mr. GIBBONS. John Kerr, the president of College Young Democrats of America.

Mr. Kerr, I have been asked to announce that Chairman Mills expresses his regret that he can't be here this morning. He, of course, is very interested in this testimony, but his other engagements require him to be out of the city.

So, Mr. Kerr, if you would, proceed.

STATEMENT OF JOHN KERR, PRESIDENT, COLLEGE DEMOCRATIC CLUBS OF AMERICA

Mr. KERR. Thank you, Mr. Chairman.

My name is John Kerr, and I appear today on behalf of the College Young Democrats of America. Our organization has 50,000 members in 400 chapters on college campuses in all parts of the country.

We commend this committee and you, Mr. Chairman, for scheduling these important hearings, and I appreciate being given the opportunity to tell you briefly how our membership views the current "health crisis." I would also like to point out how various of the proposed national health insurance bills would affect students and other young people.

Our members have a very active interest in this issue and along with other young Americans we have perhaps the greatest stake in these hearings of any group which will appear to testify. This committee and the Congress will, in the coming weeks and months, design a health insurance program which will dictate the conditions under which we and our children will receive and pay for health services for a large part of our lives.

We hope that you will design a program which is more than an attempt to "patch up" the existing hodgepodge for a few more years or until after the next election. We hope that you will create a sound new system suitable to the needs and capabilities and capacities of the 20th century. We hope that you will not fail to act boldly in a crisis that clearly calls for decisive action.

The causes of the present health care crisis have been touched upon by numerous witnesses before this committee. They include manpower shortages, uneven quality of care, maldistribution of resources, con-

stantly inflating costs and lack of effective systems to organize and deliver services. These causes are closely interrelated and cannot be solved in isolation.

In the past Congress has attempted to deal with each part of the overall problem on a piecemeal basis. As you know, there have been manpower bills, HMO bills, medicare, medicaid, and now PSRO amendments. In spite of these efforts, the crisis worsens daily.

Our organization believes that it is necessary to attack these problems in concert, to develop and pursue a coherent national health strategy. We recognize that the problems cannot be solved overnight, but the Nation must make a beginning. The longer action is postponed, the harder the task becomes.

Mr. Chairman, at our national convention held in St. Louis last February, the College Young Democrats voted to endorse H.R. 22, the health security program, as the only proposal which meets this challenge. I would add that many of our members felt that H.R. 22 does not go far enough to create an open, democratic health care system for this country. But it is the only plan before this committee which is designed to meet the needs of people and not those of powerful vested interest groups.

This country has allowed the insurance companies and the American Medical Association to dominate our health care system for far too long. They may speak in the best interests of their stockholders and members, but they do not speak in the best interests of the American people. The national health insurance plans these groups have put forward will not serve the needs of people, and especially not young people. They are based on the preservation of a system which clearly does not work for large segments of our population.

College students and other young people have been largely excluded from effective coverage under traditional private health insurance. At age 21, they are dropped from their parents family health insurance coverage—unless they are a full-time unmarried student, at which time the coverage may be extended until age 23, and the purchase of individual insurance policies is exorbitantly expensive for an age group in which the median income is only approximately $3,500 annually. Many colleges and universities have attempted to fill this gap with student accident and sickness insurance plans.

A typical student policy—this one offered by Antioch College offers poor minimal coverage. Only $27 a day are allocated for hospital room and board, while prices for hospital beds run over $100 a day. There is a deductible of $100 for each accident or sickness in addition to the amount payable in the base plan. Furthermore, the major medical provision provides 80 percent of covered charges with a maximum of $5,000. This provision pales considerably when one notes that the most frequent cause of death to the population under 35 is the result of accident. Therefore, it is feasible to have some sort of catastrophic health insurance in the event of a long hospitalization after a serious accident.

Unfortunately, however, this student policy with already extremely limited coverage also has several stipulations. If a student is injured during practice or participation in intercollegiate sports, he cannot collect a penny. Dental treatment is only covered in the event of injury. There is nothing covered for anything related to childbirth. Worst

of all, there is no coverage for any mental or nervous disorders, typically student health problems while they are in college.

Finally, the method of filing a claim is a long difficult process with which many students are totally ignorant. When viewing the poor coverage with various stipulations, it's hardly worth the effort to file a claim.

Despite the fact that students are not covered adequately under existing health insurance arrangements, most of the proposed national health insurance plans ignore our population group altogether.

The most obvious example of this neglect is the Nixon health insurance partnership plan which will provide no help whatsoever to the vast majority of college students. In order to be covered under the employer mandated insurance, an individual must work 350 hours for the same employer. Most employed students work on a half-time basis of 20 hours or less a week. At that rate, a student who works for the same employer for an entire academic year will be covered for the last 4 or 5 weeks of the spring semester.

Even if a student could qualify for the Nixon employer program, few can afford the $170 employee share of the premium or the heavy deductible and co-pay provisions. But to follow this hypothetical student a bit further, even if he worked for the same employer throughout the summer and was covered under the health insurance policy purchased for that business, the insurance company could collect his premium for 6 months without having to make any payment for a "preexisting" condition.

The FHIP program for low-income families—a condition which certainly describes most married students—won't help many college students either. Secretary Elliot Richardson admitted in his October 20 testimony before this committee that a large percentage of the 3.3 million people who fail to qualify under any of the administration's proposed plans are college students.

The AMA and insurance industry plans give slightly more advantage to students with respect to coverage; as presumably students with no tax liability would be entitled to Federal assistance in purchasing a private health insurance policy. This is modest praise, however, when you consider the deficiencies of private health insurance and the limited nature of the policies which would be available. The deductibles copayments cutoff points and exclusions in those policies place an impossible strain on individuals and families with limited incomes.

The health security program is the only plan under consideration by this committee which adequately addresses the needs of students and young people. First, its participation is universal so that a student can be assured of coverage when he marries, reaches his 23d birthday and whether he is employed or unemployed.

The services of the program are comprehensive. This is especially important to young people who use significantly fewer days of inpatient hospitalization than older people, but who more frequently have need of those types of services—such as mental health, maternity, and catastrophic accident—that are most often excluded by private health insurance.

The cost of health security is equitably based upon ability to pay. While income is low, the impact of the health security tax is negli-

gible—approximately $35 annually for the average student. There are no deductible and co-pay barriers to service when it is needed. Later, when the student has graduated and begins to have a larger income, his tax contribution is higher. This deferred payment plan makes it possible to receive services when they are needed—for those services predictably and evenly over your working lifetime.

Most important, however, we feel that the health security program provides a concrete and workable blueprint for building a strong and flexible health care system for this country. It provides the means to eventually bring high quality health care to every American citizen, whether he lives in the urban ghettos, rural areas, or affluent suburbs. The enactment of health security would take one important step toward achieving the basic social reform which must occur if this country is to survive and preserve its democratic institutions.

Thank you, Mr. Chairman.

Mr. GIBBONS. Let me thank you for your very fine and very vigorous statement.

Let's see if we have any questions. Mr. Corman?

Mr. CORMAN. Thank you, Mr. Chairman. I want to commend Mr. Kerr for that statement. I think he has pointed out to us that a significant number of people, I am afraid, are going to be neglected unless we can eventually get to passage of H.R. 22 or something similar to it. There just is no question that a great number of people necessarily fall outside of the family plan of available health insurance, and once you get outside that system, the policies are expensive. Most important of all, as you have pointed out, they exclude every foreseeable probable coverage that you need.

I know that from personal experience. I bought a policy for my 23-year-old daughter, and it was stupid for me to buy the policies, because they outguessed all of the medical care that she may need and have excluded that from the coverage.

Mr. KERR. This is especially true, I think, in regard to the mental health sections of the health security bill. Many college students I am familiar with have had problems of adjustment and have needed to seek, at times, professional help. This is why we feel especially that this section in the health security bill relates, where no comparable section exists in any of the other bills.

Mr. CORMAN. I very much appreciate your highlighting that particular shortcoming in the other bills.

I received a very nice letter from you asking me to support the Griffiths bill. I hope you will tell your colleagues in California that this bill is referred to as the Griffiths-Corman bill.

Mr. GIBBONS. I know what you are referring to. I have two male members of my family in college now, and they sure do have a lot of medical expenses. On my very fine salary, I can afford to pay their bills, but with respect to other families, I am sure they have to stretch to pay expenses that occur at collegetime.

We thank you very much for coming.

Mr. KERR. Thank you.

Mr. GIBBONS. Professor Bernstein, I think you are our next witness. If you would, please come ahead and identify yourself, sir, and proceed.

STATEMENT OF PROF. MERTON C. BERNSTEIN, OHIO STATE UNIVERSITY SCHOOL OF LAW

Professor BERNSTEIN. Thank you, Mr. Gibbons, Mr. Byrnes, Mr. Betts, Mr. Schneebeli, Mr. Corman, Mr. Pettis.

I am a professor of law at Ohio State University, but I appear entirely as an individual.

I learned something about some of the problems under consideration, as a member of the staff of the Senate Labor Committee, when I was counsel to the Labor Subcommittee headed by Senator Humphrey in 1952.

It was my privilege to be associated for several years with Senator Morse. I was special counsel to the Labor Subcommittee under Senator John Kennedy.

Mr. GIBBONS. I thought you looked familiar.

Professor BERNSTEIN. I have been around Congress before. I have, since 1960, been teaching courses and seminars dealing with social legislation, social insurance, medical care, and disability at Yale and Ohio State. I was the Chairman of the Social Security Administration's Research Advisory Committee for 3 years, but in no way do I mean to implicate that committee on SSA in the views I present.

CHANGING PUBLIC EXPECTATIONS OF MEDICAL CARE

Mr. Chairman, I think you are quite right that over the last 20 years there has been an enormous change of attitude among the American public. I think that has been universally the case. We have had an enormously productive economy. We have enjoyed over the last 20 years an increase in the standard of living, which, however, has been very unequal. We have begun to have expectations in the area of medical care and health care that simply did not exist at the end of World War II.

Today, we have expectations that are not being met, and we have an enormous expenditure on medical care.

Health care is the largest industry in the United States today in terms is the largest industry in the United States today in terms of the amounts spent and the number of people employed, yet we have a problem today of doing more, and yet keeping that much more within our financial capability, and the remarkable thing is that it can be done, because we are, as other witnesses have pointed out, wasting emormous amounts of funds that are not going to health care directly, but are going to the health care sector.

MULTIPLICITY OF HEALTH CARE PROGRAMS

We have a nonsystem of health care in this country, and one could not quickly catalog all the programs that we have, but they include public programs, publicly-operated programs, publicly-mandated programs, private programs—such as medicare, medicaid, private group health insurance, workmen's compensation, the Federal Employment Compensation Act, innumerable plans—innumerable programs which pump billions of dollars into the health care system, but in a very inefficient way.

This committee, I think, is headed toward, and Congress is headed toward, the enactment of some health care comprehensive legislation. If that legislation, if that program that eventuates, is comprehensive enough, the American people will be able to enjoy far more medical care than they enjoy today, without vast infusions of new amounts of money.

THE WORKMEN'S COMPENSATION PROGRAMS

For example, we have a separate program, separate programs, in more than 50 jurisdictions that go under the name of workmen's compensation. It is limited to work-related injury and illness. It is not as comprehensive as that may sound.

Only 84 percent of the privately employed are under such programs. The programs are not comprehensive. They exclude many illnesses that are in fact caused by work, but do not meet the very strict definitions of work-relatedness necessary for illness.

They do not reach all of the work injuries that are caused. Indeed a good deal of time, energy, and money and skilled manpower are devoted to the sterile purpose of ascertaining whether or not an injury or illness is in fact work-related.

THE ADVANTAGES OF INTEGRATING PROGRAMS

If this committee produces a measure which is sufficiently comprehensive, the United States can save literally billions of dollars by no longer having so many separate programs which expend funds on determining eligibility and the special requirements of each program.

I must say, also, that many of these programs use up health personnel in nontreatment situations, such as litigation, and it is a scandalous waste when we need that manpower for treating people.

Just to concentrate for the moment on the workmen's compensation program, I call your attention to the material on page 2 of my prepared statement.

Covered employers paid out $4.4 billion in premiums or 1 percent of total payroll. I point out, this is a larger percentage than a comparable percentage under social security. Social security tax rates are limited to covered payroll, a much more limited category. It is an enormous amount of money, and yet of that amount only $2.6 billion were paid out in benefits, which produces a 58.8 percent figure for benefits as compared to premiums.

Now, if only private insurance is taken account of, the figure is 50 percent. That is a wasteful program.

With the enactment of comprehensive care, there no longer would be a necessity for differentiating between work-caused and nonwork-related injuries.

Indeed, given the different patterns of employment today, with shorter hours, longer recreation, the greater hazards of the nonwork situation, work-related injuries no longer are the principal cause of injury and absence from work.

The cost of uncompensated injury, untreated injury, is very large in terms of work loss, inefficient production, and the like.

Now, if the workmen's compensation program and other specialized programs were absorbed into a comprehensive health care program,

their cost would be greatly reduced. So, for example, just taking—and this is a very rough approximation—if you were to take the not quite $1 billion that are paid out in health care benefits under workmen's compensation, that comes at a cost of almost $2 billion in premiums.

If you took that $2 billion and put it into a national health care program that is comprehensive, you would get almost $2 billion worth of medical care out of it, which would be a much more sensible way to organize things.

The same may be said of other kinds of programs.

TAXATION FOR A COMPREHENSIVE HEALTH CARE PROGRAM

Now, I would suggest, and this is within the special competence of this committee, that a comprehensive program is going to represent enormous expenditure savings. So, for example, if you have a really comprehensive program, industry would be relieved of insurance costs that now must be borne because they are liable for injuries caused by their activities.

So, to take as an example the billions of dollars expended for automobile insurance and truck insurance, a comprehensive program of the kind sponsored by Mr. Corman, in the Griffiths-Corman bill, also sponsored by other members of this committee, would relieve industry and commerce of very large expenditures for insurance, for injuries, health impairments which they cause, or to which they contribute.

I respectfully suggest to this committee that it use those savings as a source of contribution to support this program.

I think that a comprehensive program that relies, in part, on the payroll tax is a very efficient way of financing a comprehensive health care program.

I also suggest that those who would be relieved of a very large part of their expenditures in this area be made to contribute, by taxes, which are related to the extent to which they cause health impairments, and I think a basic principle that this committee might well consider is to charge industry and commerce with the cost of the health impairments that they cause, in addition to the payroll tax.

I think further——

Mr. GIBBONS. How would you do that?

Professor BERNSTEIN. Well, there is experience to go by, Mr. Gibbons.

Each of the Canadian provinces has a workmen's compensation board which allocates to each industry the work-related injuries attributed to that industry. So it is manageable. It would not be a very difficult matter to start out with fairly arbitrary and low figures so as not to charge too much, and then take a sample of those treated under the health care program. As a sampling, take the cause of injury or illness and make a distribution of cost according to causation—not 100 percent, but some reasonable portion of the national health program.

And, further, if by doing this every several years one could get a sense of what industries were improving their health impairment showing and what industries were not doing so and could adjust their tax rates accordingly, this would have the double purpose of providing needed funds for what will be undoubtedly a very expensive

program and it would also provide an incentive for a better showing. Such tax payments do not represent a net additional cost to those industries, because they are paying out enormous sums in insurance premiums in any event.

TAX HEALTH IMPAIRING ACTIVITIES TO HELP PAY FOR PROGRAM

Now, I suggest that this principle could be extended to all health impairing activities, so that polluters ought to make a contribution to a national health care program. Rather than causing health impairment, they ought to contribute to the alleviation of those health impairments.

Mr. GIBBONS. Could we get Mr. Corman's pipe people and Mr. Byrnes' cigarette people in on that? [Laughter.]

Professor BERNSTEIN. Yes, because not only is a smoker impairing his own health but he is contributing to impair the health of others. I say this only somewhat facetiously.

Those who drive automobiles and whose chimneys produce black soot are contributing to the health problems of the United States.

The Chairman asked earlier of one witness what the reasons for the high rate of expenditure in the United States were for health care, and yet the poorer showing vis-a-vis other western nations.

Well, sir, if you have been to a place like Stockholm, you will see there is no pollution to speak of, and yet the government in Stockholm is very zealous in its concern over the way in which industry operates in that area. One can see a clear sky during the daylight months in that city.

There are other factors, but they are very zealous in preventing the causes of illness.

It is unfortunate that to a considerable extent the costs of production are shifted to people who experience ill health as the result of activities that impair health.

I suggest that, one, those who cause these things should be taxed in some proportion to the impairments that they cause and, two, that their activities, that greater efforts be devoted to preventing their activities.

PROPOSAL FOR A JOINT COMMITTEE ON HEALTH

Now, this committee has an enormous burden in writing a comprehensive health care measure. I suggest that medical care is only part of it. The jurisdiction of this committee, which is awesome, is nonetheless not sufficiently comprehensive to deal with the multitudinous problems of preventing or reducing health impairing activities.

For instance, does it make sense to have inadequate nutrition and then have children who may be near death treated in hospitals?

It makes no sense whatsoever. It is a misallocation of funds. Prevention is not only more humane but more economical.

I earnestly suggest that perhaps this committee or others might provide the initiative for a Joint Congressional Committee on Health Care which would deal with the many activities which affect health.

If the United States were to exert not maximum, but near maximum, efforts at preventing health deteriorating activities, we would go a long way toward the cost control of health care.

INTEGRATION WITH VETERANS' HEALTH CARE

Veterans' benefits also represent another area in which coordination might take place. I don't, for a moment, suggest that veterans are getting something to which they are not entitled. I do suggest that if there were coordination of veterans' benefits with a comprehensive health care plan, veterans would be better served and those who are not veterans would be better served.

Veterans who have to go to VA hospitals and other facilities, which may be far distant from their homes would be better served if they had equal opportunities for care at places near to their homes where they could have the support of their families in recovering from illness.

COORDINATING HEALTH FACILITY OPERATIONS

So I would suggest that the Congress build on the work done by Senator Ribicoff's Subcommittee on Government Operations. He has developed a record which shows that the armed services, the VA, and private institutions duplicate costly facilities in many communities of the country at great capital expenditure, and at the same time, periodically have empty bed space which means that they are running at higher cost per patient than they should.

Mr. Pettis has pointed out that we are not making maximum use of our medical school facilities, and I heartily agree with that. Also, I suggest, we are wasting enormous sums because we have so many separate programs in the hospital area. This is not to say that there has to be one overall ownership of all hospitals.

What it does mean is that it makes no sense for the Army and the Navy and the Marines to have separate installations, in San Diego, for example, and run operations that have empty beds while civilian hospitals in the area may at the same time be overcrowded.

We are not getting the maximum amount for our health dollar by any means. We are running a very wasteful system. By coordination and rationalization, we can do a better job with the facilities we have. They may not be fully adequate, but we could get much more mileage out of what we have.

PREVENTIVE MEASURES—ESPECIALLY MASS MEASURES

Further, I would suggest that the answer to health care is not all medical care of the acutely ill, and of course a major factor in the administration bill, the Byrnes bill, and H.R. 22 is to provide preventive care. Certainly one of the greatest deficiencies of group health insurance so far has been the fact that it treats people only when they are ill, except for the HMO's, which now cover a very small minority of people.

I suggest, however, that there ought to be in any comprehensive plan an emphasis, that I do not yet find, upon preventive public health measures.

To a very considerable extent, the improvement in health and longevity in the United States today is due to public health care measures,

the elimination of some of the causes of infectious disease, and large-scale immunization programs, which have been deteriorating.

We are running the risk, for example, of a resurgence of polio, because we do not have a comprehensive national program of immunization.

I earnestly suggest to you that we can get far more for our health care dollar if we emphasize preventive programs on a mass basis.

Just as a brief example, a few weeks ago my wife and I took our four children on a Saturday morning to a pediatrician, and they all got shots, about nine in all. In addition to sore arms, we got a bill for $52. We have a marvelous pediatrician. He administered the shots, which was a waste of his time. If the youngsters had gotten their shots in the schools, along with all the other kids in the neighborhood and in the State, the same health immunization could have been achieved at the cost of pennies per child.

Now, to spend money in a national health care plan, and some of these bills would do just that, they would compensate physicians and nurses for doing that kind of activity, is wasteful. It is not sensible.

If we don't have enough health care personnel, and we don't have enough money to mount a completely adequate program, what we have got to do is spread our money and spread our personnel in a far more efficient way.

If I may make one other comment on research, one of the major reasons that today the American people enjoy greater health and greater longevity than 40 years ago or 50 years ago is the fact that we have had a tremendously productive research program.

The fact of the matter is that money devoted to research is far more productive of good health than money devoted, in equivalent amount, to the training of health care personnel.

I don't suggest that we skimp on the training of health care personnel, but I think we ought to recognize that money spent on research, particularly research devoted to preventive things, like the polio vaccine, has enormous dividends.

I thank you for your time and patience.

Mr. GIBBONS. Thank you for your statement.

Are there any questions?

Thank you, sir.

Professor BERNSTEIN. Thank you.

(Professor Bernstein's written statement follows:)

STATEMENT OF PROF. MERTON BERNSTEIN, SCHOOL OF LAW, OHIO STATE UNIVERSITY

WAYS AND MEANS COMMITTEE WITNESS MAKES NOVEL PROPOSALS FOR NATIONAL HEALTH CARE PROGRAM

In testimony before the House Ways and Means Committee a witness proposed: coordination of any new national program with many existing medical care programs—such as workmen's compensation and veterans' benefits; partial financing for the program by taxes on activities and products that cause injury and illness; a Joint Congressional Committee on Health to map a comprehensive, coordinated national program; and the wide use of public health service techniques to reduce the need for individualized medical and dental care.

Merton Bernstein, Professor of Law at Ohio State University said:

"To be fair and economical, a comprehensive national health care program should be closely coordinated with the many existing public and private health

care programs already in operation. Some might advantageously be absorbed—along with the revenues that now support them. Indeed, a cardinal rule of a new national program should be that particular activities which cause health impairments should directly help in financing the new program. Further, preventative measures—especially on a mass treatment basis—should be a major means of producing better health at lower cost."

Under the suggestions made, if the new national health care program absorbed the medical care activities of workmen's compensation, the system would receive some $2 billion in revenues while making many administrative expenditures of workmen's compensation unnecessary. At present employers pay $4.4 billion in workmen's compensation premiums but benefits total only $2.6 billion a year. In some states compensation system medical benefits are limited by law. If workmen's compensation payments are excluded from the national plan, the national program would pay out more in states with meager programs than in states with ample programs, it was noted.

Industries should be taxed for the new program in proportion to the health impairments they produce to their employees. And health harming activities and products also should be taxed to help finance a national program of health care. Professor Bernstein suggested. When they cause less ill-health, tax rates should go down.

He suggested that VA and service hospitals be meshed into the operations of private non-profit hospitals to reduce duplication of costly equipment and to better utilize their capacity—and so reduce operating deficits.

Coordination with veterans' benefits and automobile accident insurance also was proposed.

Noting that activities which contribute to ill health fall within the jurisdiction of several Congressional committees, the witness suggested a Congressional Joint Committee on Health.

The witness also urged that any national health program use public health methods and mass immunization to reduce the need for individualized health and dental care.

Professor Bernstein has taught courses and seminars in social insurance and medical care at Yale and Ohio State Law Schools. In 1968–69 he was Chairman of the Social Security Administration's Advisory Committee on Research and has written extensively on private and public group insurance, social security, workmen's compensation and disability programs.

NATIONAL HEALTH CARE

The Desirability of Coordination With Existing Medical Care Programs, Testimony of Merton C. Bernstein * Before the House Committee on Ways and Means, October 29, 1971

To be fair and economical, a comprehensive national health care program should be closely coordinated with the many existing public and private health care programs already in operation. Some might advantageously be absorbed—along with the revenues that now support them. Indeed, a cardinal rule of a new national program should be that particular activities which cause health impairments should directly help in financing the new program. Further, preventative measures—especially on a mass treatment basis—should be a major means of producing better health at lower cost.

I. Coordination With Existing Programs

Innumerable programs already exist which provide some measure of medical care to Americans. Chief among them are the more than 50 state workmen's compensation acts for private employees and (in some states) public employees, separate state programs for public employees, the Federal Government's similar Federal Employees' Compensation Act, the Federal Government's group health insurance plans, private group (employment-based) health insurance, veterans' benefits (for both service-connected and non-service-connected conditions), private automobile liability insurance, private automobile medical insurance—and other statutory programs for merchant seamen and railroad employees. Each has separate conditions of eligibility, its own administrative machinery, and

*Professor of Law, Ohio State University.

benefit schedules. Each program was created separately with little regard for the others. As a result, there are gaps in coverage, duplications of coverage, unequal treatment for similar conditions. Possibly most important, we pay large amounts for maintaining separate programs which could be saved or devoted to more adequate benefits. Possibly worse, scarce skilled man (and woman) power are consumed in tasks other than providing medical care. For the purpose of this testimony, only three systems will be discussed.

A. WORKMEN'S COMPENSATION

In 1969* (the last year for which national data are available) about 59 million employees had workmen's compensation coverage (including federal employees under FECA)—some 84% of the civilian employees in the country. In addition to the generally excluded farm and domestic workers, employees of small companies still are not covered in many states.

W. C. low benefit ratio

Covered employers paid out $4.4 *billion* in premiums—(a shade more than 1% of their total payroll)—a not inconsiderable amount. Of that amount, $2.6 billion were paid out in benefits—$920 million for hospitalization and other medical costs. In other words, 58.8% of premiums were paid in benefits. If only private insurance is analysed, it turns out that a shade more than half (50.4%) of premium was paid out as benefits (if dividend returns were counted, that showing would improve by 4 to 6%). Some small amounts go to safety engineering. Even then, private workmen's compensation insurance pays out only 60% of premium in benefits.

W. C. limits on benefits

And the benefits are not impressive. Many states do not have comprehensive disease coverage and all require that a disease, to be covered, must have a special causal relationship to the employment. The fact that a disease is *in fact* caused by the employment is not enough. Some states limit medical treatment available whether for disease or accidental injury by providing dollar or time limitations upon such care. Those limitations have not been generous.

If comprehensive medical care is to be provided under a national program but workmen's compensation cases are to be excluded (as under Part B of H.R. 7741, § 626(d) (pp 41–42) and S. 3 and H.R. 2162 § 28(a) (pp 18–19)), the coverage provided by the national plan will vary according to state law. Existing inequalities may be widened as soon as state legislatures realize that they can gain a differential cost advantage by reducing or eliminating mandatory medical care.

Difficulty and cost of determining W. C. coverage

One of the major cost burdens of workmen's compensation acts is the difficulty of determining whether a disease or injury has the requisite work-relatedness (especially in heart, back injury and hernia cases) in which individual frailty often plays a part. In addition to the costs of such difficult determinations would be added the administrative costs incurred by the entity administering the federal plan in recovering from the insurance carrier liable for the costs under state law. This could result in yet another round of litigation—which would be a cost without attendant benefits.

Proposal to have Federal program take over W.C. medical benefits

It would be far fairer and far simpler for the federal program to provide all the medical care whatever its cause—a matter not always free from doubt. Such an arrangement would assure early and adequate medicl care (although S. 3 and H.R. 2162 would cover such services if provided by a participant until they are determined to be due under workmen's compensation). This is important because serious injury claims tend to be the ones most vigorously contested. A physician should be enabled to provide the treatment necessary when it is needed and not hold back because an employee may be unable to pay if the injury turns out not to be covered.

And, even if the national program provider takes over after benefit limits under workmen's are reached, this may result in an unfortunate shift in treatment from one institution to another, from one or a team of physicians to another.

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*All data on workmen's compensation derived from "Workmen's Compensation Payments and Costs, 1969," 34 Social Security Bulletin (No. 1) 31 (January 1971).

Financing medical care for work-related injury

As a general proposition, any activity that causes injury and economic loss to others ought to bear the burden that results.

Industry and commerce conduct activities that can be counted on to cause illness and injury which require medical care. They ought to pay for them—that is the theory of workmen's compensation. Hence if the medical costs of those programs are shifted to the national health program, employers should continue to finance such care. The national health program should include taxes equivalent to the medical costs attributable to employment activities classified by industry. The Canadian provinces calculate the appropriate industry tax rates for their workmen's compensation programs based upon the apparent causation of injuries. This could be done by sampling the medical case load every few years and apportioning costs accordingly. Such a method is every bit as fair as the dubious case-by-case legal duels that now occur and much less costly. The savings can go into reduced charges to employers, improved benefits, or both. Canadian industry, much of it American owned, has had no major complaints over such a program.

What I suggest for the Committee's consideration is something like a $2 billion infusion into the national health program that now goes—quite wastefully—into workmen's compensation. It would represent, roughly, obtaining almost $1 billion for medical benefits (and/or reduced employer costs) that gets consumed in administrative and selling costs in order to run a separate program limited to work-related injury and disease when the purpose of the new national program is to provide at least comparable medical care for non-work-related injury and illness. In sum, there no longer is any policy reason for operating two separate kinds of plans while considerations of economy and fairness call for a combined program. (Workmen's compensation commission tasks in the field of income maintenance could be taken over by state unemployment compensation commissions for short term losses and the disability program of the Social Security Administration for long term losses. Commission personnel could be absorbed in both areas and in administering the new medical program.)

B. AUTOMOBILE AND OTHER HEALTH IMPAIRING ACTIVITIES—MAKING THEM PAY FOR MEDICAL CARE THEY MAKE NECESSARY

The D.O.T. automobile insurance study reports that a person seriously injured in an automobile accident incurs, on the average, almost $1,700 in medical expenses.*

The same study indicates that only slightly more than half the families sustaining automobile accidents had medical and/or automobiles insurance applicable to such losses and fewer than half collected for their medical costs under such policies. Except for the small amounts payable under workmen's compensation for such medical expenses, a comprehensive national medical care program would meet such costs (and very possibly make possible more prompt treatment). It surely would be a boon to those without such policies.

About 450,000 persons fall into this category in a year, according to the D.O.T. study—for a medical outlay cost of about $765 million. This three-quarters of a billion dollars—or a major share of it—should be raised by taxes on automobiles and truck operators whose operations create—or at least help create—the hazards which predictably result in such accidents.

It is more economical to cover and finance such medical care in this way than to incur the additional expenses involved in private insurance for the purpose even on a "no fault" basis—and "no fault" is beginning to move in this direction. Coverage and treatment under a comprehensive health plan would require only a showing of medical need, whereas there are additional items of eligibility to be shown under either "no-fault" or uninsured motorist insurance.

Taxes on polluters, cigarettes and alcohol

Similarly, those responsible for air and water pollution should be taxed to support a national health care program to the extent that their activities impair health and contribute to the necessity of medical treatment. Tobacco and alcoholic products should be taxed on the same basis. Periodically, sample of persons requiring treatment would indicate whether those activities are causing more or less illness and their tax rates adjusted accordingly.

This is a fair way to help raise the revenues for a national health care system.

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*D.O.T. Automobile Insurance and Compensation Study, *Economic Consequences of Automobile Accident Injuries*, Table 3.1, p. 46 (1970).

C. VETERANS' BENEFITS

I do not suggest for a moment that veterans' benefits are undeserved or should be reduced. Many veterans can not be adequately compensated for their sacrifices—and the sacrifices in war have been unequal. Similarly some veterans can never overcome the handicap of being out of the job market in times of manpower scarcity when unequaled opportunities occurred. Some of these could not overcome those handicaps by the training benefits of the GI bills—and they deserve medical help.

But it should be recognized that medical care received by veterans for non-service-connected disability is indistinguishable from medical care to be afforded to the rest of the citizenry under a comprehensive national plan.

There are some indications that when provided the alternative of medicare, some veterans choose its auspices rather than VA hospital treatment.* To the extent that the new program provides treatment equal to that now accorded veterans, such treatment should be available under the more neutral auspices of the national program, if for no other reason than that it would be more readily available and convenient to veterans and their families who live substantial distances from VA hospitals. To the extent that the new national program omits benefits available to veterans, those benefits—I would urge—should be maintained.

But serious study must be given to coordinating non-profit hospitals and clinics with VA and armed service installations so that costly capital expenditures are not duplicated and the cost of unused beds that periodically occurs can be avoided. It makes little sense at a time when hospital costs have become such a critical problem to fail to coordinate VA, service and private non-profit facilities to make maximum economic use of both facilities and personnel and to coordinate the research activities of those now atomized programs.

Pride in separate programs is simply too costly in today's medical market. The VA expenditures for general (non-psychiatric) medical care comes to almost $1 billion a year. When put in harness with a national medical program those funds should generate more extensive and readily available care to veterans and civilians alike—at lower cost.

II. The Desirability of Preventative and Public Health Measures

Two major components of today's health care crisis are the shortage of trained personnel and, partially in consequence, the rapidly rising costs of medical care. Both, in turn, are partially due to the methods by which care is furnished. It is commonly agreed that physicians and nurses should work at their highest skills and be relieved of tasks which can be adequately handled by less trained persons. And it is becoming recognized that the limitation of private health insurance coverage to disease and injury to the exclusion of preventative activities is both bad medicine and bad economics. While that is not a novel observation, the Committee should set as one of its major standards the encouragement of preventative medical activities. In addition, if personnel are to be used effectively and economically, the Committee should also seek to encourage to the maximum preventive efforts that utilize public health service measures.

Some preventive measures

This committee does not have the jurisdiction to do that whole job—such as the abatement of air and water pollution, although the already suggested tax measures would contribute to that end. More effective measures to reduce cigarette smoking clearly are desirable. Possibly the reduced use of pesticides and food additives would help reduce illness—including cancer. These problems cut across existing committee jurisdictions.

Proposal for a joint committee on health

The Committee might consider proposing the creation of a Joint Committee on Health Care drawing its members from the Committees on Ways and Means and Finance, Interstate & Foreign Commerce, Public Works, Agriculture & Forestry, and Labor and Public Welfare and Education and Labor so as to mo-

*E.g., Administrator of Veterans Affairs, *1970 Annual Report 8* (1971): "The continued downward trend in the proportion of the VA hospital load age 65 and over is evident in 1969 also. From a pre-medicare level of 34 percent of all VA hospital discharges in 1965, the level has declined steadily to 21.6 percent in 1969 * * * The reduction in recent years appears too great to be attributable to the decrease in the number of aged veterans." The report also projects a great increase in that age group during the 1970's.

bilize the machinery of Congress in a coordinated way. Health care is the largest industry in the United States—it deserves and requires attention of this sort.

Using the public health approach

While modern medical technology is a marvel, the main contributors to health and reduction of the death rate have been public health sanitation measures, mass prevention through immunization and the antibiotics.

These also contribute the least expensive measures for conservation of health, especially when the latter are done on a mass basis—that I call an extension of the public health method.

So, in addition to the reduction of sources of illness and injury—such as pollution, smoking, transportation, unsafe places of work, poor housing design—mass immunization requires quite limited trained personnel, accomplishes readily and cheaply what otherwise would take trained hospital or office personnel. (In contrast, immunization is specifically provided for as part of basic coverage in H.R. 7741, § 603(a)(4) (p. 7, lines 9–12)—but they are limited, unfortunately to being administered by a pediatric nurse. That seems to assume that immunization will not be available to adults or, if so, would only be available if rendered by a physician at much greater unit cost.) Mass immunization can drastically reduce disease thereby reducing not only medical costs, but preventing the causes of income loss, disrupted production, impaired health which can lead to other serious illness, and—in some cases—birth defects which are not only personal tragedies but may require long and costly custodial and remedial care.

The most readily accessible places for such services to be rendered probably are in the nation's schools, where not only children but adults can be served on a mass, low cost basis.

Similar mass efforts at preventive dental care—such as fluoride applications to childrens' teeth (and the active discouragement of candy consumption—the very opposite of what takes place on television today)—should reduce the far more costly individual visits to dentists for corrective treatment.

CONCLUSION

The nation seems ready for comprehensive health care available to all without the barrier of cost. If we are to be able to mount such an effort we must do the maximum in disease and injury prevention and provide mass preventative care, thereby reducing the necessity for large amounts of individualized medical care for which available personnel and funds may not be adequate.

THE OHIO STATE UNIVERSITY,
COLLEGE OF LAW,
Columbus, Ohio, November 8, 1971.

Mr. JOHN M. MARTIN, Jr.,
Chief Counsel, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. MARTIN: Enclosed is a copy of an article by me which just was published in the University of Pennsylvania Law Review which I would like to submit as a supplement to my testimony. (Although it appears in the May 1971 issue, that issue was just issued.)

With appreciation for your attention,

Sincerely,

MERTON C. BERNSTEIN.

Enclosure.

[From the University of Pennsylvania Law Review, May 1971]

THE NEED FOR RECONSIDERING THE ROLE OF WORKMEN'S COMPENSATION

(By Merton C. Bernstein)*

In response to "serious questions" about state workmen's compensation acts, Congress has chartered a special commission to inquire broadly into the adequacy, efficacy, and fairness of their operation and to report by mid-1972.[1] To

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[1] Occupational Safety and Health Act of 1970, Pub. L. No. 91–596, § 27, 84 Stat. 1616. The unit is titled the National Commission on State Workmen's Compensation Laws. *Id.* § 27(b).

emerge with meaningful answers, the Commission must first formulate the proper questions. I suggest that the basic threshold question should be: "Are programs to provide income replacement and medical care limited to work-related injury and illness currently justifiable by either policy or practical considerations?" [2] A major element of this issue is that yesterday's reform—workmen's compensation—is a significant part of today's problem. A review of the origins of workmen's compensation acts shows that they took shape in response to the particular exigencies existing at the end of the nineteenth century and in the early twentieth. Unsurprisingly, current and prospective conditions are markedly different. Following a brief historical review, succeeding sections of this discussion will highlight certain discrete difficulties of the present system. At a minimum, the Commission's considerations should resolve these problems; the optimal solution may be a complete restructuring and harmonization of a multitude of income replacement and medical care programs.

I. Design and Origin of the Workmen's Compensation Acts

Most industrial states adopted workmen's compensation acts in the early twentieth century, and the basic pattern took shape during the 1920's. While innumerable details differ, the several workmen's compensation acts share certain major features. They impose upon employers absolute liability for income loss and medical expense caused by work-related injuries or illness and require either employer insurance against such expenses or proof of employer ability to self-insure. In return, the employer is relieved of common law liability based upon fault, and those costs for which he is liable are limited in amount.

The original acts were shaped by common experience and problems and by debates similar throughout both this country and England during the closing decades of the last century and the first decade of this century. Nineteenth century industrialization and commercial growth created numerous new hazards for working people, and older legal norms did not fit the new situations because of the classic employer defenses: recovery required proof of employer negligence, and negligent acts of other employees were not attributable to the employer; the employee, because he received greater pay for higher risk work, assumed the risks of injury involved in work; and any negligence on the employee's part which contributed to his injury barred recovery.

In England and the United States, the first legislative responses to the changed conditions were the enactments of differing versions of an employer liability act eliminating or tempering in varying degrees the three common law defenses, particularly the fellow servant rule, then regarded as the principal hurdle to employee recompense. Almost two decades in England and another decade and nore in the United States preceded the realization that the common law defenses comprised but a minor part of the problem and the discovery that the necessity of proving employer negligence constituted the major impediment to employee recovery. But concern over the high rate of serious injury in manufacturing and transportation,[3] the impact upon the injured and their families of uncom-

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[2] This question is within the Commission's scope of inquiry:

> The purpose of [§ 27] is to authorize an effective study and objective evaluation of State workmen's compensation laws in order to determine if such laws provide an adequate, prompt, and equitable system of compensation for injury or death arising out of or in the course of employment.

Id. § 27(a)(2). The 16 specified subjects of study include the interrelationship of workmen's compensation with social security and other public and private insurance programs. *Id.* § 27(d)(1)(O).

An associated aspect of this question not considered in this discussion is whether *individual* state programs are justifiable. The traditional laboratory argument, so appealing as an abstraction, should be investigated to ascertain whether its theoretical potentiality has been realized in any substantial way or whether balkanization merely facilitated domination by local interest groups. Experimentation is possible within otherwise uniform national programs as the very limited but potentially useful demonstration projects with income guarantees suggest. Initiative can be supplied by private reform groups, industry, unions, academics, and local government, as well as by Congress and the Federal agencies involved.

The practical disadvantages of 50 separate programs include: confusion over liability in instances involving possible multiple jurisdiction; additional administrative overhead; unseemly competition for industry between restricted-coverage, low-benefit States and broad-coverage, high-benfit States; and difficulty in coordinating 50 programs with related national programs. Each of these militates for giving serious consideration to either national standards or administration, or both.

[3] *See, e.g.*, Report of the Employers' Liability and Workmen's Compensation Commission, S. Doc. No. 338, 62d Cong., 2d Sess. 22–23 (1912).

pensated losses,[4] and dissatisfaction with the delays and unfairness often in private litigation eventually led to further efforts at reform.

Indeed, by the end of the first decade of this century, the intense debate over industrial injuries had reached such a consensus that the President of the National Association of Manufacturers opened a volume on the subject with this observation:

> Employers' liability laws have perhaps been the most fruitful source of worry, dissatisfaction and friction to the employers and wage-workers of the United States. It is freely admitted that looking at the subject from the humane, economic and legal viewpoint our present system can be changed, and ought to be changed.[5]

One NAM annual meeting resolved that "an equitable, mutually contributory indemnity system, automatically providing relief for victims of industrial accidents and their dependents, is required to reduce waste, litigation and friction, and to meet the demands of an enlightened nation . . . ."[6] The resulting statutes were designed as a response to the problems raised during those debates.

Quite clearly, workmen's compensation statutes were only intended to provide income for injured manual laborers. The schedules and early statutory emphasis upon extra-hazardous occupations make this limitation quite evident. Only much later did coverage for occupational diseases creep into the laws.[7] The various state acts have been amended and patched so often in response to special situations and small group pressures that they look like crazy quilts, but are neither so colorful nor so comforting.

II. The Causes of Dissatisfaction With Workmen's Compensation

A. THE CHANGED SETTING

American society has undergone major transformations since the period during which the pattern of workmen's compensation took shape. In 1900 the population was predominantly rural and a large proportion was engaged in farming which itself directly provided subsistence for the usual three-generation household. In 1971 farming occupies only a very small minority of nuclear families, and they specialize in cash crops and products. The bulk of the population now depends upon wage and salary employment. Thus a far larger segment of the population has entered occupations for which workmen's compensation was designed.

At the same time, the life styles of working people have changed: existing to work is no longer the rule. The ten-hour day and six day week have been superseded by the eight-hour day and five-day week. Paid holidays and vacations further reduce the part of life preempted by work. As a result, the individual worker's exposure to work-related risks has declined while exposure to non-work-related risks has expanded enormously. Additionally, safety engineering has reduced the maiming potential of the workplace,[8] while "private life" is beset by hazards, many, like the automobile, the result of greatly expanded purchasing power.

Concurrently, life expectancy has increased dramatically and a far larger portion of the population lives into the seventh decade of life, due primarily to public health measures and antibiotics. Consequently a much larger proportion of the population experiences degenerative conditions.

B. THE PERFORMANCE OF WORKMEN'S COMPENSATION PROGRAMS

The intricacies of workmen's compensation law now rival those of property and tax law with which only the most expert or most naive feel at ease. Despite yesterday's plan for procedure simple enough to make unnecessary lawyers who

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[4] *See, e.g.*, G. Campbell, Industrial Accidents and Their Compensation 18–27 (1911).
[5] F. Schwedtman & J. Emery, Accident Prevention and Relief xiii (1911).
[6] *Id.* xiv.
[7] So cautious and limited was this extension of coverage that miner's black lung disease required special Federal legislation as late as 1969. *See* Federal Coal Mine Health and Safety Act of 1969, Pub. L. No. 91–173, tit. IV, 83 Stat. 792 (codified at 30 U.S.C. §§ 901–36 (Supp. V, 1970)).
[8] Complacency, however, would be inappropriate. Despite the improvements, serious on-the-job injuries remain a significant problem, to which enactment of the Occupational Safety and Health Act of 1970, Pub. L. No. 91–596, 84 Stat. 1590, attests.

earned impressive fees for Employer Liability Act cases, many union lawyers today prefer the known hazards of secondary-boycott injunction proceedings to the miasmal swamps of workmen's compensation proceedings.[9] Neither expert commissions, compulsory insurance, nor absolute liability has eliminated litigation and delays in settlement, although workmen's compensation delays are probably somewhat less serious than those in automobile accident cases.[10]

Chief among the shortcomings of workmen's compensation is the appalling gap between the losses sustained and the compensation provided. Earl Cheit's careful analysis indicates that in thirty-six jurisdictions workmen's compensation replaced less than twenty percent of the losses attributable to a worker's death and that in the most serious California disability category, median compensation replaced about one-third of the wage loss.[11] The system is not intended to work that way, but it does, and the immediate reasons are not difficult to find. Although complete restoration of monetary losses is not sought by any statute, all statutes set arbitrary ceilings in terms of benefit duration, money amounts, or non-loss-related formulas. Among the most generous provisions is Connecticut's limit of sixty percent of the state's average manufacturing wage. One analysis has demonstrated that maximum cash benefits fell below the poverty level in thirty-one states.[12] Several states even put limits on medical care payments. And private insurance, which accounts for the bulk of the coverage, does not adjust benefits to reflect cost-of-living increases after the date of injury.

Another shortcoming is high operating costs. Unimposing from the beginning, the ratio of benefit payments, including those for medical care, to premiums paid has declined. The decrease between 1962 and 1969 was from sixty-four percent to fifty-nine percent;[13] the rate of decrease is even more troublesome when federal programs are excluded.[14] Similarly, private insurance benefits amount to roughly half of private insurance premiums paid.[15] Even considering reserve requirements, the fact that a large portion of benefit payments derive from accidents in earlier years, and that some small amount of premium goes to pay for safety engineering, the current performance of workmen's compensation, as the form sheets say, "does not impress."

C. WORK-RELATEDNESS: IMPOSSIBLE TESTS AND RESULTING DISTORTIONS

Absolute liability for work-related injuries and disease is justified on the rationale that productive enterprise sets in motion unavoidable, risk-creating activities. Compensation for the disabilities that do result may be properly regarded as costs of production. Some argue further that market competition penalizes high-accident-rate enterprises, thereby stimulating accident-preventing activities, because the resulting costs are built into the product price. Ignoring that difficult and dubious theme, the very questionable tests employed in determining work relatedness remain for consideration. The talismanic phrase "accidental injury arising out of and in the course of employment," or something similar, defines workmen's compensation coverage in most states. The three tests thereby imposed are extremely difficult to administer, as Bohlen predicted long ago,[16] and Larson demonstrated more recently.[17] The heart cases epitomize one critical problem among many that cause extensive litigation. In many instances an employee may have a pre-existing heart condition. When can it be said that death or disablement due to a cardiac insufficiency is work-related? What amount or kind of work-stress is required for a heart failure by such a person to be com-

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[9] An associated problem is employee legal counsel. While a few excellent firms specialize in the area, claimant representation may often be undertaken by the marginal lawyer. *See, e.g.*, Gellhorn & Lauer, *Administration of the New York Workmen's Compensation Law, Part II*, 37 N.Y.U.L. REV. 204, 217–22 (1962). Recently expanded opportunities for claimant representation by union-paid lawyers probably will improve performance in this area.

[10] *Compare* L. MACDONALD, CONTROVERTED CASES—NEW YORK STATE WORKMEN'S COMPENSATION 29, 83–84 (1964), *with* Rosenberg & Sovern, *Delay and the Dynamics of Personal Injury Litigation*, 59 COLUM. L. REV. 1115, 1127 (1959).

[11] E. CHEIT, INJURY AND RECOVERY IN THE COURSE OF EMPLOYMENT 109, 182 (1961).

[12] O'Brien, *More Injuries, Less Compensation*, THE AMERICAN FEDERATIONIST, February 1970, at 18, 20.

[13] Skolnik, *Workmen's Compensation Payments and Costs, 1969*, SOC. SEC. BULL., January 1971, at 31, 34.

[14] *Id.*

[15] *Id.*

[16] Bohlen, *A Problem in the Drafting of Workmen's Compensation Acts*, 25 HARV. L. REV. 328, 401, 517 (1912).

[17] Larson, *The "Heart Cases" in Workmen's Compensation: An Analysis and Suggested Solution*, 65 MICH. L. REV. 441, 441–65 (1967).

pensable? As Larson points out, the medical analysis of such conditions lacks certainty. But, he argues, if the legal analysis is cogent and clear enough, the medical analysis will be less subject to error.[18] Despite his exquisite explication, it is doubtful that legal precision, even if attainable, can overcome the insufficiencies of medical skill.

A further problem is easily illustrated. *A* has a heart condition and *B* does not. They both perform the same kind of strenuous work. *A*'s heart fails but *B*'s does not. Should *A*'s family recover workmen's compensation benefits? The social pressure to provide such benefits is strong and many commissions and courts yield. But does it make economic sense to place financial burdens upon enterprises because they happen to enploy cardiac cases? Is that a cost of production properly allocable to that enterprise's products? The desirability of providing employment to those with circulatory or any other deficiencies seems quite clear. Aside from the humanitarian aspects, the savings achieved if such persons do not become public charges benefits the community fisc, which ought therefore insure against the hazards of employment attributable to their special susceptibility to disablement.

The heart cases are but a striking example of the distortions introduced into workmen's compensation by the understandable desire to succor the unfortunate. The unfortunate should not be cut adrift. But if their injuries are charged to workmen's compensation their employment opportunities may shrink. Rather, in order to encourage their employment and allocate costs more equitably and rationally, there should be a community contribution to workmen's compensation funds for their compensation and medical care.

D. THE MISMATCH: CAUSES OF DISABILITY AND CRITERIA FOR COMPENSATION

The Social Security Administration's 1966 *Survey of the Disabled* indicates that seventeen percent of the noninstitutionalized adults between the ages of eighteen and sixty-four, approximately eighteen million people, suffered work limitations from chronic conditions.[19] About one-third of this seventeen percent fell into one of the following categories: "severe" disablement (total disability or unable to work regularly); "occupational" disablement (unable to work at pre-disability occupation or unable to work full full time); "secondary" work limitation (able to work full time, regularly, at the pre-disability occupation, but with limitations on the kind or amount of work performable). The principal disabling conditions are circulatory and skeletal disorders, large numbers of which probably do not qualify for workmen's compensation because not work-related. In these and most other chronic conditions, age is a major factor—the older the group, the greater the percentage disabled. The major causes of disability, then, either are congenital or arise from wear and tear, or are a combination of both. Neither cause meets the workmen's compensation accidental-injury test. Yet, only those totally and permanently disabled qualify for social security disability insurance. Thus, large numbers of the seriously disabled fall outside the protection of our two major social insurance disability programs, while stringent definitions of disability and exacting eligibility provisions limt disability benefits of private group pension plans to comparatively few workers.

The resultant lack of coverage raises serious questions about the design of our disability programs. Intense concentration on politically acceptable formulas may have caused a failure to design our programs to meet the real needs of the community.

E. THE GROWTH OF OTHER PROGRAMS; CHANGES IN PUBLIC PHILOSOPHY

Workmen's compensation constituted the first form of social insurance and for a considerable period, especially in this country, was the sole such program. It now overlaps and collides with numerous legislated and privately-initiated programs. Since 1950 its coverage has been exceeded by social security, which insures against death, or rather the accompanying hazard of dependents' loss of support, and total disablement, regardless of work connection. The poor co-

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[18] *Id.* 468–69.

[19] This paragraph is based upon Haber, *Disability, Work, and Income Maintenance: Prevalence of Disability, 1966*, SOC. SEC. BULL., May 1968, at 14, 14–15.

ordination [20] of social security and workmen's compensation benefits bears most heavily on large, low-income families, those with the greatest needs for income replacement.

Income replacement for short-term, non-work-connected disability is mandated in five states by statutes providing compulsory temporary-disability insurance, in railroad employment as part of that industry's unemployment insurance scheme, and in government and much of industry by paid sick leave regardless of cause.

The several statutory schemes are widely supplemented by private employment arrangements, paced by collectively bargained programs. Supplementation is most generous in highly paid employment and is meager or absent in low-paying employment, where workmen's compensation itself may not apply. The same pattern obtains for private health insurance, although often the poor have poorer health; indeed, poor health is not only a consequence of poverty, it is a frequent cause. Hence illness and injury have a greater adverse impact upon the non-working dependents of low-paid employees than upon those of better-paid workers. The former are relegated to the health services of welfare and medicaid programs, which vary enormously from jurisdiction to jurisdiction.

Many of the anomalies in this diverse scheme of insurance may be traced from the differing philosophies behind each program. Workmen's compensation represented a change in the economy's ability to devote funds to non-income-producing purposes, the willingness of affected segments of the community to allocate funds for those purposes, and the power of the employed segment of the population to commandeer those funds to their purposes. The special claim of those injured in work-related situations was, as noted, that the enterprise set in motion hazards, quite apart from any negligence, which would impair the earning capacity of large numbers to the detriment of themselves and their families. Such losses were arguably costs of production to be borne by the consumers of the products and services.

While generalization is hazardous, and each program and major amendment to it has its own roots, the basis of modern fringe benefits and social insurance differs from that just described. Fringe benefits, such as employment-based group pension plans and medical care insurance, are to a great extent the result of the historical accident of World War II and Korean War legal limitations upon cash wages and salaries, from which such assertedly noninflationary fringe benefits were exempt. In addition, the economies of scale of group coverage make it clearly preferable to individual provision of such protection. While not universally agreed upon, labor economists, unions, and dominant groups in Congress regard such fringe benefits as a form of wages. In social insurance, the rationale for new programs has shifted from special claims, such as work-relatedness, to widespread need, as for example with the social security disability program and medicare, and to the desirability of providing such benefits as a matter of right. And now we seem to be in the early stages of debate about how to provide health care for the entire population. While the mode of achievement will be vigorously debated, the goal seems set.

III. Summary of the Case for Reconsidering the Role of Workmen's Compensation

Since the inception of workmen's compensation, a larger proportion of the population has come within the areas of industry and commerce, making administration a massive undertaking. Yet a larger, and often more dangerous, part of employees' lives is spent away from work than at it. Not surprisingly, workmen's compensation has not worked out quite as planned—what does? Litigation, with its attendant delays and costs, has not been eliminated. Benefits replace a distressingly small portion of losses, in part due to the lag in amending formulas as earnings rapidly increase. Additionally, unexpected complexity has caused administration costs of workmen's compensation programs to be

[20] The Social Security Act, 42 U.S.C. §§ 301–1399 (1964), *as amended*, 42 U.S.C. §§ 301–1399 (Supp. V, 1970), provides that any benefits payable under the Act on account of an individual's previous employment shall be reduced by the extent to which such benefits plus any workmen's compensation benefits exceed 80 percent of the individual's "average current earnings," subject to a minimum equal to the total such social security benefits payable, 42 U.S.C. § 424a (Supp. V, 1970). "Average current earnings" comprise the average monthly wage used for computing social security benefits. *Id.* § 424a(a).

shockingly high, possibly the most important consideration of all. This separate system may be counterproductive in the very situations where its impact is quite critical: the seriously disabled with potentially large money claims may be lured, as a byproduct of the litigation system, to resist, often quite unconsciously, rehabilitation efforts. And, whatever may be the purported advantages of a separate system, establishing and maintaining the demarcation between work-related and non-work-related injury and illness often proves impossible, particularly for death or injuries where social pressures for compensation are strong. Due to greater longevity for more people, the great disablers are no longer traumatic injury and diseases associated with hazardous processes, but have become the degenerative conditions, of circulatory and skeletal systems, that accompanying aging.

Moreover, today workmen's compensation is one of many public and private programs providing income substitution, medical care, or both, to large segments of the population. The newer programs, notably employment-based medical care for employees and their families, derive not from a concept of employer responsibility but from a combination of historical accident and the obvious cost advantages of group insurance. Although in an earlier day the employer's responsibility was the touchstone of liability, more recently insurance against the common hazards of modern life, on and off the job, has become a convenient form in which to pay part of employee compensation, and social insurance plans are justified more on the need for particular protection than on special justifications for a particular mode of providing it.

It is possible that we are on the threshold of a nationwide system of comprehensive health care whose arrangements, which may have lower costs because unencumbered by restrictive eligibility criteria problems, could obviate separate provisions for workmen's compensation. Unemployment compensation, which generally excludes those unable to work, might deal with income replacement for all short-term disabilities, thereby dispensing with the special machinery of workmen's compensation for the bulk of its cases. Whether the social security disability program, now limited to the most seriously disabled, offers the proper vehicle for what would remain at least merits exploration. These are only the most ambitious possibilities. More modest potentialities for coordination of the workmen's compensation programs with existing and potential programs should be considered. C. Arthur Williams, Jr., has suggested that private insurers devise all-risk coverage for employees and seek legislation making such plans acceptable for workmen's compensation purposes.[21]

So much has changed since the basic design of workmen's compensation was set that current reconsideration of its role requires rationalizing its functions both with those of many existing programs and with those of programs that impend. Creation of the Commission provides the occasion for such a reconsideration.[22] The many claims of ameliorative programs upon scarce resources and scarce personnel make the task imperative.

Mr. GIBBONS. The next witness is Prof. Theodore R. Marmor, of the Institute of Interdisciplinary Studies.

STATEMENT OF PROF. THEODORE R. MARMOR, STAFF ASSOCIATE, POVERTY INSTITUTE AND HEALTH RESEARCH CENTER, UNIVERSITY OF WISCONSIN

Professor MARMOR. My name is Ted Marmor. I don't represent the Institute of Interdisciplinary Studies, although I do occasionally work with their health group. I want to make it clear that I speak for myself. I do not speak for the University of Minnesota or the University of Wisconsin, or other institutions that I have affiliation with. I come here as an individual, and I want to speak only in that capacity.

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[21] C. WILLIAMS, INSURANCE ARRANGEMENTS UNDER WORKMEN'S COMPENSATION 208–10 (1969).

[22] The author is also engaged in such a study, but welcomes the presence of the prestigious commission, which should be able to mobilize the resources and efforts of the many concerned segments of our society.

Now, you have been listening to testimony all morning long, and I am hesitant to go through a not very long statement, but one which I hope at least will be provocative and not make you wait for your lunch with any more boredom.

I also should say by way of introduction one more thing. I have written a book on the politics of medicare. That meant that I went through years of research on the politics that preceded the enactment of the medicare program. I read through hearings of those 8 years, those endless hearings, and I want to make a different kind of statement than the one that you so often hear, either a statement for or against a particular proposal, as you have heard this morning, a good deal of discussion of the merits of the health Security plan, or another kind of statement, which is a statement of what the problems are, how difficult they are, the cost, the organization, the long list of what I would call, respectfully, slogans about what is wrong with American medicine.

I want to talk about the way in which we legislate with respect to health matters, and, second, about some of the defects and merits of alternative bills, and what we might learn by looking to new sources of information.

I am delighted to speak to the committee this morning about such an important matter; namely the form of national health policy this country should adopt in the coming decade. I am speaking to you this morning as a private citizen, representing no group, no organization, only myself.[1] I have, however, spent a good deal of time the last decade studying the problems of medical care and a substantial period of time writing a book on the politics of medicare. This experience, while not necessarily making me wiser than others, has certainly acquainted me with the difficulties of legislating Federal health policy and the possibilities of improving the product of that legislative activity.

My testimony falls into three parts. First, I want to talk about the lessons one might draw from the experience of enacting and implementing the medicare program. Second, I want to address myself to what one can learn from the experience of countries other than the United States who have embarked over the last quarter century on national health insurance programs. I particularly have in mind the experience of Canada, our northern neighbor who has embarked on a national health insurance plan that constitutes for the United States a very large and relevant natural experiment. Third, I want to make two modest recommendations about what the Congress should now do. These recommendations recognize the dilemma of responding to the multiple proposals on national health insurance which face this committee.

1. National Health Insurance and the Lessons of Medicare

With respect to medicare, I want to emphasize two lessons one might reasonably draw from the experience of enacting and implementing that program. (There are many other lessons one might want to discuss and we could speak about those in the question period.)

[1] I am presently a research associate of the Health Services Research Center and the Institute for Research on Poverty at the University of Wisconsin. I am on leave from the University of Minnesota, where I am associate professor of political science and public affairs. None of these institutions should be held responsible for the views expressed in this testimony.

First, I call your attention to the intemperate debate which characterized the period before medicare was enacted in 1965. That debate can best be described as virulent, unenlightening, and superficial. The sides were comprised of two warring camps who distrusted one another, learned little from one another, advocated their respective positions as mutually exclusive alternatives, and did their best to discredit both the arguments and the source of the opposition to their favorite position. This picture of the medicare struggle can be defended by looking at the hearings on the medicare proposals between 1958 and 1965, a process I, to the discomfort of my eyes, engaged in while writing my book. Reviewing those endless volumes of testimony was not only difficult on one's eyes but, more important, was disappointing substantively.

Let me explain. For those years, the major question before the Congress was whether or not to enact a program of health insurance for the aged under social security financing. Almost all the attention during those hearings was focused on the question of whether or not such an idea was attractive. Those who found it attractive found almost nothing in opposing arguments of practical worth. Those who opposed the idea of social security financing for health insurance for the aged found almost nothing admirable in the medicare proposals. The consequence was that two large well-financed, warring camps fought with each other, in full view of the Congress, for nearly 8 years. The tragedy of that warfare, in my opinion, is that each side learned so little from the other. It is my strong hope that this committee, after experiencing that relatively unenlighthening confrontation would do everything in its power to improve the present health debate and, more important, to insist that the advocates that come before it defend not only the proposals they recommend, but pay serious attention to the merits of the arguments on the other side.

Not only was the medicare debate characterized by sloganeering, by hostility, and by unenlightening acrimony, but the character of the debate provided little incentive for a sober assessment of the consequences and implications of any one of the competing plans. Let me illustrate that with one striking example with which all of you are familiar. I have in mind the decision to pay physicians under the so-called reasonable charge standard. As you all know, the method of paying of physicians was not considered as a legislative matter in the period between 1959 and 1964. There was good reason for that, at least in the minds of those who were advocating medicare. That reason was the intense hostility of the AMA toward any form of universal government health insurance. Medicare enthusiasts thought it was difficult enough to enact medicare at all; it would be even more difficult were doctors directly involved in the Government program. That hesitancy, understandable enough in the minds of medicare proponents, led to a disastrous consequence. That consequence was that no prior planning took place about how the Federal Government might pay doctors. As you recall in the period before 1965, medicare was an inappropriate epithet for the program actually proposed ('Hospicare' would have been a more accurate epithet, a point not lost on Congressman Brynes, whose remarks in the winter of 1965 partly led to the expansion of medicare to include part B). Your whole committee responded by expanding medicare to include physician services, an expansion war-

ranted by almost every consideration, especially the fact that the aged thought medicare had always included physicians services.

The difficulty with expanding medicare to physician services was that HEW was unprepared to suggest to your committee how physicians ought to be paid. Between 1959 and 1965 regular meetings were held between social security representatives and the American Hospital and Blue Cross Associations. These meetings explored the difficulties of reimbursing hospitals and nursing homes under a medicare program. But no meeting, as far as I can tell, was ever held between physicians representatives and the HEW about what method of payment to use for physicians. The excuse was that physican groups would have angrily responded even to the remote suggestion that they should be included in a medicare bill. The consequence of this excuse, however, was that nobody had learned how to pay doctors by 1965. This was true for the Committee on Ways and Means which, among all its other extensive responsibilities, had neither the time nor the staff to explore in detail questions such as how to pay physicians. As a result, you will recall, the committee adopted the reasonable charge standard, basing its decision upon the recommendations of the private insurance industry (particularly Aetna). The insurance companies claimed they knew how to pay physicians, had the appropriate data to determine what were reasonable charges, and were confident that such a program could be administered equitably, efficiently, and without excessive cost. That experiment failed. All Americans now pay more for physician services than they would otherwise have paid, a consequence in part of medicare's lack of planning.[2]

I should add that I am not blaming fully either American doctors or the Committee on Ways and Means for this outcome. Doctors had every reason to believe that reasonable charges might well be more restrictively defined in the future, and their understandable anxiety about future fee controls led many of them in the year preceding medicare to raise those fees. Nor am I blaming Ways and Means for failing to have the technical answers to whether or not the private insurance industry accurately described their competence in their Ways and Means testimony in 1965. But I am raising the question of whether this committee can rely upon the normal process of HEW staff work to give it the technical, factual, detailed understanding of the alternatives before it. And I am recommending that the discussion of goals be separated from the technical debate over mechanisms to achieve particular goals. I will return to this point in my final proposal.

I could extend the discussion of medicare's lessons or amplify my examples. But perhaps questions later could return us to this first theme. Instead, I want now to turn to my second topic for testimony; the lessons one might reasonably draw from the experience of other countries, particularly Canada's experiment with national health insurance. At no time in the debate over medicare was foreign experience extensively surveyed by HEW. The executive branch seems to accept what might be called the fallacy of comparative difference. That law states if there is any respect in which two countries are different, there is no respect in which one can learn from the other.

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[2] This argument is advanced and defended in T. R. Marmor, *"The Politics of Medicare"* (London: Routledge and Kegan Paul, 1970), ch. 6. See also my article in "Transaction," September 1968 for the initial assertion of this position.

II. National Health Insurance and the Experience of Other Countries

The United States is the last major industrial country in the world to consider the enactment of national health insurance. The extensive experience of foreign countries—Canada, France, Sweden, Norway, Germany, and many others—with various forms of government health insurance offers us ample opportunity for learning. The most promising example for American consideration is Canada. The Canadian program began in 1958 with hospital insurance and by the late 1960's covered both physicians and hospital services in almost every province in the country. The provincial plans vary as to scope, eligibility, benefits, and financing. But in all the Government plays the major role in financing personal health care services. Since Canada shares so many characteristics with the United States—size, structure of the medical profession, the tradition of private voluntary hospitals, largely unsalaried physicians under a fee-for-service system, and ethnic diversity and, I should add, the tradition of private health insurance—she offers a more helpful set of experiences than countries radically unlike the United States.

The lessons of her experience are sobering, but not disheartening. First, Canada has been unable to restrain the rate of inflation of medical care prices despite the fact that the Government plays a central role in financing health care. This should give us pause to wonder about the claim so prominently made in the United States that only through Government control of the medical care dollar can the disturbing rate of health care price inflation be curbed. Second, the Canadians have discovered that reform legislation is often inadequate to produce the desired change.[3]

This brief discussion of Canadian experiences provides no obvious clues to how we should be thinking. Nor would a hurried review of the different systems of national health insurance in the Western European countries. Instead, I hope it interests you enough to prompt further investigation of the lessons for America of the experience of other nations with government insurance of health care.

III. Two Suggestions

I recognize that my previous comments have been largely critical—of the debate over medicare, of the present debators over national health insurance, of the capacity of HEW to learn from these past and foreign experiences. I realize such criticisms can be carping and unhelpful. I hope in my closing remarks to offer some constructive suggestions.

Were I asked the question, "Which of the major national health insurance bills do you favor?" I would answer, "None of them." The

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[3] The Canadian Royal Commission on health services provides an extensive discussion of these reform proposals. It honestly faces up to the dilemma of trying to control the increasing cost of medical services while not requiring that some of its poorest citizens get less care. We have much to learn from that report and even more from the efforts to implement it. The Canadians provide a diversity of Government health insurance programs for us to monitor. The national policy establishes the right of Canadians to enjoy health care at a reasonable price. But the provinces differ in the means they have chosen to fulfill that obligation. Some of the different systems seem unable to do much about the inflation of medical care prices, or the expansion of demand for medical care services. That in itself, should give us pause when we consider the exaggerated claims made for particular administrative schemes in stemming the medical care price inflation.

point of my earlier contentions is that such exaggerated claims have been made on all sides that one does not have the basis for a sober estimate of the suggested programs; $70 billion programs are compared with $10 billion ones, all on one convenient page. Pressure groups present convenient manageable summaries of schemes which would allegedly change the face of American medicine. Cost estimates are thrown around as if they were seeds at spring plowing. And claims are made about the desirable consequences of private health insurance, HMO's, national capitation schemes, and so forth which are difficult to accept on the basis of the evidence the advocates present. My simple conclusion is that we don't yet know enough to choose the appropriate means of government health insurance.

That assessment does not lead me to counsel inaction. Rather, I suggest a quite unorthodox legislative policy: the enactment of a national health insurance policy which establishes the goals government programs are supposed to achieve. If the U.S. Congress decides health care should be more equitably distributed, more equally accessible in different geographical areas of the country, of higher quality than presently available, and provided irrespective of the citizen's ability to pay, those intentions should be enacted into law. My suggestion is that the law provide for the establishment of the American equivalent of a royal commission, a joint congressional commission [4] made up of congressional representatives, expert in health care, and the representatives of the major groups concerned with health. This would mean representatives from organized labor and medicine, from patients and hospitals, from planning agencies and pharmacists, from young and old, provider and consumer. The most distinguished representatives of American labor and American medicine should be in the group. The Congressional Members need not come from the finance committees of the Congress, but the commission as a whole should report to those committees. What I am recommending, in short, is that the congressional finance committees have the expert advice of a distinguished national commission on the form which national health insurance should take at the end of a 3-year study period. I have in mind, by way of precedent, the example of Sweden. In 1952, the Swedish Legislature enacted a national health insurance bill. The legislature called for a royal commission to implement that legislation and, for the next 3 years, Swedish interest groups cooperated with Government civil servants to find the right means of insuring equal health care in Sweden.

Many questions obviously remain about the form and pace of such a commission. There is no magic to a 3-year commission and no obvious advantage of 20 to 25 members. But intellectual excellence and wide experience with health care seem to be promising criteria for membership, and sufficient resources to do first-rate social policy analysis would seem a necessary condition. The importance of a respected group of commission members should be, by now, clear. This group must present to the Congress reasoned arguments about the desirability of alternative means of achieving announced congressional goals. Their testimony will not achieve the desired unity and cooperation if the commission members have anything less than the widest public respect.

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[4] Not just another study commission. The ways in which this commission will differ from the plethora of Executive commissions should be made clearer in the question period.

As before, I will be glad to comment further if you desire to question me on this particular reform suggestion.

My second suggestion is that this committee seriously consider reporting an adequate catastrophic health insurance bill. I have no illusion that protection against the catastrophic cost of illness will solve the problems of the quality, distribution, organization, and accessibility of American health care. Those are the problems which the above mentioned commission should deal with. But an adequate health insurance program can protect us against the crippling financial disaster which a small number of Americans experience each year. Such a bill should be judged not by the standard appropriate to a national health insurance plan, but by the standard relevant to insurance against floods and other natural disasters. For medical care can be like a lingering drought, a sudden flood, or a thunderous hailstorm that ruins the house, crop, and livelihood of a family. Senator Long has, in my judgment, rightly recognized the importance of this separable problem. Only about a third of our country enjoy major medical insurance coverage, and many of them have woefully inadequate protection against the most devastating health bills. Though I have reservations about the particulars in Senator Long's proposed remedy, I applaud his perception of the problem. However, let me, in closing, sketch briefly another remedy.

I would recommend that the Congress seriously consider the major risk insurance plan developed by Martin Feldstein of Harvard University. The plan calls for a universal insurance program, protecting families against medical bills more than 10 percent of their annual income. This conception of catastrophe—defined in relationship to income and family size—is a major improvement over the Long formulation. The Long plan defines as catastrophe those annual expenses beyond $2,000 and 60 days of hospital care; it takes little reflection to see that one man's catastrophe might fall below that level and another's above that. The Feldstein plan calls for coinsurance up to the cumulative family maximum expenditure (10 percent). This mechanism further insures that the Government will be called upon to act only when extraordinarily large medical expenses are incurred. I have no special brief for deductibles, coinsurance, expensive hospital care, or lingering chronic illness. But it is this set of problems which the Feldstein plan addresses. It comprises a set we have the knowledge to act upon imediately and catastrophic insurance, while protecting all of us, will have to make payments for only a very few of us each year: it is thus a relatively inexpensive program. I respectfully urge that you consider the Feldstein plan carefully as a solution to the problem of financial disaster, keeping that problem quite separate from the larger issues of what the larger American system of health care should be like.

I have reviewed briefly the lessons one might hope to draw from our experience with medicare and the experience of other countries in national health insurance. I have offered some modest suggestions, albeit very briefly about promising congressional action. And I have throughout insisted that the Committee on Ways and Means take the lead in making the debate over national health insurance more searching, more sober, and more enlightening than we have experienced thus far. The committee deserves no less; I urge that it accept no less.

Mr. GIBBONS. Thank you, sir. As I understand the thrust of your testimony, it is that you think that we need to look at this thing a lot harder and a lot longer and in a lot more depth than perhaps we will be able to in this set of hearings and the executive sessions that would follow, and you would suggest that perhaps we should have some kind of commission taking it out of the hands of the HEW and taking it out of the hands of opponents, to come in with a sort of neutral proposal?

Professor MARMOR. "Neutral" is a nonneutral word in this context. Some kind of a distinguished committee which would present its views about alternative means and give the Republican members and the Democratic members reason to believe they could assess the relative merits and the costs and benefits of alternative plans.

I would suggest to you that HEW not be barred from these deliberations, but I would suggest they not be relied upon so exclusively.

Mr. GIBBONS. That they be part of it?

Professor MARMOR. Yes. They have embarked on the "sole source" concept for research contracts.

I suggest that the Committee on Ways and Means embrace fully this principle by forcing HEW to compete with other sources for the Congress, and thereby expand your learning capacity. You can then tell HEW, when they bring to you half-truths, untruths, and some truths, that your basis for reaction is an independent assessment.

That is my point.

Mr. GIBBONS. Then as I perceive the second half of your suggestion, it is that perhaps there be a stopgap, but temporarily, while some other program is being adopted, that we adopt a form of catastrophic insurance based upon family income. Is that right?

Professor MARMOR. That is exactly right, Mr. Gibbons, exactly right, and I would be glad to speak further about that particular plan. I am glad you used the word "stopgap." I would like to publish this article on catastrophic health insurance in something like Medical Economics. Indeed, I tried to do that, but they told me they were so well stocked with articles on this question that they didn't need additional commentary.

However, I looked back in Medical Economics, and I found an article by an Anne Somers about catastrophic health insurance. It was an attack on the Feldstein plan. Do you know what that attack consisted of, gentlemen?

It consisted, basically, of the following assertion: If the catastrophic health insurance is being pushed by those who want to prevent the Kennedy health bill, if that is the case, beware; because catastrophic health insurance will ensure the coming of the Kennedy health insurance bill. Therefore, to complete the syllogism, don't support catastrophic health insurance if you are for—or if you are against, rather, the Kennedy health bill.

I want to say in short that major risk insurance has been criticized because it is going to help or not help the Kennedy bill.

I want you to consider it on its merits. I think it is outrageous to tell an economist like Feldstein that he is going to help the Kennedy bill. He is trying to deal with a serious problem and his plan should be judged on its merits intially.

Medical Economics should be chastized for not offering him a chance to respond to that criticism, and I urge that you bring both sides before you and make them answer to the questions you place to them.

Mr. GIBBONS. Frankly, I am not familiar with the Feldstein plan. I don't know whether Mr. Feldstein is one of the proposed witnesses we have or not. I wish, though, that you would help make this available to me.

Professor MARMOR. Are other members familiar with it? I will be glad to get to you information about the Feldstein plan.

Mr. SCHNEEBELI. I think it has considerable merit for consideration.

Mr. BYRNES. Mr. Chairman, I might suggest to the professor, that if he would, he could submit that and it could be put in at this point in the record.

Mr. GIBBONS. I think it would be a good thing to do that. If you would get that material for us, we will put it in the record at this point, without objection. I would appreciate your mailing it to me, too.

Professor MARMOR. I will be glad to mail it to you. But I will be happy to answer quick questions about its form. It is different reading it, and having its features explained to you. Might an explanation perhaps be of help?

Mr. GIBBONS. I hardly know where to start.

Professor MARMOR. I could give a brief description of what it is like.

Mr. GIBBONS I think maybe we had better do that privately, because we do have a time problem this morning.

(The material referred to follows:)

[From the Public Interest, Spring 1971]

A NEW APPROACH TO NATIONAL HEALTH INSURANCE

(By Martin S. Feldstein)

A new approach to national health insurance is urgently needed. Our present system of financing health care provides inadequate protection, encourages inefficient use of resources, and accelerates the inflation of medical costs. Unfortunately, the proposals for national health insurance that are now being discussed will not remedy this situation. I propose to outline a different approach to national health insurance that would avoid the major shortcomings in the present system and in the previously suggested alternatives.

Any proposed system for financing health care should be judged by the following six objectives:

(1) *Prevent deprivation of care.* No individual should be deprived of medical care because of inability to pay, just as no individual should go hungry or lack adequate housing because of low income. Moreover, no one should be encouraged to delay care because his insurance will not pay for preventive or ambulatory care but only for hospitalized treatment of the more serious illness that may ensue.

(2) *Prevent financial hardship.* No family should suffer substantial financial hardship because of the expense of unpredictable illness or accident.

(3) *Keep costs down.* A financing system should both encourage efficient use of resources and discourage medical care price inflation. Whenever possible, patients should use relatively low-cost ambulatory facilities rather than high-cost-in-hospital care. Hospitals should be induced to moderate the forces that raise the cost of care: increased personnel, unnecessary pay raises, and a proliferation of technical facilities and services. Physicians should not be encouraged to increase their fees by the knowledge that, because of insurance, the cost to their own patients will rise little if at all. In short, the financing method should encourage cost consciousness in the decisions of patients, doctors, and hospital administrators.

(4) *Avoid a large tax increase.* High taxes distort the supply of work effort and cause inefficient use of resources in the economy as a whole. Therefore, a na-

tional health insurance program that raises substantial funds from taxpayers and returns it in the form of health insurance has a large hidden cost in lower national income. The magnitude of our total spending on health care makes this an important consideration. In fiscal year 1968–69, government spent nearly $19 billion on personal health care; private expenditures then approached $34 billion. Transferring this private spending to the public sector would require a very large increase in tax rates. For example, if it were to be financed by an increase in the individual income tax, collections would have to rise more than 30 per cent. If the social security payroll tax were used, its rate would have to be doubled.

(5) *Be easily administered.* The administration of a health care system should not require complex procedures, which are costly and inconvenient, or arbitrary decisions, which imply that resources are not used appropriately.

(6) *Be generally acceptable.* Any new method of financing should be acceptable to physicians and to hospitals as well as to the general public. A system that is disliked by either would encounter substantial political opposition and, if instituted, would be hampered by lack of cooperation and an inadequate supply of new personnel in the long run.

THE CURRENT SYSTEM

Although almost every American is enrolled for some form of health insurance, the current coverage is typically rather "shallow." That is, families incurring large medical bills often find that their insurance pays only a relatively small portion. A 1963 National Opinion Research Center survey found that the average annual expenditure for medical care among survey families was $370 and that approximately one-fifth had exepnses exceeding $500.[1] Among the *insured* families that spent more than $500, only one-third received benefits exceeding half of their expenditures while another third received benefits of less than one-fifth of their expenditures. Today, as in 1963, most hospital insurance pays a relatively high proportion of small and moderate bills but imposes a variety of ceilings on use and an effective overall ceiling on benefits; the less restrictive major medical insurance policies cover less than half of the population under 65.

The absence of deep coverage leaves a large residue of financial hardship and may also prevent many people from seeking potentially expensive care. Moreover, the fact that hospitalization (including surgical) insurance is much more complete than insurance for non-surgical physician care discourages patients from seeking preventive care and induces them to gamble with their health in the knowledge that, should untreated minor symptoms become severe, a short stay in hospital is likely to be relatively costless.

The current system of financing medical care has also contributed to the high and rapidly increasing costs of such care. A substantial body of research has shown that, because of the structure of insurance coverage, patients obtain expensive (but covered) in-hospital care when much less expensive (but uncovered) ambulatory care would have been as effective. Insurance has also accelerated the rising cost of in-hospital care. Ironically, although the hospital patient with a large bill often finds his insurance grossly inadequate, the *average* patient stays a relatively short time (the 1968 mean stay in community hospitals was 8.4 days) and has almost his entire hospital bill paid for by insurance. For most days of care, therefore, the hospital does not sell its services to individual patients but collects its costs from an insurance company or Blue Cross plan. Of the approximately $9.9 billion of private expenditure on hospital care in 1968, more than 73 per cent was covered by insurance. Since 1966, the problem has been exacerbated by Medicare and Medicaid; government now purchases nearly half the total hospital care. Because hospitals are able to pass almost all cost increases on to insurance companies and the government, there is neither internal incentive nor external pressure from patients to moderate cost increases. Finally, the growth of medical insurance has accelerated physician fee inflation not only by increasing demand, but also, as noted above, by allowing the physician to raise his fee without imposing an equal extra burden on his own patient.

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[1] This survey of 2,367 families containing 7,803 individuals is reported in Anderson, R. and O. W. Anderson, *A Decade of Health Services* (Chicago: The University of Chicago Press, 1967).

SUBSIDY-CREDIT PLANS

Thus, our current system of financing health care provides inadequate coverage while inducing substantial cost inflation. Judged by the first three criteria, this system has failed badly.

The combination of inadequate coverage and rapidly rising costs has stimulated a variety of proposals for national health insurance. All plans are of two basic types: one involves direct subsidies or tax credits for the purchase of the current type of health insurance from private insurance companies; the other is universal comprehensive public health insurance.

The proposals to give subsidies and tax credits to purchasers of voluntary insurance differ only in detail. Each provides a maximum level of tax credit or subsidy that would be paid to purchasers of insurance in the lowest income group and a schedule of lower subsidies to higher income groups. The proponents of these schemes have concentrated their attention on the method of government finance for the program (general tax revenue and payroll taxes) and the costs of the particular schedules of subsidies. The maximum premium subsidies have varied between $200 per family and $500 per family in the different proposals; these numbers should be compared with an estimate [2] of $850 per family of four for a fully comprehensive health insurance in 1968 (including dental care and drugs as well as hospitalization and physicians' services) and the actual 1968 average premium per family of four of $304.[3]

These subsidy proposals have two major objectives: to encourage the purchase of more health insurance and to replace Medicaid. However, a subsidy would have no effect on the purchase of insurance by families that already spend as much as their maximum subsidy for insurance. As the estimate of $304 for the average actual premium indicates, proposed subsidies of $200 to $300 are likely to have little effect on the total purchase of insurance, except perhaps among relatively low-income groups. (Surprisingly, there has been no estimate of the extent to which subsidies or credits would exceed current expenditures on insurance by families at different income levels.) As for the second objective—the replacement of Medicaid—it is true that these plans might remove a substantial burden from state and local governments. But it would also replace the current relatively comprehensive insurance coverage that Medicaid provides in many states for low-income families with more limited coverage. The major effect of the subsidy-credit plans would be an income transfer, generally in the form of tax reduction, from higher income groups to middle- and lower-middle income groups. For many such families, there would be no incentive to purchase more health insurance—their current policies costing as much as the maximum subsidy which they would be entitled to receive—but only a welcome reduction in taxes.

Because the subsidy-credit plans rely on current forms of health insurance, they perpetuate all the weaknesses of our present system. Some individuals would still be deprived of care because of prohibitive costs. The danger of financial hardship would remain. The forces that encourage medical care price inflation would not only remain but would be intensified to the extent that insurance coverage grows. Moreover, the program would require a substantial tax increase, estimated at between $10 billion and more than $15 billion; expenditure increases resulting from such a program would probably make the actual tax increases much greater.

It is worth emphasizing that because a large proportion of the government expenditure on these programs would simply redistribute income without increasing health insurance, they should be compared to the negative income tax and other programs for welfare reform. In terms of its ability to alleviate real poverty, the subsidy-credit health insurance schemes are much less effective per dollar of tax increase than more direct redistributive programs.

There is, in short, little to recommend these proposals as a way of improving our health care system, or of containing costs, or of increasing protection. They are an inefficient way of redistributing income and an inappropriate way of assisting state governments currently burdened with Medicaid expenditures.

UNIFORM COMPREHENSIVE HEALTH INSURANCE

The proposals for uniform comprehensive health insurance generally advocate something like an extension of Medicare to the entire population. More compre-

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[2] Waldman, S., *Tax Credits for Private Health Insurance* (Social Security Administration, Dept. of Health, Education, and Welfare, 1969).

[3] Reed, L. S., "Private Health Insurance, 1968: Enrollment, Coverage, and Financial Experience," *Social Security Bulletin*, December 1969.

hensive programs would abolish the small deductible and co-insurance features of Medicare, eliminate its limit on the length of covered hospitalization, and extend coverage to drugs and dental care.

There is no doubt that under comprehensive insurance no one would be deprived of needed care because of inability to pay or suffer any financial hardship because of unpredictable illness. In terms of our other criteria, however, such plans must be judged unacceptable.

Althuogh comprehensive insurance would remove the current incentive for patients to use in-patient rather than ambulatory care, it would not introduce any positive incentives for the efficient use of resources. Whatever cost consciousness still exists among patients, doctors, and administrators would be removed. There would be no incentive to limit the rising cost of hospital care, to use paramedical personnel more widely, or to produce physicians' services more efficiently. With all bills paid by the government, nothing would limit the rise in hospital wage rates and physicians' incomes. In such a situation the government would be forced to introduce direct controls and produce incentives in an attempt to contain costs.

Detailed controls, fee schedules and limits on hospital charges might, of course, prevent rising costs, but the experience of Canada, Britain and Sweden suggests that health costs rise very rapidly even in government health programs with extensive direct controls. Such controls would not achieve, and might actually work against, an efficient use of health resources. They would certainly require a large number of arbitrary policy decisions and engender the hostility of the basic providers. Such arbitrary decisions pose a more serious problem than may be generally recognized: What is a "reasonable" level of hospital daily cost? At what rate should hospitals improve facilities, add staff, raise the level of amenities? How many beds should there be per thousand population? How much should different medical specialists earn? These are not technical questions that can be answered "objectively" if only enough research were done—they involve tastes and value judgments about the relative desirability of different goods and services.

Finally, even if expenditures were not to rise, the provision of comprehensive insurance would require a substantial tax increase; over $20.5 billion to replace current private expenditure on physician and hospital services and an additional $13.3 billion, if drugs and personal health care were to be included.

Comprehensive insurance would thus shift the problems of the health care sector to a conflict between cost inflation and controls. No matter where the balance between these were struck, there would be no natural incentive to efficiency and a large government expenditure to be paid for by higher taxes.

A NEW APPROACH

My proposal is extremely simple: major risk insurance (MRI) and government guaranteed postpayment loans. Every family would receive a comprehensive insurance policy with an annual direct expense limit (i.e., deductible) that increased with family income. A $500 "direct expense limit" means that the family is responsible for the first $500 of medical expenses per year but pays no more than $500 no matter how large the year's total medical bills. Different relations between family income and the direct expense limit are possible. For example, the expense limit might start at $300 per year for a family with income below $3,000, be equal to 10 percent of family income between $3,000 and $8,000, and be $800 for incomes above that level. The details of the schedule are unimportant at this point. The key feature is an expense limit that is large in comparison to average family spending on health care but low relative to family income. The availability in addition of government guaranteed loans for the postpayment of medical bills would allow families to spread expenditures below the expenses limit over a period of a year or even more.[4]

Major risk insurance is the most important type of health care insurance for the government to provide. It concentrates government effort on those families for whom medical expenses would create financial hardship or prevent appropriate care. Because relatively few families have such large expenditures in any year, MRI need not be a very costly program. Moreover, as explained below, MRI is likely to help limit the inflation of medical costs. In terms of our six criteria, these are the advantages of the MRI plan:

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[4] For a detailed discussion of postpayment, see Robert Eilers, "Postpayment Medical Expense Coverage: A Proposed Salvation for Insured and Insurer," *Medical Care* (May–June 1969).

(1) *Deprivation of care.* If the maximum annual expenditure on health would be limited to ten percent or less of family income, no family would be deprived of care because of inability to pay. (If it is believed that certain preventive care and early diagnostic tests would not be done as much as is desirable, the MRI policy could be supplemented by specific coverage for these activities at relatively little additional cost.

(2) *Financial hardship.* MRI would also prevent financial hardship by limiting the financial risk to ten percent or less of annual income. The availability of government guaranteed postpayment loans would permit bills to be spread more comfortably over the year.

(3) *Cost inflation.* An increase in insurance coverage generally exacerbates the inflation of hospital costs. However, the universal provision of MRI might reduce hospital cost inflation by eliminating or at least decreasing the current use of shallow coverage insurance. Families would have little to gain from such insurance when MRI had removed the risk of major expense. The cost of an insurance policy would be high relative to the upper limit on expenses guaranteed by the MRI. The ensuing reduction in ordinary insurance would help to check inflation by reintroducing cost consciousness and incentives to efficient resource use.

Some figures and an example will clarify these ideas. The table below, which is based on a 1963 survey updated to 1968–69 prices, shows the distribution of family expenses for medical care.

Expense	Percent of families	Cumulative percent
0 to $79	17.8	17.8
$80 to $159	11.7	29.5
$160 to $319	18.7	48.2
$320 to $479	12.8	61.0
$480 to $639	9.5	70.5
$640 to $799	6.3	76.8
$800 to $1,199	10.0	86.8
$1,200 to $1,599	5.1	91.9
$1,600 to $3,199	6.5	98.4
$3,200+	1.6	100.0

The average family spending was $600, but half the families spent less than $320. This uneven distribution—with a high percentage of the costs falling on a relatively small proportion of the families—suggests why MRI would reduce the use of ordinary shallow coverage. An $800 MRI policy would lower the average uncovered expenditure to approximately $400. Although a family could therefore, buy comprehensive insurance for somewhat more than $400, why should they pay for insurance protection when the *maximum* difference between the benefits and the premiums is a relatively small amount—less than $400?

The effect is even stronger for families with a lower MRI limit. An MRI policy with a $320 limit would reduce average uncovered expenditure to $230. There would be little for a family to gain by paying a premium of at least $230 for an insurance policy against a maximum risk of only $320, especially if postpayment loans are available to spread the expense.

The primary virtue that makes health insurance attractive today is its protection against the risk of larger expenses; when this feature is pre-empted by the MRI policy, additional coverage should cease to be attractive. The demand for additional insurance would therefore come only from those families that expected to have higher than average medical bills—by the families for which the expected benefits were larger than the premium. But such a process of self-selection would raise premiums, further limiting the demand for insurance. The result would be to reduce and perhaps eventually eliminate the current shallow coverage.

This reduction implies that although individuals would be protected by MRI against major expenses for health care, the vast majority of payments for physician and hospital services would not be covered by insurance. Because most physician and hospital care would be paid for directly by the patient, the inflationary forces inherent in our current insurance system would be checked. The current tendency to use insured hospital care instead of relatively less expensive ambulatory services would be replaced by an incentive to choose the most efficient combination of resources to obtain care: ambulatory care, paramedical

personnel, etc. Although patients often do not have the technical information to make such choices, the prospect of substantial cost differences would induce them to seek their physician's advice.

The potential impact on hospital costs is substantial. In 1968 the average daily cost in short-term voluntary hospitals was approximately $70 and the average stay was about eight days, implying a total cost of $560. Under MRI, most families would find a high proportion of their bill not covered by insurance. Patients and doctors would, therefore, become more careful in selecting a hospital. Hospital administrators would become more cost conscious in order to maintain demand for their beds and to reduce the burden on their patients. The doctors affiliated with a hospital would become less interested in cost-increasing acquisitions with little impact on patient health and more concerned to keep costs down and obtain high value for money spent on new equipment; high costs would encourage patients to seek a physician who could provide care in another hospital and in addition would impose an extra burden on the patients who remain with them.

Patients' desire to substitute ambulatory care for the more expensive hospital services would increase the demand for physicians' services and therefore tend to raise their fees. This would be somewhat offset by a second shift in demand—from physician care to care by supervised paramedical personnel. Moreover, to the extent that physicians have been raising fees not merely in response to the pressure of demand but because doing so imposes little or no burden on insured patients, future fee inflation could be expected to decrease.

For families that exceed their expense limit, MRI would be equivalent to comprehensive insurance. They would therefore have no incentive to limit their spending for medical care.[5] But the basic cost per day in hospitals would not be determined by the willingness of those relatively few families to spend but rather by the preferences of the far larger number of patients who would not be reimbursed. MRI insurance carriers could prevent excesses in physicians' fees and hospital durations of stay by requiring that the same care be given and fees be charged to these patients as to those who are paying for their care. Because most medical services would be paid for directly, the standard of "customary charge" and "customary care" would provide a meaningful reference standard as they currently do not.

In short, MRI would introduce a cost consciousness and a basis for cost comparison that could improve efficiency and contain medical care inflation.

(4) *Tax burden.* The cost to taxpayers for an MRI program would not be large relative to the benefits conferred. The exact amount would depend on the particular schedule of deductibles and the overall impact of the program on utilization and unit costs. I estimate that the cost per family with an $800 limit MRI policy would be $186; with a $300 policy limit, the cost would be $355. By 1968–69, more than half the households had incomes over $8,000 and would therefore receive $800 limit MRI policies. If we assume that 55 per cent of households receive $800 limit policies and that the remaining 45 per cent are distributed evenly among $640, $480 and $320 limit policies, the total cost of MRI for the population below 65 years of age would be $13 billion. Against this figure would have to be offset savings from Medicare and Medicaid. Moreover, the universal provision of MRI would suggest ending the income tax deduction for medical expenses, further reducing the net cost of MRI.

(5) *Administrative simplicity.* The MRI insurance would be relatively simple and inexpensive to administer. Survey data indicate that less than 25 per cent of the families with $800 limit policies would make any claim. Even among families with $300 limit policies, only 52 per cent would make claims. Each family that exceeds its MRI limit would submit only one claim in a year. Additional families could, of course, apply for postpayment loans.

Reduction in the use of shallow insurance plans with their vast number of small claims would permit a substantial saving in administrative costs. In 1968–69 private expenses for prepayment and administration exceeded $1.7 billion. Because MRI would act to contain cost inflation and to increase efficiency, there would be no need for detailed controls or essentially arbitrary policy decisions. Planning efforts could be concentrated on those problems that cannot be solved by the natural forces of supply and demand.

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[5] The next section describes a way of modifying the MRI principle to include a coinsurance feature that would substantially reduce the number of families that exceed their expenditure limit without any increase in the maximum financial burden for each family.

(6) *General acceptability.* An MRI scheme should be acceptable to physicians, hospitals, and the general public. It would have the virtue of providing full protection against serious financial hardship without the controls or fee schedule that would accompany other forms of insurance. The current freedom of physicians and hospitals would be preserved. If MRI were administered by the same insurance companies that currently provide health insurance, the net effect would be a small increase in their total premium.

CO-INSURANCE

MRI could be improved by introducing a co-insurance feature above a basic deductible. This would make consumers cost sensitive over a wider range of expenditures without increasing the maximum risk to which they are exposed.

For example, the annual direct expense limit of 10 per cent of income could be replaced by a basic deductible of five per cent of income followed by 50 per cent of co-insurance for an additional 10 per cent of income. A family with a $6000 income would thus be fully responsible for the first $300 of medical expenses and half of the next $600, implying a maximum total payment of $600. The maximum total expenditure is thus the same as for the MRI plan described above.

Although the family's maximum payment would be unchanged, the co-insurance would make families cost conscious over a much wider range of expenditures. With an income of $8000 or more, the family pays half of the bills for expenditures from $400 to $1200. Fewer than one family in seven has expenses exceeding this amount. For lower-income families the effect is equally great: although a $4800 income family would have a 40 per cent chance of exceeding a $480 expense limit, there is only one chance in four of exceeding the $720 limit implied by the 50 per cent co-insurance plan.

The co-insurance variant of MRI would not only have the adavntage of increasing cost consciousness without raising the maximum risk; it would also reduce the chance that the family would be required to spend the maximum amount. For families with incomes of $8000 or over, the risk of incurring net costs of $800 is reduced from one chance in four to one chance in seven. For families with incomes of $4800, the risk of spending $480 is reduced from 40 per cent to 25 per cent.

There is only a slight extra cost to the government for this extra protection and the added cost consciousness of co-insurance. The average cost per family of MRI with co-insurance is $249 compared to $233 without it. There would be a small increase in the cost of administering additional claims. But these extra costs would be more than justified by the much greater cost consciousness that would be obtained.

SOME QUESTIONS, SOME ANSWERS

The MRI and postpayment proposal raises a number of questions. What would happen to Medicaid and Medicare? How would group practice, the increased use of paramedical personnel and other improvements in efficiency be encouraged? Would preventive care be neglected? What would be the role of the area-wide planning? This section answers these and related questions.

MRI would make Medicaid unnecessary. "Medical indigency" for families above the poverty line ($3300 in 1969 for a family of four) would be eliminated by the provision that health care spending not exceed 10 per cent of income. Families below the poverty line who are currently covered by Medicaid could be given in addition to the MRI policy a cash grant equal to their expected health spending; as noted above, with a $320 deductible this would be approximately $230. This would leave the family with little risk of unsubsidized and uncovered expenditure (a maximum of about $90 per year for the family), would remove the distinction between welfare patients and others, and would encourage these families to have the same cost consciousness in health spending as the rest of the population. This method of replacing Medicaid is consistent, both in spirit and in administrative machinery, with the new approaches to welfare policy such as the Family Allowance Plan and Negative Income Tax, advocated by members of both political parties. It could alternatively be administered within the framework of our current welfare system but without the complex details of the Medicaid program.

Because of the special economic and health problems of the retired aged, it would probably be best to continue Medicare in its current general form as part of the Social Security program. In the spirit of the MRI proposal, the deductibles in parts A and B of Medicare could be increased and compensating amounts

added to the Social Security retirement benefits. Even if Medicare is left essentially unchanged, its future cost levels would be restrained by the cost-conscious environment that MRI would create.

A related issue is raised by those conditions, such as total chronic kidney failure, in which treatment costs several thousand dollars per year and tens of thousands of dollars a single illness. MRI might either include these or, by imposing a ceiling, leave their financing to special public programs and private health insurance as at the present. The appropriate solution to this delicate social problem lies outside the scope of this essay.

Organizational changes that might increase the efficiency with which medical care is produced, such as group practice and the use of paramedical personnel, would be encouraged under MRI by the natural pressure from patients to obtain care at lower cost. A specially trained pediatric nurse or other paramedical worker, capable of providing the same quality of care currently rendered by physicians but at lower cost, would be easier to incorporate into our system of medical care if patients have an incentive to keep costs down than if, because of comprehensive insurance, they can request the more expensive physician care at little or no cost to themselves. Similarly, if group practice is a more efficient way to produce medical care, demand for this type of service would grow as lower costs are passed on to patients in the form of lower fees. Comprehensive prepaid group practice could easily be incorporated into an MRI system by allowing families to apply the actuarial value of their MRI policies against the annual charge of the prepaid group.

The increased reliance on individual preferences and the market mechanism made possible by MRI would not completely eliminate the need for area-wide planning. A variety of decisions—the location of expensive diagnostic and treatment equipment, the investment in long-lived hospital facilities, the training of specialized personnel—might still be improved by such coordination. But the behavior of patients who are paying for a large portion of their medical care would help to guide these planning decisions and would act as a long-run check on their appropriateness. Moreover, the MRI system would leave to the market those decisions that planners would have to make if a high proportion of expenses were reimbursed by insurance: What is the "right" level of hospital cost per patient day? What is the "appropriate" charge for different doctors' services? How much "should" doctors in different specialties earn? In short, area-wide planning would be able to concentrate on the problems that cannot be solved by the natural forces of supply and demand.

Mr. GIBBONS. Do we have any other questions?

Mr. BYRNES. I do want to compliment Professor Marmor for his statement, and the paper. I think he has made a real contribution to these hearings.

Professor MARMOR. I did that partly as a representative of the Wisconsin group, so you have some interest, a direct relationship, to this statement.

Mr. BYRNES. As a taxpayer.

Professor MARMOR. You supported the University of Wisconsin, which generously provided me office space and time to write this testimony. However, I should add that most of it was written last night at the offices of Midwest Planning in Minneapolis. They should get some of the credit, too.

But I should say, Mr. Byrnes, that your use of the Poverty Institute is to me an example of the proper use of experts.

Mr. BYRNES. They were helpful, very helpful.

Professor MARMOR. I think you need the same thing in health. I don't see why in health care the standards of argument are so different than what they are in trade, or tariffs.

More unfounded assertions are made in this area, I think, than any other area of American politics. Maybe elections vie with it, and that explains it all.

Mr. SCHNEEBELI. Mr. Chairman, I am not trying to prolong the discussion further, because we have three other witnesses, but I, too, would say that you have given us a lot to think about. Rather than a long discussion of the Feldstein program, do you have a summary you are able to send me? Something like 10 pages?

Professor MARMOR. I have something nine and a half pages, just for your liking.

Mr. GIBBONS. I will take one of those, too.

Professor MARMOR. There is one available about 9 pages, which is quite clear. We can send longer things to people like Mr. Bill Fullerton. Incidentally, your committee document here, the basic facts in the health industry, is the most enlightening health document I have come across in the last few months, and I want to compliment the committee. I don't know who did it. I assume Mr. Fullerton had something to do with it.

I think every researcher in the country working on this problem, trying to bring some illumination to this issue, is indebted to your committee for doing this. It represents probably 10 man-years of work to collect all those materials. It is a job I could not do as a private researcher. It is one that Congress, and particularly you and your staff, deserve the highest praise for once trying to anticipate the actual barrage of factual statements with detailed statistical summaries you can refer to.

Mr. SCHNEEBELI. You are aware of the fact that we have a long list of witnesses from all facets of interest in this problem. I would think that we have a rather detailed study in depth on the problem.

Professor MARMOR. To be candid with you, I think the length of the witness list has nothing to do with its quality. I have read all of your past health hearings, and I must say, when I looked at the executive sessions on medicare—I think when you were present—I know Mr. Byrnes was there, I don't think Mr. Gibbons was—I was struck with the number of questions the gentlemen present had over what the bill included. That was March 1965.

Mr. SCHNEEBELI. Do you recall a question of medicaid cost that we asked HEW for, and the reply, the paltry reply?

Professor MARMOR. I think I could remember almost any paltry reply you got. I remember the three-layer cake discussion.

I don't think I can add anything to your own sober lessons from medicare. I hope that this experience——

Mr. SCHNEEBELI. Medicaid.

Professor MARMOR. I think both cost estimates were just as bad. I think, frankly, medicaid has been scapegoated compared to medicare. The normal cliché about this is "medicare has been a blooming success and medicaid has been an unmitigated disaster."

Medicare would have run into financial problems if it had had to depend on annual appropriations and State moneys. Your chairman said, for example, when discussing the part B premium in 1965, "Why should it be $2.50 a month"? "Look, I want to make a conservative estimate here. We ought to go to $3," and everyone finally agreed.

And that proved barely adequate to handle the cost of part B. He and others were worried, but they were worried without getting much help from the debators over medicare.

Mr. SCHNEEBELI. Will you send me the 9-page outline?

Professor MARMOR. I will send it to all of you.

Mr. GIBBONS. Mr. Corman?

Mr. CORMAN. I want to thank you, Professor, for your testimony. I wonder if you would comment on your observation of the Committee of 100. It seems to me the health security program has come to this Congress with considerably more study by an outside group than legislation we normally get, and it was a rather broad-based committee. Though I think we may very well need the kind of commission you are talking about, I am wondering if we haven't done a lot of work already in that Committee of 100.

Professor MARMOR. I think that is a fair question. I think you are a fair man for asking me to come here to testify, even though you knew I was not going to celebrate any of your ideas, and I applaud you for that.

Now to your good question. "Do you think the Committee of 100 has done sufficient work to make it a fully trustworthy guide to a National Health Plan?"

Not yet, but I think it represents an improvement over past efforts. Let me tell you why I think it is not yet enough. If you look at the composition of the 100, and go back to the 1940's and look at the people who were advocating national health insurance in the 1940's, I think you will find an extraordinary similarity.

Look at the role of I. S. Falk, a distinguished medical economist. I am not arguing that I. S. Falk is not competent. What I am saying is that I am concerned that a committee made up of people who have been taking the same position for so long be seen as an adequate expert group.

I think for the expert group you want to get different faces, new faces, a combination of faces, including some of the people on the Committee of 100.

What I would say there is that it has been an improvement, Mr. Corman. There is no question about it, but I think if there were the time here to go through the details of the Kennedy bill or the Committee of 100 bill, I would be glad to point out to you flaws that I don't think have been dealt with. I could do the same, I assure you, with the HMO's or the Nixon bill.

I don't think this is the day for that kind of detailed review. Though I think there has been some improvement, I would not rest my case on the Kennedy plan or the Committee of 100's research. I think they will make a major input, and I would like to see members of that Committee of 100 on the Commission.

Mr. CORMAN. Turning to your proposal on catastrophic illness, it does seem to me that 10 percent of income is probably a reasonable figure to say what is catastrophic.

On the other hand, considering the median income of this country—it is $9,000, if I remember it—I wonder if catastrophic illness coverage wouldn't have to cover almost every hospital case that lasts more than 4 days.

Professor MARMOR. That is a good question. Two answers to that: One, it all depends on what you count as an expenditure for health. If you count as part of your deductible, expenditures made by one's private insurace company, then your problem comes up rather starkly.

Most of the country has health insurance, and particularly hospitalization insurance. But expenses paid for on your behalf do not have to count as part of the $900 deductible, the out-of-pocket expenses. I am worried about catastrophe, about how much money is extracted from a man's pocketbook in 1 year. Therefore, the premiums for health insurance would be part of the catastrophic deductible, not the bills paid by one's health insurance.

That is one way of dealing with the problem.

Second, how many people do you think spend more than 4 days in a hospital in a year? The median expenses are something like $345 a year. The key to the idea of a high deductible is that you don't pay the health bills of most of the people in the country, and you only pay the bills of those that go at something like double the median expenditures in any one year.

Mr. CORMAN. But if I were making $9,000 a year and spending $40 a month for my family's insurance, I might just decide to drop that $40 a month, because I wouldn't be buying very much coverage.

Professor MARMOR. Mr. Corman, you would be buying the coverage on exactly the first $900 of expenses.

Mr. CORMAN. That is, I would be paying $480 a year to buy $900.

Professor MARMOR. Yes. That is not a very good deal.

Mr. CORMAN. So if we had your plan, I probably wouldn't carry any private insurance.

Professor MARMOR. This all depends on whether you like to avoid risks or not. If you are a cautious man, what you would do is buy the insurance, budget monthly for your health care, and avoid the risk of having to pay the first 10 percent in any one month.

Mr. CORMAN. Not necessarily. There are some things you can insure yourself about. I don't carry collision insurance, because I pay too much for the coverage on my automobile. I can afford to replace my car if it gets wrecked, and I save myself $250 a year by not taking it. If I am paying $40 a month, which I guess is about a reasonable amount for a limited coverage policy, that is $480 a year, but if I just assume the risk of the first $900, everything else is paid for and I may out-guess the 1 year and not have any expenses.

Professor MARMOR. Right. What is wrong with that?

Mr. CORMAN. I can't see why I should continue to pay nearly $500 a year when the only payment I have to protect myself against is a $900 expenditure.

Professor MARMOR. Professor Feldstein would just love you for saying that, because that is his central idea. His idea is to get out of the insurance business the whole group of people who are trying to cover the very first dollars and make sure the last dollars of expenditure are adequately covered.

American private health insurance is a disaster area when it comes to protecting us against catastrophe. We want deep coverage beyond the first 10 percent. We are not worried quite as much about the first 10 percent, even though some people, in order to budget in a regular way, might well decide to do it.

What would happen, Mr. Corman, is that your $480 a year would be like a prepaid group practice plan. You would be preparing your first $900. You could treat it just the way the premium would be under

group health. You would know that if you paid for that insurance, it would cover the first so many dollars of your expenses.

You would know that the probability of your going beyond that is very slight. If you went beyond that, you would have to be protected. So you would have to decide. "Do I take the risk? Am I a risk-taker with respect to the first dollars as long as I am protected, and my family, against financial disaster"?

It is analogous to flood insurance, with a high deductible. You are saying to a person, "If the floods come and your house gets wiped out, after you pay a thousand dollars, that is it. You don't have to worry about the flood beyond a known amount of money that you could scrape up."

Flood insurance doesn't make the house better. It just leaves you protected against financial ruin.

Mr. CORMAN. But if we had catastrophic coverage on that house of mine past the first $900, I wouldn't spend $480 a year to protect myself against the first $900 loss. I would take the gamble, and I would win, because I won't have a catastrophic illness every year.

I wish we had that kind of a system. I don't think it is catastrophic illness. I think it is very comprehensive insurance.

Professor MARMOR. That is right.

Mr. CORMAN. For the people who don't get sick, it won't come into play, but for almost anybody who gets sick, as a matter of fact, the first $900 is gone very quickly. Of course, you get some people in the upper brackets that still make some insurance provisions——

Professor MARMOR. The deductible we have in mind is not arranged so that once one spends $900 he never spends another dollar. That would mean that when one spent $899—if you said, "Pay $900 and beyond that you pay nothing," if it went to $900 in the first 4 days when a man were in the hospital, what incentive would the doctor or patient or hospital have to keep down the expenses? None.

One way to handle this would be to have 50 percent of the coinsurance up to a cumulative deductible of 10 percent. So on the first $1,800 of medical expenses your responsibility would be $900. Up to $1,800 you would be sharing it. Beyond $1,800 it would be dollar-for-dollar reimbursement by the Federal Government.

You look at the estimates of the number of people whose medical expenses go beyond the level of $1,800 in a year. It would be small indeed.

Mr. CORMAN. That makes more generous. The Government is going to pick up the tab for all expenses. We have about a $35 billion Federal expenditure, as I remember the figures.

Professor MARMOR. The answer is that you just don't pay—the Government does not pay until the patient has exceeded 10 percent of his income. But the form of the expenditure of 10 percent is not—need not be the straight deductible. It could be a copayment. We could work out those details any time. Indeed Professor Feldstein is now at work on various versions of a catastrophic bill.

Mr. CORMAN. I would be interested to discuss with you some of the limitations. My own observation is that I think this is underfinanced. They have underestimated what it will cost, and if half is to be borne by a payroll tax, it would have to be a larger tax. But I don't want to take time now.

Professor MARMOR. It will be a pleasure to talk to you in the future.

Mr. GIBBONS. We will have to ask you back again.

Professor MARMOR. I would be delighted to come back. The only thing is, after 6 o'clock Minneapolis time there isn't a flight out. I nearly had a heart attack, requiring Medicare, wondering if I would get here in time to present my testimony, and you were fogged in here this morning.

With that one request for more advance notice, I would be happy to come back.

Mr. GIBBONS. The staff didn't tell us they were imposing on you that way.

Professor MARMOR. I came as an individual. I felt sort of angry that since I came as an individual I came last, but somehow I was put as an individual, representing no group, in the morning list of witnesses.

If it is possible at all, I would be glad to come back.

Mr. GIBBONS. Thank you.

Professor MARMOR. Thank you very much.

Mr. GIBBONS. Professor Joseph D. Cooper of Howard University.

STATEMENT OF PROF. JOSEPH D. COOPER, DEPARTMENT OF POLITICAL SCIENCE, HOWARD UNIVERSITY

Professor COOPER. Thank you, Mr. Chairman.

I am on the faculty of the Howard University as professor of political science and also on that of The American University. Since about 1960 I have been studying various aspects of that burgeoning area which you might call health politics.

No less than any other American, I am interested sincerely in remedying the defects in our own medical care delivery system. I differ from others, however, in saying that we must distinguish between the ideally desirable, the dreams of Utopia, and the reasonably attainable, consistent with other national priorities. And I also agree with others who believe that other more positive aspects of health care—as distinguished from medical care—deserve a priority.

Briefly, the points covered in my full statement, which you have——

Mr. GIBBONS. Let me interrupt. We will put your full statement in the record at this point.

(Professor Cooper's statement follows:)

STATEMENT OF PROF. JOSEPH D. COOPER, DEPARTMENT OF POLITICAL SCIENCE, HOWARD UNIVERSITY

If anything can be said in general about the testimony in both houses of the Congress on the need for new health legislation it is that there has been a conspicuous absence of description of specific medical outcomes of the various proposals for financing and reorganizing the health care delivery system. Rather, there is an assumption, more implicit than explicit, that if doctors were to be organized into groups and if everyone had access to the same standard of medical care financed through some form of insurance the health of the public would be improved. And that conditions in areas without adequate service would also be remedied.

It is true that many urban and non-urban areas are without a single doctor. This geographic maldistribution should be corrected—and many have testified convincingly as to the need for such correction—but none of the legislative proposals would in themselves achieve such an improvement.

One would think that before the Congress passes far-reaching legislation with respect to health benefits that there would be some reasonably specific statement

of defined needs and goals priorities. If there is such a statement, I have had difficulty finding it. Rather our goals seem to be:

1. To move toward a publicly financed health service which would relieve individuals of responsibility for payment for health services and supplies.

2. To organize doctors into groups, as distinct from individual practices, on the assumption that this will make more medical care available to more people more efficiently and of better quality.

3. To move toward the replacement of group practice with a single, locally, regionally, and nationally integrated health service.

Additionally, although it is not brought out in the testimony but is to be found in legislation now pending before the Congress, there is a non-health-related objective of using the health system as the assault mechanism for re-structuring the political-economic organization of the country.

On the one hand, then, we do not really have definitions of needs, goals, and priorities for the achievement of qualitatively-described medical outcomes. On the other hand, we do not have valid information and data to demonstrate that fiscal and organizational innovations will have any constructive impact on access to quality medical care. To the contrary, if we move into the cradle-to-grave, universal-access systems of health care delivery being proposed to the Congress we are likely to make essential health care less accessible and of lesser quality. This is likely to occur as a consequence of systems-induced demand which would turn us into a waiting room society in which it would be difficult to distinguish between essential need as compared to imagined or inconsequential need. This prediction is based on more than personal skepticism. It derives from observation of the experiences of other countries in which limits have not been placed upon access. In short, little attention has been given to more important but less simplistic approaches to meeting real needs.

Returning briefly to the problem of maldistribution of physicians, much has been made of this as a reason for urgency in passing new legislation. Of course, no country in the world has been able to solve this problem satisfactorily. Curiously, there is nothing in pending legislation which would solve this problem. I dont' know what the solution might be in a democratic society. The situation might well get worse before it gets better. The fact is that throughout the world there has been a movement away from areas of least to greatest density. Furthermore within metropolitan areas of great density, service to central areas have become less available. Apparently, no less than other citizens, doctors want to live and practice in areas which offer the best living and cultural facilities and advantages for their families: areas which also minimize physician inconvenience and risk. Nevertheless solutions must be found through development of medical models which emphasize direct service and health models which emphasize attention to environmental, socio-economic, and cultural improvement and attention to primary prevention to which so much lip service is given. Without the latter, increased access to direct medical care for slum area residents is not likely to be highly productive except, perhaps, in a political sense. The ordinary medical needs of the population are best held to a minimum if people live in wholesome environments, eat nutritionally balanced food and ample quantities, and are given the benefit of simple preventive measures. This approach should receive top priority within the framework of a health model which would be broader in scope than the medical model which emphasizes direct access alone.

A fundamental error in the design of medical care systems is that they tend to equate demand with need. To the extent that solutions have been sought for this problem, they have not been highly successful in discouraging unnecessary demand. The tragedy is that excessive demand inevitably leads to dilution and depersonalization of service and to the erection of load barriers to the provision of exceptional attention to those who have real problems.

It is not uncommon for Americans to visit other countries and to bring back glowing reports of the successes of medical care delivery systems in those countries. Yes, there have been great successes in other countries but whether in fact they have achieved the aims proposed for our own country is doubtful. They have all succeeded in becoming waiting room societies without really achieving a single standard of medical care. I recognize that investigators are prone to find that for which they look and that, therefore, I could be subject to the same bias in the studies I have made abroad. Accordingly, I shall quote from a distinguished and leading public health authority in one of the Eastern Euro-

pean countries: "* * * permanently increasing demands for medical/health care urgently ask for a more adequate technology in programming, planning, and evaluation of accomplished results. If this is not the case the medical and health care expenses will soon far exceed the funds made available by the socio-economic progress of any country."

I repeat that this is a worldwide phenomenon. I recall the Slovakian physician who said: "On my days in the clinic I will see 60 patients. When I begin my examinations I will ask myself, 'Which 10 of these people will really be sick?' When I have finished I will ask myself, 'Have I correctly identified those with real complaints and have I given them the attention they require?'"

Then there was the rural physician in Yugoslavia who said: "Today I have seen 100 patients." The next day I asked a city health official about this. He said: "He saw perhaps one patient." I pressed him to explain, so he added: "Well, in his area maybe two or maybe three, but a hundred * * *? These were mostly visitors and complainers and people who wanted sick absence excuses."

In the United Kingdom, sick absence rates have been increasing at the same time that expenditures in behalf of the National Health Service have also been increasing. In the year ending June 1969 there were almost 9.8 million spells of sickness absence, accounting for a total of 329.4 working days lost recorded in Great Britain. This is an average over 15 days lost per person insured. Both the number of spells of sickness absence and the total number of working days lost were the highest ever recorded. The number of spells has increased by almost 50 per cent since 1954.

One of the functions of the medical care delivery system, apparently, has become to reinforce the desire of many people to become less productive instead of more productive.

If one studies the representations of need made before the Congress and elsewhere he finds an emphasis on maximizing patient care without adequately defining need. Definitions of need are, indeed, difficult to achieve. In part this is due to changes in population and health characteristics. In part it is difficult to distinguish between normal and diseased individuals based on so-called objective data. And in large part it is difficult to distinguish between subjective public expectations of what should be available as against what needs really to be available considering finite resources; between idealized professional expectations and the practical limits of the attainable, again considering finite resources. There is, in fact, a variant of Parkinson's Law which can be imputed to medical service which can be expressed as: "Demand rises to consume and exceed the available medical service resources."

The big push now in the United States and elsewhere is to accommodate demand through organizing doctors into groups or polyclinic types of practice. This is an application of principles of scientific management to the processing of a stream of human service claimants through an organized assemblage of medical talent and facilities. Theoretically, this should make a great deal of sense, but the "processing" of humans is something different than the processing of papers and of raw and finished materials.

The case for group prepaid practice might very well be a good one, but not necessarily in terms of greater efficiency, more patients served per physician, and better quality. If *all* of the private practitioners were to be drawn into group practices along with *all* of their patients of *all* ages, it would be interesting to observe the congestion and backlogging that would result. The first administrative change would be that doctors would work shorter hours thereby calling for an increase in the number needed to treat the expanded service population. It is said that technicians and paramedicals could expand the workload reach. They might very well do so, but no matter how the words might be gilded, they would not be doctors of medicine and, at least to that extent (under the most ideal of circumstances) service would thereby be diluted. It is sometimes said that the greatest beneficiaries of group practice are the doctors who, in exchange for a reduction in income, are able to work under shorter, regularized schedules.

To the extent that group practices have been able to keep their costs under control this is attributable mainly to their avoidance of acquiring service risks as members and to their acquisition of younger members in prime condition, as a group. Consider what would happen to costs of groups if they were obliged to care for high risk populations for reasons of age and of socioeconomic origin. We need more information on performance characteristics of prepaid group practices which have had many years of experience. The leading group practice in which I have had charter membership since 1939 has had a tenfold increase

in its basic dues since then, with the end not in sight, plus the imposition of innumerable fees for service. At the same time, over the years (at least in my own perception) I have observed a growing depersonalization and a loss of quality control as inevitable reactions to size of membership and turnover of professional personnel. To the extent this is true it might also be attributable to a broadening of the socioeconomic base of membership, however desirable this is from a social standpoint, and of increasing age of long-standing members. We need more information as to the reasons for members and doctors resigning from group practices and as to why members may engage outside medical services at their own expense, beyond their group practice entitlements.

I do not oppose group practice. Rather, I suggest that this interesting form of organization, which offered so much that has not been achieved since the time that I joined the movement as a young man over 32 years ago, should be studied in greater depth and balance before it is promoted more extensively. We ought to have a better appreciation of strengths and weaknesses so that the one might be enhanced and the other minimized. We ought to know more about the true experiences of the Kaiser Permanente organization, for it has the largest prepaid group practice membership in the country. How does it cope with its acknowledged problem of excess or unnecessary demand by the "worried well" who exercise their "right" to "free" care? How well do doctors fare? What is the quality of their service as compared to that of independent practitioners? How effective is peer review in governing the quality of service? Such questions and many more should be addressed to other group practices including those characterized as Health Maintenance Organizations (HMO's). To what extent does the profit or savings motive introduced into group practice affect service availability and quality? Perhaps the answers are available, but if so they should be presented to the Congress and the public as inputs for this time of decision.

A cardinal principle of those who seek what they call the rationalization of medical care delivery is that there should be a single standard of service for all regardless of means. How could one object to this ideal principle? To do so would be akin to taking a stand against motherhood. The principle assumes utter rationality upon the part of consumers and providers, whereas neither is possessed of this facility, in the sense of total submission of self to the needs of the whole. There is no country which has installed a national system of medical service without significant limit which has been able to confine both providers and consumers to the ordinary systems channels on a single standard basis. Where a country permits an alternative at private expense, this has emerged, as in Britian in the form of a Blue Cross/Blue Shield type of organization called the British United Protective Association which enables insured members to bypass the long lines of the waiting room society, particularly in hospital admissions. In countries which do not legally and openly permit such alternatives, corrupt practices emerge in the form of side payments to doctors of salary to induce them to grant preferential or even illegal services. In some countries this is more rule than exception under particular conditions of demand.

The case of prescription drugs is an interesting one insofar as it yields insight into the consequences of generating or encouraging induced demand. Throughout the world there has been an increase in consumption of prescription drugs. In countries where there is pharmaceutical promotion, some have attributed this to advertising activities of the drug companies. This does not, however, comport with the experience of countries in which there is no such advertising and in which there is no drug detailing. The latter have also experienced increases in prescribing of the same general categories of drugs. The problem has been studied by the World Health Organization and by individual countries as well as by independent professional investigators. What seems to come through as the single most important set of governing influences is that consumers, on the one hand, seem to feel that they need some form of visible treatment when they go to the doctor while, on the other hand, the harried doctor who can give only minutes to a patient is inclined to yield to that expectation through the generous use of his prescription pad.

Proposals have been made to limit the availability of prescription drugs through use of formularies. All that would be accomplished would be the limitation of the specific drugs that would be available without influencing materially the volume that would be consumed. Presumably, the formulary approach should lead to lower pharmaceutical costs, but that is not likely to occur, for one way or another pharmacy groups would protect their retail markups, one of the

biggest chunks of prescription costs. They would have to do so to be able to stay in business. From a medical standpoint what would be lost would be the flexibility of the physician to prescribe as he believes necessary for the individual patient. This would be another classical application of the tendency for function to be governed by form whereas the reverse should be true.

Ingenious schemes have been devised whereby prescription drug costs could be assumed by the public for Medicare and other health insurance claimants. They involve proposals, for the most part, which would require dispensers to keep records, to submit claims, and to make reports which, presumably would have collateral value in medical program planning. It is a good principle to derive planning data from essential operations data, as a byproduct, but in this case we ought to question the notion of making drugs freely available without charge or on a co-payment basis.

The case of prescription drugs could offer some insights into how more general medical costs should be treated. There is a special aspect to prescription drugs: relative to price indexes, they have had the least increases among all the elements of medical cost, as reported by the Bureau of Labor Statistics and the Department of Health, Education and Welfare. Considering the problems of retail prescription cost markups, there is little to be hoped for in cost reductions through whittling away at manufacturers' prices. The greatest economies are to be achieved in holding down total consumption and in obliging consumers who can afford to do so to absorb non-burdensome prescription drug costs.

According to the Social Security Administration, reporting for 1970, the average annual cost of prescription drugs for people of all ages was $15.40. For people under 65, the average annual cost was $16.29. For those aged 65 and over, the average expenditure was $50.94. Certainly, there were people at all age levels who must have had catastrophic expenditures not expressed in simple averages, but these HEW figures clearly point to the people aged 65 and over as those who include them at least some for whom purchase of prescription drugs would be burdensome. Let us, however, look more deeply into this age group. In 1968, the Task Force on Prescription Drugs of the HEW made an estimate of the distribution of annual prescription drug expenditures of elderly persons by size of expenditure, as follows:

ESTIMATED DISTRIBUTION OF ELDERLY PERSONS BY SIZE OF ANNUAL PRESCRIPTION DRUG EXPENDITURES, 1971

Annual expenditures per capita	Number of individuals (millions)	Average expenditures per category	Total drug expenditures (millions)	Number of prescriptions purchased (millions) [1]
Total	20.5		$1,230	308
None	3.9			
$1 to $50	8.3	$27	222	56
$51 to $100	4.5	73	327	82
$101 to $250	3.1	151	467	117
$251 and over	.7	306	214	53

[1] Assumes an average expenditure of $4.00 per prescription in each category.

The analytical projection brings out that 3.4 percent of those in the category 65 and over account for about 17½ percent of total drug expenditures for the age category while their average annual expenditures were to be an extremely high $306.

If now we apply the exception principle, a time-honored management principle, we would treat routinely or leave to their own devices those who have no real burdens and provide some form of insurance coverage to that tiny fraction of the population who have substantial burdens. We should extend such coverage to people without adequate resources regardless of age. Thereby we would save the assumption by the public of the costs of the drugs as well as the direct and indirect or hidden administrative costs. The money saved in this way could well go into other social and environmental programs having a direct bearing on health improvement through primary prevention.

The exception principle can be applied to health care in general. Some aspects could be covered at public expense because they constitute basic prevention in the broader interest and because administratively it is simpler and cheaper to

handle them so. Examples are injections of children, infant screenings, polio vaccinations, etc. Most medical expenses can be absorbed quite easily by most people out of their own incomes. They do not even need employer contributions for those become folded into the costs of goods and services and marked up accordingly, ultimately to be repaid by the employees through the higher prices they pay. One really gets nothing for nothing.

The insurance system, whether public or private, should provide primarily for the burdens that people cannot assume, recognizing also in some way that burdens are relative to income.

Some might say that I am suggesting the use of a means test. Not at all. I am suggesting a resource test! Call it means or resource, we use such tests in many fields of activity. If a student applies for a scholarship, he must pass a means test. If summer jobs are to be allocated to youth, priority is given to disadvantaged or low income minority members. This, too, is a means test. And at least many if not most of those who are opposed to means tests in health and social welfare support them for purposes such as those just stated. It is not really the fact of a test that should matter but how it is used. Means or resource tests need not be demeaning. They ought not be.

What should the Congress do now? It should certainly move with haste to protect people against catastrophic or ruinous costs relative to personal resource. It should require of the Secretary of HEW that he continue his examination of a variety of approaches to the delivery of medical care and that he report as to their advantages and disadvantages in terms of medical outcomes and costs as a basis for cautious, incremental legislation on the basis of demonstrated experience rather than the promotional expectations of various systems proponents, no matter how sincere most of them are. It should call for substantial economies in hospital administration and for inquiries into optimal size of hospitals relative to both efficiency of service and economics of operation. It should demand concrete evidence of beneficial outcomes of any provision to be incorporated into law.

What should the Congress not do? It should exclude social and political experimentation en masse and irrevocably in toto, such as top heavy and bottom heavy citizen control mechanisms that would unavoidably consume vast amounts of medical staff time in education and negotiation. We know too little about what makes a citizen participation program work, desirable as it might be. And the Congress should also look most cautiously at those provisions which have been slipped into legislation with the intent of creating new regional and community forms of government via health systems administration.

Most important, the Congress should call for a realistic examination of medical goals and priorities with due regard to medical and social outcomes. This could desirably serve as the springboard for a constructive national debate.

Earlier this year, at the Sun Valley (Idaho) Forum on National Health, the general consensus was that "a very large number of Americans are overdoctored, overhospitalized, and overdrugged." The Forum, in which many distinguished health planners participated, challenged the common supposition that the way to alleviate medical systems inadequacies is to spend more. Mr. Harry Schwartz of the New York Times, reporting the discussion, wrote: "Millions of Americans would benefit more from changing their dietary habits, losing weight, exercising, stopping cigarette smoking, and cutting down or ending their consumption of alcohol and other drugs than from having more physicians and more hospitals available to treat them after their bad habits laid them low."

I do not want to close without drawing attention to the great opportunities and responsibilities the country has in restorative medicine. The gains to be achieved are scarcely being tapped. Millions of people can be restored to partial or full self-sufficiency through the extension of existing technology in physical rehabilitation and the advancement of that technology through further research and development. I was impressed with this potential in the most general way until I visited the Texas Institute for Rehabilitation and Research, directed by Dr. William A. Spencer. There I saw dramatic and inspiring evidence of the transformation of people from physically and socially dependent states to a morale-building self-sufficiency which also instilled a sense of personal dignity. As I read and hear about the billions of dollars to be tossed about casually for the support of schemes whose contributions to good health are of doubtful value, I cannot but think: "How wonderful if only a few of those billions were to be invested in the salvaging of millions of people upon whom society has largely turned its back!"

Professor COOPER. Thank you. I will summarize.

One, the various legislative proposals would not provide for lack of access to medical care by some groups in our society. It would be wrong to convey the impression that greater access would be achieved. Although this access problem urgently should be solved, no country that has tried to do so has really succeeded.

Two, efforts to improve the medical care delivery system have not distinguished between demand and need. There is a great difference between the two. The demand for health service is insatiable. Any country which fails to limit demand will either bankrupt itself or suffer a distortion in the balance of its national priorities.

Three, the extension of group practice is being promoted in one form or another as the means for providing more abundant medical service to more people. There may, indeed, be advantages to group practice, a form of service in which I have been involved for over 32 years, but the case has not been made that this type of service is necessarily more efficient, more productive, or of better quality. To the contrary, mass conversion to group practice could very well aggregate service deficits.

Four, an idealized goal is to achieve a single standard of care for all people regardless of income. Laudable as this is from a social standpoint, it is infeasible because it depends upon other rationality of consumers and providers, neither of which is attainable. The effort has been made in other countries, none of which has succeeded in achieving or enforcing the single standard. Rather, they have achieved either alternative private insurance systems or nonlegal secondary markets. They don't talk about them, but they exist and can be found easily if you look for them: corrupted, fee-for-service public systems.

Five, the overwhelming majority of people of all age groups are able to absorb their own ordinary medical costs under whatever system of medical care they elect or that may be available. Hardly anyone is able to pay for the costs of catastrophe, hospitalization of moderate duration, some chronic diseases, incurable degenerative diseases, and rehabilitative medicine. Insurance designs should be organized to protect against these exceptional burdens. This pertains also to insurance protection for these who must incur undue prescription drug cost burdens.

Six, a governing principle in insurance design must be simplicity and economy of administration. This is most readily attainable through adherence to the principle of selective coverage as just discussed. The best approach to economy is not through elaborate systems of control which somehow add to costs, but to restriction of benefits to those who actually need them.

Seven, the best way to provide maximum medical care to those who need the most is to minimize the dissipation of resources in behalf of those who need them least.

Eight, we should not confuse political systems legislation with health legislation as some have tried to do in order to bring about changes in our political structure.

Nine, the billions of dollars saved through selective coverage could well be allocated to important targets of preventive health management, including improvement of socioeconomic, environmental, institutional, and related conditions.

No greater deed of compassion and sound economic investment could be done than to invest in rehabilitative programs to restore millions of people to self-sufficiency, decreasing dependency, and enhanced feeling of dignity.

I shall take only a few minutes to expand upon a couple of these points from my full statement.

A fundamental error in the design of medical care systems is that they tend to equate demand with need. To the extent that solutions have been sought for this problem, they have not been highly successful in discouraging unnecessary demand. The tragedy is that excessive demand inevitably leads to dilution and depersonalization of service and to the erection of load barriers to the provision of exceptional attention to those who have real problems.

It is not uncommon for Americans to visit other countries and to bring back glowing reports of the successes of medical care delivery systems in those countries. Yes, there have been great successes in other countries, but whether in fact they have achieved the aims proposed for our own country is doubtful.

We should borrow both from their positive and negative experiences as applicable to our own country.

They have all succeeded in becoming waiting room societies without really achieving a single standard of medical care. I recognize that investigators are prone to find that for which they look and that, therefore, I could be subject to the same bias in my own studies abroad. Accordingly, I shall quote from a distinguished and leading public health authority in one of the Eastern European countries: ". . . permanently increasing demands for medical/health care urgently ask for a more adequate technology in programing, planning, and evaluation of accomplished results. If this is not the case, the medical and health care expenses will soon far exceed the funds made available by the socioeconomic progress of any country."

I repeat that this is a worldwide phenomenon. I recall the Slovakian physician who said, "On my days in the clinic I will see 60 patients. When I begin my examination I will ask myself, 'Which 10 of these people will really be sick?' When I have finished I will ask myself, 'Have I correctly identified those with real complaints and have I given them the attention they require?' "

Then there was the rural physician in Yugoslavia who said, "Today I have seen 100 patients." The next day I asked a city health official about this. He said, "He saw perhaps one patient." I pressed him to explain, so he added, "Well, in his area maybe two or maybe three, but a hundred * * *? These were mostly visitors and complainers and people who wanted sick absence excuses."

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One of the functions of the medical care delivery system, apparently, has become to reinforce the desire of many people to become less productive instead of more productive.

If one studies the representations of need made before the Congress and elsewhere, he finds an emphasis on maximizing patient care without adequately defining need. Definitions of need are, indeed, difficult to achieve. In part this is due to changes in population and health characteristics. In part it is difficult to distinguish between normal and diseased individuals based on so-called objective data. And in large part it is difficult to distinguish between subjective public expectations of what should be available as against what needs really to be available considering finite resources; between idealized professional expectations and the practical limits of the attainable, again considering finite resources. There is, in fact, a variant of Parkinson's law which can be imputed to medical service which can be expressed as: "Demand rises to consume and exceed the available medical service resources."

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The case for group prepaid practice might very well be a good one, but not necessarily in terms of greater efficiency, more patients served per physician, and better quality. If all of the private practitioners were to be drawn into group practices along with all of their patients of all ages, it would be interesting to observe the congestion and backlogging that would result. The first administrative change would be that doctors would work shorter hours, thereby calling for an increase in the number needed to treat the expanded service population. It is said that technicians and paramedicals could expand the workload reach. They might very well do so, but no matter how the words might be gilded, they would not be doctors of medicine and, at least to that extent—under the most ideal of circumstances—service would thereby be diluted. It is sometimes said that the greatest beneficiaries of group practice are the doctors who, in exchange for a reduction in income, are able to work under shorter, regularized schedules.

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actions to size of membership and turnover of professional personnel. To the extent this is true, it might also be attributable to a broadening of the socioeconomic base of membership, however desirable this is from a social standpoint, and of increasing age of longstanding members. We need more information as to the reasons for members and doctors resigning from group practices and as to why members may engage outside medical services at their own expense, beyond their group practice entitlements.

I do not oppose group practice. Rather, I suggest that this interesting form of organization, which offered so much that has not been achieved since the time that I joined the movement as a young man over 32 years ago, should be studied in greater depth and balance before it is promoted more extensively. We ought to have a better appreciation of strengths and weaknesses so that the one might be enhanced and the other minimized.

The case of prescription drugs is an interesting one insofar as it yields insight into the consequences of generating or encouraging induced demand. Throughout the world there has been an increase in consumption of prescription drugs. In countries where there is pharmaceutical promotion, some have attributed this to advertising activities of the drug companies. This does not, however, comport with the experience of countries in which there is no such advertising and in which there is no drug detailing. The latter have also experienced increases in prescribing of the same general categories of drugs. The problem has been studied by the World Health Organization and by individual countries as well as by independent professional investigators. What seems to come through as the single most important set of governing influences is that consumers, on the one hand, seem to feel that they need some form of visible treatment when they go to the doctor while, on the other hand, the harried doctor who can give only minutes to a patient is inclined to yield to that expectation through the generous use of his prescription pad.

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ought to question the notion of making drugs freely available without charge or on a copayment basis.

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The analytical projection brings out that 3.4 percent of those in the category 65 and over account for about 17.5 percent of the total drug expenditures for the age category, while their average annual expenditures were to be an extremely high $306.

If now we apply the exception principle, a time-honored management principle, we would treat routinely or leave to their own devices those who have no real burdens and provide some form of insurance coverage to that tiny fraction of the population who have substantial burdens. We should extend such coverage to people without adequate resources regardless of age. Thereby we would save the assumption by the public of the costs of the drugs as well as the direct and indirect or hidden administrative costs. The money saved in this way could well go into other social and environmental programs having a direct bearing on health improvement through primary prevention.

The exception principle can be applied to health care in general. Some aspects could be covered at public expense because they constitute basic prevention in the broader interest and because administratively it is simpler and cheaper to handle them so. Examples are injections of children, infant screenings, polio vaccinations, et cetera. Most medical expenses can be absorbed quite easily by most people out of their own incomes. They do not even need employer contributions for these become folded into the costs of goods and services and marked up accordingly, ultimately to be repaid by the employees through the higher prices they pay. One really gets nothing for nothing.

The insurance system, whether public or private, should provide primarily for the burdens that people cannot assume, recognizing also in some way that burdens are relative to income.

Some might say that I am suggesting the use of a means test. Not at all. I am suggesting a resource test! Call it means or resource, we use such tests in many fields of activity. If a student applies for a

scholarship, he must pass a means test. If summer jobs are to be allocated to youth, priority is given to disadvantaged or low income minority members. This too, is a means test. And at least many, if not most, of those who are opposed to means tests in health and social welfare support them for purposes such as those just stated. It is not really the fact of a test that should matter, but how it is used. Means or resource tests need not be demeaning. That ought not be.

Thank you, Mr. Chairman.

Mr. GIBBONS. Thank you, Dr. Cooper.

Are there any questions?

Mr. SCHNEEBELI. Just one observation. I am very interested in one statement you have in your formal statement, that a very large number of Americans are overdoctored, overhospitalized and overdrugged. This is quite a breath of fresh air in this area where we continue to get this clamor for more national health service.

I find your approach to the problem very unique and very interesting. Thank you.

Professor COOPER. Thank you very much.

Mr. GIBBONS. Mr. Corman.

Mr. CORMAN. Thank you, Mr. Chairman.

Doctor, you had me on the edge of my seat the whole time, because I thought you were going to give me the answer. Regrettably, you never did. You said that we ought to put our medical resources where they are needed, but you never gave any clue as to how we were going to find out about that.

I assume that you don't really want to use financial ability to determine entitlement to health care.

And you are not going to let consumer demand decide how we are to spend medical resources. Who is going to decide where we are going to put these medical resources?

Professor COOPER. Ultimately, you have to budget. It was rather interesting in Yugoslavia. Nothwithstanding their loaded waiting rooms and a seeming shortage of doctors, they are an exporter of doctors on balance. They go to other countries, because in Yugoslavia they finally determined that they had to put budgetary limits on what they could spend. This is one negative approach to the problem, because demand as such is insatiable and it is very difficult for a physician to make a distinction when a person comes to him.

The other approach in the design of insurance is, as I suggested and as the preceding speaker suggested, is that you have to design the insurance system to accommodate the people who are likely to have insufferable or unmanageable family burdens.

Mr. CORMAN. But those things are to give access to people regardless of their financial ability. But your complaint is that there is this tremendous overdemand. You may well be right, but who is going to decide who goes to the doctor?

Professor COOPER. It is a problem that no one has decided. The usual response of people in public health planning is, "Well, how does the doctor know whether or not the patient has a real complaint; the doctor has to have him come in."

The answer of the Kaiser Permanente people—they are an HMO in a sense and they have a profit motive—is to set up a master screening system, Mr. Corman, through multiphasic screening which, incident-

ally, has not yet demonstrated itself as cost-saving. It might be cost-generating. We don't yet really know about it.

You have a very interesting phenomenon that in any situation some categories of people account for most abuses. This is true in industrial organizations where there is a lot of malingering, or in grievance problems with employees.

Well, the medical records system could be employed by institutions, group practices, or polyclinics, or HMO's or whatever the mechanism or even private practitioners, to bring in that patient who seems to overuse the system and to examine him comprehensively to see what counseling he might need, if indeed he is abusing the system.

That is one approach to it.

Mr. CORMAN. But you would agree we shouldn't just make financial ability the screening?

Professor COOPER. Oh, no, sir, but I think we have to pay much more attention to preventive medicine. We have to act on it, not talk on it.

Mr. Disraeli made quite a point in his time of the importance of health in politics. Bismarck, who was not a great liberal, saw the political advantage of introducing health insurance. Today, there are many people who are very actively pursuing goals in health. It is the modern utopia. Somehow if we could find new national goals which people would pursue and out of which they would achieve their own organizational or professional gains, maybe we would shift the focus away.

As your colleague Mr. Schneebeli pointed out, my testimony refers really to the Sun Valley, Idaho, Forum on National Health, and the point was brought out there by very distinguished people that we cannot set up a system to take care of overfed or overindulged people in one way or another who don't have good personal hygiene in their eating, drinking, smoking or other habits, and then when they become sick because of their bad habits, then the public must bankrupt itself in order to accommodate them.

What we really need, and what you should have before this committee is the testimony of people who have studied the nature of disease and the nature of the homeostatic entity, which is man, because he is largely a self-restoring individual under ordinary conditions. He tends to get well by himself in most cases, and only if a catastrophic involvement occurs, or only in the cases of presently incurable diseases does he become a real problem, or in the case of trauma, because of accidants on the highway, as leading examples.

Mr. CORMAN. How many people are going to die of cancer this year?

Professor COOPER. I don't have the figures.

Mr. CORMAN. As I recollect, it is high, and I think most of them are going to die because the first 3 or 4 years they were going to get well by themselves.

Professor COOPER. That is an area where we need attention on the preventive side.

Mr. CORMAN. How about the diagnostic side? I keep hearing from the American Cancer Society that if you diagnose these problems very early that there is a much greater probability of cure. You seem to be going contrary to that.

Professor COOPER. You should ask the American Cancer Society then to give you the short list of precancerous conditions which can be identified. It is all very well for them to say that through early diagnosis we can prevent so many cancers, but there are not very many they can put on their list.

It is an unfortunate situation, but most cancers are detectable under present technology when they become discernible, visible or palpably, and there we need much more attention than has been given to it.

Mr. CORMAN. That is the point with which I am concerned. How do you get the person to the doctor when it is discernible, but at the very early stage? Because it would seem to me that if we follow your philosophy that most people get well by themselves that you would condemn to death those people.

Professor COOPER. I wouldn't want to be misunderstood on that, and you didn't intend to, Mr. Corman. What I meant was that from most ordinary ailments, people recover, and I excluded the presently incurable degenerative diseases, which includes cancer.

But there is no point in getting people in for checkups for forms of cancer for which there are no precancerous diagnostic procedures, or even early detection procedures.

Mr. CORMAN. You mentioned the waiting rooms in Eastern Europe, as I recollect it. You don't have to go that far. We have that in southern California. There have to be two questions answered properly. The person has to think he is sick, and the doctor has to think he can pay it. All the waiting rooms in my district are full this morning.

Thank you, Mr. Chairman.

Mr. GIBBONS. Mr. Pettis?

Mr. PETTIS. Thank you, Mr. Chairman.

Dr. Cooper, I am aware of your writings and research concerning government policies in other countries with regard to drugs. I am wondering in light of your testimony here this morning if you could tell us from your experience something that might be helpful to this committee in its deliberations.

Professor COOPER. With respect to drugs, my full statement went into the rising prescription costs and the utter desperation that other countries have had leading to studies by the World Health Organization in how to cut down on total drug consumption apart from the problem of individual drug costs.

Now, there are two approaches pertaining to promotion of drug sales which you find in Europe, one of which is very similar to ours. Drug companies advertise and promote in some countries. In others, they do not.

Really, there are very few differences in the consumption patterns, in both types of situations, leading to the general conclusion that there are other forces at work which cause doctors to write prescriptions, and one of them is the pressure of the patient for something, something to drink, something to swallow. He wants something visible that comes out of the doctor-patient interaction. So there is that pressure on the physician, and they have told me so.

But the thing, particularly, Mr. Pettis, that I found, is that in England where they would impose copayment charges on drugs, at first this would stem the consumption, but only for a while, and then consumption would rise again. This was a matter of great consterna-

tion, because people complained bitterly about it, notwithstanding the billions of pounds they spend on legal gambling in Britain and many other countries. But they do complain about paying for drugs, because this relates to health, and it is their God-given right to get free health services for which they don't want to pay, at least directly and knowingly.

So that the mere imposition of a copayment just didn't work in Britain very effectively. I don't know what it is now because they have raised the charges again. I want to look into this next January when I will be there.

In the Eastern European countries they found—and in Britain, too—that the doctor could also conspire with the patient against the system. This is that nonrational element to which I referred. The patient would come in, and if he wanted some cotton balls for the baby or things to wipe out the ear—ordinary notions and sundries—the doctor would write this on a prescription. In Britain, under an earlier procedure, there was never enough room for the doctor to crowd in all the things he could on a single prescription form. I think there was a 1 or 2 shilling charge per prescription and the doctor would load everything he could on one form. He didn't care about that. He would tend to do this for the patient, because he wanted the patient to like him. There is a great need by the doctor to be liked and admired and respected.

So he couldn't be depended upon to cut down the expenditures. Your committee will need more than the recommendations of the economists and the systems designers. You need the sociologists and the others who study human behavior to give you some insight into what people will use and abuse.

The pattern I observed in Europe was that if people could abuse the system they would, and in fact the system has been abused so that the very first thing they showed me in Czechoslovakia during my first of three annual visits, in 1967, was charts showing the rising consumption of prescription drug costs. They said, "What are we going to do about this? We don't have the money for it."

And there is no detailing, no drug advertising in Czechoslovakia.

Mr. PETTIS. Thank you, doctor. When you get back from your trip in January, I personally would like to receive a letter and an analysis from you of what you find there now compared with before.

Professor COOPER. I would be glad to submit it to you, sir.

Mr. PETTIS. Particularly in the field of drugs.

Professor COOPER. Yes, sir.

Mr. CORMAN. Mr. Chairman, I have one further question.

I was at Sun Valley this summer, too, now that you mention it. My wife sometimes gets a sore throat, and she did there, and so for $10 a doctor wrote a prescription for $10 worth of drugs, and that is the way

we got them, and there were 12 of them in the bottle. Is there anything there that ought to concern us? She told the doctor the kind of drug she needed.

Professor COOPER. I wonder if in that case she needed a prescription, necessarily.

Mr. CORMAN. The doctor thought she did.

Professor COOPER. It might have depended on why she had the sore throat. She might have had a bacterial infection, in the doctor's judgment. There are, however, many sore throats that can not be treated except in a palliative way, and if the doctor wrote a prescription to provide symptomatic relief, I think there ought to have been some less expensive drugs for that purpose. But for most upper respiratory infections, throat infections, you know the old homily, "Treat it well and you will recover in 2 weeks; do nothing, and you will recover in a fortnight."

Mr. GIBBONS. On behalf of the committee, we thank you for coming, and we, perhaps, will bring you on for an encore sometime.

Professor COOPER. Thank you very much, Mr. Chairman.

Mr. GIBBONS. Professor Havighurst, we are glad to have you here. If you have a statement, would you submit it for the record? It will be in the record as if delivered.

STATEMENT OF CLARK C. HAVIGHURST, PROFESSOR OF LAW, DUKE UNIVERSITY

PROFESSOR HAVIGHURST. Mr. Chairman, my name is Clark C. Havighurst, and I am a professor of law at Duke University. For the past 2½ years I have been director of the Committee on Legal Issues in Health Care, which is organized under a contract with the National Center for Health Services Research and Development of the Department of Health, Education, and Welfare. I am appearing here in my individual capacity, however, and do not purport to speak for the members of the Committee on Legal Issues in Health Care.

My interest in the health care industry grows out of my academic interests in the fields of antitrust law and public regulation of business. I have recently spelled out my views on many of the matters now being considered by your committee in a lengthy article entitled "Health Maintenance Organizations and the Market for Health Services," which is published as part of a symposium on "Health Care" which I edited for the journal Law and Contemporary Problems. I believe that copies of an abridgement of that article which I prepared have been or will be made available to the committee members, and I have provided several reprints of the entire article for the committee's use.

(The material referred to follows:)

HEALTH MAINTENANCE ORGANIZATIONS AND THE MARKET FOR HEALTH SERVICES

By
CLARK C. HAVIGHURST

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HEALTH MAINTENANCE ORGANIZATIONS AND THE MARKET FOR HEALTH SERVICES

CLARK C. HAVIGHURST*

In its health care proposals pending in the Ninety-second Congress, the Nixon administration has specified the so-called "health maintenance organization," or "HMO," as one cornerstone of its solution to the widely noted health care crisis in the United States. First, the pending Medicare amendments, which were included in H.R. 1 along with the President's "Family Assistance Plan" of welfare reform,[1] would incorporate HMOs into the Medicare program as potential providers of care for those program beneficiaries who elect to enroll in them at the federal government's expense. Second, the President's package of health care proposals that was originally announced on February 18, 1971,[2] places heavy emphasis on the restructuring of the health care delivery system by stimulating the organization and growth of HMOs through a series of affirmative measures. The administration hopes that by 1980 HMO enrollment will be available to ninety per cent of the population as an alternative means of procuring health care.[3]

In addition to the administration's proposals, a number of other proposals for meeting the health care crisis are also pending in Congress. Many of these plans incorporate models of health care delivery organizations that are at least subspecies of HMO, indicating the breadth of the consensus that has embraced this mode of rendering health services. Thus, the Kennedy-Griffiths proposal[4] for "national health insurance," widely thought to be the leading contender against the administration's

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[1] H.R. 1, 92d Cong., 1st Sess. § 239 (1971). H.R. 1, as reported by the Ways and Means Committee, was passed by the House on June 22. 117 CONG. REC. H5717 (daily ed. June 22, 1971).

[2] MESSAGE FROM THE PRESIDENT OF THE UNITED STATES RELATIVE TO BUILDING A NATIONAL HEALTH STRATEGY, H.R. Doc. No. 92-49, 92d Cong., 1st Sess. (1971) [hereinafter cited as PRESIDENT'S HEALTH MESSAGE]. The final bill embodying the President's proposals was finally submitted to the Congress on April 22, 1971, after this article was substantially completed. S. 1623, 92d Cong., 1st Sess. (1971) (the "National Health Insurance Partnership Act of 1971") [hereinafter cited as S. 1623]. *See also* H.R. 7741, 92d Cong., 1st Sess. (1971), which is the administration's bill with changes made by Representative Byrnes before introduction. *See* N.Y. Times, Apr. 28, 1971, at 31, col. 1. Other bills constituting part of the President's program are H.R. 5614 and H.R. 5615, 92d Cong., 1st Sess. (1971). No effort was made to analyze the administration's bills completely in this article, although important points are noted.

[3] Letter to the author from John G. Veneman, Under Secretary of HEW, May 21, 1971.

[4] S. 3, H.R. 22, H.R. 23, 92d Cong., 1st Sess. (1971) (all substantially identical) [hereinafter cited as Kennedy-Griffiths bill].

plan,[5] incorporates the "comprehensive health service organization" as an important feature.

This paper is addressed to the policies needed to obtain the best possible implementation of the HMO concept. The ultimate thrust is toward detailing the policy choices necessary to create a market-oriented system of health care delivery, with HMOs as an essential element. My thesis is that a congeries of legislatively and professionally conceived and executed trade restraints have heretofore prevented the market from functioning with close to its potential effectiveness and that restoration of a market regime offers the best hope for solving the nation's health care problem in all of its numerous dimensions.

Although the paper discusses the role of HMOs in several of the various legislative proposals now before Congress, it does not attempt to give a complete and current picture of any of them. It focuses to the greatest extent on the administration's proposals because I find them to embody an interesting and useful device for effectively implementing the HMO concept in the context of a federally funded insurance scheme covering the poor and the aged. This device, operating against the background of a functioning health care marketplace, would provide simple, nonbureaucratic, but effective protections against excessive costs to government on the one hand and, on the other hand, against turning HMOs into purveyors of "second class" medical care to disadvantaged citizens.

Presupposing adoption of this device and an adequate health insurance plan for the poor, I then proceed to describe the benefits which I think the market, supervised and supplemented by selective regulation, would be able to deliver. This hopeful model is then evaluated in the light of concerns about emphasizing the profit motive in health care and about monopoly tendencies in the health care marketplace. Ultimately I advocate vigorous antitrust enforcement, explicit federal preemption of restrictive state laws, and a number of other policies designed to assist in recreating an unrestrained competitive market for health services. The result is, surprisingly enough to those who think the market is currently being relied upon and has been found wanting, a fairly radical proposal. Although Congress may lack the decisiveness expressly to embrace the notion of a competitive health care marketplace, something approaching it might still be realized if the legislation adopted does not exclude the possibility and if the Antitrust Division of the Department of Justice could be persuaded to take up the cause.

The article is being written in the midst of intense Congressional activity, and the conditions it discusses are subject to sudden change. Nevertheless, some kind of HMO is certain to emerge, with government support, as a permanent feature of the health care scene,[6] and extended discussion of its role and the means available for implementing it must begin before all minds are made up. At the very least, my

[5] Altogether eight different plans have been introduced in Congress. N.Y. Times, Apr. 28, 1971, at 31, col. 1.

[6] *See, e.g.*, Am. Med. News, Apr. 5, 1971, at 1.

emphasis on what the market, if given a chance, could be expected to achieve should improve many observers' perspective on the health care "crisis." At best, it might provoke some reconsideration of the desirability of continuing to adopt ever more intrusive governmental policies designed to ameliorate the symptoms of monopoly without considering whether the disease itself might be subject to cure by using traditional remedies.

I

The Nature, Pros, and Cons of HMOs

A. Terminology

The exigencies of legislative drafting are such that some term will have to be chosen to identify those entities which the government is willing to support in the provision of health care by means of per capita payments rather than on a cost-reimbursement or fee-for-service basis. The most common form of health care delivery featuring such capitation payments is "prepaid group practice," in which this mode of payment by consumers is coupled with the organization of physicians in groups.[7] Because capitation payments may also be accepted by organizations of independent practitioners and by middlemen of various kinds, the term "prepaid group practice" or "group practice prepayment" was too narrow for statutory purposes. The Nixon administration therefore chose "health maintenance organization," and Senator Kennedy and Congresswoman Griffiths selected "comprehensive health service organization," to describe what they had in mind.[8] The distinctive characteristic of the entities encompassed is that the provider of care is also a risk bearer, being paid an actuarially determined premium in return for its largely openended contractual undertaking to provide specified care to the extent of the subscribers' needs.[9] Although the terms selected signify similar concepts, their proposed definitions in the administration and Kennedy-Griffiths bills differ in important respects both from each other and from the traditional model of prepaid group practice.

The term "health maintenance organization" (HMO), which was either coined

[7] For an excellent, up-to-date, and exceedingly well-documented discussion of such plans, see Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 Harv. L. Rev. 887-1001 (1971). In view of the comprehensive documentation provided by this source, I have occasionally felt justified in limiting my own.

[8] Senator Javits' proposals use the designation "comprehensive health service system." S. 836, 92d Cong., 1st Sess. § 407 (1971); S. 837, 92d Cong., 1st Sess. § 2(a) (1971).

[9] An analogy to provider prepayment can be found in service contracts sold by some retailers, such as Sears Roebuck, with major appliances. Warranties providing for free repair are also similar, but when, as with auto warranties, they run from the manufacturer and provide for reimbursement of independent dealers or repairmen, they are more analogous to third-party insurance. The problems that have arisen with respect to auto warranties therefore do not reflect adversely on provider prepayment. They do, however, call attention to the need for uniform disclosure of coverage and the problems of controlling utilization under an insurance scheme, which the auto manufacturers have tried to control, with uneven results, by reducing the profitability of warranty work to dealers.

or popularized by Dr. Paul M. Ellwood, Jr.,[10] and subsequently adopted by the Nixon administration, is something of an overstatement, but it serves a useful descriptive purpose. Thus, under a system where the provider is paid a predetermined premium, it has a direct financial interest in keeping the patient well or in restoring him quickly to health. Fee-for-service medicine, on the other hand, provides no such incentive to practice "preventive medicine."[11] Nevertheless, the expression "health *maintenance* organization" probably promises too much. Medical care is primarily a remedial service, and, while there are some preventive measures (such as prenatal care and some immunizations) that are worthwhile,[12] preventive medicine practiced by providers cannot achieve health benefits even remotely approaching those obtainable from public health measures, over which HMOs will have no direct influence.[13] As a consequence, the "health maintenance" idea, while a sound one, runs the risk of being oversold.

Despite this reservation about the reference to "health maintenance" and despite the gracelessness of the abbreviation, I have still employed the term "HMO" in this paper. "HMO" has not yet been given a statutory meaning, and the definition proposed in the administration's pending Medicare amendments is quite unrestrictive in comparison with the Kennedy-Griffiths bill's definition of "comprehensive health service organization." Moreover, unlike "prepaid group practice," the term is not closely identified with existing plans, and therefore its use will facilitate discussion of those delivery mechanisms that feature prepayment of the provider but differ in some ways from these traditional forms.

For reasons that will appear later on, I wish to exclude the so-called "medical care foundations" from the HMO category. The concept as embodied in the administration's bills would encompass these entities, which are prepayment plans sponsored by medical societies and featuring fee-for-service compensation of the participating doctors. However, being creatures of the medical societies, they are unique in purpose, organization, and function from the independent entities otherwise referred to under the HMO rubric, and any generalizing about HMOs is greatly complicated if the exceptional status of the society-dominated foundations must be constantly noted. It is my view, developed later,[14] that, in a market-oriented system, the foun-

[10] *See* P. ELLWOOD, THE HEALTH MAINTENANCE STRATEGY (Institute for Interdisciplinary Studies, 1970). Dr. Ellwood is widely credited with being the architect of the administration's proposals.

[11] On the nature of the incentives provided by the fee-for-service system of payment, see generally W. GLAESER, PAYING THE DOCTOR 138-203 (1970).

[12] Many preventive measures, such as periodic physical exams, are of debatable value. *See* Note, *supra* note 7, at 897-99. Particularly in a time of shortage, the opportunity costs of devoting health resources to preventive medicine—that is, the value of other benefits that might be obtained from their use—must be counted and might be substantial.

[13] However, the reversal of incentives would substantially increase the interest of HMO physicians in promoting preventive measures such as pollution control, sanitation, immunization, and better food and drug regulation. Enlistment of the direct interest of a growing segment of the medical profession in these matters might prove the more important contribution of the HMO concept to "health maintenance."

dations are distinctly anti-HMO and that, if the Sherman Act were applied to them, they would be held to violate it.

After excluding the foundation plans, the HMO I am left with differs in outline from familiar group practice prepayment in such matters as its size, the auspices under which it may be formed, and its capacity for rendering care in kind as opposed to providing it through purchase from hospitals or fee-for-service doctors.

B. The Advantages of HMOs

Even more remarkable than the spate of health policy proposals in recent months is the widespread agreement—the medical societies excepted—on the need to steer away from preponderant reliance on fee-for-service medicine toward a system in which consumers, if they wish, may obtain care by prepaying (or having the government prepay) the provider. The enthusiasm for this approach has been prompted in large part by the apparent success over a period of time of the prepaid group practice plans, which, though existing in only some parts of the nation, now serve around eight million people and have generated some impressive statistics on the per capita cost of providing care of a generally high quality.[15]

In addition to the track record of existing prepaid group practice plans, there are important technical arguments, many of them seemingly borne out by the statistics, for supporting the concept of care rendered under a system of provider prepayment.[16] These arguments, stated without documentation or evaluation,[17] are to the effect that HMO-type care does the following things:

(1) reverses the incentives inherent in fee-for-service medicine (especially where health insurance removes the doctor's direct fiduciary obligation to his patient) for physicians and hospitals to provide unnecessary services in order to increase their income;

(2) introduces incentives, particularly absent where third-party insurance is available, for physicians to consider cost effectiveness and to avoid overusing expensive facilities and resources for such purposes as (*a*) obtaining an incommensurate medical benefit for the patient, (*b*) adhering uncritically to "routine" practice, (*c*) minimizing perceived malpractice risks,[18] (*d*) rendering a certain

[14] See text accompanying notes 157-80 *infra*.

[15] *See* Note, *supra* note 7, at 921-24, and references there cited.

[16] In Group Health Cooperative v. King County Medical Soc'y, 39 Wash. 2d 586, 604, 237 P.2d 737, 747 (1951), the court summarized the advantages of a prepaid group practice plan as follows:

"increased opportunities for, and convenience in, effectuating referral of patients to other doctors to take advantage of various specialties; access to more and better equipment and laboratory facilities; improved quality of service because of constant surveillance by other members of the staff; opportunities for consultation, staff conferences, refresher courses, and post-graduate studies; better organization of time as, for example, the rotation of emergency night-call service; greater incentive to give patients proper treatment; security of professional income regardless of daily patient load; and disassociation of the business aspects of the service, so that the doctors may devote themselves entirely to professional matters."

[17] For a fuller statement, documentation, and tentative evaluation, see Note, *supra* note 7, at 921-33.

[18] This motivation is often alleged to cause excessive x-ray and other diagnostic tests by physicians

service in such a way (for example, on an inpatient basis) as to bring it within the terms of the patient's insurance coverage, or (*e*) catering to the nonpaying patient's perceived preference that "everything possible" be done whatever the expense;[19]

(3) creates a decision maker with both the knowledge and the incentive to discriminate on the basis of price and value in the purchase of needed goods and services—particularly drugs,[20] hospital services, and specialists' care—, thus strengthening competition and economic performance in markets adjacent to the market for primary care;

(4) strengthens incentives for realizing available efficiencies in the use of manpower and other resources, incentives that are weak where providers are not subject to substantial price competition due to the structure and customs of the marketplace or where cost-reimbursement is more or less assured by government or private health insurance;

(5) creates an organizational structure in which available efficiencies and improvements in performance can be more readily realized in such areas as (*a*) maintenance of complete, up-to-date, and nonduplicative medical records; (*b*) manpower and equipment utilization; (*c*) utilization of specialists' services; (*d*) continuing education for personnel at all levels; and (*e*) administration generally, particularly in billing and in freeing physicians of business details;

(6) creates an incentive for providers to keep patients well by such preventive measures as are economic, to detect disease at an early stage, to treat causes rather than symptoms, and generally to effect an early cure;[21]

(7) improves incentives affecting referrals and outside consultations, whereby fee-for-service physicians may only lose income from a patient but prepaid pro-

practicing "defensive medicine." This allegation is currently being evaluated in a study being conducted by the *Duke Law Journal.*

[19] This last item differs from (a) only in suggesting how physicians tacitly combine with their patients to form coalitions to take advantage of insurance coverage. These coalitions operate to make health insurance extremely expensive by exploiting the absence of the usual cost constraint on consumers' decisions concerning whether a particular expenditure is worthwhile. Detailed coverage provisions to some extent limit the "luxuries" that may be enjoyed without cost, but since no effort is likely to be made to limit the number of diagnostic x-rays, for example, many x-rays will be done under circumstances where their "value" is less than the sum of the cost plus the discounted hazard from irradiation. It is reasonable to regard the added procedures thus done, or the unwarranted hospitalization expenses incurred in the absence of a cost constraint, as an inefficiency of third-party insurance. In an HMO, on the other hand, the consumer might be denied on purely medical grounds an x-ray or day of hospitalization that he would have elected to purchase if he had been free to do so. The frequent use of outside fee-for-service physicians by prepaid group practice subscribers may be explained in part as the indulgence of such preferences by consumers. It is entirely appropriate for consumers to have and to exercise the right to purchase such additional reassurance, and, without more, their election to do so should not reflect adversely on the HMO concept; indeed, such luxuries *should* be purchased separately with one's own funds.

[20] Advantages connected with drug prescribing are potentially of great importance but are seldom cited in support of HMOs because existing plans do not often cover prescription drugs. The subject is developed at length in another connection in the text accompanying notes 189-99 *infra.*

[21] *But see* note 104 *infra.*

viders may gain protection against the financial costs of a subscriber's worsened condition;

(8) offers the opportunity for organizing care more conveniently for consumers by providing an accessible and continuously available "entry point" into the health care system and responsible guidance for the patient through the system so that he may obtain promptly and centrally such services as he requires;

(9) provides, by encouraging larger organizations of physicians in the place of solo practitioners, a better vehicle for maintaining the quality of care rendered outside the hospital; and

(10) provides stronger incentives for maintaining effective peer review and other quality controls in hospitals than exist in the present system of hospital practice.

The foregoing are persuasive reasons for wishing to see wider use of HMOs. They are especially appealing arguments when the nation is faced with both an existing imbalance between the supply of medical resources and the demand for them and a strong desire for a further stimulation of demand by expanding government's role in health care financing. In this climate, HMOs hold out a politically appealing hope that, by eliminating overutilization and introducing substantial efficiencies, existing resources can be spread further, giving care to more people without sacrifice of essential quality.

C. Some Negative Considerations

A few negative considerations need to be noted here without any attempt at analysis. Several of these matters will be discussed at a later point.

First, despite the governmental boosting that would be put behind HMOs under the various pending proposals, there are still severe impediments to their rapid growth. While several of the proposals would provide financial assistance for HMO formation, the sufficiency of the incentive to private parties to create them and to doctors to accept employment with them remains far from clear. The funds and organizational efforts called for, the difficulty of educating and attracting sufficient enrollees from a public accustomed to fee-for-service medicine, and the problems of attracting physicians into such plans[22] are all likely to be underestimated. It is argued below that these barriers are so substantial that they can be overcome in a reasonable time only by allowing plans to generate profits for the benefit of nonphysician investors of capital and talent in the enterprise.

A more fundamental objection to group practice prepayment centers on the incentive created to deny needed care in some circumstances. Of course, the plan has

[22] HMO employment appeals to some physicians as professionally rewarding, and it allows physicians to have greater leisure through better organization of the workload. Greater leisure for individual physicians implies a possible loss in total manhours of physicians' services which might not be offset by improvements in their efficiency, but it is not clear why HMO physicians, like lawyers in large firms, would not take on more paying clients than they could serve in a 40-hour week.

an appropriate stake in quickly restoring health so as to avoid the costs of a worsened condition, but occasionally there would be a temptation to omit an expensive form of treatment solely because of cost considerations. The clearest example would be in the temptation to let a patient die of a cardiac arrest rather than place him in the intensive care unit at a cost of $300 per day. This possibility, while important to consider, is not quite so hair-raising as it sounds, and it is discussed later in connection with the question whether a for-profit HMO is open to particular criticism on this score.

Another area of concern is the fear that HMOs will become a vehicle for delivering care exclusively to low-income or elderly elements in the population and thus, either in appearance or in reality, a "second-class" type of medicine. Again, the possibilities for avoiding this outcome are discussed later on.

Finally, it should be noted that the evidence on prepaid group practice is subject to some dispute, if not as to the existence at least as to the extent of the cost savings realizable from this method of organizing health care delivery. For one thing, plan enrollees are known to purchase substantial amounts of care outside the plan,[23] resulting both in understatement of the costs of serving plan members and in an increase of the services rendered in the fee-for-service sector and counted against that mode of delivery in statistical analyses. Further, the enrolled population of a prepaid group practice plan is probably not comparable to the clientele of the fee-for-service physicians in the community, making statistical comparisons difficult and very possibly misleading.[24] There is also evidence that, while existing plans have been generally well received, they have not been conspicuously successful in delivering care in a personalized and convenient way. Expectations concerning HMO success must take into account the possibility that the advantages of HMOs may have been overstated[25] or that gains in efficiency may be offset by losses in other relevant departments.

Against this background, it can be said that, although enthusiasm for the HMO concept should not be unquestioning, the arguments provide a warrant for affirmative governmental efforts to stimulate HMO formation to the end that consumers and

[23] *See* Note, *supra* note 7, at 921-22 n.1; *The Kaiser Foundation Medical Care Program*, in 2 REPORT OF THE NATIONAL ADVISORY COMM'N ON HEALTH MANPOWER 197, 207 (1967).

[24] M. PAULY, MEDICAL CARE AT PUBLIC EXPENSE 95-96 (1971), suggests that HMOs, because of their tendency to provide less care, may attract only those Medicare beneficiaries with below-average demands for care. This would make HMO's performance seem better in comparison with the fee-for-service sector than it in fact was. Pauly does not indicate whether the apparently lower costs of prepaid group practice plans might be explained by this thesis, but it would seem that they could be in some part.

[25] *See, e.g.*, Klarman, *Approaches to Moderating the Increases in Medical Costs*, 7 MED. CARE 175, 183 (1969); Densen, *et al.*, *Prepaid Medical Care and Hospital Utilization*, HOSPITALS, Nov. 16, 1962, at 62. On the other hand, many existing plans have been quite conservative in their use of paramedical personnel and in other respects. *See, e.g.*, *The Kaiser Foundation Medical Care Program*, *supra* note 23, at 206. The purposes behind this hesitancy have probably been to avoid accusations and malpractice suits and to reassure their subscribers. Nevertheless, the many potential economies that have not yet been tapped are one basis for the hope that the HMO concept may indeed revolutionize health care. Competitive pressures will be needed, however, to stimulate the search for and implementation of available economies.

providers shall have this mode of transacting for health services available as an option; going any further, such as by forcing any group in the society to accept HMO care, seems unwarranted either by the pro-HMO evidence or by the total performance of the fee-for-service sector. Competition between HMOs and fee-for-service medicine would maximize consumer choice and would determine most democratically—by consumer votes—the role of each system in the delivery of care. Creating the basis for a restructuring of incentives to curtail overuse and to spread resources more widely would seem to be a justifiable goal of public policy at the present time. Moreover, clearing away obstacles to the introduction of larger-scale primary care providers, with greater potentiality for achieving available efficiencies and providing internal quality controls, may also be regarded as a proper function of government.

II

The Role of HMOs in Recent Policy Proposals

It is beyond the scope of this paper to do full justice to the various pending health policy proposals. The discussion here is primarily for the purpose of highlighting the role contemplated for HMOs in different approaches to health care delivery. The greater portion of the discussion focuses on the administration's proposals, and my main interest here and throughout this discussion is to discover the extent of reliance, if any, on the market and how the various mechanisms proposed would relate to or affect the functioning of market forces.

A. The Administration's Health Care Program

1. *The 1971 Proposals*

On February 18, 1971, the President announced his program to provide almost universal health insurance coverage for the American people.[26] The program's main thrust was toward financing health care and expanding, extending, and prescribing the scope of health insurance coverage. To these ends, (1) employers would be required to provide specified basic health insurance coverage for their employees on a cost-sharing basis; (2) less extensive insurance coverage would be provided by the federal government for poor families headed by self-employed, intermittently employed, or unemployed persons by means of a "Family Health Insurance Plan" (FHIP) in which the very poor would participate without charge but others would pay increasing premiums, deductibles, and coinsurance payments in accordance with their income; (3) Medicaid would be continued for the aged poor, the blind, and the disabled; (4) Medicare would be continued for persons over sixty-five but without the special monthly charge for part B coverage; and (5) special insurance pools would be established for the self-employed and for high-risk individuals denied other coverage.

[26] *See* President's Health Message 14-17. *See also* note 2 *supra*.

The President's message expressed the administration's enthusiasm for the HMO concept, reciting the importance of altering incentives in health care delivery to induce efficiencies and reduce overutilization. He indicated his hopes for rapid development of HMOs throughout the country and set forth some strategies for bringing it about. In the way of financial support,[27] he proposed to allocate $23 million for planning grants and to provide $300 million in guarantees of private loans to HMO sponsors. In addition, he proposed $22 million in subsidies for HMOs that would locate in areas where medical resources were in particularly short supply, primarily rural areas and urban ghettoes.

The administration's health insurance bill would require each employer to offer an HMO option to his employees,[28] a step that would open up HMO opportunities to a significant degree since an individual would no longer be locked into the fee-for-service sector by the terms of insurance protection dictated by his employer. Unfortunately, however, the notion of free choice stops here, because the employee is not to be given a choice among available HMOs in the community but would instead be bound by the employer's election of an HMO to which his participation is transferable. It would have been simple enough to allow the employee such a choice and to have the employer pay an appropriate amount to whatever HMO he selected.[29] If this were done, employees would have, in effect, a voucher entitling them to enter the marketplace in search of the kind of HMO care that appealed to them most.[30] Such a strategy would vastly expand the opportunities for competitive HMO development. The administration's bill appears first to assume, and then to guarantee, that the business of rendering HMO-type care will be monopolized.

Under the President's proposal, those poor persons covered by FHIP would have the option of joining an HMO at government expense, and indeed they would have a free choice among those available. The proposed arrangement for exercising this option is similar in many ways to the arrangements for such elections by Medicare beneficiaries that is contained in the administration's pending Medicare proposals.

2. *The HMO Defined (The Medicare Proposals)*

The administration's proposed Medicare amendments set forth a definition of a "health maintenance organization" for the purpose of confirming in the Secretary of HEW the power to contract with such an agency to provide prepaid health care on a capitation basis to persons whose care has become a federal responsibility

[27] PRESIDENT'S HEALTH MESSAGE 6-7. *See also* H.R. 5615, 92d Cong., 1st Sess. (1971) (the administration's "Health Maintenance Organization Assistance Act of 1971") [hereinafter cited as H.R. 5615].

[28] S. 1623, § 101, proposed § 603(h).

[29] The President referred to the "actuarial value" of the employee's insurance coverage as being transferable, PRESIDENT'S HEALTH MESSAGE 6, but this seems wrong. If "community rating" for persons under 65 is required of HMOs, then the employee should be able to transfer his pro rata share of the employer's total premium. Otherwise only older persons will transfer to HMOs, since only they would not have to make a supplementary payment.

[30] In order to induce cost and value comparisons, an employee transferring his membership to an HMO should be entitled to a cash refund if the HMO membership is cheaper than the insurance coverage, or else he might be given additional benefits by the HMO in lieu of a refund.

under Medicare.[31] Thus, persons covered by the program who would elect to be enrolled in an HMO would become the subject of such a contract, and their federal benefits would then take the form of a periodic fixed-sum payment to the HMO rather than, as formerly, of payments to hospitals or fee-for-service physicians for services actually rendered. Under the FHIP proposal, similar contractual arrangements would be authorized to permit HMO coverage of that program's beneficiaries.[32]

On its face, the administration's Medicare bill (H.R. 1)[33] promised to generate, to the extent HMOs were in fact utilized, an immediate and politically appealing saving in cost over the present method of providing Medicare benefits. Thus, the bill provided that the rate of payment to the HMO "shall be designed to provide payment at a level not to exceed 95 per centum of the amount that the Secretary estimates (with appropriate adjustments to assure actuarial equivalence) would be payable" for Medicare services for the same population if the services were to be furnished by fee-for-service providers.[34] From this it appeared that the draftsman expected that bringing the HMO into the picture would save at least five per cent on the cost of caring for the HMO-enrolled population.

H.R. 1 defined the term "health maintenance organization" at some length. It appeared in most respects to have modeled the HMO on the most familiar type of prepaid group practice plan. As set forth in the version of the bill recently passed by the House of Representatives, an HMO would be a public or private organization which

> (1) provides, either directly or through arrangements with others, health services to . . . [enrollees] on a per capita prepayment basis;
>
> (2) provides, either directly or through arrangements with others, . . . (through institutions, entities, and persons meeting the applicable requirements of section 1861), all of the services and benefits covered under parts A and B of this title;
>
> (3) provides physicians' services (A) directly through physicians who are either

[31] The immediate occasion for the amendments was the problem that Medicare, providing only for cost reimbursement, did not adequately reward the efficiencies achieved by prepaid group practice plans. The problem has been described by the Senate Finance Committee as follows:

> "Under present law, organizations providing comprehensive health services on a per capita prepayment basis cannot be reimbursed by medicare through a single prospective capitation payment such as the organizations normally charge for services covered under both . . . parts of the medicare program. Instead, medicare reimbursement to group practice prepayment plans, whether it is made on a cost or charge basis, must be related, retrospectively, to the costs to the organization of providing specific services to beneficiaries, so that some of the financial incentives which such organizations may have in their regular non-medicare business to keep costs low and to control utilization of services are not fully incorporated directly in their relationship with medicare."

S. REP. No. 91-1431, 91st Cong., 2d Sess. 131-32 (1970) [hereinafter cited as S. REP. No. 91-1431]. *See also* Phelan, Erickson & Fleming, *Group Practice Prepayment: An Approach to Delivering Organized Health Services*, in this symposium, p. 796, 811-12; Note, *supra* note 7, at 988-90.

[32] S. 1623, § 201, proposed § 628(j).

[33] H.R. 1, 92d Cong., 1st Sess. (1971) [hereinafter cited as H.R. 1]. The House-passed version (*see* note 1 *supra*) is hereinafter cited as "H.R. 1 as amended."

[34] H.R. 1 § 239(a), proposed § 1876(a)(2).

employees or partners of such organization, or (B) under arrangements with one or more groups of physicians (organized on a group practice or individual practice basis) under which each such group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physician members of any such group are paid on a fee-for-service or other basis;

(4) demonstrates to the satisfaction of the Secretary proof of financial responsibility and proof of capability to provide comprehensive health care services, including institutional services, efficiently, effectively, and economically;

(5) except as provided . . . [elsewhere], has at least half of its enrolled members consisting of individuals under age 65;

(6) assures that the health services required by its members are received promptly and appropriately and that the services that are received measure up to quality standards which it establishes in accordance with regulations; and

(7) has an open enrollment period at least every year under which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll . . . in the order in which they apply for enrollment (unless to do so would result in failure to meet the requirements of paragraph (5)).[85]

There is of course no uniform mold from which existing prepaid group practice plans have been cast, but certain features associated with the largest plans may have come to be regarded as typical. As defined in H.R. 1, the HMO seems to be distinct from the typical prepaid group practice plan in at least four important respects. First, it appears that the HMO might be permitted to serve some patients on a fee-for-service basis.[86] Thus, any clinic or hospital might form an HMO to serve some of its clientele while continuing to provide traditional care to others. This would greatly facilitate HMO formation by existing providers since an abrupt change in methods of doing business would not be necessary. Moreover, individual physicians could become associated with an HMO without abandoning their former patients, thus simplifying physician recruitment by the HMO. While there is no reason for existing prepaid group practice clinics not to provide fee-for-service care to the general public, this has not been common.[87] The medical care foundations, which fall within the definition of HMO by virtue of a recent clarification of paragraph (3),[88] render all their services through fee-for-service physicians who are paid on a piecework basis for services rendered to foundation enrollees.

Under the H.R. 1 definition, HMOs would be free to be substantially smaller

[85] H.R. 1 as amended, § 226(a), proposed § 1876(b). A similar definition originally appeared in H.R. 17550, 91st Cong., 2d Sess. § 239(a) (1970), and H.R. 1, § 239(a). The administration has since changed its basic definition somewhat. *E.g.*, S. 1623, § 101, proposed § 604(a); *id.* § 201, proposed § 628(b); H.R. 5615, § 2(c), proposed § 1101(1).

[86] The Kennedy-Griffiths bill, § 47(b), would also permit this.

[87] One example is the Palo Alto (California) Clinic, which has 15% prepaid subscribers. Note, *supra* note 7, at 903-04 n.9. It is not clear that all consumers are offered a choice of prepayment or fee-for-service care. *See also id.* at 938.

[88] *Compare* H.R. 1, § 239(a), proposed § 1876(b)(3), *with* H.R. 1 as amended, § 226(a), proposed § 1876(b)(3).

than are the familiar prepaid group practice plans, and this could contribute to the existence of a greater number of HMOs, featuring different prices and varieties of service and contributing to a competitive environment. Other pending definitions of HMO offered by the administration have included a requirement that they have at least 10,000 enrollees.[39] Why so arbitrary an exclusion of would-be providers might be deemed desirable is not clear. Such a requirement would greatly reduce both actual and potential competition and would discourage innovation and free choice. It is notable that H.R. 1 as recently passed by the House, quoted above, does not contain the requirement of 10,000 enrollees.

The third way in which an HMO, as defined in H.R. 1, appears to differ from the familiar type of prepaid group practice plan is in the apparent opportunity for organizing and operating an HMO for the express purpose of earning a profit for someone other than the physicians involved. Most prepaid group practice plans have been organized either by the doctors themselves or by consumer groups, unions, or employers for the benefit for their membership or employees. In the case of consumer-sponsored or employer-sponsored groups, the founding organization normally contracts with a group of doctors to provide the care in return for a per capita payment by or on behalf of the individual participants. The organization itself acts only as a sponsor and takes no profit off the top for its entrepreneurial initiative. The proposed bill would not limit HMO organization to enterprises of the voluntary, nonprofit kind, leaving open the possibility that profit-seeking middlemen might become engaged in HMO formation. The suggestions developed below, which look to potential profits as an important stimulus for HMO formation, depend heavily on the accuracy of this appraisal of the expectations underlying the drafting of H.R. 1. It is notable that the Senate Finance Committee found this a major point of difference with the administration in 1970[40] and that the Kennedy-Griffiths bill contemplates only nonprofit "comprehensive health service organizations."[41]

A final area of difference between HMOs, as defined, and the most familiar variety of prepaid group practice plan lies in the provision of hospital and specialists' services. Many of the major plans of provider prepayment furnish hospital services in hospitals owned either by the plan itself or by the medical group with which the plan contracts.[42] Similarly, physician services are rendered almost exclusively in-house, except where emergency care must be obtained by subscribers away from the plan's facility. No requirement concerning the form in which hospital or physician services are provided would be imposed on the HMO by H.R. 1, leaving it free to provide them by purchase from independent public or private hospitals where its

[39] S. 1623, § 101, proposed § 604(a)(5); *id.* § 201, proposed § 628(b)(5).

[40] *See* S. REP. No. 91-1431, at 131-32, and text accompanying note 90 *infra*.

[41] Kennedy-Griffiths bill § 47(a)(2).

[42] The differences between hospital-based plans and others are discussed in Note, *supra* note 7, at 910-18. Some existing plans do not cover hospital benefits at all, requiring the member to purchase hospitalization coverage elsewhere.

doctors have staff privileges[43] and from fee-for-service specialists by referral of its patients.[44] This freedom would go far towards permitting HMOs to be formed on a relatively small scale compared to the best known prepaid group practice plans and to be constituted without large capital inputs. It would also assure subscribers that specialized hospital and physician care of the highest quality could be obtained when it was needed. Even more important perhaps, HMO purchasing of hospital and physician services could introduce desirable influences into the market for each.

3. *A Device for Avoiding "Second-class" Status and Protecting the Public Purse*

Because the President's program would provide optional HMO-based care for Medicare beneficiaries and for beneficiaries of the proposed FHIP, there is a risk that it will provide for these disadvantaged persons, the aged and the poor, only a type of "second-class" medicine. Of course, such consumers would be free not to select HMO-type care and to remain in the fee-for-service sector, obtaining care as needed from physicians whom they locate by their own efforts. But the alternatives available to many health care consumers in these groups are so few and so unattractive that this opportunity to reject HMO membership provides only slight protection against forcing the elderly and poor into accepting care from institutions that they might regard as somehow second-class. Some means of guaranteeing that HMOs will not become a vehicle for second-class medicine would be desirable not only as a protection for the poor but also to protect the "image" of HMO-provided care so that the middle-class will not associate it with ghetto dwellers and be induced to reject the HMO for their own purposes.

Another problem is the difficulty of determining the price that government should

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[43] The Kennedy-Griffiths bill, §§ 47(a)(2)-(3), 87(c), also contemplates the possibility that hospital services may be provided on other than an in-house basis. For the view that hospital services must be at least contracted for rather than purchased randomly, see DIVISION OF MEDICAL PRACTICE, AMERICAN MEDICAL ASS'N, HMO's AS SEEN BY THE AMA—AN ANALYSIS 7-8 (1971). The AMA's argument turned on H.R. 1, § 239(a), proposed § 1876(b)(6), which was altered slightly but significantly in H.R. 1 as amended, § 226(a).

[44] H.R. 1 as amended, § 226(a), proposed § 1876(b)(3), quoted in text at note 35 *supra*, indicates that physicians' services shall be provided "directly through physicians who are either employees or partners" of the HMO or members of a group that has contracted with the HMO to provide the services on a fixed-fee basis. One reading of this language would preclude the possibility of an HMO's purchasing some of the services that it provides from fee-for-service physicians to whom it refers its enrollees from time to time, perhaps for more specialized care than it can render. There is no reason that, having contracted with the patient to provide all the care he needs, the HMO should be precluded from doing so on occasion by employing outside physicians for the purpose, and indeed it would be prejudicial to HMO subscribers to cut off the possibility that specialists' services could be obtained in this manner. Thus, one hopes that the bill will be read as being nonexclusive in its requirement, so that it would be sufficient if the HMO provided only *some* physicians' services, perhaps all primary care, through the specified mechanism. Similarly, although the requirement in *id.*, proposed § 1876(b)(4), of "proof of capability to provide comprehensive health care services" might be read to require either in-house capability or the financial capability to purchase needed additional services in the open market, the regulations should recognize either kind of capability as sufficient. The Comprehensive Health Service Organization of the Kennedy-Griffiths proposal would be permitted to purchase the services of outside physicians. *See* Kennedy-Griffiths bill § 47(a)(2). A proposal in New York would allow only emergency services to be purchased. *See* Note, *supra* note 7, at 979.

pay for the coverage of Medicare and FHIP beneficiaries. The price must be fair to the government and to the HMO and ideally should not involve the government too deeply in supervising the costs and practices of the HMOs with which it deals. The maximum price that the government would pay is, as noted above, ninety-five per cent of the cost of serving the same patient population under a fee-for-service system. Since this is a maximum figure, lower rates might be appropriate, but H.R. 1 provided only an indefinite guide as to how such rates would be fixed, stating that, subject to the ninety-five per cent ceiling, federal payments to HMOs would be determined by "taking into account the health maintenance organization's premiums with respect to its other enrollees (with appropriate actuarial adjustments to reflect the difference in utilization . . .) and such other pertinent factors as the Secretary shall prescribe in regulations . . . ."[45] It was thus contemplated that the primary guide for pricing services received by Medicare and FHIP beneficiaries would be the prices charged by the HMO to private subscribers purchasing HMO services with their own funds.

Tying the government's payments to the prices paid by private subscribers is an attractive idea. It makes each potential private subscriber a sort of proxy who would "shop" for health services not only for himself but also for one or more Medicare, FHIP, or Medicaid clients. For this "proxy-shopping" approach to be effective, however, there would have to be some requirement that each HMO have some minimum proportion of private subscribers. The administration's FHIP bill would require that at least half of the HMO's enrollees not be FHIP or Medicaid beneficiaries,[46] and H.R. 1 would similarly limit HMO enrollment of Medicare beneficiaries to fifty per cent.[47] If the two bills could be coordinated so as to preclude development of plans with half Medicare and half FHIP or Medicaid enrollees and to require specifically that self-supported subscribers constitute at least fifty per cent of the membership, the government should be able safely to rely on such subscribers' willingness to pay for the service as a guide in setting the price it would pay for persons under its sponsorship.

The proxy-shopping device would guarantee that the price the government paid for its clients was one determined, in effect, by a competitive market. It would control costs to the government not by introducing a cumbersome system of quality and cost audits but by relying on the private consumer, who is still the most sensitive indicator of relative values yet discovered. It would maximize free choice and would make the passing of the ultimate market test—the attraction of a relatively sophisticated paying customer—a prerequisite for the HMO's enrollment of each government-sponsored individual. This test would have to be met again and again and would in fact increase the HMO's incentive to attract paying customers since each "sale"

[45] H.R. 1, § 239(a), proposed § 1876(a)(2).

[46] S. 1623, § 201, proposed § 628(b)(5). Exceptions are made for the early years of operation and for special problems precluding compliance. *Id.*, proposed §§ 628(h)-(i).

[47] H.R. 1 as amended, § 226(a), proposed § 1876(b)(5).

would carry with it, as a bonus, the right to sign up a person who, not being price-conscious, must be persuaded only to want the service. The HMO's interest in attracting paying customers would serve to keep the price down, while its interest in attracting customers of both classes would serve to sustain the quality of care (at least as apprehended by the subscribers) and the conditions under which it was rendered. The problem of second-class medicine would be substantially avoided.[48]

The flaw in the proxy-shopping device in the original H.R. 1 lay in the lack of incentive to Medicare and FHIP beneficiaries to accept HMO enrollment rather than more expensive fee-for-service care. If their coverage was the same in either event and the advantage of the HMO's lower cost accrued not to them but to the government, they would be unlikely to surrender the free choice and possibility of greater attention at no extra cost that accompany government-financed fee-for-service care. The administration has evolved an answer to this problem that appears not to sacrifice the advantage of the proxy-shopping device. In the FHIP bill,[49] the cost problem is dealt with by first requiring the HMO to account separately for the costs of serving FHIP beneficiaries and other subscribers. Then there is a requirement that the "retention" rate—that is, profit as a percentage of income—on the FHIP group must not exceed that for the other group, and any such "excessive retentions" are required to be returned to the government unless they are applied either to providing increased benefits or to reducing premiums, coinsurance payments, or deductibles. Thus, as long as such "excessive retentions" are used to make HMO coverage more attractive than coverage under FHIP itself, the government will not require the HMO to refund any of its payments made at the full rate of ninety-five per cent of the anticipated cost of fee-for-service coverage.[50] Although first appearing in the FHIP bill, this approach was recently incorporated by the House Ways and Means Committee in its version of the Medicare amendments, which subsequently passed the House[51] and are now awaiting action by the Senate.

The FHIP bill thus represents a useful modification of the proxy-shopping device, providing in effect a 100 per cent subsidy to the HMO to provide attractive extra benefits to beneficiaries of the government program. The source of the funds for providing this subsidy is the efficiency of the HMO itself, which accounts for the existence and extent of the spread between the HMO's regular charges to private subscribers and the maximum amount the government is willing to commit. The most efficient HMOs will therefore be able to provide the most attractive benefit package to induce enrollment by FHIP beneficiaries.

[48] The private-subscriber requirement should of course be imposed with respect to each facility the HMO might operate in order that it could not be met by establishing one branch in the ghetto and one in the suburbs. In addition to avoiding the "separate-but-equal" stigma, this would encourage HMOs to locate themselves so as to be convenient to subscribers of both classes.

[49] S. 1623, § 201, proposed § 628(a)(2)(B).

[50] *Id.*, proposed § 628(a)(2)(A).

[51] H.R. 1 as amended, § 226(a), proposed § 1876(a).

Appropriately, the modified proxy-shopping device also allows the HMO to earn a profit in serving its FHIP enrollees that is proportionate to the profit which it is able to earn in caring for its private subscribers. The profit incentive is thus left intact, and only minimal government supervision is necessitated. The most difficult regulatory problems would probably be accounting ones, particularly in allocating joint costs between the government-sponsored enrollees and others.

Subsequent discussion relies heavily on the modified proxy-shopping technique of accomplishing the dual goals of controlling costs and providing attractive care for the elderly and the poor. Indeed, it forms an important cornerstone of the market-oriented delivery system that I advocate. Of course, a competitive market is essential to the functioning of the modified proxy-shopping device, and most of the rest of the paper explores the prospects in this regard.

B. Some Other Proposals

1. *The Proposed Health Security Act (The Kennedy-Griffiths bill)*

This bill, sponsored by Senator Edward M. Kennedy and Representative Martha W. Griffiths, would provide federally financed comprehensive health services for virtually all U.S. residents.[52] Financing of the program would be effected through a tax on employers, on employee income, and on self-employment income, with the federal government contributing up to an equal amount of funds, as required, from general revenues. The Health Security Trust Fund established with these contributions would pay for a wide range of services if rendered by a "participating provider," the qualifications for which are specified at length. Independent practitioners could qualify as "participating providers" and could elect to be paid on a fee-for-service basis, although a fee schedule would be imposed for each region, state, or area.

The bill indicates particular support for the delivery of services on a prepaid basis. The independent practitioner would have the option of electing to be compensated by the capitation method, receiving a fixed sum for each person on his list—that is, those to whom he is obligated to render, or arrange for, comprehensive care; a practitioner so compensated would fall just outside my definition of HMO since the capitation payment he receives covers only primary and not comprehensive care. The large-scale HMO is presented as a feasible, and perhaps favored, alternative, though under a different name—Comprehensive Health Service Organization (CHSO). Organizations satisfying specified criteria may be "participating providers" under the proposed scheme and will be eligible to receive the prescribed capitation payment for each person enrolled. An analysis of the bill provided by Congresswoman Griffiths describes the CHSO provisions as follows:[53]

[52] *See* note 4 *supra*.

[53] M. Griffiths, Section-By-Section Analysis [of the Proposed Health Security Act] 6, 1971.

> The section [47] is designed to accommodate forms of organization typical of existing prepaid group practice plans, but also to be flexible enough to permit experimentation with somewhat different forms. In some urban or rural areas, for example, it may be impracticable to bring all of the various services together in one place, and the section has been designed to encompass what has been described as "comprehensive group practice without walls"; the basic essential is the assumption of responsibility for a reasonably comprehensive range of services (including health maintenance) on a continuing and coordinated basis, to a group of persons who have been chosen to receive all or nearly all their health care from the organization.
>
> Other requirements are spelled out in this section: The organization must furnish services through the prepaid group practice of medicine, or as near an approximation to prepaid group practice as is feasible. It must be a nonprofit organization, or if several providers share in the furnishing of services the prime contractor with the Board must be nonprofit. All persons living in or near a specified service area will be eligible to enroll, subject to the capacity of the organization to furnish care and subject to minimal underwriting protections. Services must be reasonably accessible to persons living within the specified service area. Periodic consultation with representatives of enrollees is required. Professional policies and their effectuation, including monitoring the quality of services and their utilization, is to be the responsibility of a committee or committees of physicians. Health education and the use of preventive services must be stressed, and lay persons are to be employed so far as is consistent with good medical practice. Charges for any services not covered by Health Security must be reasonable. Finally, the organization must agree to pay for services furnished by other providers in emergencies, either within the service area of the organization or elsewhere, but may meet this requirement to the extent feasible through reciprocal service arrangements with other organizations of like kind.

This formulation differs from the administration's HMO (1) in requiring the CHSO (*a*) to be a nonprofit entity, (*b*) to consult on policies and practices with its enrollees, and (*c*) to replicate the prepaid group practice model to the extent feasible, and (2) in providing greater specificity about numerous elements that are consistent with the HMO concept in the administration's bill but would not be legally embodied in it, such as utilization of paramedical manpower, maintenance of reasonable charges on services not insured, and maintenance of health education and peer review. The bill seems to contemplate greater supervision of internal affairs than the administration's proposal would impose.

Incentives for the formation and efficient functioning of CHSOs would be afforded by allowing a bonus payment, in addition to the capitation payment, if the organization can establish that, during a fiscal year, (1) the average utilization of hospital and skilled nursing home services was less than the average utilization of such services by comparable population groups not enrolled in such organizations, and (2) the services of such organization have been of high quality and adequate to the needs of its enrollees. The bonus would be equal to seventy-five per cent of the savings achieved and could be used by the organization for "any of its purposes,"

including the elimination of deductibles and copayments and the provision of additional services not covered under the bill.[54]

In assessing the probable performance of CHSOs, it can be seen that the utilization bonus, if applied to giving additional benefits or to beautifying the clinic's surroundings or to membership recruitment, could lead to increased enrollments. To the extent increased enrollments would permit realization of further efficiencies and hence higher salaries, the physicians involved in formulating CHSO policies might be inclined to invest in such growth, and over-all (though perhaps gradual) growth of the CHSO sector could reasonably be anticipated. The bonus and the benefits of other efficiencies of course represent a "profit" which, in view of the requirement of nonprofit status, may not be distributed to investors but may be reflected in physician and administrator salaries. It does not appear that these would be controlled, although distribution of the utilization bonus directly to the medical staff might be prevented under the vague requirements noted above.

2. *"Ameriplan"*

This is the designation of a plan approved by the American Hospital Association (AHA) as its proposed solution to the nation's health care needs.[55] The plan would be similar to the administration's in providing for the aged through the Social Security mechanism and for the poor and near-poor through a federal program. Other persons would purchase basic protection—the "standard benefits package"—from prepayment plans or private insurance companies. As a distinctive feature, a two-part package covering "health maintenance and catastrophic illness benefits" would be provided for all persons through a federal program covering the poor and near-poor from general federal revenues and all others through a tax collected though the Social Security system.

Entitlement to the "health maintenance and catastrophic illness benefits package" would be conditioned on a consumer's previous purchase of the "standard benefits package" and registration with a "Health Care Corporation" (HCC). The HCC is the cornerstone of the plan and its nearest counterpart to an HMO. It will be paid on a capitation basis to provide the federally financed "health maintenance" benefits but will be paid for all other services at rates regulated prospectively by state health commissions. Forswearing capitation for these remaining services because of "technical difficulties" and the HCC's undue exposure to financial risk, it nevertheless looks ahead to "the development of total capitation payment."[56] The HCC

[54] Kennedy-Griffiths bill §§ 87(d)-(e).

[55] AMERICAN HOSPITAL ASS'N, AMERIPLAN—A PROPOSAL FOR THE DELIVERY AND FINANCING OF HEALTH SERVICES IN THE UNITED STATES (Report of a Special Committee on the Provision of Health Services, 1970) [hereinafter cited as AMERIPLAN]. The plan is said to have been modeled on Health, Inc., of Boston, which is described as a "primary responsibility" organization. Note, *supra* note 7, at 919.

[56] AMERIPLAN, *supra* note 55, at 45. It has been said of Health, Inc. (*See* note 55 *supra*), that "[W]hile it offers fee-for-service on the theory that most people are unfamiliar with anything else, it will encourage consumers to contract with the plan for prepaid comprehensive care." Note, *supra* note 7, at 919.

could make any arrangement it wished with actual providers, employing physicians on a salary, capitation, or fee-for-service basis. The state health commission would license HCCs and establish their primary service areas. Such service areas would be exclusive unless more than one such corporation could establish its capacity to "coordinate needed services effectively" within the area.[57] The HCC would have to demonstrate its ability to care for all persons in its service area who might voluntarily register during regular periods of open registration and would be expected to attempt to recruit an assigned list of potential registrants. It could, however, also accept registrants from outside its primary area to fill its quota.

Each HCC would be directly responsible for the delivery of health care to its registrants, either through its own facility or through contracts with other providers. It would be required to render emergency care to nonregistrants and could provide other services to nonregistrants to the extent that the quality and adequacy of services to registrants would not be jeopardized. The HCC would also be responsible for monitoring the quality of care and for securing the participation of physicians in management and of consumers in policy making. Incentives for rendering preventive care and efficient utilization would be supplied by means of bonuses of the kind described in connection with the Kennedy-Griffiths bill. The HCC would be responsible for the competence of its personnel, and the proposal recommends that the present manpower licensure system be phased out.

By withholding important federal benefits from persons not registered with an HCC, Ameriplan would effectively compel such registration. This requirement would make the Health Care Corporation not merely an available alternative but practically the sole vehicle through which health care could be obtained. Consumers would have no opportunity, or at least no encouragement, to purchase HMO-type care, and individual HCCs would effectively monopolize most markets, with exclusionary regulation apparently contemplated through the system of primary service areas. Each HCC would probably be dominated by physicians dedicated to the preservation of lucrative fee-for-service medicine and would therefore be operated merely as a fiscal agent with that purpose in view. Unless this orientation was reasonably guaranteed, physicians would not accept the plan, since a monopsonistic purchasing agent not under their control might be capable of greatly depressing their incomes.

3. *"Medicredit"*

The proposed Health Care Insurance Act of 1971, introduced in the Ninety-second Congress as H.R. 1460 and S. 987, is the so-called "Medicredit" proposal of the American Medical Association (AMA). The plan is designed to encourage and facilitate the voluntary purchase of basic and catastrophic health insurance coverage. For persons with no income or income so low as to produce no income tax liability for the base year, the federal government would issue vouchers for full payment for

[57] AMERIPLAN, *supra* note 55, at 20.

the coverage specified by the act. Persons with income tax liability would likewise have the portion of the premium attributable to catastrophic coverage paid in full by the government. Tax credits scaled to the amount of tax liability and in some cases part-payment vouchers from the government would be available for application toward the premium for basic coverage.

The principal thrust of the proposal is thus concerned with the financing of insurance protection, although necessary components of the benefit packages are specified and carriers would have to meet qualifications established by state insurance departments pursuant to minimum federal standards. The crucial problem of the system whereby care is actually rendered is not addressed other than by a proscription against federal supervision or control over the practice of medicine, and apparently no federal encouragement of change in delivery methods is contemplated. The AMA's preference for maintaining the many existing barriers against HMO formation is manifest.

III

A Market-Oriented Health Care System

The administration's proposals stand out among the competing plans in allowing the market a more substantial role in allocating resources, stimulating efficiencies, and controlling utilization of the system. Other proposals, particularly Kennedy-Griffiths, would introduce financial incentives here and there to induce physicians and administrators to do what the proponents think they should do, but otherwise would abjure the market and substitute comprehensive economic regulation in its place. The AMA plan would perpetuate the status quo with respect to the organization of the health care system and, while ostensibly relying on the market, would in fact continue in effect the restraints that have so far precluded a fair test of the HMO's attractiveness to consumers. The AHA Ameriplan, by forcing everyone into large Health Care Corporations, would create monopolistic tendencies in the marketplace so that market forces would have little opportunity to perform their customary functions, necessitating comprehensive regulation.

It is my thesis that a market-oriented system—by which I certainly do not mean laissez-faire or contemplate such drastic measures as termination of physician licensure—would be preferable to the alternatives so far presented. But the market cannot function until existing legislative and professional restraints in health care are lifted, until regulatory efforts are redirected to stimulate and guide, rather than to displace or repress, market forces, and until all the American people are provided with the means of entering the health care marketplace. The administration's proposals, while requiring some substantial modifications and clarifications, have the potential for creating conditions under which market forces could adequately perform their usual allocative and incentive functions and vastly improve the performance of the health care industry.

70-174 O - 72 - pt. 4 -- 10

A. The Possibility of Price Controls to Minimize the Impact of Increased Health Insurance

Prompt government action to make health care available to all Americans is, of course, desirable as a long overdue recognition of a basic civil right and public responsibility. But a sudden influx of previously deprived users into the system would necessarily stimulate the market to ration the limited available resources by attaching still higher prices to them. This result would appeal only to the sellers of these services, and Congress could understandably refuse to appropriate funds to provide care for the poor if, as has happened with Medicare, a large part of the public's investment would be lost in higher prices.[58] Price controls may therefore appear practically imperative if government is not to see providers enriched largely at its expense and care still denied to those whose circumstances, even with a government supplement for health care, would not permit them to bid effectively in the market against the more affluent.

The problem with price controls is that, if prices are not allowed to perform their usual rationing function, some other means of rationing must be found. The system has long used queuing—waiting time—to limit consumption in public clinics, and this could be expected to increase throughout the system. Physicians would be overburdened and would probably, in keeping with either a sense of professional obligation or much stricter utilization controls, tend to ration their time in accordance with direness of need, turning away the insignificant, self-limiting complaints. Quality of care might be more seriously jeopardized as less ethical physicians, of the kind who profited so handsomely from Medicaid,[59] shortened the time given to treating substantial complaints, without reducing their bills. Whether a black market in health services could get established on a broad scale is perhaps doubtful, but the temptation to resort to bribery would certainly be present.

These possibilities are far from palatable, but the alternatives are perhaps no more attractive. The shortage of resources and the consequent need for a nonprice rationing system would be equally great under the Kennedy-Griffiths national health insurance proposal, which would, however, not provide adequate incentives for attracting private talents and capital into the service of the nation's health, thereby prolonging the shortage and the need for rationing services. The hope, of course, is that rapid HMO growth would introduce new resources, efficiencies, and checks on utilization that would render short-lived any shortage created by new federal programs of health care financing. One cannot of course make reliable predictions in this regard, but the expectation seems not unrealistic.

My preference for a "market-oriented system" of health care delivery does not

[58] One estimate is that approximately half of the additional funds poured into medical care between 1966 and 1969 was swallowed up in price increases. Cooper, *Medical Care Outlays for Aged and Non-aged Persons, 1966-1969*, Soc. Sec. Bull., July 1970, at 3, 11.

[59] *See* Stevens & Stevens, *Medicaid: Anatomy of a Dilemma*, 35 Law & Contemp. Prob. 348, 407-15 (1970).

necessarily exclude price controls designed to minimize the impact of universal health insurance. The question reduces to which rationing system is more appealing, all things considered, and this is ultimately a political decision. One can appreciate Congress's reluctance to repeat the Medicare-Medicaid experience with the unpredictable magnitude of price increases attributable to bidding for scarce resources.[60] Moreover, I have a sense that the disadvantaged would come out worse, at a higher price to taxpayers, if prices are not controlled and that a system of queuing and utilization controls would steer medical resources to their best uses more reliably than an auction system would. Furthermore, Congress may find it politically easier to impose an added burden in finding health care on middle-class voters than to vote the appropriations and the taxes necessary to finance new health services under conditions of shortage. In any event, without venturing a final opinion on the ultimate issue of the need for or desirability of price controls, I can advance several conditions that, under my preference for primary reliance on market forces, should be met by any controls that might be introduced.

First, they should be temporary. There is as yet no reason for making health care the first industry brought by Congress under comprehensive economic regulation since the Depression era. Indeed, the experience with existing schemes of such regulation is anything but reassuring about the ability of regulation to cope with even relatively easy problems, let alone the incredibly complex job of costing individual medical procedures, eliminating price discrimination, valuing the services of individual practitioners, and maintaining the quality of service under a system of "public utility" medicine.[61] The basis for my confidence concerning the market's ability to take over the bulk of the regulatory job once the supply-demand imbalance is roughly restored is set forth at length later on.

Second, price controls should be ceilings only—with lower competitive charges encouraged—and should be in the nature merely of a freeze on all but cost-related increases. In addition to being the simplest and, in the short run, the fairest regulatory mechanism, a price freeze contemplates and lends itself to eventual lifting of the controls and restoration of a market regime. The pending Medicare amendments would use existing prices as a basis for establishing price ceilings,[62] and a temporary freeze might be easily modeled on those provisions.

Third, no direct price controls should be imposed on HMOs except for an across-the-board limit of the kind proposed for government payments to HMOs in the Medicare amendments, namely a premium ceiling of ninety-five per cent of the actuarially determined cost of caring for the HMO's patient population in the fee-for-service sector.[63] Since prices in the latter would be temporarily controlled, the

[60] *See* note 58 *supra*. On the estimation problems, see Stevens & Stevens, *supra* note 59, at 378-90. Conceivably the bad experience provided data that would facilitate better estimates in the future.

[61] Some of the problems of introducing comprehensive regulation of hospital charges are indicated in the text accompanying notes 128-39 *infra*. The same arguments would apply a fortiori to physicians' fees and HMO charges.

[62] H.R. 1, § 224. *See* H.R. REP. No. 91-1096, 91st Cong., 2d Sess. 35-38 (1970).

[63] *See* text accompanying note 34 *supra*.

danger of HMO profiteering would be substantially eliminated, and indeed the public would be assured of at least a five per cent saving over the controlled price to the extent it elected HMO-provided care. A particularly attractive by-product of leaving HMOs free to earn profits within this liberal constraint might be substantially increased attractiveness to physicians of HMO employment as providing both a relative haven from government control and a better opportunity for increasing earnings. Such increased incentives for HMO organization under a system of frozen fee-for-service prices would speed the realization of efficiencies and the needed reallocation of resources.

B. Has the Market Already Failed?

My advocacy of a market-oriented system will seem strange to those who believe that the present health care crisis itself reflects a colossal market failure.[64] A word to clarify this point may therefore be in order.

The medical profession's remarkable success in repressing market forces has been amply demonstrated elsewhere.[65] The American Medical Association's domination of the licensure system and particularly of the medical schools since the Flexner Report[66] has limited the number of physicians and raised physician incomes.[67] Emulating the physicians' example, other health professions have likewise obtained exclusionary licensing legislation, which has further raised costs by restricting the supply and mobility of health manpower and the opportunities for achieving efficiencies in the rendering of care.[68] In the name of medical "ethics," prepaid group practice was successfully limited in its impact, often by restrictive state legislation, and generally prevented from competing on an equal footing with fee-for-service providers.[69] A combination of "ethics," customs of the trade, and pressures of varying degrees of subtlety have repressed even the vestiges of price competition in

[64] This belief is widely shared and indeed is a dominant assumption in the debate. *See, e.g.*, Letter to the Editor from William J. Taylor, N.Y. Times, Apr. 16, 1971, at 36, col. 3; Falk, *National Health Insurance: A Review of Policies and Proposals*, in this symposium, p. 669, 693.

[65] *See generally* E. RAYACK, PROFESSIONAL POWER AND AMERICAN MEDICINE (1967); Kessel, *The A.M.A. and the Supply of Physicians*, 35 LAW & CONTEMP. PROB. 267 (1970); Rayack, *Restrictive Practices of Organized Medicine*, 13 ANTITRUST BULL. 659 (1968); Kessel, *Price Discrimination in Medicine*, 1 J. LAW & ECON. 20 (1958). Note, *supra* note 7, at 954-60; Comment, *The American Medical Association: Power, Purpose, and Politics in Organized Medicine*, 63 YALE L.J. 937 (1954).

[66] A. FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA (1910).

[67] *See* Kessel, *The A.M.A. and the Supply of Physicans*, 35 LAW & CONTEMP. PROB. 267 (1970); CARNEGIE COMMISSION ON HIGHER EDUCATION, REPORT ON MEDICAL EDUCATION (1970).

There has been much debate as to whether there is truly a physician shortage, some arguing that resources are simply badly distributed. *Compare* R. FEIN, THE DOCTOR SHORTAGE: AN ECONOMIC DIAGNOSIS (1967), *with* E. GINZBERG & M. OSTOW, MEN, MONEY, AND MEDICINE (1969), and McNerney, *Why Does Medical Care Cost So Much?*, 282 N. ENG. J. MED. 1458 (1970). Of course, since there is no easy means of redistributing physicians, the debate seems academic. Improvement of money-making opportunities in areas of shortage would seem to be only one step in luring physicians to those places; educational subsidies to area residents also seem promising.

[68] *See* Forgotson, Bradley & Ballenger, *Health Services for the Poor—The Manpower Problems*, 1970 WISC. L. REV. 756. On licensure generally, see M. FRIEDMAN, CAPITALISM AND FREEDOM ch. 9 (1962); L. Friedman, *Freedom of Contract and Occupational Licensing 1890-1910: A Legal and Social Study*, 53 CALIF. L. REV. 487 (1965).

[69] *See* Note, *supra* note 7, at 954-75; Comment, *supra* note 65, at 976-96.

the delivery of physicians' services.[70] Under these conditions, the market has never had a chance.

It is ironic that ethics and the quality of care have been so successfully advanced as justifications for restrictive legislation and professionally authorized restraints of trade. Whether this was always wholly a pretext on the part of the proponents of restrictive policies is of course doubtful, but the total effect was a raising of the cost of care and the incomes of health professionals. It was apparently not recognized that the allegedly high ethical and quality standards resulting from these exclusionary practices would be heavily paid for, not only in cash by paying patients but also in the suffering and lives of those who were effectively denied care. One regrettable but still recurring theme in medicine is the continuing willingness of many people, most of them prompted only by professional conscientiousness and a real concern for patient welfare, in effect to deny care to large groups in the society on the ground that such care, if provided, might not be good enough by the standards of middle-class medicine. For example, this tendency to ignore the need for expanding quantity, even at the risk of some sacrifice in average quality, is manifested in the frequently encountered hesitation about permitting physicians freely to delegate functions,[71] about scrapping most licensure requirements, and—particularly relevant here—about allowing HMOs and other health care providers to return a profit to their nonphysician organizers. The point is also generally relevant to the objections to reliance on market forces to see that health care gets delivered: the objections are basically quibbles about whether quality might be slightly impaired, while the cost in undelivered care has been and can continue to be high.

The general obeisance to the medical profession's professions of ethical concerns where their economic interests were at least equally affected[72] is matched by this language from the Supreme Court's 1952 decision in *United States v. Oregon State Medical Society*,[73] an antitrust action brought unsuccessfully by the government to vindicate the position of health care prepayment plans in Oregon against certain alleged activities of the medical society:

> We might observe in passing, however, that there are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession.[74]

[70] Kessel, *Price Discrimination in Medicine*, 1 J. LAW & ECON. 20, 42-51 (1958).

[71] *See* Havighurst, *Licensure and Its Alternatives*, in PROCEEDINGS OF THE 3D ANNUAL DUKE CONFERENCE ON PHYSICIAN'S ASSISTANTS 121, 125-26 (1970).

[72] One citizen who has not been taken in by the profession's ethical pretensions is the typesetter responsible for the following in a recent galley proof: "The American Medical Association's Principles of Medical Ethics are . . . 'not laws but standards by which a physician may determine the proprietary [*sic*] of his conduct . . . .'" *Cf.* Note, *supra* note 7, at 955, *quoting* AMA, PRINCIPLES OF MEDICAL ETHICS.

[73] 343 U.S. 326 (1952). *See also* text accompanying notes 160-63 *infra*.

[74] 343 U.S. at 336. It was noted that the trial judge, in deciding against the government, had engaged in "irrelevant soliloquies on socialized medicine, socialized law, and the like . . . ." *Id.* at 331; *see*

Since this view has had many adherents in the state legislatures and in attorney-general offices as well as in the courts, the medical profession has been largely self-regulated by the medical societies and by the doctor-run state boards of medical examiners, who are legally charged with policing the profession's ethics. Any student of antitrust knows that a self-regulatory regime organized for the prevention of "unethical business practices" is likely to be a device to suppress competition. In most other areas the courts have rejected pleas that a particular industry is a "special case" and have enforced the antitrust laws to restore a competitive regime.[75] With respect to medicine, however, neither courts nor legislatures were so perspicacious, and the market was denied its accustomed role.

The greatest failure of the health care system has of course been in delivering care to the poor. Some of the responsibility here is government's, for failing to recognize the need and to employ its powers of wealth redistribution to make decent health care financially available to all citizens. Government largely surrendered its responsibility to the medical profession, which undertook to provide charity services in return for noninterference. It was thus the profession's failure properly to honor its commitment that produced the crisis, for if the profession had been meeting the needs, there would have been either no need for Medicare and Medicaid or no supply-demand imbalance when they were enacted. Nevertheless, government's abdication of its wealth redistribution function in favor of the medical profession and private charity seems the ultimate cause of the system's failure. The market was implicated only to the extent that it distributes the rewards of the society unequally, a circumstance that is to some extent within the power of government to change. Fortunately, Congress seems about to act to bring about a long overdue rectification of wealth discrepancies with respect to health care.[76]

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95 F. Supp. 103, 109-10 (D. Ore. 1950). This juxtaposition of the two professions' interests should indicate that lawyers, who have reasonably effective trade associations of their own, are not conspicuously well qualified to pass, either as legislators or as judges, on the proper role of the market in the delivery of professional services. The judiciary's somewhat more enlightened treatment of the legal profession's analogous activities deserves mention, however. *Cf.* Brotherhood of R.R. Trainmen v. Virginia *ex rel.* Virginia State Bar, 377 U.S. 1 (1964).

[75] *E.g.*, United States v. National Ass'n of Real Estate Boards, 339 U.S. 485 (1950); Fashion Originators' Guild of America, Inc. v. FTC, 312 U.S. 457 (1941); Sugar Institute, Inc. v. United States, 297 U.S. 553 (1936); Northern Calif. Pharmaceutical Ass'n v. United States, 306 F.2d 379 (9th Cir.), *cert. denied*, 371 U.S. 862 (1962); United States v. Utah Phamaceutical Ass'n, 201 F. Supp. 29 (D. Utah), *aff'd per curiam*, 371 U.S. 24 (1962).

[76] The basis for treating health care as a specific subject for wealth redistribution—a "merit good"—is complex. *See generally* R. MUSGRAVE, THEORY OF PUBLIC FINANCE (1959). To some extent there has always been a societal commitment to render care to persons unable to pay, and the question is in large part merely one of how to finance this service and how better to deliver on a moral commitment long since made but not conspicuously well honored. Further, better health care for the poor may generate externalities benefiting the public generally, primarily by helping to break the poverty cycle and produce more self-supporting citizens. *But see* Lave & Lave, *Medical Care and Its Delivery: An Economic Appraisal*, 35 LAW & CONTEMP. PROB. 252, 255 (1970). The harder questions relate to the *limits* of the commitment and particularly to their implementation. For example, who tells the indigent patient that his benefits are exhausted and that he is asked to leave the hospital? At this point, the burden, which the state escapes by impersonally declaring a dollar limit on the benefits it will pay, falls on the providers of care as a moral matter. While some providers are the beneficiaries of direct public sub-

In the light of the foregoing it cannot be argued that the market's failure accounts for the present state of affairs. In attaching blame, if that is important, it seems unfair to expect the organized medical profession to have acted against its self-interest. Rather, the fault lies with well-meaning policy makers who failed to make the profession's trade-restraining activities unlawful and indeed enacted many trade restraints into positive law. The mystique surrounding medical care and the "physician-patient relation" served to validate the profession's assertions of high ethical and quality standards and led many well-meaning persons into becoming, in Kessel's phrase borrowed from the 1930s, "dupes of the interests."[77] It is thus ironic in a purportedly free-enterprise system that, where radical reforms of the health care delivery system are being proposed on every side, the most radical reform possible might be restoration of a free market. This, coupled with supplementary regulation and a carefully designed system of universal health insurance, could be expected to produce swift and dramatic but orderly change.[78]

C. Some Shortcomings of the Market for Health Services[79]

Even under the best of circumstances, the market for medical care could never function as smoothly as might an unrestrained market for services like those of, say, a barber. For one thing, consumers are not always capable of accurately evaluating the doctor's skill. Moreover, they are not in a position to know what services are and are not needed, and they are consequently forced to delegate numerous economically important decisions to the physician. Finally, these decisions of the physician as well as the consumer's own may often be influenced by the presence of health insurance, which largely removes the cost constraint on the consumption of health services.

We have already seen how HMOs can help to overcome the problem of the consumer's ignorance as to when he is receiving excessive care as well as some of the distorting effects of third-party payment, but, again because of consumer ignorance, HMOs may feature tendencies of the opposite kind, toward denial of needed care as a result of excessive cost-consciousness on the provider's part. The further problem of consumer inability to judge the quality of services received would also still exist to some extent in an HMO-dominated marketplace, and some fee-for-service providers would continue to operate with their bills paid in large part by health insurance carriers, thus perpetuating for consumers choosing that mode of care

sidies which enable them to absorb some such costs, the system is anything but rational. Moreover, it seems to defy rationalization that would satisfy both economic and ethical concerns. Clearly there remains a large role for charity even in a health care system dominated by government.

[77] Kessel, *supra* note 67, at 268.

[78] *See* T. Lowi, The End of Liberalism 59 (1969), which, in ranking public and private policies according to their relative likelihood to produce change, includes "Social Security programs based on graduated income tax," "real antitrust," and "competitive business" near the top of the list.

[79] *See generally* H. Klarman, The Economics of Health (1965); Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 941 (1963); Fuchs, *The Contribution of Health Services to the American Economy*, 44 Milbank Memorial Fund Q., pt. 2, no. 4, at 65 (1966); Lave & Lave, *supra* note 76, at 252.

some of the market irregularities that have contributed to the present problem. Nevertheless, significant as these departures from the competitive model are, consumers of medical care are probably not much worse off than consumers of many other technical services. For example, I feel about as competent to deal with doctors as I do to instruct an auto mechanic. And in either case my opportunity for repeated dealings and for obtaining confirming opinions from other consumers permits me more secure judgments than I can exercise in choosing a one-time supplier or serviceman from the "yellow pages."

Although many goods and services are bought and sold under substantially less than ideal competitive circumstances, the government has not always intervened. More important, it has often limited its intervention to a strengthening of market forces or to the introduction of some requirement thought to be inadequately enforced either by the market or by apprehensions about potential tort liability or other legal consequences.[80] Therefore, the first question with respect to health care is whether acceptable performance could be expected of the market mechanism if policies were tailored in a conscious attempt to achieve it. If doubt persists, then a regulatory alternative must be considered, but, because regulatory schemes, like economic analysis, are also based on faulty assumptions—about regulators' motivations, resources, and competence and about the tractability of problems—, they should be evaluated with as much skepticism as is the market's behavior. Unfortunately, a comparative inquiry into the relative imperfections of a market-oriented solution to the health care crisis on the one hand and a comprehensive regulatory solution on the other is beyond the scope of this paper. But, while I have confined myself to showing how the market could be expected to function under policies designed to improve its performance, I must say that I have greater confidence in both our ability to predict these matters and the attractiveness of the outcome (even with some deviation from expectations) than I have in our ability to design an appealing regulatory and administrative scheme. I am also impressed by the difficulty of reversing our direction once we are committed to the latter course.

D. How a Market-Oriented System Might Work

Taking the administration's proposals as a starting point, it is possible to speculate about the total performance of a health care market which has been freed of pernicious restraints and which is instead regulated in accordance with wiser policies. It will be appropriate after offering this hopeful description to deal with some specific issues that may be raised and to indicate the policies necessary to realize the hopes expressed and to minimize any fears.

[80] For example, the automobile industry is widely thought to be less than highly competitive, due in large part to there being only four domestic manufacturers. Nevertheless, when safety issues were raised, it was thought sufficient to regulate only the industry's safety equipment, since the market and the legal system appeared not to supply sufficient incentives to cause either consumers or producers to value safety highly. *See* National Traffic and Motor Vehicle Safety Act of 1966, Pub. L. No. 89-563, 80 Stat. 718, 15 U.S.C. §§ 1381-1425 (Supp. III, 1968).

In these prognostications I have assumed that HMOs will prove capable of offering significantly lower prices for coverage than do health insurers. The assumption is reasonable, since, whether due to inherent advantages or not, HMOs do appear to feature greater organizational efficiency and effective discouragement of overutilization. Of course, the HMO may gain further advantages by skimping on needed care or by attracting less intensive users of the system—persons less put off by the difficulty of getting the HMO to give attention to minor, self-limiting complaints;[81] if these are real possibilities, the HMO's competitive effectiveness may be somewhat greater than is warranted by the quality of its product, placing fee-for-service medicine at a slightly unfair competitive disadvantage. The corner-cutting issue is discussed at length shortly and is not deemed an insurmountable problem. The further possibility that consumers with low use propensities will be attracted seems not to be a valid basis for criticism since there is room for a system that is less responsive to insignificant complaints; moreover, lower use propensities should entitle subscribers to pay less for coverage than they do under health insurance, where they cannot select themselves out and are consequently exploited by those who overuse the system. In any event, whatever the source of HMOs' advantages, their presence in the marketplace seems likely to enforce efficiency and less discriminatory pricing in the fee-for-service sector with an effectiveness that no other system of social control could easily match.

HMOs could reasonably be expected to spring up in large numbers in a market freed of physician-sponsored restraints. Availability of federal funding would be a factor, though a small one, in such growth. More significant would be the attractiveness to private investors of the potential profits, which could be earned even with rates significantly below health insurance premiums for the same coverage. A requirement that employers make a choice among HMO alternatives available to all employees could open up tremendous competitive opportunities, and consumers, offered a lower-cost alternative and educated by advertising for the first time, could be expected to respond to that inducement as long as other factors did not reduce the attractiveness of HMO-type care. The market opportunities opened up would not be merely short-run phenomena since the federal financing commitment would promise permanent stability. Moreover, the health industry is one in which high rates of return are likely to prevail generally due to consumer willingness to pay for psychic satisfactions and not to make price the main consideration. In economic terms, the possibilities for differentiating "products" and exploiting consumer loyalties would seem to be great, and these factors, coupled with the likely prevalence in health care of large amounts of "consumer surplus"—the excess of each consumer's valuation of his benefits and satisfactions over the price he pays for them—, would allow each seller some pricing freedom. The resulting high profit potential could be counted on quickly to lure resources into the health care industry.

[81] *See* note 24 *supra.*

Offsetting the high profit potential would be a high degree of risk. Consumers of health services are apt to be volatile, transferring their patronage whenever their confidence in the provider wavers.[82] The marketplace envisioned would offer a sufficient number of both HMO and fee-for-service alternatives and sufficient information concerning each that providers would be faced with fluctuating profits. Once the supply catches up with the demand, high profits would be assured only so long as the provider succeeded in delivering a combination of cost, quality, convenience, and reassurance that a sufficient number of consumers desires.

One possible deterrent to the entry of profit-seeking enterprises would be the presence of nonprofit providers with whom it would be necessary to compete. These enterprises would be accorded certain tax advantages, would enjoy a preference among many consumers, and would have no need to show net earnings at the end of the year, making them formidable competitors. Therefore, rather than competing head-to-head for the customers of an existing nonprofit provider, profit-seeking enterprises would usually prefer to enter those markets, such as the inner city, where consumers were newly supplied with the means for purchasing care and where existing resources were inadequate to meet the new demand.[83] Nevertheless, nonprofit providers may often be so inefficient or may have priced their services so discriminatorily[84] as to invite entry. The competition thus offered by profit-seeking new entrants should be deemed healthy because it would compel efficiency and the elimination of the practice of pricing in accordance with ability to pay.

Greater problems may lie in the lack of managerial talents necessary to create HMOs[85] and in the lack of physicians' interest in accepting employment with them.[86] Nevertheless, no greater stimulus to the creation of the needed expertise could be imagined than the profit potential offered by the market, and businesses interested in diversifying into HMO operation would invest heavily in the necessary training.

[82] There is no inconsistency with the earlier reference to consumer loyalty. Volatility would occur at the margin and only when confidence was lost. Otherwise consumers would be disinclined to accept services elsewhere even at lower cost. The incentive to maintain consumer confidence would be very great.

[83] *See* Steinwald & Neuhauser, *The Role of the Proprietary Hospital*, in this symposium, p. 817.

[84] Discriminatory pricing takes several forms. One is pricing some services below cost and making up the difference through higher prices on other services. *See id.* at 832-34, discussing "cream-skimming," the name given to the proprietary hospital's alleged tendency to provide only the profitable services and to leave the unremunerative services to be provided by voluntary hospitals. Because benefit packages will be prescribed, HMOs will not be able to pick and choose the services they will cover, but in deciding what services to provide in-house they will have an opportunity to practice "cream-skimming" of this kind. The tendency will be to cause hospitals to price their various services more in line with costs.

Another kind of discriminatory pricing is the tendency to price in accordance with willingness and ability to pay. *See* notes 151 & 159 *infra*. To the extent HMOs offer a flat rate to all subscribers this discrimination would be eliminated. The only troublesome possibility might be a tendency of HMOs to neglect to recruit poor persons, even those supported under a federal insurance system, because of the expectation of unpaid bills for deductibles and coinsurance and for benefits in excess of those contracted for. *See* text accompanying notes 235-36 *infra*. The burden of caring for these persons would then fall on the voluntary sector, perhaps placing it at a competitive disadvantage.

[85] Note, *supra* note 7, at 953-54.

[86] *Id.* at 946-48.

Physicians, too, would respond to a substantial profit potential held out by the market. Particularly if fees in the fee-for-service sector were controlled to prevent the bidding up of prices for health services, doctors might find the HMO sector more attractive from an earnings standpoint. The potential efficiency gains in HMO operation could be made to redound very largely to the physicians' personal benefit, and they could be expected to move in significant numbers toward those areas where potential gains were greatest.

If a ceiling were imposed on fee-for-service charges, HMOs might soon be established in sufficient numbers to compete effectively with each other and with fee-for-service medicine, perhaps rather quickly driving charges in some areas well below the ceiling. Because competition would develop at different rates in different areas, the greater profit potentials remaining in areas not yet penetrated by HMOs would quickly lead to nationwide HMO establishment. The market would eventually establish the appropriate spread between the HMO's charge and the higher cost of health insurance applicable to the purchase of fee-for-service care; this spread—which could be denominated a "premium" if the word were not already being used in its insurance sense—would probably be substantially greater than the five per cent discount from fee-for-service cost contemplated in the administration's proposed Medicare amendments. Thus, if HMO charges should stabilize in the neighborhood of, say, eighty-five per cent of the current fee-for-service cost of caring for the same population, fee-for-service charges in the market area served by HMOs might fall to, say, ninety-four per cent of their present level if consumers found fee-for-service care only that much more attractive than HMO enrollment. In these circumstances, health insurers, faced with the shrinkage and possible disappearance of the fee-for-service sector, would tend to be stricter about utilization and the level of charges, ultimately driving costs down to levels where fee-for-service care would coexist in some measure with HMOs.

Smaller HMOs, lacking in-house capacity to render hospital and some specialized physician services, would purchase these in the fee-for-service sector, introducing a knowledgeable purchaser who could control utilization and shop with regard to price. Conscientious smaller HMOs, in serving their customers in this important middleman capacity, would hire the best specialists or highest-cost hospitals only for the most difficult cases; in more routine matters they would use less expensive providers, thereby helping the market to perform its important function of allocating scarce health resources to their best uses. (If such informed purchasing became widespread, the incomes of the best specialists might increase while the incomes of mediocre practitioners fell, improving currently weak incentives for achieving and preserving competence.) Patrons of such smaller HMOs, having access to the best specialists in time of greatest need, would possess an advantage denied subscribers to the larger, "closed-panel" plans. In a competitive market, less conscientious HMOs of this smaller variety which skimped too much in search of

economies in the purchase of specialist and hospital care would lose subscribers, and serious cases of such overeconomizing would be subject to regulatory control.

The prices charged by different HMOs would vary, of course, even in the same market area. Because HMOs would be of different sizes and would have different reputations for quality and convenience and other things that consumers value, they would be able to price their service differently. Smaller HMOs, for example, would probably be less efficient but might provide more personalized and responsive care, enabling them to survive even at a substantially higher price than was charged by competing HMOs modeled on the Kaiser plans. By the same token, consumers would have a range of choices even in the HMO sector of the marketplace and would be able to shop for the combination of cost, quality, convenience, and amenities that best suited their particular need and pocketbook. As a further example of what the market, responding to consumer wants, might produce, one can visualize a two- or three-man pediatric HMO, providing well-baby and routine sick care in kind and purchasing orthopedic and other specialized attention in the open market; parents subscribing to such a plan might elect either membership in another HMO or insured-fee-for-service care for themselves.

In such a system, the poor and elderly would directly benefit from the efforts of HMOs to attract paying customers from among the self-supporting classes. As described earlier, this result might flow from use of the modified "proxy-shopping" device whereby a certain proportion of private subscribers would have to be attracted and satisfied before the government would pay the HMO to care for its clients. The HMO's efforts to attract such subscribers could be expected to drive down costs and keep up the quality and convenience of the services offered. In such a system, there could never be an accusation that "second-class" care was being provided to those groups who were sponsored by the government so long as the government was willing to pay the higher premiums—up to the ninety-five per cent ceiling—for Medicare, Medicaid, and FHIP beneficiaries who wished to enroll in smaller, higher-priced HMOs.[87] In addition to assuring the poor and elderly access to care of high quality, such a policy would increase the number of smaller HMOs that might exist in the marketplace, thereby preserving not only price competition but also competition in the quality and convenience of the care rendered.

E. The Issues Presented

In trying to picture the results of a properly organized marketplace, I have made some assumptions about market behavior and ignored certain possibilities that must

[87] H.R. 1 and the FHIP bill would permit payments up to the 95% amount, thus supporting the higher-priced HMOs. See text accompanying notes 49-51, *supra*. The latter would not be able to offer the inducements of greater coverage to the same extent as the larger HMOs but could compete on other grounds. Because the government would presumptively derive a 5% cost saving on every federal program beneficiary who could be induced to switch from the fee-for-service sector to HMO-type care, it should cultivate HMOs having different characteristics. Concern about relegating the poor and the elderly to the mammoth, superefficient, and impersonal HMOs should argue for the same policy.

now be examined. In the next section, I will take up the possible risks of introducing the profit motive into HMOs and particularly the fear that overeconomizing at the expense of patients' health might be encouraged.

Another controversial question is whether competition and the market can be relied upon to produce acceptable results or whether monopolistic and other anticompetitive forces might subvert the market's functioning. In this connection, the natural monopoly characteristics of the health care market will be considered, together with the risks of medical society exclusionary tactics that might foreclose meaningful HMO development. This discussion leads to a consideration of the antitrust laws as the appropriate means of policing the marketplace against anticompetitive activities. Next, the legislation necessary to overcome the effects of restrictive state laws is suggested, and, finally, a number of supplementary measures to improve market performance are discussed.

If the picture I have drawn of the market's potential performance seems overly hopeful, it is not beyond the range of realistic possibility. To the extent HMO development falls short of my optimistic estimate for reasons unconnected with continued market restraints, nothing would have been lost, and much might have been gained in widening the range of consumer choice and compelling greater efficiencies and utilization controls in the fee-for-service sector. The important thing is to provide the field for a fair market test.

IV

For-Profit HMOs

A truly vexing issue raised by a market-oriented system of health care delivery is whether an HMO should be permitted to earn a "profit"—that is, whether it may distribute to investors other than the participating physicians all or a portion of whatever is left of the premiums after the care contracted for has been rendered. The Nixon administration's proposal makes no distinction between nonprofit and for-profit HMOs, whereas the Kennedy-Griffiths bill would not allow a for-profit CHSO to participate as a provider of primary care.[88] The issue has already provided an occasion for substantial controversy.

In the Ninety-first Congress, the House of Representatives accepted that portion of the administration's proposed Medicare amendments which would have placed no limit on the profitability of HMOs and would have excluded no HMO from

[88] In introducing S. 836, *supra* note 8, Senator Javits termed it

> "an effort to use the whole private enterprise system for the purpose [of providing access to health care], rather than to establish a new system, to use existing carriers, profit and nonprofit, and to encourage, by financing and other means, the development of group practice and other health maintenance organizations."

117 Cong. Rec. S1472 (daily ed. Feb. 18, 1971). Governor Rockefeller's plan for restructuring medical practice in New York State is reportedly similar to the administration's proposals, but it appears that the plan's equivalent of the HMO will be restricted to nonprofit status. *See* Severo, *Rockefeller Asks a Nonprofit Setup for Health Care*, N.Y. Times, Apr. 16, 1971, at 1, col. 1.

participation in Medicare solely on the ground that it was organized for profit.[89] The Senate Finance Committee, however, took issue with this tolerance of for-profit enterprises in the business of rendering government-financed health care. After noting the administration's strong advocacy of the HMO as a stimulus to cost reduction and quality improvements, the Committee said that it was

> concerned that, to the contrary, the health maintenance organization provision could turn out to be an additional area of potential abuse which might have the effect of increasing health care costs—paying a larger profit than is now or should be, paid to these organizations—and decreasing the quality of service available or rendered.[90]

The Committee proposed some rather complex revisions of the House bill to curb profitability,[91] and its version passed the Senate[92] only to die at adjournment before the differences between the two bills could be resolved. The debate on this issue is likely to be joined again in the Ninety-second Congress.

A. The Consequences of Excluding For-Profit HMOs

Before discussing the validity of the objections that may be raised to for-profit HMOs, it is useful to consider what may be at stake in excluding them since it seems to be more than a matter of principle. HMO formation is a costly and risky business, often involving major construction, extensive delays in reaching break-even operations, difficulty in employing medical staff and experienced managers, and problems in attracting sufficient numbers of consumers. Thus, although the potential for profitably delivering low-cost health care of acceptable quality would seem to be considerable, the risk attending any particular initiative in the formation of an HMO would also be substantial. In these circumstances, it is not clear that the voluntary-nonprofit sector or the governmental sector will be capable of generating either the funds or the entrepreneurial talents necessary to make rapid HMO growth a reality.

Without a profit stimulus, most of the HMOs likely to be formed will be sponsored by labor unions, employers, and substantial consumer groups. These plans will have primarily a middle-class base and may lack interest in caring for the persons now deprived of adequate care.[93] HMOs developed by university medical centers will be community-oriented and dedicated to meeting social needs, but the financial resources of these medical centers are already depleted and are badly needed

[89] H.R. 17550, 91st Cong., 2d Sess. § 239 (1970).
[90] S. Rep. No. 91-1431, at 132.
[91] *Id.* at 133-35.
[92] 116 Cong. Rec. S21314-46 (daily ed. Dec. 29, 1970).
[93] A requirement that the plan accept persons on a first-come, first-served basis will not prevent a plan from locating in areas far from the poor and from emphasizing middle-class persons in its recruitment efforts. The first-come, first-served requirement should not be viewed as in itself a substantial protection for the poor. This can come only by giving HMOs an incentive to seek them out and enroll them because it pays to do so.

to expand the capacity of their medical schools. It is therefore unlikely that many broad-based HMO ventures will be commenced except where massive federal support is supplied. President Nixon has proposed a substantial program of such support.[94]

Of course, physicians themselves may be counted upon to start a number of HMOs using their own capital or capital that they borrow on their own account. Their incentive for doing this is, of course, the hope of improving their own level of earnings by providing a service for which consumers will pay. There is no difference in principle between such investments by physicians and investments by private investors not possessing a license to practice medicine, except that the latter would have to retain or employ physicians on some basis to provide care that they or their HMO service corporation had contracted to provide. Thus, an HMO may be organized as a not-for-profit enterprise without its being so in fact, and to this extent it is misleading to attach great importance to the ownership of the sponsoring corporation without reviewing as well the terms of the contract with the physician group and the salaries or other compensation paid by it to its members.[95] No one but the AMA could find a reason for wanting to exclude all but physicians from participating in the profits of this potentially lucrative industry.[96] In any event, physicians, though affluent as a group, cannot be relied upon to supply sufficient funds.

To expect all HMO initiatives to originate with physicians seems clearly unwise. While many doctors are dedicated to social service, there is a limit to what they can do even with lavish federal grants. They are not trained as administrators, and, although the medical schools with which many of them are affiliated could provide administrative skills, the number and location of medical schools impose limits on what can be realistically expected. Doctors have certain preferences about where they want to live and about the kinds of patients they wish to treat. Only exceptional ones are likely to have both the taste and the entrepreneurial skills to initiate an enterprise that would take them into those areas where needs are most acute. Profit-seekers are less fastidious or particular, on the other hand, and could be expected to create opportunities for those physicians who might be attracted into deprived-area practice by the right offer but who otherwise would take the path of least resistance to the suburbs. Finally, physicians are also subject to pressures from their colleagues and, for this reason or because of more subtle influences traceable to their education and professional acculturation, might be more inclined to honor the organized profession's preferences as to the nature, scope, and aggressiveness of any HMO they might organize; nonphysician organizers, less inhibited by the "ethical" im-

[94] *See* text accompanying note 27 *supra*. The Health Policy Advisory Center (Health-PAC) estimates that the President's proposed $23 million in grants would pay for setting up HMOs serving 1,400,000 people. HEALTH-PAC BULL., Apr. 1971, at 3. In H.R. 5614, 92d Cong., 1st Sess. (1971), the administration proposes aid for medical-school-based HMOs.

[95] *See, e.g.*, Complete Serv. Bureau v. San Diego County Medical Soc'y, 43 Cal. 2d 201, 272 P.2d 497 (1954). The shakiness of the profit-nonprofit distinction is observed in Note, *supra* note 7, at 962.

[96] *See* COMMITTEE ON MEDICAL FACILITIES, AMA COUNCIL ON MEDICAL SERVICE, REPORT ON PHYSICIAN-HOSPITAL RELATIONS 4 (1964) (recording opposition to plans in which "a third party . . . derive[s] a profit from payment received for medical services"), quoted in Note, *supra* note 7, at 956.

plications of competition, would be freer to start HMOs and to realize their true potential. The medical profession's inertia seems too great to be counted on alone for the needed initiatives.

There would therefore seem to be some reason to fear that elimination of the profit potential for nonphysician HMO organizers would significantly retard the growth of the HMO sector.[97] This would mean, quite simply, that needed care would not be rendered and that available efficiencies would not be realized. Even if some arguments against for-profit HMOs seem to have validity, they must be weighed against forfeiture of this potentiality for increased efficiency and for delivering care to people who are now seriously deprived. What may be at stake is whether the HMO will be an occasional experimental curiosity or a serious contender for the role of family doctor for millions of persons at all levels of society in all parts of the country.

Even at best, nonprofit HMOs would probably distribute themselves in such a way that few consumers would have access to more than one, producing a monopolistic situation not conducive to efficiency or to vigorous efforts to please consumers. Moreover, many nonprofit HMOs would be dominated, directly or indirectly, by persons beholden to the organized medical profession and consequently operated responsively to its interests rather than the interests of potential customers. Similarly, university medical centers are often alleged to operate with primary emphasis on their educational and research missions and to fail to hold the interests of their patients foremost. By this token, the performance of university-sponsored HMOs may fall short in important nonscientific respects.

In addition to being slow to develop, nonprofit HMOs are not likely to recruit aggressively both in the middle classes and among the poor. Even under statutory compulsion to engage in such recruitment, there may be a tendency to sign up blue collar employment groups exclusively. The result might be a kind of "public utility" medicine to which, even though the quality of care might be extremely high, the "second-class" image might attach because the conditions under which care was rendered were neglected. Waiting rooms would be crowded, and one could predict an increase in the agitation for consumer control of the delivery of medical care. On the other hand, under the market-oriented system outlined earlier, poor and elderly persons would generally be admitted only to plans that had proved their ability to attract paying patrons in a competitive environment. Health care consumers would indeed have a voice in the care they received, since they would have reasonable alternatives rather than the Hobson's choice of the public utility customer.

Another important dimension of the health care crisis has been the misallocation of capital resources, reflecting excessive or unwise investments undertaken by the

[97] The experience of proprietary hospitals, recounted with care by Steinwald & Neuhauser, *supra* note 83, at 818-30, demonstrates the importance of the profit motive in stimulating prompt response to new demand for health services. They show that proprietaries appear primarily in those places where the voluntary sector has failed to generate needed investment.

voluntary-nonprofit and governmental sectors.[98] One consequence of the predominantly nonprofit orientation of the industry has been to free decision makers to maximize just about any value they choose, including in too many cases the gratification of administrators' empire-building impulses or physicians' convenience and income derivable from utilization of plant purchased with government or charitable funds.[99] Thus, a few influential surgeons may be enriched through occasional use of an expensive heart surgery unit which was purchased with charitable funds and is maintained out of monopolistic charges to the hospital's paying patients.[100] The movement toward "comprehensive health planning" can be seen as an attempt to structure decision making in the nonprofit sectors so as to minimize these tendencies and eliminate the impact of conflicts of interests on the part of decision makers.

Of course no one contends any longer that the pursuit of profits inevitably benefits the public or that profitability equates directly with service of the public interest. Nevertheless, decision makers in profit-making enterprises are more closely disciplined—by the market, a constant if not perfect taskmaster—than are decision makers in the nonprofit sector, and their decisions are more likely to accord with public needs than the decisions we have gotten in the past from managers with the other primary goals. Indeed, the competition of profit-making HMOs, by eliminating discriminatory pricing, will deprive many decision makers in the nonprofit sector of substantial amounts of discretionary funds. This should increase accountability by requiring them to appeal more often to legislatures, bureaucrats, and private benefactors, who, with the help of comprehensive health planning, should be able to impose the cost-benefit discipline so lacking in the past. Although comprehensive health planning does promise some improvement in the handling of discretionary funds earned by monopolistic hospitals, curtailment of the opportunity to earn such funds through pricing of services without regard to cost should also be a goal of public policy. Even assuming that discriminatory pricing may once have served a useful function in making care more widely available, the tax system is a better means of redistributing the society's wealth. Indeed, the need for direct public subsidies for capital construction or other purposes may be largely obviated by a truly adequate system of universal health insurance and federal financing for the poor. Once all consumers have or have been given the ability to pay for health care,

[98] *See* Legislative Findings and Purpose, 1969 Laws of N.Y., ch. 957, § 2, *quoted in* Annot., N.Y. PUB. HEALTH LAW § 2803 (McKinney Supp. 1970) ("Continued pressure for unnecessary duplication of facilities and heavy standby commitments for under-utilized services in one area contrast with long waiting lists for admission to facilities in other areas."); Randal, *Wasteful Duplication in Our Hospitals*, THE REPORTER, Dec. 15, 1966, at 35; Note, *Unplanned and Uncoordinated Development of Hospital Facilities—A Need for Legislation*, 52 IOWA L. REV. 1187 (1967).

[99] *See* Cherkasky, *Resources Needed to Meet Effectively Expected Demands for Service*, 42 BULL. N.Y. ACAD. OF MED. 2D SER. 1089, 1091 (1966) (reference to "the haphazard manner by which programs and institutions have grown up in response to a local need, a trustee's pride, an administrator's ambition, a doctor's self-interest").

[100] *See id.*; H. KLARMAN, *supra* note 79, at 137.

the market should be able to attract and allocate resources satisfactorily, and perhaps only remote rural areas would then require special public investment.

The medical profession could be relied upon vigorously to oppose for-profit HMOs on ethical grounds,[101] and many legislators and policy makers will lend an attentive ear, for an ethical concern is indeed presented.[102] Nevertheless, physicians' preference for reserving the profits of the industry for themselves alone should not be taken too seriously. Denial of profit participation to outsiders in the past has deprived the industry of the benefit of entrepreneurial input and thus of one important ingredient of creative change. With innovational and managerial talents devalued and excluded by the holders of the industry's purse strings, the system failed to develop organizationally, and, partly as a consequence, the current crisis is one of disorganization and misallocation of human and material resources. The ethical importance of the system's breakdown and failure to deliver needed care would seem to outweigh whatever it is that the profession would have in mind in opposing proprietary influences in HMO formation.

Of course many nonphysician observers doubt the wisdom of market-inspired investment and incentives in a field where consumers are thought to be ignorant about true values and consequently prone to select their provider on irrational grounds. There is, however, no obvious reason to fear that mass merchandising will have anything like the effects in the health care field that Galbraith attributes to it in other areas.[103] On the other hand, consumer preferences for such things as convenience, personalized care, and certain amenities are entitled to expression, and indeed irrational factors have an important place in medical care, suggesting that

[101] *See* note 96 *supra*. The medical profession might attempt to bring its concerted opposition to for-profit plans under the recent case of Marjorie Webster Junior College, Inc. v. Middle States Ass'n of Colleges and Secondary Schools, Inc., 432 F.2d 650 (D.C. Cir. 1970). In that case, the association refused to accredit the plaintiff college on the sole ground that it was a proprietary institution, without regard to whether it measured up in quality terms. The court of appeals held that the Sherman Act did not apply to activities having "noncommercial" objectives, citing Apex Hosiery Co. v. Leader, 310 U.S. 469 (1940), and further that judicial interference with private groups would be limited by deference to professional judgment where the apprehended harm was not great. The court added, "we do not think it has been shown to be unreasonable for appellant to conclude that the desire for personal profit might influence educational goals in subtle ways difficult to detect but destructive, in the long run, of [an] atmosphere of academic inquiry . . . ." 432 F.2d at 657.

The *Marjorie Webster* case turns primarily on assumptions about the association's motives and objectivity, which the plaintiff had failed adequately to impugn. In the medical care field, where the profession's economic interests are so near the surface, there would be a much firmer basis for skepticism about any effort to exclude for-profit HMOs, and the result should be different. Neither the profession nor any "blue-ribbon" group within it should be given a chance to justify any flat exclusionary rule, with or without the benefit of judicial deference. The judgment on this question should be made finally by Congress, which alone can appraise the total situation and decide whether the health care system needs the shake-up that for-profit HMOs could provide.

[102] The yielding of a profit to one other than a physician could be considered a fee-splitting arrangement. *See* AMA, PRINCIPLES OF MEDICAL ETHICS § 7 (1957). The existence of a third-party profitmaker may also be thought to impose a risk of interference with "the free and complete exercise of [the physician's] medical judgment and skill." *Id.* § 6. More broadly, the risks of corner-cutting in patient care are fundamentally an ethical problem.

[103] *See* J. GALBRAITH, THE NEW INDUSTRIAL STATE 199-210 (1967).

consumers' wishes ought not to be too regularly second-guessed. Moreover, the consumer's highly valued right to take his business elsewhere should not be curtailed without good reason, particularly in a field, unlike telephone service, where personal rapport with and confidence in the provider of the service are so important. Certainly abuses are possible that would require control, but the needed controls can be achieved through regulation of advertising content and through supervision by accrediting agencies and other groups—the HMO offering free tonsillectomies to the children of new subscribers could not long remain in business! In view of the benefits derivable, selective controls on the excesses of the profit seekers should seem sufficient to obviate uneasiness about them.

Whether my high hopes would all be realized is, of course, uncertain. What is clear is that there is a realistic expectation that more health care could be rendered more efficiently and more cheaply to more people sooner if Congress is not too reluctant to allow market forces to function. A high profit potential has traditionally signaled the public's need for new resources, and the question is whether there is sufficient reason to depart from controlled use of the market's allocative function here.

B. The Risks

Recognizing that there is much to gain, we may now consider what risks would be run if for-profit HMOs were tolerated. In the course of this discussion it will be appropriate to consider the ways in which these risks can be minimized, if not eliminated, in order that the substantial benefits anticipated can be achieved without more than minimal danger. What must be avoided here, as elsewhere in the health care system, is the temptation to indulge fastidiousness about quality and other matters to the extent that some members of the public are denied their right to basic health care altogether.

1. *Overeconomizing*

The most arresting argument against for-profit HMOs is that they will on occasion be tempted to economize at the expense of patients' safety. Generally, of course, it is to the HMO's advantage to cure a patient as quickly as possible in order that his condition not worsen, thereby requiring greater expense to effect a cure. In the vast majority of cases this incentive will work to the combined benefit of the patient and the HMO proprietors, and their interests can be seen as coinciding. The troubling cases are those in which it would be clearly cheaper to let a patient die—death being the ultimate "economy" in these circumstances—rather than undertake expensive efforts to prolong his life, and there would probably also be instances in which the HMO would face the choice of providing a superior treatment that was extremely expensive or a less effective one that was cheaper. The problem in each case is that even with an HMO the incentives are not yet perfectly ordered, and therefore we still cannot rely totally upon the HMO's balancing of costs and benefits

to produce optimal results; indeed, we would get closer to the desired incentive system if HMOs also provided life insurance coverage and if employers paid bonuses to the HMO for restoring their employees to good health—both extremely attractive possibilities that should be encouraged and perhaps even required by policy makers. Finally, there may be some reason to fear false economies which HMOs, taking too short-run a view, may occasionally practice.[104]

I think there are many reasons to doubt that HMOs will allow their economizing instincts to jeopardize life unduly or to dictate the choice of treatment. Moreover, I find a variety of substantial controls that already exist or could be introduced to prevent this from occurring.

Whether overeconomizing is a risk associated exclusively with for-profit HMOs is doubtful. If physicians are to respond to the incentives that HMO-type care is supposed to introduce, they must be given a financial stake in the outcomes of particular cases. This is typically done through profit-sharing arrangements and other incentives, and it would seem that the incentive to overeconomize would accompany the implementation of these incentive arrangements whether or not the HMO itself was organized on a for-profit basis. In either case the primary decision maker would be faced with a conflict of interests that could conceivably influence his judgment adversely to a patient in a particular case. There is no evidence that I know of, however, that prepaid group practice plans have been guilty of overeconomizing.

The lay management of a for-profit HMO might exercise limited control over some of the conditions under which care is rendered, influencing, for example, the ratio of staff to patient population or the decision on purchasing life-saving equipment. Those quality matters that are within the control of the HMO management would seem to be rather easily regulated from the outside by quality control teams assigned to visit the installation. Interference by lay management in the actual rendering of care is likely to be strictly prohibited.

Overeconomizing would be subjected to a number of significant sanctions. The first is, of course, the threat of malpractice suits against the HMO.[105] While many

[104] The representation that the HMO has an incentive to practice preventive medicine, to detect disease early, and to treat causes rather than symptoms assumes a long-range perspective. Presumably there will sometimes be uncertainties about payoffs and a tendency to short-run conservatism, yielding false economies of the sort referred to.

[105] *See generally* ASPEN SYSTEMS CORP. (HEALTH LAW CENTER), GROUP PRACTICE AND THE LAW: A DIGEST OF STATE LAWS AFFECTING THE GROUP PRACTICE OF MEDICINE 9-11 (1969). Note that malpractice law would fulfill a different quality control function with respect to HMOs than it has performed with respect to fee-for-service medicine, where undertreatment would seem to be a potential problem only when the patient lacks the ability to pay. *Cf.* Cantor, *The Law and Poor People's Access to Health Care*, in this symposium, p. 901, 909-13. (I know offhand of no malpractice case where skimping in the care of a nonpaying patient was charged.) Because of the limited cost-benefit awareness of fee-for-service doctors, courts should avoid being too much influenced by prevailing custom and practice in defining a standard of minimum treatment for HMOs. It is unlikely, however, that HMOs would be allowed by the courts to depart very far from standards in the fee-for-service sector, and therefore they may be compelled to adopt conservative policies in omitting x-rays and other tests and procedures of doubtful medical value. *See* notes 18 and 25, *supra*, and accompanying text. Nevertheless, since

instances of overeconomizing that might occur would escape the notice of potential malpractice plaintiffs, standards in the HMO would probably reflect a healthy respect for the possibility of such litigation, thus drastically cutting down the instances of corner-cutting. Regulatory oversight of quality could be expected to take into particular account those areas where overeconomizing would be likely to occur,[106] and it is certain that any federal legislative move into the health field will provide for substantial increases in external supervision of quality. While there are probably many things related to quality that such medical audits and other investigatory techniques cannot uncover, I would think that most kinds of overeconomizing on any substantial scale could be easily detected. In view of the small return from overeconomizing on any but the largest scale, coupled with the likelihood of detection and the high stakes involved—loss of accreditation, malpractice judgments, and, above all, the loss of consumer confidence—, the HMO's incentive to skimp on patient care would be small indeed.

The HMO's professional staff could be expected to maintain standards, to resist lay interference, and to insist on honoring their Hippocratic Oath. Consumers would be quick to react to any evidence of overeconomizing at their expense, either in the form of malpractice suits, formalized complaints, or word of mouth charges conveyed to other consumers. Anticipating consumer reactions, the HMOs would be extremely concerned about their image and any possible criticism on this score; indeed, I would expect the management to take no chances about matters of this importance. In very few cases will competition ever become so intense as to force HMOs into corner-cutting in search of short-run survival. Occasional cases of this kind might occur, but again there is little reason to think they would be more frequent in for-profit enterprises.

Finally, if one still fears overeconomizing by HMOs, it would be possible to require reinsurance against those risks that seem most likely to produce the temptation. Thus, an HMO might insure its enrollees against the need for such things as treatment in a cardiac care unit or hemodialysis. In any event, reinsurance is likely to be widely used by those HMOs which, because of the smaller patient population enrolled, could not safely rely on actuarial estimates to predict their costs. Reinsurance promises to play an important role in making smaller HMOs feasible and in improving their financial stability. It should also minimize fears about overeconomizing in those HMOs most likely to practice it.

HMOs may find it possible to have malpractice claims arbitrated rather than litigated, Doyle v. Giuliucci, 62 Cal. 2d 606, 401 P.2d 1, 43 Cal. Rptr. 697 (1965), a standard might be evolved in that forum which (1) would allow some freedom to cut back on the numerous minor items having a benefit-cost ratio of less than unity, but (2) would enforce a duty to care for the extremely sick patient without regard to cost, up to the limits of his coverage. Query, however, the HMO's obligation to preserve, at extraordinary cost to itself, the life of a comatose patient whose brain function is permanently impaired.

[106] The administration's proposals include a procedure that would enable consumers to bring their complaints about denial of desired services before an administrator. H.R. 1, § 239(a), proposed § 1876(f); S. 1623, § 101, proposed § 604(c); *id.* § 201, proposed § 628(f). Query whether these provisions would create a new forum in which to bring a certain class of malpractice cases. Query further whether the forum would be or should be the exclusive one for prosecuting such complaints.

2. *Exploitation and Commercialism*

A respectable body of judicial authority and tradition stands opposed to for-profit enterprises in the health care field. Much of the sentiment is expressed in the common-law rule against the corporate practice of medicine, which has been applied almost exclusively to for-profit enterprises.[107] The history of medicine discloses many examples of commercialism and exploitation of an unwary public by quacks and profiteering physicians,[108] and most recently distress has been voiced about the advertising, hard-sell tactics, and high prices of the abortion clinics in New York City.[109] Furthermore, proprietary hospitals and proprietary nursing homes have a bad name in some circles and have been the subject of some controversy.[110] All of these factors have contributed to producing a firm conviction on the part of many that the nonprofit tradition must be maintained. But, while these convictions do credit to their harborers, they cannot be honored without regard to cost. Thus, the countervailing considerations noted earlier—the need for incentives to stimulate HMO growth, the potential contribution of proprietary institutions to stimulating economic efficiency, and the need to enlist entrepreneurial talents in the reorganization of health care delivery—must be weighed against the substance of these concerns.

A popular shibboleth is that no one should profit from the illnesses of others. In a free economy, however, reasonable profits signify, at least prima facie, that a needed good or service is being adequately and efficiently supplied, and "excessive" returns betoken a shortage and serve the useful purpose of inducing new efforts to supply the still unsatisfied wants.[111] Of course, some may be tempted to turn the shibboleth around and to insist that health services are so important in the greater scheme of things that the rewards attached to delivering them should be very great. But this is equally wrong, for the price of services must ultimately relate to their cost, including what is needed to induce sufficient numbers of competent people to enter the business of rendering them. In any event, the whole argument has no substance, for physicians and other health personnel—and lawyers, too, for that matter—already "profit" from the misfortunes of others, and there is no way of arranging things otherwise.

Still, "excessive" profits earned in the rendering of health care remain ethically and socially troubling. I have already expressed my willingness to accept a temporary freeze on price increases in health services so that the shortages that would be

[107] *See* Note, *supra* note 7, at 960-62 and references there cited.

[108] *See, e.g.*, J. YOUNG, THE MEDICAL MESSIAHS (1967); Note, *Quackery in California*, 11 STAN. L. REV. 265 (1959).

[109] *E.g.*, *Disciplinary Action for Abortion Solicitors Backed*, Am. Med. News, Dec. 14, 1970, at 9.

[110] *See generally* Steinwald & Neuhauser, *supra* note 83, at 830-37.

[111] While distasteful in the extreme to many, the abortion clinics are providing a service intensely desired by some persons and in seriously short supply. The business is therefore profitable, and advertising makes it more profitable by stimulating demand. If health services of a less controversial kind were involved, their profitability and the effort to make them more widely available might strike us more positively. A New York trial court has recently held abortion referral agencies illegal in large part because of their "commercial" nature. N.Y. Times, May 14, 1971, at 1, col. 6.

created by improved accessibility would not overwhelm government's financing efforts and merely enrich providers. High profits earned temporarily by HMOs under such ceilings would not seem so objectionable since they would flow from achieved cost savings rather than from exploitative price increases.

As to the relevance of some of the experience of the past, some distinguishing elements can be observed. Government's legal powers and administrative capabilities are now somewhat better developed and suited to the job of policing the unethical and dangerous provider. Thus, reasonably effective controls can be exerted over existing operations, and primary reliance need not be placed on exclusion of would-be providers from the marketplace, a costly form of over-kill in an era of shortage. Perhaps more important, the market-oriented system would leave very little room for exploitation of the poor and the elderly, the groups most likely to be imposed upon by unethical providers. This results from the adoption of the modified "proxy-shopping" mechanism, which requires the HMO to demonstrate an ability to attract younger, self-sufficient, and relatively sophisticated consumers before the government would allow it to care for those citizens who are its special responsibility.

The poor reputation enjoyed by proprietary hospitals and proprietary nursing homes—on the justification for which I express no opinion—might suggest to some that tolerance of proprietary HMOs would be an invitation to abuse. But this loses sight of the fact that, whereas HMOs will generally have a direct stake in restoring their patients to health as quickly as possible, proprietary hospitals and nursing homes may not have been adequately penalized by the market for poor performance. The reason for their escape is that, due either to a shortage of facilities or to ignorance, infirmity, or the necessity of the moment, their customers may often not have been able to exercise free and informed choice. Thus, the accusations directed toward proprietary hospitals have been largely confined to their alleged use by their physician-proprietors as a means of facilitating overutilization, which their patients have not the opportunity, the knowledge, or perhaps the interest[112] to detect, and of avoiding the kind of peer supervision that is customary in voluntary hospitals.[113] Similarly, nursing homes may have had insufficient incentive to make their inmates' lives cheerful, since many patients, due to infirmity, disinterested families, and shortage of facilities, effectively lack the opportunity to take their business elsewhere.[114] It would seem that the proprietary HMO could be rather fundamentally distinguished from either of these institutions and that what may be regarded as their poor record ought not to be held as evidence against the proprietary HMO's potential for rendering quality care.

[113] *See* note 19 *supra*.

[112] Some think that proprietary hospitals have been to some extent the refuge of poor doctors. *See* Steinwald & Neuhauser, *supra* note 83, at 829. Whether or not this is so, HMOs would certainly not be such a refuge and could be expected to exercise more vigilant peer supervision than do other types of providers.

[114] *See generally Hearings Before the Subcomm. on Long Term Care of the Senate Special Comm. on Aging*, 91st Cong., 1st Sess., pt. 1 (1969).

The decision on for-profit HMOs is not likely to be made by a careful weighing of the merits of the issue but will instead reflect special interests and some emotions. Not only will the health care "establishment" oppose the challenge to their power that rapid HMO promotion by outsiders could produce, but most liberal reformers in the health field will also react negatively. Many of the latter will object viscerally to the proposed comingling of the profit motive with the humanitarian impulses which they wish reform both to reflect and to restore in medical practice. The notion of a market-oriented system also flies in the face of the emerging consensus among reformers in favor of "planning" in health care, and inducing a reconsideration of this preference by these persons, many of whom personally anticipate power and prestige in the new order, is probably impossible. Congress nevertheless has the opportunity to resolve the question as part of the larger decision it must reach on the direction which health care will take. This decision will not necessarily be dictated by health care insiders.

Finally, whatever one's a priori preferences may be on profits from care of the sick, current emoluments—including not only net cash income but also power, prestige, and perquisites—belie most of the health industry's nonprofit pretensions.[115] An explicit recognition of the existing profit orientation thus has the merit of avoiding much hypocrisy. More important, however, it would cause policy makers to focus on the market as the appropriate form of social control and to concentrate on improving and supplementing its functioning. Heretofore their assumption has too often been that the industry is fundamentally humanitarian, ethical, and nonprofit and that more admirable instincts uniformly prevail over crass self-interest. Under the new assumptions, the question becomes the market's ability, with supplemental regulatory assistance, to provide adequate policing of profits and practices. The risk presented by monopolistic and monopolizing tendencies in the marketplace is therefore the next subject for attention.

V

Shaping Policies to Improve the Market's Performance

A. Natural Monopoly

An argument can be made that in some circumstances HMOs will monopolize the market for health services, rendering it unwise to rely on competition and the market to control prices and to maintain the quality of care. If this is a substantial danger, then it may be that more direct regulation than I contemplate would be called for.

A "natural monopoly" is possessed by an enterprise that occupies an entire market by virtue of economies of scale that make it inefficient for more than one competitor to survive. If two competitors were to exist in a natural monopoly market,

[115] *See generally* Health Policy Advisory Center (Health-PAC), The American Health Empire: Power, Profits and Politics (1971).

one of them would drive the other out, barring collusion preventing this outcome. One competitor or the other would eventually get a size advantage, and, because its unit costs would then be lower by reason of scale economies, it would be able to set a price with which the other competitor could no longer contend. That hospitals may sometimes enjoy a natural monopoly seems clear. Scale economies are thought to be substantial up to 250 beds,[116] and a hospital of this size is roughly adequate to serve a population of 65,000.[117] Thus, in many population centers a single hospital may exist without significant actual or potential competition due to technological and other efficiencies which are available to only one seller, the incumbent. The implications of this market structure for policy toward HMOs are several.

HMOs themselves are not likely to be the beneficiaries of a natural monopoly except as it derives from that belonging to hospitals with which they are affiliated. Aside from the provision of hospital services, HMOs would probably enjoy some scale economies in the provision of physicians', laboratory, and x-ray services, but these are not likely to be substantial enough to be decisive.[118] HMOs associated with nonmonopolistic hospitals will have additional economies available, but competing hospitals could also be expected to offer HMO care, providing adequate competition. Perhaps most important, consumers are interested in more things than price in purchasing physician services or HMO membership, and some consumers will prefer to patronize a solo fee-for-service practitioner or a small-scale (two- or three-man) HMO, even at a higher cost, because of personalized attention and convenience that a somewhat more efficient HMO could not match; the competitive position of such plans would be further improved by the government's willingness to pay the higher rates (up to the ninety-five per cent ceiling) for Medicare, Medicaid, or FHIP clients electing care though such a plan. Thus, it seems most doubtful that an HMO not affiliated with a monopolistic hospital could ever have a monopoly "thrust upon it."[119] Nevertheless, the number of hospitals with substantial monopoly power is large, and therefore the danger of HMO monopoly derived from a hospital's natural monopoly must be considered in some detail.

An HMO sponsored by a monopolistic hospital will have a potentially decisive competitive advantage over competing, non-hospital-based HMOs and fee-for-service physicians in the community. Depending upon the distance to and competitive environment of the nearby alternative hospitals, independent HMOs would be more or less, but always in some degree, compelled to pay the monopolist's price for hospital services needed by its enrollees; patrons of fee-for-service physicians would likewise

[116] Steinwald & Neuhauser, *supra* note 83, at 836. *But see* Lave & Lave, *Hospital Cost Functions*, 60 AM. ECON. REV. 379, 394 (1970) ("if economies of scale exist in the hospital industry, they are not very strong").

[117] Based on the national ratio of 3.9 beds per 1000 of population.

[118] Group practice by physicians (without prepayment) has shown a tendency to grow but not at a rate suggestive of overwhelming scale economies. *See, e.g.*, Note, *supra* note 7, at 903-04 n.9.

[119] United States v. Aluminum Co. of America, 148 F.2d 416, 429 (2d Cir. 1945).

face these charges, which would in turn influence their health insurance premiums. Under these circumstances the hospital-sponsored HMO would be able to offer comparatively attractive rates by, in effect, subsidizing its HMO operation with the monopoly profits from its hospital services.[120] This subsidization process can also be visualized as the product of discriminatory pricing, whereby the captive HMO is charged lower hospital rates than its competitors and thereby derives a critical cost advantage.[121]

The situation thus presented is not an uncommon one in other contexts involving vertically integrated enterprises.[122] For example, it resembles closely the "price squeeze" described in the famous aluminum monopoly case.[123] In that case, Alcoa, the monopolist of aluminum ingot and one of several sellers of rolled aluminum sheets, was said to have

> consistently sold ingot at so high a price that the "sheet rollers," who were forced to buy from it, could not pay the expenses of "rolling" the "sheet" and make a living profit out of the price at which "Alcoa" itself sold "sheet."[124]

Judge Learned Hand's opinion also indicated the applicable legal rule:

> That it was unlawful to set the price of "sheet" so low and hold the price of ingot so high, seems to us unquestionable, provided, as we have held, that on this record the price of ingot must be regarded as higher than a "fair price."[125]

By making an assumption (to be examined later) that interstate commerce is adequately affected, the *Alcoa* price squeeze principle can be translated to the hospital-

[120] It is far from clear that a monopolist would want to spend its money, hard-earned or not, in subsidizing an HMO's competitive ventures. Such an investment would not pay unless the profits from eventual monopolization would more than recoup it, and there are reasons to doubt that the monopoly would be so valuable. *Cf.* Leeman, *The Limitations of Local Price-Cutting as a Barrier to Entry*, 64 J. POL. ECON. 329 (1956). Still, in view of the hospital's control of the supply of a service essential to survival or entry of competitors, the possibility of monopolization, at least of the business of giving HMO-type care, cannot be ignored.

[121] *Cf.* Comment, *Application of the Robinson-Patman Act to Price Discrimination in Intra-Enterprise Transactions*, 53 NW. U.L. REV. 253 (1958), which discusses the general problems; however, the Robinson-Patman Act, ch. 592, 49 Stat. 1526 (1936), 15 U.S.C. § 13 (1964), would not apply to the pricing of hospital services.

[122] *See generally* C. EDWARDS, MAINTAINING COMPETITION 97-99, 171-75 (1949); C. KAYSEN & D. TURNER, ANTITRUST POLICY 122, 125-27 (1959).

[123] United States v. Aluminum Co. of America, 148 F.2d 416 (2d Cir. 1945). For other examples of the "price squeeze," see United States v. Corn Products Ref. Co., 234 Fed. 964 (S.D.N.Y. 1916); United States v. New York Great Atl. & Pac. Tea Co., 173 F.2d 79 (7th Cir. 1949), *affirming* 67 F. Supp. 626 (E.D. Ill. 1946).

[124] 148 F.2d at 437. *See also* Baush Machine Tool Co. v. Aluminum Co. of America, 72 F.2d 236 (2d Cir. 1934), 79 F.2d 217 (2d Cir. 1935). The best explanation of the "squeeze" is that Alcoa was seeking to compete with sheet steel by lowering prices to auto makers, thus practicing price discrimination in favor of that class of users. *See* Adelman, *Integration and Antitrust Policy*, 63 HARV. L. REV. 27, 45 (1949). Vertical integration facilitates the segregation of markets necessary to permit such price discrimination, and a price squeeze may often be an incidental effect of this practice rather than a predatory tactic. *See* note 126 *infra*.

[125] 148 F.2d at 438. The squeeze potential is itself objectionable even if unexercised, because it discourages entry by those who recognize the risk and because it can be used to discipline aggressive competitors. For these reasons mergers creating a squeeze potential may be held unlawful. *See* U.S. DEP'T OF JUSTICE, MERGER GUIDELINES para. 13 (1968).

sponsored HMO context. The antitrust rule thus derived would be that, although a lawful (natural) hospital monopolist does not violate the law by charging monopoly prices, if it elects to compete with its HMO customers and with fee-for-service physicians by forming an HMO, it may not disadvantage them—that is, "squeeze" them, in the case of competing HMOs—by its pricing policies.[126] The most likely antitrust penalty for so doing would be a treble-damage award to all injured competitors, including fee-for-service doctors. Divestiture and break-up of the HMO would be likely also, and criminal sanctions could be imposed in flagrant cases. Rigorous enforcement of such a rule against unfair competition would be one hope for controlling the problem, but its administration would be difficult because a price advantage of the hospital-based HMO could be as easily attributed to efficiencies from integration of functions as to predatory behavior.[127]

Direct regulation of hospital rates might appear to be another possibility for coping with this problem. This expedient has been adopted in New York, to deal with hospital costs generally,[128] and it is recommended by the apparent congruence of the theory supporting it and the argument for public utility regulation, which is also founded on the natural monopoly characteristics of the market.[129] The public utility analogy is deceptive, however, primarily because it is based on a premise that utility regulation has proved a distinct social success, a pervasive assumption that has nevertheless been effectively disputed.[130] Among other things, utility regulation has proved quite incapable of governing the quality of service and indeed has often foundered on the fact of life that if rates are kept too low, or merely if management prefers short-run profitability, the utility always has available the option of reducing its office staff or plant maintenance or otherwise curtailing the present, or borrowing

[126] Classic discussions of vertical integration argue that use of a monopoly position to bring about equivalent domination at a lower level of the market can seldom increase market power, but an exception is noted where domination of a complementary product or service is achieved. *See, e.g.*, Bork, *Vertical Integration and the Sherman Act: The Legal History of an Economic Misconception*, 22 U. CHI. L. REV. 157, 171-72, 196-99 (1954). The instant case of an HMO that might use its hospital monopoly to drive out competing HMOs and fee-for-service physicians falls within this (or a related) exception. Although not all services rendered by independent physicians and HMOs involve hospital care, availability of such care at a reasonable price is necessary to their survival. If a hospital-sponsored HMO squeezed all of its competitors out of the market, it would thereby somewhat increase the sum of its power, thereafter being able to earn monopoly profits on physicians', laboratory, x-ray, and other outpatient services previously rendered competitively.

The situation can also be recast as a "tying" problem by visualizing the hospital's refusal to accept patients except by referral from its own HMO, which refusal would be little different from charging a prohibitive price to patients of the HMO's competitors. Although the usual analysis again recognizes few occasions in which it is possible to increase monopoly power by tying, monopolization of the business of rendering primary care through such a tie-in could expand the hospital's monopoly power. *See* Bowman, *Tying Arrangements and the Leverage Problem*, 67 YALE L.J. 19, 25-27 (1957).

[127] On the remedies available and the problems with their administration, see KAYSEN & TURNER, *supra* note 122, at 125-27; EDWARDS, *supra* note 122, at 171-75.

[128] N.Y. PUB. HEALTH LAW §§ 2803, 2807 (McKinney Supp. 1970).

[129] *See* Priest, *Possible Adaptation of Public Utility Concepts in the Health Care Field*, in this symposium, p. 839.

[130] Posner, *Natural Monopoly and Its Regulation*, 21 STAN. L. REV. 548 (1969). *See also* related articles by Comanor, Swidler, Shepherd, and Posner, in 22 STAN. L. REV. 510 *et seq.* (1970).

against the future, quality of service. This chronic deficiency in regulatory performance is a particularly ill omen in the health field,[131] and it is certainly doubtful that outside accrediting agencies and other supervisory mechanisms would be able to sustain the quality of care in a hospital that is deprived of adequate funds.[132]

Another problem generated by rate regulation is the reduction in the incentive to achieve efficiency.[133] If regulation were able to achieve its theoretical objective and could effectively limit the regulated firm's profits to a predetermined rate of return on invested capital, there would be practically no incentive for the firm to reduce costs. But fortunately, and perhaps ironically, regulation's own inefficiency makes it possible for regulated concerns to enjoy at least temporarily the fruits of improved efficiency. Thus, because of so-called "regulatory lag," reflecting inertia and the time necessary for discovery and negotiation or litigation of a rate reduction, a firm that outperforms predictions of its profitability is not immediately subject to a cutback in rates. This factor, combined with some regulators' willingness to recognize a "zone of reasonableness" in rate of return—that is, to allow some increases in profit rates above the original target rate without intervention—,[134] suggests that efficiency incentives have not been altogether eliminated although they have been reduced. Given the vast inefficiencies known to exist in hospital management, it is fair to ask whether *any* weakening of the incentives to seek and achieve efficiencies would be wise.[135]

Of course, because hospitals are largely nonprofit institutions, many of the normal economic assumptions do not hold. Perhaps my main reason for speaking as if they do is that the natural-monopoly argument for hospital regulation seems likewise to proceed from such assumptions. But monopoly profits earned by a nonprofit institution at consumers' expense are not plainly objectionable from a social

[131] One possible answer to the argument that effective rate regulation could not guarantee, and indeed might undermine, the quality of hospital care is that the regulators should be liberal. But that course represents an invitation to "gold-plating" and overinvestment in capital goods, a danger which exists in the regulated sector even when liberality is not an express goal. *See* Averch & Johnson, *Behavior of the Firm Under Regulatory Constraint*, 52 AM. ECON. REV. 1052 (1962); Baumol & Klevorick, *Input Choices and Rate of Return Regulation: An Overview of the Discussion*, 1 BELL J. ECON. & MANAGEMENT SCI. 162 (1970); Posner, *supra* note 130, at 599-601. There is already a widely deplored tendency to excessive and uncoordinated investment in hospitals, attributable in large part to excessive discretion residing in decision makers. *See* notes 98-100 *supra* and accompanying text. Rate-of-return regulation, which also allows excessive room for maximization of managers' welfare at the expense of efficiency, Posner, *supra*, at 601-03, would do little to correct these influences and might play into their hands. Conceivably avoidance of rate-of-return regulation and substitution of comprehensive planning and of rate regulation based on "financial requirements," as tentatively recommended by Professor Priest, *supra* note 129, at 845-47, could avoid some of these particular traps.

[132] *Cf.* Worthington & Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW & CONTEMP. PROB. 305 (1970).

[133] *See* Posner, *supra* note 130, at 597-606.

[134] The "zone of reasonableness" seems an eminently sensible notion until it is realized that a firm approaching its upper boundary has not merely no incentive to seek but a positive incentive to *avoid* further efficiencies that might push it over the top, prompting a return to the lowest reasonable rate. One can only hope that managers lack the means of exercising such subtle control over profits.

[135] Rate setting on the basis of "financial requirements," looking in large measure to costs, *see* Priest, *supra* note 129, at 845-47, would appear to offer no stronger cost-cutting incentives.

standpoint since they are not redistributed to wealthy investors but are retained in the service of the enterprise, whose purposes are presumptively of general public benefit.[186] Indeed, such wealth-redistributive effects of hospital monopoly as can be identified favor the poor, since it is only the more affluent who are paying more than the cost of the service they receive. Moreover, the public has been dependent on hospital monopolies for a long time to generate the funds needed to provide care for the indigent.[187]

Since enrichment of the monopolist is not likely to be the concern that justifies hospital regulation, it must be that efficiency concerns, stemming from the notion that monopolists—particularly nonprofit ones—are inherently lazy and wasteful, are foremost.[188] I have already expressed my doubts that familiar forms of rate regulation are likely to induce efficiency. Perhaps, however, a loose kind of regulation on the basis of classification of hospitals and comparison of rates within each class might be instituted;[189] receivership of conspicuously inefficient hospitals might then be employed as a sanction against their managements, who, after all, are the people whose self-interest must ultimately be either threatened or appealed to.

Whatever one may think of the foregoing arguments against the regulation of hospital charges, it is easily demonstrable that no kind of regulation can deal adequately with the problem of the hospital-sponsored HMO. The problem is a fairly common one in regulated industries and can be illustrated by a recent rule-making decision by the Federal Communications Commission.[140] The issue was the right of communications common carriers to offer data processing services to the general public. The difficulty lay, first, in the fact that data processing requires the use of telephone or telegraph lines and, second, in the fears of data firms that communications carriers entering the data processing industry would have an advantage because the regulated end of the business might subsidize the unregulated portion; such subsidization could be accomplished either by providing personnel, facilities, or services at less than cost or by purchasing data services at a favorable price. The danger, of course, was that the monopoly of communications services, even though regulated, could be used to create a monopoly in data processing. The FCC dealt with the problem by ordering "maximum separation," the creation of a rigid barrier between the carrier and its data processing activities. It required that a separate subsidiary be established, that it maintain separate books, offices, and

[186] Of course, although I know of no reason to think there have been serious abuses, high salaries and perquisites and payments to enterprises affiliated with trustees or administrators do offer opportunities for diverting profits from public use. Possibly an affiliated HMO would greatly expand opportunities for diverting the nonprofit hospital's earnings into private hands through imaginative bookkeeping, salaries, profit-sharing, and strategic patient referrals.

[187] *See* note 151 *infra*.

[188] *See* Legislative Findings and Purpose, *supra* note 98.

[189] *Cf.* Lave & Lave, The Extent of Role Differentiation Among Hospitals, 1970 (working paper, Graduate School of Industrial Administration, Carnegie-Mellon University).

[140] Regulatory and Policy Problems Presented by the Interdependence of Computer and Communication Services and Facilities (Final Decision and Order), No. 16979 (F.C.C., Mar. 18, 1971), in 21 P & F RADIO REG. 2d 1591 (1971).

personnel, and that the carrier not purchase any data services from the subsidiary or engage in any transactions with it other than the sale of communications services at published rates and on a nonpreferential basis. The decision amounted to a confession that no amount of regulatory supervision of bookkeeping or of the nature, purpose, or price of intracorporate transactions could assure that the regulated monopoly was not in some way subsidizing the unregulated portion of the enterprise.

Of course, the FCC might have barred the carriers entirely from entering the data processing business. Its decision not to do so was based on a sense that the data processing field might benefit from the entry of the carriers as a new competitive force with unusual technological capabilities,[141] but the ruling prevents realization of some potential economies which the carriers would have been capable of achieving through integration of functions.[142] The lesson for handling the problem of hospital-connected HMOs seems to be that regulation of one segment does not allay the apprehension that the regulated arm of the enterprise might subsidize the unregulated arm, by allowing customers of the former to bear some hidden expenses of the latter or by other means. Total separation, along the lines ordered by the FCC, seems in no way preferable to a complete prohibition of HMO formation by monopolistic hospitals, and the latter choice, even at the sacrifice of significant economies, would seem a possible solution.[143] This remedy would of course be available whether or not the hospital was regulated, and it would be expedient only in communities where a powerful hospital monopoly existed and, because of the market's characteristics, could not be broken up. In no event could cost accounting be depended upon to protect the public from possible abuse since it could not supply the precision necessary to police transactions and joint-cost allocations between a hospital and its captive HMO.

One possible policy toward the possibility that a "natural" hospital monopoly could be extended into the market for primary health care would be to take no immediate action, on the ground that the problem's dimensions cannot be adequately anticipated at this time. Perhaps, with clarification of the interstate commerce point, the antitrust rule against predatory behavior could be relied upon to protect against serious abuses, and many monopolistic hospitals, being nonprofit enterprises, might abjure aggressive competition and allow other providers to coexist. Those tempted to achieve domination would be faced not only with antitrust risks but with the threat of regulation by their local communities if consumers came to feel that they were being exploited and denied the full benefits of HMO care. The relative ease

[141] *Id.* para. 11.

[142] *Id.* paras. 13, 15.

[143] The following opinion on the appropriate antitrust remedy in specific cases is applicable as well to the formulation of a general policy where this class of problem is presented: "There will be at least some cases where horizontal dissolution is not feasible but where vertical dismemberment is, and the superiority of such relief to injunctive remedies—even for the victim—warrants that it be used." KAYSEN & TURNER, *supra* note 122, at 126.

of entry into fee-for-service medicine would impose some restraint, although solo practitioners' higher costs, their reluctance to advertise and to compete on the basis of price, and the HMO's established contractual relationships with its enrollees would dilute this influence. Although somewhat inhibited by vulnerability to the squeeze, potential new entry by an HMO—perhaps stimulated by large employers or consumer groups—would prevent the hospital-affiliated HMO from exploiting its position very far. Finally, the competitive impact of other HMOs on the fringes of the market area would seldom be negligible.

Looked at in another way, however, the problem is somewhat different and substantially more serious than we have yet observed, and it therefore requires a better solution than any of those canvassed above. The source of the additional difficulty lies in the likely domination of community hospitals by the local medical society and physicians dedicated to the preservation of fee-for-service medicine. Traditionally, these hospitals, while nonprofit and often community-owned, are effectively controlled by local physicians and operated largely for their convenience and profit. An HMO established under such domination, far from being an overly aggressive competitor abusing competing HMOs and fee-for-service physicians alike, might instead be enlisted to protect the fee-for-service sector against the encroachment of HMO-type care. In pursuing this objective, it would preempt subscribers, making them unavailable as converts to other HMOs during the term of their contracts, and would serve generally as a "fighting ship," defending against HMO invasion threats by occasional price warfare[144] but otherwise not aggressively developing the potentialities of HMO-type care as a substitute for fee-for-service medicine. The likely pattern would be that local physicians would recommend the hospital-sponsored HMO, would accept referrals only from it, and would use other sanctions of a more or less overt character against physicians and patients associating with new HMO entrants. The hospital-sponsored HMO would probably be designed primarily to serve a low-income clientele, relieving practitioners of their charity burden but leaving unimpaired their opportunities for practicing price-discriminating fee-for-service medicine among the middle and upper classes.

The thrust of our problem is thus abruptly changed. We are no longer worried primarily about HMOs' monopolistic potential but about the indestructibility of the fee-for-service monopoly and its ability to adapt to new environments by invoking

[144] The "fighting ship" analogy, drawn from the history of ocean shipping conferences (cartels), can be seen in the following:

> "The crudest form of predatory practice was the fighting ship. The conference would select a suitable steamer from among its lines to sail on the same days and between the same ports as the non-member vessel, reducing the regular rates low enough to capture the trade from the outsider. The expenses and losses from the lower rates were shared by the members of the conference. The competitor by this means was caused to exhaust its resources and withdraw from competition."

Federal Maritime Bd. v. Isbrandtsen Co., Inc., 356 U.S. 481, 488 (1958). Shipping conferences, like medical societies, are combinations of competitors interested in the exclusion of noncooperating providers of the service. Monopolists of other kinds have on occasion used "fighting brands" to similar effect.

the profession's control over many of the inputs needed for effective competition and its remarkable ability to police itself. In this new light, the issue becomes joined with that presented by those existing prepayment plans (mostly not hospital-connected) which have been sponsored by medical societies in many communities as a means of reducing the threat of independent entry by prepaid group practice plans. These plans and their legal status are the next subject for discussion, and my final solution to the issue of hospital-sponsored HMOs will be offered as part of an attempt to resolve the larger problem of medical societies' power to inhibit new entry into local markets.

B. The Risk of Subversion by Local Medical Societies

The ability of the medical profession to enforce its preferences as to the organization of the medical care industry has been impressive. The welding of so large a number of economic units into a stable and effective organization to repress competitive tendencies has been accomplished by a variety of customs and devices that could not be easily uprooted or dismantled even if the will to do so could be found.[145] Even assuming that pro-HMO legislation emerges intact from the legislative process without emasculating amendments—such as proscription of for-profit plans—, policy makers must be alert to the danger that realization of the HMO's potential by a fair test in a free market might be somehow prevented by doctors. It is my belief that the antitrust laws, if allowed to operate with accustomed force, could provide much of the needed protection.

The greater threat to realization of the hopes underlying the HMO proposals is presented not by the American Medical Association but instead by state and county medical societies or even by small groups of powerful doctors who occupy strategic positions on hospital boards and in the societies. In *Group Health Cooperative v. King County Medical Society*,[146] decided by the Supreme Court of the State of Washington in 1951, the county medical society claimed to be enforcing "ethical" standards higher than those of the AMA against the Cooperative's prepaid group practice plan, and the court's discussion reflects credit, by comparison at least, on the AMA for its less restrictive policies. Since the AMA was somewhat earlier convicted of antitrust violations in its activities in opposition to Group Health Association, Inc., in Washington, D. C.,[147] the antitrust laws may have contributed something to its moderation of attitude.[148]

[145] *See* references cited in note 65 *supra*.

[146] 39 Wash. 2d 586, 237 P.2d 737 (1951).

[147] American Medical Ass'n v. United States, 317 U.S. 519 (1943).

[148] I do not mean to express an opinion as to whether the AMA is complying with the antitrust laws at the present time. My point is rather that the local societies and local professionals often take the initiative in the skirmishing, are so deployed as to be tactically effective, but have lagged behind the AMA in falling back to positions that would be at least arguably defensible in an encounter with the antitrust laws. The AMA's public position on HMOs is a sort of unconvinced tolerance, acceptance of a need for a pluralistic system, and opposition only to government favoritism and subsidies for one delivery mode at the expense of others. *See* DIVISION OF MEDICAL PRACTICE, note 43 *supra*.

Many of the tactics employed by local societies to disadvantage HMO-type care are clearly illegal by federal antitrust standards and would probably be held so if interstate commerce was found to be adequately affected. Some state courts have applied state antimonopoly legislation or other sanctions to restrain such activity. Thus, the practice of refusing medical society membership or hospital staff privileges to HMO-affiliated doctors has been disapproved,[149] and other concerted activities of local professionals undertaken for the purpose of discouraging HMOs would probably be treated similarly by most courts.[150] My concern here is with less overt strategies that the societies might adopt in opposition to HMOs.

Each fee-for-service doctor has a substantial amount of monopoly power over his individual patients as a result of their medical ignorance and dependency and their willingness to pay. Medical societies can thus be viewed as coalitions of monopolists whose purposes in coming together include protection and strengthening of their individual market power. This view explains why the medical societies behave somewhat differently than do classical cartels, not bothering to fix prices or to make overt anticompetitive agreements; not facing intense competition to begin with, they have no need to collude to eliminate it and can be content merely to preserve the status quo. In a sense, of course, the societies engage in market division—a common cartel practice—by enforcement of ethical undertakings not to advertise their services or to criticize their competitors, in effect recognizing each doctor's "sphere of influence" over his particular patients. A further parallel to the activities of other cartels is reflected in the societies' commitment to preservation of a particular, highly discriminatory[151] pricing system—fee-for-service.[152]

The power of a coalition of lawful monopolies may be greater than the sum of its

[149] Group Health Cooperative v. King County Medical Soc'y, 39 Wash. 2d 586, 237 P.2d 737 (1951). New York has by statute prohibited the denial of hospital privileges because of participation in a group practice plan. N.Y. PUB. HEALTH LAW § 206-a (McKinney Supp. 1970).

[150] Apart from the antitrust implications, courts may be willing to find a denial of equal protection on the basis of an arbitrary classification when the hospital denying privileges to HMO-affiliated physicians receives state funds. *Cf.* Sams v. Ohio Valley Gen. Hosp. Ass'n, 413 F.2d 826 (4th Cir. 1969).

[151] Price discrimination in medicine involves charging different prices for the same service, usually on the basis of ability to pay. *See generally* Kessel, *supra* note 70. *See also* notes 84 *supra* & 159 *infra*. The presence of such discrimination proves the absence of effective competition since competing providers would drive each other to price uniformly in accordance with cost or the physician's supply function. Health insurance and prepaid group practice reduce the discrimination possibilities and have thus been opposed by the profession except as a means of providing for low-income persons, whom they make better able to pay. *See* Kessel, *supra*. The popular justification for such price discrimination was that it permitted free care for the indigent and made care available irrespective of wealth. As health insurance covers more people and as government pays more and more of the cost of care for the elderly and the poor, this justification, whatever it was once worth, fades. *But see* note 84 *supra*.

[152] Maintenance of a particular pricing system seems often to characterize the stabler form of cartel. For helpful comparisons, see FTC v. Cement Institute, 333 U.S. 683 (1948) ("basing-point" pricing, which produced complete price uniformity, irrespective of freight differentials, from all sellers to each buyer, making shopping and bargaining unproductive); United States v. Paramount Pictures, Inc., 334 U.S. 131 (1948) (motion picture distributors' efforts to preserve a particular system of "runs and clearances"); Securities Exchange Act Release No. 8239 (1968) (describing the New York Stock Exchange's long battle to repress cost-justified quantity discounts and "give-ups" on brokerage services).

parts.[153] Thus a medical society can preserve and strengthen the market power of each physician-monopolist by enforcing mutual recognition of spheres of influence, by collective maintenance of the conditions giving rise to such power—such as consumer ignorance and inability to combine for bargaining effectiveness—, by influencing legislation, by collective opposition to forms of health care financing and delivery that would weaken individual monopolies, and perhaps even by controlling members' exploitation of their individual monopolies so as to reduce the likelihood of government intervention or new entry. Where certain of these purposes appear,[154] the coalition may be open to attack either as monopolization under section 2 of the Sherman Act or as a "combination . . . in restraint of trade" under section 1.[155]

An important defensive tactic employed by the medical profession has been the organization by state and local medical societies of their own prepayment plans. In the 1930s and 1940s, following the example of Blue Cross hospitalization plans, the profession established Blue Shield, a series of state and local physician-dominated service and indemnity plans covering physicians' services primarily.[156] More recently a movement has begun toward creation of society-sponsored "medical care foundations," which are prepaid service organizations whose chief distinguishing characteristic is that they provide intensive peer review of fees and utilization as a means of controlling health insurance costs.[157] Blue Shield reflected the profession's early recognition that avoidance of government intervention in the health care system required, first of all, an available insurance mechanism whereby consumers could obtain financial protection against the risk of illness. It was an attempt to meet that need in the manner least disruptive of the valued relationship between the physician-monopolist and his patients, since independent insurers, representing a vehicle of pro-consumer bargaining, were seen as excessively inclined to police fees

[153] In United States v. Grinnell Corp., 384 U.S. 563 (1966), it was held to be monopolization to join together firms controlling 87% of "accredited central station protective service," a business having distinct natural monopoly characteristics at the local level. The Supreme Court's analysis was not satisfying, but the result is easily defensible by observing that the local monopolies were greatly strengthened by eliminating competition along the margin of market areas and the threat of new entry in expanding markets.

[154] The societies' efforts to obtain protective legislation or administrative action cannot be made the subject of antitrust action. *Cf.* Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127 (1961).

[155] 15 U.S.C. §§ 1, 2 (1964).

[156] *See, e.g.*, H. SOMERS & A. SOMERS, DOCTORS, PATIENTS & HEALTH INSURANCE 317-40 (1961).

[157] *See* Sasuly & Hopkins, *A Medical Society-sponsored Comprehensive Medical Care Plan*, 5 MED. CARE 234 (1967); Note, *supra* note 7, at 919-21; Comment, *supra* note 65, at 992-94; Am. Med. News, Aug. 10, 1970, at 8. The foundations are in fact a species of HMO, but they resemble physician-sponsored health insurance somewhat more than provider prepayment. The society in effect accepts prepaid memberships which entitle enrollees to obtain care from any society member or other participating doctor, who in turn bills the society on a fee-for-service basis. The only departure from ordinary health insurance is the society's oversight of utilization, fees, and quality of care, which is typically more intensive than the review of claims by insurers. Some foundations are underwritten by insurance companies, and some in California have accepted capitation payments from the state for Medicaid beneficiaries. The plans offer no substantial opportunity for reorganizing the delivery system in more efficient ways, and indeed "they are intended to buttress and accommodate the traditional forms of medical practice in a time of change." Sasuly & Hopkins, *supra*, at 234.

and to second-guess the need for service. The medical care foundations represent, in part at least, a further response to the same fears and conditions, being prompted by the increasingly recognized need for some control—preferably administered in the collective interest of physicians rather than of patients—over those abuses of the insurance system that tend to inflate its cost. More immediately, the foundation plans have often been linked to specific fears about the encroachment of prepaid group practice plans in the medical society's territory.[158]

If society-sponsored prepayment plans could be viewed merely as an attempt to improve the service and performance of the insured-fee-for-service sector,[159] they would present no antitrust problem. Even seen as an attempt to head off consumer coalitions for bargaining, the society plans might be deemed objectionable only if they actively prevented such coalitions from forming, and perhaps a distinction would be drawn between collective action merely removing the abuses inviting consumer coalitions and collective action to create obstacles to coalition formation. In any event, collective efforts preemptive of market opportunities for agencies likely to represent consumer interests, where undertaken with exclusionary intent, would seem promising candidates for a firm antitrust prohibition.

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[158] A study of the Foundation for Medical Care of San Joaquin County, California, revealed that the impetus behind the formation of that foundation plan was physician concern over "the rapidly rising prices of health care services and the rise of new kinds of health care organization. Viewed as a particularly troublesome problem was the growth in California of the Permanente medical group, providing service for the Kaiser Foundation Health Plan." Sasuly & Hopkins, *supra* note 157, at 235. *See also* Am. Med. News, Aug. 10, 1970, p. 8, 9, col. 1: "At issue, the physicians thought, was the control of the private practice of medicine by physicians. The 'threat' was the proposed establishment of 'closed panel' systems of medicine in hospital-based group practices. Physicians on salary would be a reality." For further evidence of the purpose behind formation of society-sponsored plans, see notes 159 & 163 *infra*.

[159] Where they have been able to get away with it, society-sponsored plans have practiced price discrimination. *See generally* notes 84 & 151 *supra*. This fact and the profession's interest in preserving its ability to price according to ability to pay are revealed in this 1952 statement by a former president of the New York County Medical Society:

> "Too many physicians . . . seem still to think that a medical society should be organized solely for scientific purposes and medical education and that it should not consider and act upon the economic and ethical problems that arise . . . [W]ith health insurance plans accepting persons with incomes of $6,500 and over, private practice with free choice of physician is being destroyed . . .
>
> "Blue Shield and similar [doctor-controlled] plans should widen their coverage. The private practitioner must cooperate and be willing to accept lower fees. Medical coverage cost must be made more reasonable for the lower and middle income groups. That this can be done to full satisfaction of patient and physician alike is exemplified by the Windsor plan. The Windsor Medical Services, of Windsor, Ontario, Canada, a voluntary, nonprofit, prepaid medical care plan sponsored by the Essex County Medical Society . . . is a comprehensive insurance plan in which more than 95% of the physicians in [the] Society participate. The physicians are paid on a fixed schedule of fees. The monthly subscription rate varies, according to income, from a single subscriber earning $300 or less to the family subscriber earning $6,500 or less. . . . The successful plan shows what prepaid fee for service could do. That is what Blue Shield should strive for. Compulsory health insurance will then be prevented."

Master, *Impact of Medical Care Plans on the Medical Profession*, 150 J.A.M.A. 766, 770 (1952) (footnotes omitted). *See also* Kessel, *supra* note 70, at 53, which notes that in California, "[i]n an effort to meet this competition [from the Kaiser plan], service-type plans have been offered by orthodox members of the medical profession that are non-discriminatory with respect to income."

In *United States v. Oregon State Medical Society*,[160] the Supreme Court affirmed the lower court's dismissal of the government's charge that a plan of the Blue Shield variety violated the Sherman Act. The plan, the Oregon Physicians' Service, was adopted by the medical society in response to the encroachment of health insurance and other prepayment plans in the state. After noting that before 1941 the society had engaged in a "tooth-and-claw struggle" and "a crusade to stamp . . . out" the prepayment plans, the Court noted that an "abrupt about-face" occurred in that year and that the doctors, "instead of trying to discourage prepaid medical service, decided to render it on a nonprofit basis themselves" through a society-sponsored plan.[161] Because the lower court had found as a fact that the medical society had undergone a change of heart, the Supreme Court had no basis for treating the plan as an exclusionary tactic. Moreover, the Court's description of the two kinds of "contract practice" against which the society-sponsored plan was directed indicated that they were not of the sort that could be successfully excluded from the market by the society's plan.[162] They were merely simple insurance schemes and employers' plans providing care in kind to their employees. Since, unlike an HMO, neither type of plan is dependent on attracting some minimum number of subscribers in a community but can instead depend upon individual physicians devoting some part of their time to treating plan members, the Court did not view the case as one in which the society's plan had any exclusionary or monopolistic effect.[163] If a preemptive or exclusionary purpose or effect of the society-sponsored plans vis-à-vis independent HMOs can be identified, the *Oregon Medical Society* case should not be a barrier to adoption of an antitrust rule condemning them.

I elect not to pursue the antitrust status of Blue Shield plans any further here.[164]

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[160] 343 U.S. 326 (1952).

[161] *Id.* at 329-30.

[162] *Id.* at 328. There were in fact, according to the trial court's findings, some HMO-type plans in existence in Oregon, including one of the Kaiser-Permanente groups. 95 F. Supp. 103, 114 (D. Ore. 1950). Nevertheless, the government failed to indicate any particular effectiveness of the society-sponsored plan in excluding this variety of prepayment plan.

[163] The record clearly revealed that the society plans were conceived for the purpose of eliminating existing insurance plans. *See* Brief for the United States at 25-29, 36-41. Several plans were driven out of Oregon, but this result may have appeard to flow only from fair competition. The government did not strongly assert that Oregon Physicians' Service was itself illegal, but instead relied on exclusionary practices and an alleged boycott.

[164] Under the federal McCarran-Ferguson Act, the business of insurance is subject to the antitrust laws only "to the extent that such business is not regulated by State law," except that the Sherman Act would apply to "boycott, coercion, or intimidation." 15 U.S.C. §§ 1012(b), 1013(b) (1964). If the society-sponsored prepayment plan were regulated as an insurer, as Blue Shield usually is, it might be entitled to claim this exemption. This is not perfectly clear, however, since the federal rather than the state definition of "the business of insurance" will govern, SEC v. National Securities, Inc., 393 U.S. 453, 458-61 (1969), and group practice prepayment plans have been held by the federal courts not to be insurance for other purposes. Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939) (applying the D.C. Code). Moreover, in California, a society-sponsored prepayment plan of the Blue Shield variety was not deemed to be engaged in the insurance business so as to be subject to insurance regulation. California Physicians' Service v. Garrison, 28 Cal. 2d 790, 172 P.2d 4 (1946). Aside from their delegated plenary authority respecting "the business of insurance," the states cannot by regulation or statutory authorization insulate society-sponsored plans from the antitrust laws *if* federal policy can

For one thing, the *Oregon Medical Society* case indicates that they do not in themselves have a serious exclusionary effect although the surrounding conduct deserves close scrutiny. Moreover, while they do preempt many employer-sponsored groups and thereby help to foreclose HMO entry, they are no worse in this respect than independent insurers, and they must compete for this business on a cost basis with such insurers as well as with HMOs. Introduction of an unrestricted HMO option for all members of employer-sponsored groups would eliminate all market foreclosure effects as to HMOs (a result that might also be accomplished by an antitrust decree if an occasion were presented). Although I do not wish to concede that the antitrust laws are inapplicable to Blue Shield, I am avoiding the issue because I doubt that Blue Shield alone poses a very substantial obstacle to emergence of a satisfactorily competitive health care marketplace.

My reasons for objecting to the medical care foundations more than I do to Blue Shield are the same reasons that one should fear an efficient and subtle monopolist more than a lazy and obvious one: the latter will soon lose its monopoly to new entrants—assuming they are not excluded by law or otherwise—, whereas the former may find sophisticated and highly effective means to ward off new competition. The foundations, properly viewed, are a mechanism for curbing the excesses of some cartel members for the purpose of preserving the cartelists' respective monopolies and profits against government attack and new competition. While they may in fact succeed in lowering health care costs, they will not duplicate the results of maintaining a competitive market. Instead, they will seek an entry-limiting price level which, though responsive in fact to potential HMO competition, will not be a competitive level. Of course, if there is to be no commitment to a market-oriented health care system, then the foundations may have a beneficial impact and should be tolerated or even encouraged,[165] but, under my procompetitive premise, they should be recognized as part of a profit-maximizing strategy of a coalition of monopolists. As such, they may be open to antitrust attack.[166]

A difficult question is presented concerning whether establishment of a foundation might be treated as an "exclusionary practice" for purposes of applying section

fairly be said to preempt the field. *Cf.* Sears Roebuck & Co. v. Stiffel Co., 376 U.S. 225 (1964). ***But see*** the line of cases commencing with Parker v. Brown, 317 U.S. 341 (1943).

[165] The foundations have attracted a good deal of attention and are generating some enthusiasm among reformers. The Nixon administration specifically amended its definition of "HMO" to clarify that foundations could qualify. *Compare* H.R. 1, § 239(a), proposed § 1876(b)(3), *with* S. 1623, § 101, proposed § 604(a)(3); *id.* § 201, proposed § 628(b)(3). The Kennedy-Griffiths bill, § 48, also endorses the foundation concept.

[166] The foundations may be held exempt from federal antitrust law either because they are deemed to be engaged in the "business of insurance" and regulated by the state or because the state has authorized their activities. *See* note 164 *supra*. State laws authorizing *only* society-sponsored or society-approved plans might, for example, be given such an effect. *E.g.*, GA. CODE ANN. tit. 56, § 56-1806 (1960); IOWA CODE ANN. § 514.4 (Supp. 1970); KY. REV. STAT. § 303.180 (1962); REV. CODES MONT. 1947, § 15-2304 (repl. vol. 2 (pt. 1), 1967); NEV. REV. STAT. § 696.100 (1963). By the same token federal legislation revealing a preference for a competitive health care marketplace would improve the chances that antitrust policy would be deemed paramount. ***But see*** note 165 *supra*, which indicates the foundations may receive an express Congressional blessing.

2 of the Sherman Act, which requires only proof that a monopoly exists and that it has been obtained or protected by such an exclusionary practice. By this doctrine, a monopolist is denied the right to engage in certain kinds of conduct that would be wholly innocuous, or even indeed desirable, if undertaken by a competitive firm. Thus, in the two leading cases on the subject, Alcoa was held to have violated section 2 by the simple act of enlarging its productive capacity to keep ahead of the market's growth,[167] and United Shoe Machinery Corporation was found to have defended its monopoly unlawfully by the nonpredatory tactic of leasing rather than selling its machines.[168] Although it is an interesting question whether a monopolist who simply moderated his pricing policies to discourage new entry would be held to have engaged in an exclusionary practice for the purpose of applying section 2, it is reasonable to assume that he would not. Since a foundation plan does little more than control the abuses that some physicians might perpetrate against the insurance system with respect to utilization and fees, it can be said to be doing nothing more than moderating monopolistic behavior, and this conduct, while exclusionary in fact and restrictive of competition in the long run, may not be enough to make out a section 2 case. Perhaps the real objection lies in the collective nature of the effort being made, and this suggests that it may be more appropriate to pursue the matter as a combination in restraint of trade under section 1.

Taking the society-sponsored foundations briefly through the standard section 1 analysis,[169] I find that a "per se" antitrust rule, requiring no specific showing by the plaintiff of anticompetitive purpose or effect and permitting no justification to be offered in defense, might well be appropriate to condemn them. Looking first to the possible benefits that foundation plans might yield, I expect that the highly desirable controls on fee-for-service physicians[170] could probably be introduced in an equally effective but much less troubling way—namely by independent health insurers, acting ultimately on behalf of consumers but perhaps working in close cooperation with organizations of fee-for-service doctors interested in policing their colleagues for the purpose of reducing health insurance premiums.[171] If this less

[167] United States v. Aluminum Co. of America, 148 F.2d 416 (1945).

[168] United States v. United Shoe Mach. Co., 110 F. Supp. 295 (D. Mass. 1953), *aff'd per curiam*, 347 U.S. 521 (1954).

[169] *See* P. AREEDA, ANTITRUST ANALYSIS 286-87 (1967).

[170] On the efficacy of these controls see F. GARTSIDE, THE UTILIZATION AND COSTS OF SERVICES IN THE SAN JOAQUIN PREPAYMENT PROJECT (UCLA School of Public Health 1971).

[171] At a later point I discuss the need for fee-for-service doctors to police each other in order to make themselves competitive, *i.e.*, to make health insurance premiums attractive as compared to HMO charges. *See* text accompanying note 232 *infra*. Although the foundation plans might seem a good vehicle for accomplishing this needed control over charges and utilization, it is preferable to retain health insurers as intermediaries. For one thing, I would fear the societies' attempts to assert jurisdiction over the charges of all providers, including HMOs, a goal already announced. Am. Med. News, Aug. 10, 1970, p. 8, 15. Furthermore, independent insurance companies would be more likely to dedicate themselves to stimulating some kind of price competition in the fee-for-service sector as a means of reducing premiums and thereby maximizing health insurance sales; a cartel of fee-for-service providers—such as Blue Cross or Blue Shield—would seek price reductions only to that level where monopoly profits would be maximized, resulting in a lower output of fee-for-service medicine. Of course, insurers might find safe and useful ways to enlist the medical societies in the reviewing process.

restrictive alternative is indeed available, a court should not count the obvious benefits very heavily in weighing the plans' validity.

On the potential detriment side of the ledger, the threat to the public interest is considerable. The plans purport to regulate prices to a substantial degree, at least to the extent of setting limits on the fees that can be charged. Although the case law prohibiting the fixing of maximum prices is not terribly convincing on its face,[172] it would almost certainly be binding in these circumstances. Indeed, a much stronger case can be made against the fixing of maximum prices here, not only because the maximum price would almost certainly also become the minimum—as physicians would have no incentive to charge less than the maximum permitted—, but also because the purpose is to set prices not at a competitive level but merely at a level that will reduce the likelihood of entry and therefore restrict competition in the long run. The entry barrier created by the foundation plans' contractual preemption of employer-sponsored groups and other prospective HMO subscribers provides another strong objection to the plan.[173] Finally, although an occasional society plan might be helpful as a counterweight to a monopolistic HMO or as a means of checking the excesses of certain greedy fee-for-service doctors, these benefits would be hard for a court to identify in a given case or to weigh against specific identified harms, since it would seldom be possible to know what would have happened in the plan's absence. In such circumstances, a flat prohibition cutting off an activity with clear anticompetitive tendencies may be appropriate in spite of arguable benefits, and such a prohibition would serve the additional salutary purpose in this instance of not inviting societies to push right up to the line of whatever narrow exception might be carved out. The simplification of enforcement and discouragement of conduct that is at least highly questionable are substantial benefits that would flow from a per se rule.

A per se rule should probably not be adopted without a full judicial inquiry into the nature and functioning of foundation plans,[174] and the outcome of such an inquiry is not easy to predict. Departures from the foregoing analysis are possible at several points. First, the utilization and fee review might be deemed a permissible "ancillary" restraint, a reasonable incident of running a prepayment plan the legitimacy of which might be deemed supported by the *Oregon Medical Society* case, state Blue Shield statutes, and general public policy.[175] Second, the fee review

[172] *See* Albrecht v. Herald Co., 390 U.S. 145 (1968); Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc., 340 U.S. 211 (1951). Both cases involved so-called vertical restraints whereby a seller sought to limit the resale prices of his retailer-customers. The illegality of a horizontal restraint on maximum prices would seem to follow a fortiori. The elements of coercion, of assumed extragovernmental power, and restriction on "the freedom of traders," *id.* at 213, are the same in either case.

[173] I suspect that market preemption, rather than real concern with fees and utilization, is the chief object in forming a foundation. In the San Joaquin situation, where a defensive purpose was uppermost, *see* note 158 *supra*, perception of the foundation's defensive effectiveness must have been based on the society's ability immediately to sign up employers who might otherwise welcome or even solicit Kaiser's entry. Intent plays a major role in antitrust outcomes.

[174] *Cf.* White Motor Co. v. United States, 372 U.S. 253 (1963).

[175] *Cf.* Addyston Pipe & Steel Co. v. United States, 85 Fed. 271 (6th Cir. 1898). I find this far

program might be viewed as something other than price fixing,[176] and the adoption of entry-limiting pricing and utilization policies might be somehow viewed as a legitimate collective endeavor, perhaps by analogy to the monopolization argument noted above. Third, the beneficial controls over fee-for-service medicine might be held not to be achievable by other means that did not produce dangers of "lay interference," and, finally, perhaps the plans would be found not to inhibit HMO development in fact.[177] An antitrust court, hearing the enthusiasm of the many eminent physicians and other witnesses that could be produced on behalf of the foundation plans, would in any event have to possess remarkable clarity of vision to see their less appealing side. Perhaps few judges, or other observers for that matter, will be uncompromising enough to share my view that, on the basis of past history, doubts should be resolved against continued domination of health care delivery by organized medicine.

Upon a complete inquiry an antitrust court might reject the per se rule in favor of approaching each society-sponsored plan under what antitrust lawyers denominate the "rule of reason." Under this approach the facts of each case are considered in detail, the courts relying on the ability of enforcement agencies to detect, of evidence to reveal, and of judges to recognize the existence of abuses when they do in fact occur. Many trade association activities of a standard-setting variety have been evaluated and tolerated under such a rule-of-reason approach,[178] and this case might be deemed to fall closest to these precedents. Still, courts have erred egregiously on some occasions,[179] and have so far been inexplicably reluctant to impose the

and away the best argument for upholding the foundations. Properly, it requires an assessment of whether public policy should or should not encourage medical societies' provision of prepayment plans. Since such collective endeavors are fundamentally at odds with a competitive marketplace, they should not be permitted unless an antitrust exemption can be found in federal or state law. *See* notes 164 & 166 *supra.*

[176] Recently some efforts by Blue Cross and others to provide insurance coverage of prescription drugs have run into difficulties with state antitrust laws because of the price fixing involved in obtaining commitments from pharmacists on the amount of their professional service charge on each prescription. *E.g.*, Blue Cross v. Virginia *ex rel.* State Corp. Comm'n, 211 Va. 180, 176 S.E.2d 439 (1970) (held to violate Sherman Act as well); B & L Pharmacy, Inc. v. Metropolitan Life Ins. Co., 46 Ill. 2d 1, 262 N.E.2d 462 (1970) (upheld on the basis of special statutory exemptions); Opinion of the Attorney General of Michigan, 1969 Trade Cas. para. 72,801. *See* Comment, 57 VA. L. REV. 315 (1971); Comment, 65 NW. U.L. REV. 940 (1971). Had the insurance plans been sponsored by an organization of the pharmacists themselves they would have resembled the medical care foundations more closely and been even stronger candidates for illegality. Possibly, however, the foundations could find a way of regulating fees—perhaps merely ascertaining whether they exceed the physician's usual and customary charges—that presents less of an antitrust problem.

[177] Their exclusionary impact would indeed be greatly lessened if market opportunities for HMOs are successfully opened up in other ways—*e.g.*, by requiring employers to make available the option of applying the cost of employer-purchased insurance coverage toward HMO enrollment. *See* text accompanying notes 28-30 *infra.* My estimate of the foundation plans' exclusionary impact is impressionistic, *see* notes 158, 159, 163, 173 *supra*, and subject to correction if HMOs are found capable of entry.

[178] *See* Wachtel, *Products Standards and Certification Programs*, 13 ANTITRUST BULL. 1 (1968); *Legality of Standards—Recent Developments*, 39 MAGAZINE OF STANDARDS 18 (1968).

[179] A trade association's standard-setting scheme caused a firm which truly had a "better mousetrap," a new kind of plywood, to fail, and, in spite of this egregiously anticompetitive effect, the courts could find no antitrust violation. Structural Laminates, Inc. v. Douglas Fir Plywood Ass'n, 261 F. Supp. 154 (D. Ore. 1966), *aff'd*, 399 F.2d 155 (9th Cir. 1968), *cert. denied*, 393 U.S. 1024 (1970).

burden of establishing "reasonableness" on those competitors who would engage in collective activity presenting grave anticompetitive risks though some arguable benefits as well.[180] My preference for a per se rule would be somewhat abated if, as an intermediate solution, the burden of establishing an innocent purpose and absence of an anticompetitive effect could be shifted to the plan's proponents. The treble-damage remedy might then adequately deter excesses.

The foregoing theorizing about society-sponsored prepayment plans can be usefully laid alongside the earlier discussion of the monopolistic potential of an HMO affiliated with a hospital enjoying a high degree of "natural" monopoly power. The fear was there expressed that such hospitals, and thus their HMOs, would often be dominated by the local medical society and that the HMOs would in such circumstances be used primarily as a stalking horse for fee-for-service medicine. Thus it could preempt subscribers, and this foreclosure of market opportunities, together with additional competitive advantages and the "squeeze" potential derived from its hospital connection, would make entry by independent HMOs very difficult. Nevertheless, despite the apparent applicability in these circumstances of the rigid antitrust rule that I approved above, a more selective rule seems to me to be appropriate here. The difference in the two cases is simply that the hospital-based HMO is capable of achieving important efficiencies in the delivery of health care, whereas the society-sponsored prepayment plan is not. This difference could justify applying a more flexible antitrust rule to the former, allowing a private antitrust plaintiff or the Justice Department to succeed only if it could affirmatively establish the purpose or the effect of preempting market opportunties, excluding other HMOs, or protecting the fee-for-service sector of the market from outside competition.

A monopolization or conspiracy-to-monopolize theory under section 2 would seem the soundest doctrinal approach to the problem of the hospital-based HMO dominated by local fee-for-service doctors.[181] The inquiry would be whether the HMO was

[180] *Cf.* United States v. Arnold, Schwinn & Co., 388 U.S. 365, 374 n.5 (1967): "The burden of proof in antitrust cases remains with the plaintiff, deriving such help as may be available in the circumstances from particularized rules articulated by law—such as the *per se* doctrine." Rational allocation of the burden of proof would have prevented the travesty described in note 179 *supra*.

[181] Use of § 1 of the Sherman Act, outlawing contracts, combinations, and conspiracies in restraint of trade, would be appropriate for dealing with the foundation plans since they so clearly involve a combination of competing physicians. The hospital-based HMO, on the other hand, is not a creature of the medical society, and the requisite multiplicity of actors would be harder, though probably not impossible, to identify. The conspiracy-to-monopolize theory would seem to raise a similar problem, but in this context it seems less important that the conspirators be competitors.

There should be no doubt that fee-for-service physicians who by whatever means effectively exclude HMO competition are "monopolizing" (or attempting or conspiring to monopolize) the market for medical care. Their success in eliminating one form of competition strengthens their market power—that is, their ability to discriminate in price, a distinctive feature of monopoly, and to increase returns by artificially creating demand and by repressing both price and quality competition through customary restraints. *See* references cited in note 65 *supra*. One can anticipate some difficulty in persuading courts that a mere strengthening of earning power provides the basis for finding a violation of § 2, since monopolization has traditionally been defined in terms of an overwhelming market share possessed by a single producer. *E.g.*, Aluminum Co. of America v. United States, 148 F.2d 416 (2d Cir. 1945). But no such exacting definition has been insisted on in attempt and conspiracy cases where anticompetitive

being used to perpetuate the local physicians' market power. While taxing the perspicacity of judges, the evidence in such a case should permit discriminating judgments to be made. The following would be relevant subjects for proof: (*a*) the coexistence of other HMOs; (*b*) the hospital's pricing policies, particularly any price squeeze attempts; (*c*) the hospital HMO's aggressiveness in attracting subscribers, with particular reference to whether recruitment efforts are pursued among middle-class patrons of fee-for-service doctors or are confined to low-income groups; (*d*) the means of securing specialists' services, whether by spreading its business evenly among fee-for-service practitioners while avoiding creation of in-house capability or by practicing selectivity on the basis of skill and price; (*e*) aggressiveness in exploiting available economies, particularly in the use of paramedical personnel; and (*f*) the mechanism of control, particularly with respect to the possibility of domination by fee-for-service doctors.[182]

C. Applicability of the Antitrust Laws

The difficulty of introducing a competitive regime into health care delivery should not be underestimated. Traditions are opposed to it, and doctors can be expected to resist what strikes them as unhealthy "commercial" influences. The best means of overcoming this resistance is by vigorous enforcement of the antitrust laws against all concerted efforts to exclude HMOs from the marketplace. Some possible uses of antitrust law have been suggested already.[183]

The Sherman Act is the law most likely to be called into play against professional combinations in restraint of HMO development or collective monopolization of the medical care market by fee-for-service physicians. Two threshold problems that must be faced are raised by the question whether in a particular case the alleged restraint affects "trade or commerce among the several States" within the meaning of the statute. The first question is whether we are dealing with either "trade" or "commerce," and the second is whether, if so, there is sufficient interstate impact.

As to the first question, the Supreme Court held in 1943 in the *AMA* case that Group Health, Inc., of Washington, D.C., a nonprofit prepaid group practice plan whose activities were restrained by organized medicine, was engaged in "trade" and that the Sherman Act applied to the restraints imposed.[184] Any HMO that might be formed would seem to be equally involved in "trade." Even if the case presented should involve a restraint practiced against a single doctor connected with an HMO,

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intent was clear. *See* Turner, *Antitrust Policy and the Cellophone Case*, 70 HARV. L. REV. 281, 303-08 (1956). To inquire whether the hospital-based HMO has monopolized merely HMO-type care in the community—perhaps a separate economic market despite the availability of fee-for-service care as a substitute—would not sufficiently open up the question of domination by fee-for-service doctors, though it would be appropriate where extension of the hospital monopoly was the only issue.

[182] Active participation by consumer groups in the policy-making function would go far toward dispelling concern.

[183] *See also* notes 185, 220, 221, & 229 *infra*.

[184] American Medical Ass'n v. United States, 317 U.S. 519, 528-29 (1943).

he should have no trouble if he can relate the restraint to a purpose to exclude HMOs from the market or to weaken their competitive position.[185]

The interstate commerce question is harder, in part because the *AMA* case arose under section 3 of the Sherman Act, which is specifically directed to restraints occurring in the District of Columbia. Even though the Supreme Court in that case was not called upon to make a finding of the presence or absence of interstate commerce, some implication of its absence seems to have attached by reason of the Justice Department's selection of the case and its invocation of the more limited jurisdictional nexus. Likewise, in the *Oregon Medical Society* case, the Court did not have to consider whether the restraint alleged in the formation of the Society's own prepayment plan had any interstate impact. The trial court had assumed the existence of interstate commerce in dismissing the case,[186] and the Supreme Court had no occasion to consider the point since the government had failed to establish any violation.[187] Thus, the case law respecting HMO-type providers is indefinite. However, other cases suggest that medical practice generally involves no interstate aspect,[188] reflecting the circumstance that its primary ingredient is personal services rather than goods moving across state lines and that the market area in which consumers purchase these services is localized by factors of convenience and accessibility.

The most likely argument that interstate commerce is involved in HMO operation would be based on the HMO's effect on commerce in prescription drugs. It would probably not be sufficient merely to show that HMOs would engage in pre-

[185] Where specialty board membership or hospital staff privileges are to be denied to a physician affiliated with an HMO, stringent procedural requirements may attach because of the anticompetitive risk presented. In Silver v. New York Stock Exchange, 373 U.S. 341 (1963), the Exchange (a "combination" of its members) was held to have violated the Sherman Act by exercising its statutory powers to cut off wire services to the plaintiff without first according him notice of the grounds for the action and an opportunity to rebut the charges. The Court reasoned that the danger of anticompetitive use of the Exchange's self-regulatory powers required that they be exercised in the least restrictive manner compatible with fulfillment of the Exchange's statutory functions. Assuming the requisite impact on interstate commerce, the denial of privileges to an HMO-connected physician is closely analogous: Hospitals and specialty boards have been entrusted by the public with responsibility for quality control in medicine, a power that is subject to grave anticompetitive abuse; procedural protections are therefore appropriate, and failure to provide them, as well as revealed abuses, will be penalized by treble damage awards under the antitrust laws. It is noteworthy that the Joint Commission on Accreditation of Hospitals (JCAH), which includes representatives of several trade groups, including the AMA and the AHA, provides significant procedural protections. *See* JCAH, STANDARDS FOR ACCREDITATION OF HOSPITALS 109-11 (1969). Procedural protections may be required for other reasons as well. *See* Ludlam, *Hospital-Physician Relations: The Role of Staff Privileges*, in this symposium, p. 879.

Another antitrust theory useful to physicians excluded from hospital staff privileges or society membership would be that applied in Associated Press v. United States, 326 U.S. 1 (1945). In that case, an open membership policy was compelled where deprivation carried with it a distinct competitive disadvantage. Presumably the staff's quality-control responsibilities could be reconciled with this principle.

[186] 95 F. Supp. at 105.

[187] The Court did discuss the interstate commerce point with respect to another issue in the case. 343 U.S. at 337-39.

[188] *See, e.g.*, Riggall v. Washington County Medical Soc'y, 249 F.2d 266 (8th Cir. 1957); Spears Free Clinic & Hospital for Poor Children v. Cleere, 197 F.2d 125 (10th Cir. 1952); Polhemus v. American Medical Ass'n, 145 F.2d 357 (10th Cir. 1944).

scribing and occasionally dispensing drugs. Rather the restraint would have to have some likely direct and substantial impact on interstate drug sales.[189] Prescription drugs are a substantial item in the nation's health bill. Out-of-hospital prescriptions cost the public $3.2 billion in 1966, which was 7.6 per cent of national expenditures for health services and supplies in that year.[190] If specific activities of a medical society that are repressive of HMO development could be said to affect this commerce materially, that effect would certainly be substantial enough to warrant application of the antitrust laws. Moreover, this result shoud not appear strained or unreasonable, since the drug industry is already the subject of extensive federal regulatory concern exerted under the commerce power.

If HMOs were required to cover and pay all or a portion of their enrollees' drug bills, there would be an extremely persuasive argument that any restriction on HMOs' ability to penetrate a market area would have substantial effects on interstate commerce and would warrant antitrust action. It is well recognized that fee-for-service physicians are not ideally situated to prescribe drugs in a manner assuring the public the highest value from the drugs they consume. Solo practitioners are thought not to be as well informed about drug therapy as they should be, and the method of merchandizing drugs by brand name and intensive promotion has often been criticized for failing to provide adequate information in a usable form.[191] Physicians are apt to make prescribing decisions without reference to the price that the patient must pay the pharmacist. The result is that the prescription drug market is though to be excessively profitable for the drug companies and generally unresponsive to price competition.[192] Although discussions of provider prepayment plans do not always recognize it, drug prescribing would appear to be an area in which HMO-type care could provide substantial and highly desirable efficiencies.

HMOs providing coverage of their enrollees' drugs would be in a position either to dispense them themselves or to prescribe them. In either case the HMO would be motivated to evaluate efficacy, safety, and price more carefully than do fee-for-service physicians. Judicious prescribing by generic rather than brand name and careful price and quality comparisons among pharmacists would contribute substantially to better performance in the prescription drug market. Furthermore, HMOs would be generally larger-scale providers and would therefore be in a better position to retain a staff pharmacologist or to seek out pharmacological literature and advice

[189] *See* Elizabeth Hospital, Inc. v. Richardson, 269 F.2d 167 (8th Cir. 1959).

[190] TASK FORCE ON PRESCRIPTION DRUGS, FINAL REPORT 1 (1969) [hereinafter cited as TASK FORCE REPORT].

[191] *See, e.g.*, H. DOWLING, MEDICINES FOR MAN ch. 7 (1970); Ruge, *Regulation of Prescription Drug Advertising: Medical Progress and Private Enterprise*, 32 LAW & CONTEMP. PROB. 650 (1967); TASK FORCE REPORT, 7-11, 21-24, 36-37.

[192] *See generally Hearings on Competitive Problems in the Drug Industry Before the Monopoly Subcomm. of the Senate Select Comm. on Small Business*, 90th Cong., 1st Sess. (1967); TASK FORCE REPORT 11-15; DOWLING, *supra* note 191, chs. 5 & 6; Baehr, *Drug Costs and the Consumer*, in DRUGS IN OUR SOCIETY 179 (H. Talalay ed. 1964).

so as to improve the results of drug therapy. Under these circumstances there would be good reason to think that HMOs would improve the working of market forces in interstate commerce in prescription drugs and could substantially reduce the nation's drug bill while increasing the benefits of drugs to patients.[193] These beneficial results would occur even where a coinsurance or deductible provision was incorporated.[194]

Although the arguments for including coverage of drug costs in HMO coverage are persuasive, the administration's proposals pending in Congress at the present time would not require coverage of out-of-hospital drug costs.[195] This can be explained as an effort to reduce the cost of the insurance provided and to concentrate on those areas where rising costs are the greatest problem.[196] The argument that interstate commerce in drugs would be adversely affected by restraints of trade directed against HMOs would be somewhat weaker if HMO coverage does not typically include drugs. Nevertheless, drugs prescribed while the patient is hospitalized will probably be covered,[197] and HMOs would have the option of making drug insurance available to its enrollees.[198] Furthermore, the larger-scale organization of HMOs would provide opportunities for improved prescribing, and normal competitive urges should lead HMOs to attempt to please consumers by helping them obtain the best drug for the money. One can visualize, for example, an HMO advertising that its prescriptions include generic drugs where appropriate and are written in consultation with a qualified pharmacologist. I would think that the government could procure a sufficient number of medical and economic experts to testify convincingly to the substantiality and desirability of these effects that an antitrust court could be persuaded that interstate commerce was in fact substantially and adversely affected by exclusionary tactics directed against HMOs.

The chances of persuading courts that antitrust enforcement is appropriate in these areas would be increased by a declaration by Congress as part of the legislative history of health care legislation that the antitrust laws are to be relied upon to

[193] *See* McCaffree & Newman, *Prepayment of Drug Costs Under a Group Practice Prepayment Plan*, 58 AM. J. PUB. HEALTH 1212 (1968), which finds a net cost saving to plan subscribers of 28% even after provision for profits earned and taxes payable on drugs purchased outside the cooperative. The substantiality of the potential impact of HMO coverage of prescription drugs is indicated as follows: "If costs similar to the Group Health level could be achieved for most of the population, the nation's drug bill would decline by over $800,000,000 or just about 2 per cent of the nation's total health care expenditures." *Id.* at 1218.

[194] The HMO would seek to minimize drug costs in order to prevent the using up of the deductible or to reduce its coinsurance liability.

[195] Medicare does not cover outpatient drug costs either. *See* TASK FORCE REPORT 49-69. Under Medicaid most states have exercised the option to cover drugs. *See* CCH MEDICARE & MEDICAID GUIDE para. 15,504 (1971). Section 25(b) of the Kennedy-Griffiths bill provides for coverage of the costs of *approved* drugs furnished to CHSO enrollees.

[196] Drug costs have remained remarkably stable, particularly as compared to other health costs. *See* BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 62 (1970).

[197] Since these are covered under Medicare, they are likely to be covered in any new scheme. I have not been able to determine how substantial an item this is, but it is not likely to be insignificant.

[198] Several plans, most notably Group Health Cooperative of Puget Sound, have provided drugs with considerable success. *See* Baehr, *supra* note 192, at 183-86; McCaffree & Newman, *supra* note 193.

maintain HMOs' market opportunities. Further, express recognition of the importance of HMO formation in improving the performance of the drug industry would serve as a helpful guide to a judge faced with appraising the interstate commerce impact. If the Congressional committees should differ with my conclusions on this matter, one can visualize enactment of a "little Sherman Act" specifically applicable to the health care field. If interstate commerce were not thought a sufficient constitutional nexus, the legislation could be seen as being in aid of a legitimate federal purpose under the taxing and spending power as utilized in the Medicare, Medicaid, and proposed FHIP legislation.[199]

Although some of these matters are not as clear as one might wish, it would seem desirable for the Antitrust Division of the Department of Justice to commence some actions to determine the antitrust laws' capacity to recreate a competitive market in health care delivery. If the Nixon administration is sincere in its expressed desire to foster HMO development, it should quickly authorize such litigation, perhaps directed at some of the medical-society-sponsored prepayment plans.[200] There seems to be no reason to await Congressional action on the various health proposals before moving in this constructive way to create opportunities for HMO formation. The Federal Trade Commission might also take an interest in these matters, dealing with exclusionary tactics as "unfair methods of competition."[201]

D. Federal Preemption as a Means of Overcoming Restrictive State Legislation

Many states have statutes, enacted largely at the behest of organized medicine, that in some way inhibit the formation of HMOs.[202] In varying degrees, these laws will have the effect of deterring the formation of HMOs altogether or will tend toward the creation of plans of the kinds supported by medical societies, which, as we have seen, may be nothing but a defensive gambit by fee-for-service medicine. The administration and the national health insurance proponents agree that the presence of these laws would obstruct implementation of any federal policy for dealing with the health care crisis.[203]

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[199] *See* notes 211-13 *infra* and accompanying text.

[200] In recent years the Antitrust Division has performed much useful service in reminding regulators and policy makers of the role that competition can play. It would be appropriate to add health care to the long list of fields, including banking, securities exchanges, transportation, and broadcasting, in which competition had been de-emphasized by policy makers and the Division's influence was exerted to restore it to a higher place. *See* REPORT OF THE TASK FORCE ON PRODUCTIVITY AND COMPETITION (1969), urging that the Antitrust Division serve "as the effective agent of the Administration in behalf of a policy of competition."

[201] 15 U.S.C. § 45 (1964).

[202] *See* Note, *supra* note 7, at 960-75, which concludes that the law is not as restrictive in practice as it appears to be on paper at least as regards nonprofit HMOs; ASPEN SYSTEM: CORP., *supra* note 105.

[203] *See* PRESIDENT'S HEALTH MESSAGE 6; S. 1623, § 401(a); Kennedy-Griffiths bill § 56(b). Both S. 1623, § 401(b), and the Kennedy-Griffiths bill § 56(a) would also deal with restrictive state policies toward manpower licensure and utilization.

The following language from the text of the Kennedy-Griffiths proposal suggests both the nature of the laws creating the problem and the remedy proposed:

> If the Board finds that a proposed corporation will meet the requirements . . . for participation as a comprehensive health service organization . . . , but that it cannot be incorporated in the State in which it proposes to furnish services because the State law requires that a medical society approve the incorporation of such an organization, or requires that physicians constitute all or a majority of its governing board, or requires that all physicians in the locality be permitted to participate in the services of the organization, or makes any other requirement which the Board finds incompatible with the purposes of this title, the Board may issue a certificate of incorporation to the organization, and it shall thereupon become a body corporate.[204]

The Kennedy-Griffiths proposal also would permit a nonprofit hospital or CHSO to render care directly through employees without regard to whether state law would regard its activities as prohibited "corporate practice of a profession"; the provision would not, however, permit any employment or arrangement that was "likely to cause lay interference with professional acts or professional judgments."[205]

The Kennedy-Griffiths bill would leave intact any state law requiring the CHSO to be a nonprofit enterprise.[206] Since I consider this an extremely unwise policy, one that is embodied in the Kennedy-Griffiths proposal itself, I would like to see federal law expressly override it. While I recognize that the issue is not free from doubt and that states might have an interest in protecting their citizens in this regard, I am concerned that it will be difficult to get an open-minded re-examination of the question. Moreover, state policy makers may too readily accept the medical societies' version of the issue.

State laws also may purport to regulate HMOs under insurance laws.[207] Federal law regulating HMOs, as under the Kennedy-Griffiths bill, would probably be construed to preempt these efforts.

The Nixon administration's FHIP proposal would deal with laws restrictive of HMO formation by declaring that agreements entered into by the Secretary of HEW with HMOs, under which services would be rendered to FHIP beneficiaries, would make state law inapplicable "to the provision of such services under such an agreement to the extent that such law or regulation is inconsistent with the obligations of the health maintenance organization under the agreement."[208] While effective in dealing with the corporate-practice and insurance regulation problems

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[204] Kennedy-Griffiths bill § 56(b).

[205] *Id.* § 56(a)(4).

[206] Such a requirement usually flows from interpretation of the rule against corporate practice of a profession. *See* Note, *supra* note 7, at 960-62 and references there cited. A for-profit HMO, Omnicare, is currently trying, without success, to obtain a favorable ruling from the Attorney General of California. *See* letter from R. Stromberg to V. Stein, Nov. 26, 1969 (legal opinion and brief to the effect that Omnicare would not violate the corporate-practice rule).

[207] *See* Note, *supra* note 7, at 969-74.

[208] S. 1623, § 401(a).

insofar as implementation of FHIP is concerned, there may be a question whether this provision would have any effect on state laws as applied to the care of persons not covered by FHIP.[209] If not, the result might be to create federal instrumentalities that are permitted to serve the poor and perhaps the elderly but are prevented by state law from serving other elements of the population. However, in view of the requirement in the FHIP proposal that HMOs must have non-FHIP enrollees to the extent of at least half their enrollment,[210] a state law purporting to limit its right to accept non-FHIP enrollees would be "inconsistent" with the federal scheme.[210a]

The constitutional power of the federal government to override state legislation is of course not plenary. It seems clear, however, that a law like the Kennedy-Griffiths bill, which would be enacted under the same taxing and spending powers of Congress that permitted creation of the Social Security system in furtherance of the "general welfare,"[211] would allow Congress to preempt the field against state laws in aid of achieving its legitimate constitutional purpose.[212] It would be anomalous if a less far-reaching measure, such as the administration's proposals, could not be implemented by a similar express overriding of state authority, but, since the administration plan leaves much of the financing of health care in the private sector, it might be argued that the constitutional basis for preemption—federal spending—does not exist.[213] Nevertheless, federal involvement through Medicare, Medicaid, and FHIP would seem a sufficient basis for specific and total invalidation as to all providers caring for beneficiaries of federal programs. If this were done, a physician with Medicare patients could not be interfered with by state authorities even as to his ability to treat other patients since the federal government could reasonably demand that its clients not be segregated from the general population in obtaining health care. If the taxing and spending power were deemed insufficient, the federal government could act in aid of its power over interstate commerce in prescription

[209] The narrowness of the preemption attempted is attributable to the administration's attempt to use the government's contracting power as its basis for moving against state laws. *See* Paul v. United States, 371 U.S. 245 (1963). Subsequent discussion indicates that this is perhaps too narrow an approach to the problem.

[210] S. 1623, § 201, proposed § 628(b)(5).

[210a] The AMA fails to recognize this wider preemptive effect. *See* DIVISION OF MEDICAL PRACTICE, *supra* note 43, at 12.

H.R. 1 as amended, § 226(a), proposed § 1876(j), provides, "The [contracting] function vested in the Secretary . . . may be performed without regard to such provisions of law or of other regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purposes of this title." This language is obscure, but presumably state laws inhibiting performance of HMO contracts, including satisfaction of the membership requirements, would be superseded.

[211] Steward Machine Co. v. Davis, 301 U.S. 548 (1937); Helvering v. Davis, 301 U.S. 619 (1937). *See also* Chapman & Talmadge, *Historical and Political Background of Federal Health Care Legislation*, 35 LAW & CONTEMP. PROB. 334, 342-46 (1970).

[212] Although the regulation of medical practice has traditionally been within the province of the states under their police power to legislate for the protection of the health, safety, and morals of their citizens, Congress may affix conditions to the expenditure of federal tax funds. *See* Oklahoma v. United States Civil Service Comm'n, 330 U.S. 127 (1947).

[213] *See* note 209 *supra*.

drugs and over the interstate health insurance industry. It is hoped that Congress will see the need for clearing away all state legislation likely to inhibit the operation of market forces.

E. Supplementary Measures to Strengthen Market Forces

Numerous factors contribute to the strength or weakness of market forces in any marketplace, and many of these factors are susceptible to legislative and administrative influence to improve the market's over-all performance. A survey of the market for health services suggests some ways of making doubly sure that the market will deliver the things for which we count on it.

1. *Lowering Barriers to Entry*

HMO formation will occur more quickly and more often if the obstacles to their creation are fewer or less difficult to surmount, and it is therefore important that governmental policies be directed to reducing both the number and the negotiability of such obstacles. Only for compelling reasons should policy makers render entry materially more difficult than it has to be. The inquiry here is what entry barriers exist for would-be HMO organizers and what, if anything, can be done about them.

The administration has proposed federal financial aid for HMO formation as a means of reducing entry barriers.[213a] However, subsidies for start-up costs are usually inconsistent with market functioning and can distort competitive outcomes by permanently lowering the costs of the subsidized enterprise (by eliminating the need to earn a return on the full original investment). Nevertheless, the President's aid program may perhaps be justified, at least as to the concept if not as to the precise amount, as a means of compensating for allegedly unnatural and unwarranted barriers to acceptance created in consumers' and physicians' minds by the past activities of government and organized medicine; the proposed planning grants, temporary absorption of operating losses, and loan guarantees are all consistent with a purpose to lower barriers reflecting ignorance and risk attributable in part to these historical factors. More important perhaps, HMO subsidies seem quite appropriate in an industry where charitable and governmental subsidies are already so much a part of the landscape; however, this rationale provides little justification for subsidizing HMOs' provision of primary care, since fee-for-service doctors, their chief competitors in this business, do not enjoy such support.

Government should see that, to the extent possible, HMOs face no requirements for large capital investments. It is therefore significant that in the House-passed Medicare amendments HMOs are not required to render hospital care or to provide all specialists' services but may instead purchase these as needed in the fee-for-service sector. Some financial responsibility requirements will no doubt be imposed, but care should be taken not to be too demanding in this regard, perhaps accepting

[213a] *See* text accompanying note 27 *supra*.

bonds from the organizers as a way of protecting plan subscribers. Reinsurance has an important role to play in making small-scale HMOs viable and should be encouraged by policy makers.

Any legal provision mandating large size in an HMO seems inappropriate. It may prove to be the case that certain scale economies will compel many HMOs to be quite large, and indeed these economies are reportedly not exhausted in a hospital-based HMO until it has 25,000 to 30,000 enrollees.[214] Nevertheless, the ability of smaller HMOs to survive, perhaps by dint of characteristics other than rigorous efficiency and low cost, should be tested in the marketplace and not in legislative halls. The Senate Finance Committee, in its version of the proposed 1970 Medicare amendments, would have required an HMO to have at least 10,000 subscribers,[215] and, regrettably, the administration's proposed National Health Insurance Partnership Act of 1971 incorporates this requirement.[216] This would be a most unfortunate and unnecessary blow to the functioning of a health care marketplace.

I wish that it were needless to say that entry by HMOs should not be restricted by government on any grounds but minimal requirements of character, fitness, and financial responsibility. Congress should provide expressly that, even in the currently popular name of "comprehensive health planning," no for-profit HMO should be excluded from the marketplace on the ground that a "need" for it has not been demonstrated or that existing institutions require protection against its competition. Comprehensive health planning, admittedly needed, should not be turned into a system of licensing by "certificate of public convenience and necessity." Instead, it should be seen as a technique for coordinating the health investments of various levels of government and of the voluntary-nonprofit sector and for eliminating all factors besides the public interest in decision making regarding these expenditures.[217] Monopolistic elements created by such governmental intervention

[214] Note, *supra* note 7, at 904-05.

[215] S. REP. No. 91-1431, at 136.

[216] *See* S. 1623, § 101, proposed § 604(a)(5); *id.* § 201, proposed § 628(b)(5).

[217] Unfortunately, Congress is on the brink of adopting legislation that would effectively create a system of rigid entry restrictions in the states and would, perhaps inadvertently, remove any realistic hope of recreating a dynamic and workable market for health services. A section of the House-passed version of H.R. 1 as amended, § 221, which seems to this moment to have generated little controversy, would reduce federal Medicare payments to health facilities and HMOs to the extent that they represent recovery of depreciation and other costs connected with capital investments in facilities costing more than $100,000 that are constructed without approval (subject to federal review) of state planning agencies. Thus, the health planners would be ceded the power effectively to control all major new public and private investment in health facilities, including HMOs, and to prevent all new construction for which they are not satisfied that a "need," as they define it, exists. Experience in other regulated industries tells us that "need" is almost always defined with an eye to possible adverse effects on other providers of the service, indicating that legislation of this kind invariably protects existing providers from competition and explaining why it is regularly sponsored by them. This kind of law is depressingly similar to, among other things, the law restricting bank chartering and branching on the basis of "convenience and needs," which developed in the 1930s as an expedient to protect against bank failures but which is now recognized as unnecessarily restrictive of needed and healthy competition. *See, e.g.*, Kreps, *Modernizing Banking Regulation*, 31 LAW & CONTEMP. PROB. 648 (1966).

As discussed earlier (*see* notes 98-100 *supra* and accompanying text), health planning agencies should

have too often redounded to the public detriment and private profit and should be prevented from doing so again.

Ease of entry not only enlarges opportunities for entrepreneurs interested in HMO formation but supplies a beneficial restraining influence on sellers already operating in the market. Thus, a market populated by only a few sellers may yet behave competitively, in part because sellers recognize not only their existing rivals but also the risk that other sellers will appear if prices rise to a level making entry appear attractive. Preservation of such "potential competition"—which might come from HMOs operating in adjoining areas, employers interested in cheaper care for their employees, or indigenous fee-for-service physicians—should be an important policy consideration.

"Entry barriers" and "potential competition" have become largely talismans in antitrust law, used more for conjuring than as analytical tools.[218] Nevertheless, careful antitrust enforcement could perform a useful service wherever certain practices appeared to have an entry-limiting effect. For example, the duration of HMO contracts with subscribers would be subject to control through antitrust rules on exclusive dealing,[219] and tying arrangements, if identifiable, would be subject to antitrust action.[220] Further, the disadvantages of non-hospital-based HMOs in purchasing hospital services might be deemed to flow from entry-limiting devices having conspiratorial aspects.[221] Still, although the antitrust laws might serve, issues of these

be scrupulously limited to dealing with the investments of the governmental and nonprofit sectors and should be given no authority over private investment. The expediency arguments advanced for absolute control over entry are that public investments must be protected in order to improve their borrowing prospects and their capacity to serve the poor. But the losses from precluding competition for inefficient, price-discriminating monopolists would surely outweigh any saving in the cost of borrowing, and Congress is likely to improve the ability of the poor to pay for their own care, obviating the need for price discrimination. *See* note 151 *supra*. In any event, the arguments for protectionist regulation on behalf of hospitals, weak as they are, are far stronger than the case for restricting HMO entry. The Ways and Means Committee was responsible for extending the coverage of this provision to HMOs. *Compare* original H.R. 1, § 221. Its work should be undone in the Senate so that at least non-hospital-based HMOs will not become public utilities.

[218] *See, e.g.*, FTC v. Procter & Gamble Co., 386 U.S. 568, 585 (1967) (Harlan, J., concurring); General Foods Corp., [1965-67 Transfer Binder] TRADE REG. REP. 22,743, at 22,746 (1966) (Commissioner Elman dissenting).

[219] *See, e.g.*, FTC v. Motion Picture Advertising Service Co., 344 U.S. 392 (1953).

[220] Consider, for example, whether a hospital-based HMO, such as a Kaiser plan, should be allowed to exclude competing HMOs and fee-for-service physicians and their patients from access to its hospital services. The antitrust issue would seem to turn on whether prepaid health care is a "single product" or whether hospital and outpatient services are deemed to be "tied" together by the HMO, thereby foreclosing competitors from a needed service. *Cf.* Fortner Enterprises, Inc. v. United States Steel Corp., 394 U.S. 495 (1969). A holding that this was an illegal tying arrangement would be surprising, but it would perhaps be defensible on the theory, often stated with respect to tying, exclusive dealing, and vertical integration, that entry barriers are objectionably raised if, because customers or suppliers are foreclosed, the potential entrant must come in on two levels with commensurately greater capital and know-how, supplying in this case not merely primary care but perhaps hospital services as well.

[221] The difficulties faced by non-hospital-based HMOs are recognized in Note, *supra* note 7, at 907, 910-18. They take the form, in part at least, of preferential rates given to Blue Cross. Although I choose not to get into the problems of dealing with Blue Cross and Blue Shield under antitrust principles—primarily they are problems of state versus federal power (*see* note 164 *supra*)—, it may be that an antitrust attack on Blue Cross-Blue Shield will have to be mounted if HMO entry on equal terms is

kinds seem to me more appropriately committed to administrative oversight when presented in a specific industry context. Congress might wish to adopt this mechanism, specifying that maximization of HMO entry opportunities is to be a primary object.

2. Facilitating Consumer Choice

Whatever the precise nature of the insurance scheme adopted, consumers should be in a position to exercise free and informed choice in selecting a mode of coverage and the appropriate provider. The administration's plan would allow employees covered by their employer's health insurance program to elect to apply the cost of that coverage toward the purchase of an HMO membership, but this option should be exercisable with respect to any available HMO, not simply to HMO-type coverage provided by a subsidiary of the health insurer or by the local medical society. HMO subscribers and beneficiaries of health insurance should be entitled to withdraw from either type of plan at fairly short notice in order to transfer their business elsewhere. Administrative requirements should be introduced to define benefit packages on a uniform basis in order to facilitate price comparisons. Thus, some minimum package would be defined by law, and additional benefits could be classed and priced separately.

The medical profession has studiously maintained ethical rules against advertising by physicians.[222] Under these rules the only information which can be conveyed to the public by physicians or groups thereof relates to the type of practice, office location and hours, and similar matters which are not likely to influence greatly the selection of a particular physician. Similarly, the means of communicating even this limited data are restricted. These "ethical" rules cannot be allowed to interfere with HMO developments, and advertising, at least to the extent of permitting consumer education and informed comparisons, seems necessary to facilitate choice between the traditional and innovational systems and among the innovational plans themselves. Administrative attention should be given to some regulatory prescription of disclosure in advertising messages.[223] In addition to standardizing coverage and

to be facilitated. If it could be obtained, a legislative or administrative solution would be preferable since it would be both swifter and surer. Probably any attempt to deal with this issue can await a clearer demonstration that there is a problem.

[222] An early version of AMA, PRINCIPLES OF MEDICAL ETHICS § 4 (1953), contained the traditional proscription of advertising by members of the medical profession:

> "Solicitation of patients, directly or indirectly by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician . . . ."

Section 5 further elaborated on the proscription. In 1957 a simplified revision of the *Principles* was promulgated in which advertising was prohibited in the following brief sentence: "He should not solicit patients." AMA, PRINCIPLES OF MEDICAL ETHICS § 5 (1957). It was emphasized that the semantic streamlining in this revision did not alter the traditional meaning. *See also* AMA, OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL 25 (1969).

[223] California's Knox-Mills Health Plan Act, CAL. GOV'T CODE §§ 12530-39 (West Supp. 1969), provides regulation of this kind. *See* Note, *supra* note 7, at 977-78.

terminology to facilitate price and quality comparisons, regulators might require disclosure of nonaccreditation or official quality control ratings or demerits. The medical profession's preference for noninformational advertising should be recognized as one more cartel tactic.[224] Although there are of course some legitimate ethical considerations in advertising medical services, they do not extend to advertising of alternative modes of care. Apparently Kaiser-Permanente and other prepaid group practice plans have succeeded in advertising their services.[225]

3. *Preventing Competition in Risk Selection*

One danger in insurance schemes is that competition will take the form of competing for the better risks while excluding those most in need of insurance protection. Any legislative solution to the health care crisis must provide against this development. The pending proposals all appear to introduce the requirement that HMO-type providers adopt a first-come, first-served policy, and this would appear to be a reasonable approach to the problem. A similar requirement should also be imposed on health insurance companies.

Conceivably, an HMO or health insurer that found its enrolled population to be excessively risk-prone, due to age distribution or a high incidence of chronic ailments, could be allowed to apply for exemption from the first-come, first-served requirement. Such a provision for waiver would seem to be necessary to enable insurers to remain competitive. There are probably other difficulties of this kind that I cannot visualize at this point, but it is perhaps sufficient to call attention to this category of problems and to urge that administrative attention be directed to solving them in the manner most conducive to market competition. It seems almost essential to the achievement of this goal that "community rating" be required, since "experience rating" is probably workable only with a captive population, which would be antithetical to the operation of a competitive market. On the other hand, administratively granted exemptions from the first-come, first-served requirement would allow a plan to re-establish its ability to compete on a community-rating basis.

4. *The Role of Private Health Insurers*

The Nixon health proposals have been criticized, most notably by Senator Kennedy, as providing a "windfall" to the health insurance industry.[226] Of course, if HMOs become a major provider of primary health care, the role of health insurers would be reduced, though they might find a new function in reinsuring smaller HMOs. Whether the long-term net effect of the administration's plan would be to increase the size or profits of the health insurance industry may not be predictable at this time.

[224] The trade association in FTC v. Cement Institute, 333 U.S. 683, 715 (1948), "in the interest of eliminating competition, suppressed information as to the variations in quality that sometimes exist in different cement."

[225] Kessel, *supra* note 70, at 44.

[226] N.Y. Times, Feb. 19, 1971, p. 1, col. 8, at p. 16, col. 1.

Of course, health insurers might move directly into HMO formation and might profit handsomely in so doing. I see substantial merit, however, in prohibiting health insurers from entering the HMO sector. The obvious reason is to avoid domination of the market by Blue Cross-Blue Shield, which might in some communities come to sell the bulk of the health insurance while also controlling the major HMO and reinsuring the competing HMOs against excessive risks.[227] Since Blue Cross is widely accused of being operated in the interest of the medical establishment,[228] the arguments against Blue Cross's extension into the HMO sector parallel the arguments against medical society sponsorship of prepayment plans: there is good reason to suspect that Blue Cross HMOs would hang back rather than develop the full potential of the HMO concept and that avoidance of the establishment's discomfiture would be their primary *raison d'être*.[229]

A more subtle reason also supports excluding health insurers from HMO sponsorship. Health insurers must have a powerful financial stake in the survival of fee-for-service medicine if their efforts are to be directed, in a way they have never been before, to reducing costs and increasing efficiency in that sector of the market. As long as health insurers have enjoyed a protected position, they have been willing to confine themselves to paying the bills submitted, seldom disputing the amount of fees or the patient's need for the therapy or surgical procedure performed or the hospitalization ordered. The rise in medical costs has not hurt health insurers enough to enlist them in policing the providers, and the easier course has been to seek rate increases from regulatory agencies or experience-based rate adjustments from insured groups. The public has thus lost practically the entire benefit of health insurers' potential economizing influence over providers.[230]

Faced in a free market with vigorous competition from a cheaper and more efficient delivery system, the fee-for-service sector might not survive as more than a vestige if health insurance premiums—which consumers will compare to HMO membership charges—continued to reflect the inefficiencies of the solo practitioner and his overutilization of hospitals and other resources. While some might not mourn the passing of this delivery mode, it seems desirable to maintain fee-for-service medicine as an available alternative for the benefit of those who value highly the

[227] Blue Cross has already commenced its move into HMO formation. *See* Am. Med. News, Apr. 5, 1971, p. 12.

[228] *E.g.*, HEALTH-PAC, *supra* note 115, at 153-63; Kotelchuck, *Trying to Shake the Blues*, HEALTH-PAC BULL., Mar. 1971, p. 1.

[229] Whether the antitrust laws could be used to accomplish the exclusion of Blue Cross and Blue Shield from HMO formation is not clear. As long as Blue Cross or Blue Shield performs solely as an indemnitor, it would normally be regulated under state insurance laws and therefore exempt from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. § 1012(b) (1964). *See* note 164 *supra*. If, however, it should engage in the provision of services in the manner of an HMO, it would seem no longer to be engaged in "the business of insurance" under the most accepted definition. *See* Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939). This would cause the loss of the McCarran-Ferguson Act exemption and might open up remedial possibilities similar to those canvassed with respect to HMOs affiliated with monopolistic hospitals.

[230] *See* generally SOMERS & SOMERS, *supra* note 156, ch. 20.

personalized care and the right of physician selection that it affords. Moreover, HMO enrollees are known to purchase some fee-for-service care, and this alternative source of care should be kept available.[231]

The market alone cannot adequately weed out the inefficiencies of fee-for-service medicine. The reasons are familiar: patients cannot easily recognize excessive treatment and often welcome it for psychological reasons. On the other hand, an insurance company barred from HMO formation would be intensely motivated to keep costs down in order that its premiums not become prohibitive in comparison with HMO charges. While there are substantial limits to what they can achieve without undesirable interference with actual treatment, they are capable of more than they have achieved up to now and could be expected to maximize their efforts only if they are not indifferent whether patients choose health insurance or HMO care. The medical profession should see the benefit to themselves in stimulating insurers' assistance in preserving the best and eliminating the worst aspects of fee-for-service medicine. They should also see the need to strengthen peer review and other utilization controls in the fee-for-service sector.[232] If the great power of the organized profession over its membership is not redirected to this task, fee-for-service medicine may not survive even to the extent to which, on merit, it is entitled.

The health insurance industry will also find an important role in reinsuring HMOs against those risks that the HMOs themselves cannot safely assume. Again, barring unnecessary restrictions, many of the services covered by such reinsurance will be specialist and hospital services purchased in the fee-for-service sector, and insurers will be motivated to control these costs in order that their reinsured HMOs will be better able to compete with larger HMOs which provide these services in-house and require less reinsurance. In this process they will be assisted by the insured HMOs themselves, which will face experience-rated premiums and will therefore seek the best available value in specialist and hospital services. Because insurers and HMOs are more medically aware than other consumers buying care in the fee-for-service sector, their influence will be salutary. With all of these factors operating, it would be reasonable to expect in the future a much better performance from the fee-for-service sector, including its insurance component, than it has delivered in the past.

5. *Implications for Financing Schemes*

The functioning of the market for health care could be destroyed by a financing scheme that failed to preserve the cost-consciousness of at least the greater number of consumers. Medicare and Medicaid have already destroyed the cost-consciousness of many consumers, and these models cannot be extended very much farther. The administration's proposed FHIP would expand the number of federally subsidized consumers, but, since many participants in that plan would be paying their own

[231] *See* notes 19 & 23 *supra*.

[232] *See* notes 157-59, 169-80 *supra* and accompanying text on the form that such efforts should not be permitted to take.

way in part, it has been possible to design the plan to preserve cost-consciousness. The critical feature in making the market-oriented system work even with substantial numbers of federally subsidized consumers is the "proxy-shopping" device explained earlier. Under this system the government in effect accepts a private subscriber's judgment on the value and price of the care rendered by a particular HMO in paying for such care on behalf of one of its clients. Whatever financing system is ultimately adopted—and it will not pay to evaluate specific proposals here—, every detail of it must be evaluated in the light of its effect on consumer cost-consciousness.

The handling of coverage, coinsurance, and deductibles will also require care if the market's ability to function is to be maximized. Complete exclusion from coverage throws consumers back on their own resources, which may be inappropriate from the standpoint of equity to the poor, protection against catastrophe, and loss of the potentiality for improved incentives through HMO development. Outpatient prescription drugs, for example, might be profitably included in coverage, though possibly subjected to a deductible or coinsurance requirement that would reduce program costs while retaining the correct incentives.[283]

While perhaps useful in reducing costs of the program to the government, coinsurance may also serve an important function in discouraging overutilization. A small per-visit charge is commonly recommended for this purpose, and outpatient psychiatric care is sometimes subjected to a large copayment requirement, presumably on the ground that it is largely elective and can be quite costly. Coinsurance does not deter equally in all economic classes, however, and may cause low-income consumers to forgo needed care. Graduated deductibles and coinsurance of the kind provided for in the FHIP proposal could be used to prevent unfairness in this regard.[284]

Another significant set of considerations relates to the benefits of any insurance scheme covering the poor. If coverage is significantly reduced by limits, deductibles, and coinsurance, plans may hesitate to enroll the poor because of the losses to be anticipated from defaults on bills for the services not covered.[285] If enacted in its present form, the administration's proposed FHIP, which imposes more substantial limits on benefits for the poor than for the nonpoor, might disappoint many of the hopes expressed earlier.[286] Because price competition among the plans would substantially eliminate the opportunity for making those overcharges to the affluent which have previously subsidized the poor, inability to pay will be even more significant than it previously was, and the disadvantage to the poor may in this respect be increased. But, since the affluent may ultimately benefit from a lowering of

[283] *See* notes 189-98 *supra* and accompanying text.

[284] S. 1623, § 201, proposed § 626(b).

[285] *See* notes 76 & 84 *supra*.

[286] Much would depend on whether, as an accounting matter, collection losses could be counted as an expense of caring for the FHIP group in determining "retentions." *See* text accompanying notes 49-50 *supra*.

charges over-all, Congress should be less hesitant to employ the income tax system to provide the resources needed to care adequately for the poor and to protect them against discrimination by profit-conscious providers. Parsimony at this stage, by retarding realization of a functioning market-oriented system, would be a false economy.

Conclusion

Enactment of the Nixon administration's health care proposals, even without the changes which I think are needed to create a truly dynamic market and the conditions for optimum HMO development,[287] would somewhat strengthen the basis for relying on the market to improve the health care system's performance. A broadened health insurance plan for the poor, universal health insurance with an HMO option for everyone, and general encouragement of HMO development should expand consumer choice, restore some vigor to price and service competition in health care, and increase cost consciousness. Congress, attracted by the combination of a reasonable likelihood of meaningful change and the essential conservatism of a market-oriented approach, may well find the administration's program to its liking.

The danger that I most apprehend is that Congress, in enacting a program dependent on the market as the primary means of social control, would fail to close

[287] Specifically, I would propose the following changes and amendments:

(1) If it is not already so, FHIP coverage should be made adequate to prevent discrimination against program beneficiaries. *See* text accompanying notes 235-36 *supra*. Federal payment of less than 100% of the cost of caring for the poor (after reasonable deductibles and copayments) would be merely a further subsidy to charitable providers but would exclude profit-conscious providers from participating in such care and would bar the poor totally from "mainstream" medical care.

(2) Consideration should be given to whether price controls may be needed to cushion the impact of a truly adequate FHIP. *See* text accompanying notes 58-63 *supra*. The intermediate approach of limiting payments under Medicare and FHIP, while protecting the public treasury, results in the discrimination against the poor objected to in (1) above.

(3) Provisions to put teeth into health planning legislation should exempt HMOs or at least non-hospital-based HMOs. *See* note 217 *supra* and accompanying text. While recognizing the complexity of the question, I also have reservations about enacting protection for existing hospitals.

(4) The legislative history should specify the market as one of the chosen mechanisms of social control and should note the appropriateness of antitrust enforcement to maintain it even in the face of inconsistent state law. *See* text accompanying notes 199-201 *supra*.

(5) To perfect the "proxy-shopping" device, the HMO definition should require that at least 50% of plan subscribers be self-supporting. *See* text accompanying notes 46-47 *supra*.

(6) Employers should be required to give employees a choice of enrolling with any available HMO, not just a selected one. *See* text accompanying notes 28-30 *supra*.

(7) Requirements as to the minimum size of HMOs should be eliminated. *See* text accompanying notes 39 & 214-16 *supra*.

(8) Medical societies and monopolistic hospitals should be barred, by antitrust action if not by statute, from HMO formation if they have the effect of preventing competitive HMO development. *See* text accompanying notes 119-82 *supra*.

(9) Health insurers should be barred from HMO formation. *See* text accompanying notes 226-32 *supra*.

(10) Attention should be given to reducing the incentive to engage in favorable risk selection. *See* p. 788 *supra*.

(11) The provisions preempting the field against the states should be clarified to confirm my understanding of their intended breadth. *See* text accompanying notes 208-13 *supra*.

all of the loopholes that might allow some group—the medical societies, the emerging new elite in university medical centers, or the health planners[288]—to dominate developments and the resulting market to an excessive degree. I have been at pains to show the vulnerability of the health care marketplace to trade restraints and monopoly, often imposed in the euphemistic name of quality assurance, ethics, and, lately, planning, and I have attempted to focus on the precise measures needed to combat monopolistic tendencies wherever they appear. Unfortunately, I see little room for compromise on the need to maximize HMO entry possibilities throughout the system and to foreclose collective action preempting or otherwise restraining independent HMO development. Congress must therefore scrupulously avoid enacting, and indeed must expressly prohibit—or anticipate antitrust action with respect to—, exclusionary measures of all but the most minimal kinds, such as character, fitness, and financial responsibility requirements. It must also prevent the provision of HMO-type care from being dominated, directly or indirectly, by persons—whether in the medical societies or the medical schools—who lack a total commitment to its maximum development, not as a stop-gap to forestall competition or government control or as a social welfare agency but as a competitive alternative attractive to all consumers. Where the need for added quality assurance or for compromise with the health care establishment appears, Congress should offer only strengthened oversight of the care rendered and stricter policing of objectionable practices, not exclusionary measures or exclusive privileges.

The chief obstacle to complete acceptance of the market model for health care delivery is probably an impression that increased reliance on the market and competition will exalt self-interest and commercialism, will dispel what altruism remains in health care, and will further devalue the human element in the relation between provider and patient. The probabilities seem otherwise to me, precisely to the extent that consumers value and, given the opportunity, will shop for attentive and sympathetic care and will express aversion for both the commercialized and the insensitive provider. Furthermore, the HMO's comprehensiveness and direct financial interest in its subscribers' health should make it responsive to the consumer's desire for health security, and salaried doctors in an HMO setting would seem freer to practice medicine altruistically—albeit with regard for economic efficiency—than are fee-for-service doctors. Moreover, the important object of pre-

[288] Michaelson, *The Coming Medical War*, N.Y. REV. OF BOOKS, July 1, 1971, p. 32, observes how a three-way split in the ranks of the medical profession is occurring, with the medical societies losing power to "the new medical elite," which resides in the "urban university medical center," *id.* at 34, denigrates the ordinary practitioner and his trade associations, and claims itself fit to be entrusted with all the decisions that must be made. The third group is a new radical fringe, which is about as critical of the new elite as of the old. A book originating with this third group, HEALTH-PAC, *supra* note 115, convincingly demonstrates that too often the values maximized by the decisions of the new elite, which controls vast sums dedicated by government and charity to health needs, are not consistent with the welfare of consumers. *See* notes 98-100 *supra* and accompanying text. The lesson may be that, because of this unresponsiveness to the public's concerns and the opportunities for abuse of power, nonprofit monopolies are no more to be trusted than the other kind.

serving or increasing the physician's respect for his patients, particularly the disadvantaged ones, is more likely to be achieved by giving the latter meaningful alternatives—and assuring that they have the financial means of selecting among them—than by any other scheme that government might foster; only a vigorously competitive marketplace can overcome the monopolist's tendency to take its customers for granted. Unfortunately, the tendency these days is toward fostering monopoly in various forms, often under the protection of exclusionary regulation by comprehensive health planning agencies.[239] This movement seems to pose a much greater threat than does the market to the consumer's freedom to select a provider on the basis of affinity and its responsiveness to his personal needs. The pluralism to which lip service is often paid by health planners and the contrivers of comprehensive "solutions" to the health care crisis is usually a pale substitute for the dynamic diversity that competition could inspire.

If the market model cannot be embraced wholeheartedly, it will probably have to be rejected altogether in the long run. Halfway measures are what we have now, and, lacking a clear perception of the problem, we are already moving clumsily to greater restrictionism. The addition of a monopolistic HMO to each market, which may be all the administration's plan in its present form would be able to achieve, seems to promise only an improvement, not a solution. While consumer choice would be increased slightly, consumers would hardly feel that their sovereignty had been restored, and the doctors' ability to run the health care system in large part for their own rather than consumers' advantage would not be greatly undercut, although power might be subtly shifted away from the medical societies toward what has been called "the new medical elite" in university centers.[240] In these circumstances, the movement for a greater consumer role in decision making would prosper as a continuing exercise in "countervailing power," which is the last resort of a public confronting a powerful and unresponsive monopoly. I personally find such politicization an unsatisfying alternative when compared with what I regard as the market's ability to re-enfranchise consumers by offering them attractive alternatives and, with universal health insurance, meaningful freedom of choice. Even if one pretends, against the evidence, that nonprofit monopolies involve no opportunity for undue private gain, their demonstrated capacity for staggering inefficiency and for ignoring consumer wants should argue for a strong antimonopoly policy and a reinvigorated health care marketplace.

My expectation that independent HMOs can substantially improve the performance of the entire health care system rests, first of all, on their ability to impose, almost for the first time, a needed cost constraint on physicians in caring for their patients. Price and benefit-package competition from aggressive and cost-conscious HMOs

[239] *See* note 217 *supra*, describing a federal effort to put teeth in state planning efforts. Parallel legislation in the states poses the same threat. North Carolina, for example, has just passed a bill denying anyone the right to construct health facilities until the "need" for them is certified by a state agency.

[240] *See* note 238 *supra*.

would then introduce unprecedented but essential pressure to control costs in the insured-fee-for-service sector, and health insurers would be driven to institute at least a mild form of peer review calculated to reach the most substantial abuses. The extent of HMOs' actual penetration of the market will therefore not directly measure HMOs' over-all value to consumers, and indeed consumers may continue in large numbers to prefer fee-for-service care even at a higher price. Nevertheless, an available lower-cost substitute, even if it is perceived to be somewhat inferior, can impose an effective check on the exercise of monopoly power, resulting in lower prices and greater efficiency than would otherwise prevail. Thus, even if HMO-type care should appear inferior in some respect to fee-for-service medicine, it still has a vitally important market function to perform. No evidence suggests that any loss in essential quality can be anticipated that would outweigh or even approach the substantial benefits that can be expected to flow from infusing HMOs into the health care system.

Professor HAVIGHURST. The issues in the health policy debate are, to say the least, exceedingly difficult to disentangle. Nevertheless, the overriding policy choice that has to be made is between a decentralized market-oriented delivery system and a system in which the financing and the greater portion of the decisionmaking are taken over by the Federal Government. The administration proposals, which I generally support, look toward major improvements in the functioning of the health care marketplace as a result of introducing health maintenance organizations as competitors of the insured-fee-for-service sector, compulsory health insurance with an HMO option for all employees, and Government-supported health insurance, again with an HMO option, for the elderly and the poor. My remarks today are confined to making the affirmative case for such a market-oriented health care system on the assumption, based on precedent from other fields, that displacement of the marketplace as a means of social control is warranted only if the market is found to be unable to do an acceptable job.

Posing the central issue as a choice between primary reliance on the market and primary reliance on bureaucratic control and regulation is helpful. Some may see this as a choice between the system we now have and the only remaining alternative, but it is possible to demonstrate that, due to past legislative and other restraints imposed by or at the behest of the medical profession, the market has never been given a chance to prove itself in delivering health care. The choice is therefore between two strategies of reform each of which holds out a hope for some fundamental improvement over the discouraging situation that we now confront. Resolution of the issue must include consideration of which scheme is more predictable in its outcome, would be more attractive even with significant deviations from expectations, and would leave viable future alternatives in the event of disappointing results.

The trade restraints to which the health care delivery system has been subjected are of several kinds. First, the medical profession's longstanding stranglehold on the supply of physician manpower long ago created a chronic shortage of physicians, thereby enhancing the income of those admitted to the trade. It is perhaps a fitting irony that this artifically maintained shortage is a primary ingredient of the crisis that now threatens to overwhelm physicians and convert them into adjuncts of a statist system.

Another important variety of trade restraints practiced or brought about by the medical profession reflects its dedication to preserving fee-for-service medicine, particularly against possible encroachments by plans of provider prepayment. Given the chance, such plans—the familiar forms of prepaid group practice or newer forms that could be encompassed under the rubric of "health maintenance organizations"—could long ago have provided the means for allowing the consumer to select a provider not only with regard to convenience, affinity, and his perception of quality but also with regard to price. Fee-for-service doctors would then have been driven by the price and service competition of the prepaid sector, as transmitted through health insurers, to reduce overutilization of the system, to improve their efficiency, and to attend to combining the elements of health care in packages that consumers would find reason to prefer.

The lesson from past experience is thus that it was not the market but a combination of legislative and professional restraints plus inadequate governmental support of care for the poor, that has blocked the delivery of health care resources when and where they were needed. This conclusion should argue for directing attention to the elimination of these restraints and the recreation of a functioning market system.

One seeming obstacle to a working market-oriented system is the fact that the health services industry features a high degree of monopoly power. Hospitals of course enjoy monopoly power by reason of their small numbers in particular geographic areas. Less obviously, each fee-for-service physician "monopolizes" in an important sense the market represented by his individual patients, whose medical ignorance, dependency, willingness to pay, and inability to bargain, when coupled with the doctors' agreement among themselves not to advertise or otherwise compete for business, prevent them from exercising that degree of choice necessary to make a market function effectively. Much of this monopoly power is probably inevitable, resulting as it does from economies of scale in hospital operation and from professional and societal mores, and there is probably no likelihood that the industry's performance could be significantly improved by stimulating competition within the fee-for-service sector as it now exists.

It is my view that that monopoly power which is inevitable in health care can be tolerated, but that it would be unfortunate to adopt policies that would foster further monopoly by reducing competition either overtly or by unintended consequence. Although most monopoly power in health care may be exercised by providers that are technically nonprofit enterprises, such monopolists have frequently slighted their patients' wishes, possess much weaker incentives to maximize efficiency than do their profitmaking counterparts, and have shown a propensity to operate for the convenience and benefit of their managers and medical staff. It is noteworthy that latter-day radicals object to monopoly less for its mere profitability than for its dehumanizing aspect and the power it accumulates, suggesting that a monopolist's nonprofit status is no defense. Health policy, it seems to me, must recognize the legitimacy of these concerns and could do so by making the individual consumer, rather than the provider, sovereign.

It is wrong to say, as many have, that the administration's program is unlikely to bring about needed basic changes in the health care system. In my view, it has the potential for being, with only minor changes, truly revolutionary. The primary condition that must be satisfied is that HMO entry not be made materially more difficult than it has to be.

My expectation that allowing free market entry for HMO's can improve the performance of the entire health care industry rests, first of all, on HMO's ability to impose, almost for the first time, a needed cost constraint on physicians in caring for their patients. By discouraging overutilization and realizing other efficiencies, HMO's will be able to quote a lower price than do health insurers for the same benefits or to give more coverage for the same price. Such competition would introduce unprecedented but essential pressure to control costs

in the insured-fee-for-service sector, and health insurers and professional groups would be driven to institute at least a mild form of peer or other review calculated to reach the most substantial abuses and thereby lower insurance premiums.

For the foregoing reasons, the extent of HMO's actual penetration of the market in terms of subscribers enrolled will not directly measure HMO's overall value to consumers, and indeed large numbers of consumers will probably continue to prefer fee-for-service care even at a higher price. Nevertheless, an available substitute can impose an effective check on the exercise of monopoly power, resulting in lower prices and greater efficiency than would otherwise prevail. Thus, HMO-type care, as a possible substitute for the fee-for-service variety, has a vitally important market function to perform.

I have attempted to evaluate these predictions in light of the possibility that monopolistic HMO's will emerge and so dominate the market as to deprive the public of the benefits which I have predicted will accrue, and I have found little reason to fear this result so long as proprietary HMO's are permitted to function and no requirements of minimum size and no unreasonable financial requirements are introduced. However, I strongly believe that the local medical societies and monopolistic hospitals which they dominate should be barred, by antitrust action if not by statute, from HMO formation if they have the effect, or adopt policies designed to have the effect, of preventing competitive HMO development. It is most important, to my mind, to prevent the provision of HMO-type care from being dominated, directly or indirectly by persons—whether in the medical societies or in the medical schools—who lack a total commitment to its maximum development, not merely as a stop-gap to forestall competition or government control or as a social welfare agency to serve the disadvantaged but as a serious contender for the role of family doctor for all Americans.

Mr. Chairman, enactment of the administration's health care proposals would, in my opinion, greatly strengthen the basis for relying on the market to improve the health care system's performance. A substantially broadened health insurance plan for the poor, compulsory health insurance with an HMO option for nearly everyone, and general encouragement of HMO development should expand consumer choice, restore some vigor to price and service competition in health care, and increase provider cost-consciousness throughout the system, all with generally favorable implications for the quality of care. I have, however, suggested in my prepared testimony a number of specific classifications or modifications in the Administration's program that I believe are called for to assure the creation of a truly dynamic marketplace and the conditions for optimum HMO development. I hope the committee will have an opportunity to consider those suggestions. I thank the committee for the opportunity to appear here today.

Mr. GIBBONS. We thank you for your very well-reasoned and sound arguments.

Are there questions?

Mr. BETTS. Are your suggestions included in the summary?

Professor HAVIGHURST. Yes. The summary lists 10 items developed at great length under item IV in the prepared statement. If you would

like me to run through them, I would be glad to do so. Some of them are largely technical, while others are of a fairly general nature.

Mr. BETTS. I personally intend to read them.

Mr. GIBBONS. Are there any questions?

Thank you, sir.

Professor HAVIGHURST. Thank you.

(Professor Havighurst's complete statement follows:)

STATEMENT OF CLARK C. HAVIGHURST, PROFESSOR OF LAW, DUKE UNIVERSITY

My name is Clark C. Havighurst, and I am a professor of law at Duke University. For the past 2½ years I have been Director of the Committee on Legal Issues in Health Care, which is organized under a contract with the National Center for Health Services Research and Development, U.S. Department of Health, Education, and Welfare. I am appearing here in my individual capacity, however, and do not purport to speak for the members of the Committee on Legal Issues in Health Care.

My interest in the health care industry grows out of my academic interests in the fields of antitrust law and public regulation of business. I have recently spelled out my views on many of the matters now being considered by your Committee in a lengthy article entitled "Health Maintenance Organizations and the Market for Health Services," which is published as part of a symposium on Health Care which I edited for the Journal Law and Contemporary Problems. I believe that copies of an abridgement of that article which I prepared have been made available to the Committee members, and I have provided several reprints of the entire article for the Committee's use.

The issues in the health policy debate are difficult to disentangle. Even though everything seems to be linked to everything else, the overriding choice that has to be made is between a decentralized market-oriented delivery system and a system in which the financing and a greater portion of the decision making is taken over by the federal government. Thus, the Administration proposals look toward major improvements in the functioning of the health care marketplace through the addition of health maintenance organizations (HMOs) as competitors of the insured-fee-for-service sector, through compulsory health insurance with an HMO option for all employees, and through provision of health insurance on a contributory basis for the poor. The Kennedy-Griffiths proposal, on the other hand, would require fee schedules, hospital cost reimbursement, and government-sponsored utilization controls to curb the tendency of providers to abuse a system that is essentially costless to the patient. My remarks are confined to making the affirmative case for a market-oriented health care system on the assumption, based on precedent from other fields, that displacement of the marketplace as a means of social control is warranted only if the market is found to be unable to do an acceptable job.

Of course, all markets depart in some measure from the economists' textbook models, but in most areas governmental action has been confined to improving rather than displacing the functioning of market forces. The policy judgments required are pragmatic, and one must not forget that bureaucratic schemes that look promising, indeed incontrovertible, on paper usually fall well short in practice of achieving their theoretical objectives.

I. THE MARKET FOR HEALTH SERVICES HAS NOT "FAILED"—IT HAS NEVER BEEN GIVEN A FAIR CHANCE TO SUCCEED

Posing the issue as a choice between primary reliance on the market and primary reliance on bureaucratic control and regulation is helpful. Some see this as a choice between the system we now have and the only remaining alternative, and, indeed, one prominent supporter of the Kennedy-Griffiths proposal argues, in criticizing the Administration proposals, that "the marketplace and the payment pattern have already demonstrated on massive and all but disastrous scales their inability to stay the inflation of prices and costs or to support needed improvements in the system." Falk, "National Health Insurance: A Review of Policies and Proposals," 3 Law & Contempt. Prob. 669, 693 (1971). It is possible to demonstrate, however, that, due to past restraints imposed by or at the behest of the medical profession, the market has never been given a chance to prove

itself in delivering health care. The choice is therefore between two strategies of reform each of which holds out a hope for some fundamental improvement over the discouraging situation that we now confront. Resolution of the issue must include consideration of which scheme is more predictable in its outcome, would be more attractive even with significant deviations from expectations, and would leave viable future alternatives in the event of disappointing results.

The trade restraints to which the health care delivery system has been subjected are of two kinds. First, the medical profession's longstanding stranglehold on the supply of physician manpower long ago created a chronic shortage of physicians, thereby enhancing the income of those admitted to the trade. It is perhaps a fitting irony that this artificially maintained shortage is a primary ingredient of the crisis that now threatens to overwhelm physicians and convert them into adjuncts of a statist system.

The other variety of trade restraints practiced by the medical profession reflects its dedication to preserving fee-for-service medicine, particularly against possible encroachments by plans of provider prepayment. Maintenance of a particular kind of pricing system is a hallmark of cartel behavior, and the medical societies' vigorous opposition to alternative forms of payment is in keeping with the classical style of monopolistic trade associations.

Not surprisingly, it has been the profession's object to preserve and perpetuate those very market imperfections that the critics of the system now point to as justifications for scrapping market forces in favor of a regulatory regime—namely consumer ignorance about the quality of and need for care, the patient's consequent need to delegate decisions to his physician, patients' willingness to pay handsomely for services thought beneficial to their health and third-party payors' difficulty in overseeing care with a view to controlling costs. While these factors are indeed obstacles to perfect market performance, it does not follow that consumers should not be allowed to make decisions regarding the manner and mode of delivery of the health care they purchase. Maximizing consumer choice will allow expression of preferences for such things as personal attention and prompt service and, in view of the recognized importance of patient confidence in and rapport with the provider, may have therapeutic benefit as well. Most national health insurance schemes purport to allow some consumer choice, but the "pluralism" to which they pay lip service is usually a pale substitute for the dynamic diversity that competition could inspire.

Given the chance, provider prepayment plans—the familiar forms of prepaid group practice or newer forms that could be encompassed under the rubric of "health maintenance organizations" in the Administration's program—could long ago have provided the means for allowing the consumer to select a provider not only with regard to convenience, affinity, and his perception of quality, but also with regard to price. Fee-for-service doctors would then have been driven by the price and service competition of the prepaid sector, as transmitted through health insurers, to reduce overutilization of the system, to improve their efficiency, and to attend to combining the elements of health care in packages that consumers would find reason to prefer. Free choice would have prevailed to a degree not found in the present system despite the medical profession's persistent fostering of "free choice of physician."

The profession's trade restraints have been foisted upon the public, including a substantial number of state legislatures, by appealing to certain "ethical" considerations and the need to preserve the quality of care. Since it was somehow assumed that doctors could safely be delegated the task of protecting the public in these regards, a great deal has been tolerated that would have been unacceptable under antitrust principles in any other field of endeavor. The strength of the consensus favoring quality in medical care has uniformly excluded adequate consideration of the effect of policies ostensibly rooted in quality concerns on the cost of care and on the quantity of it available. Thus, prepayment schemes of all kinds were resisted and legislatively curtailed without recognition of the benefits of the competition they could have provided. Also, the proliferation of licensure—to the extent that California now licenses some twenty-one separate health professions—has led to serious obstacles to efficient manpower utilization, with high economic costs to some health care consumers and a denial of needed care to others. Similarly, the medical profession has used quality claims to control medical education as a means of reducing the number of physicians in practice to a fraction of what the public would be willing to support. There is of course no way by which any improved care ob-

tained by some patients can justify the effective denial of needed care to millions of less advantaged persons.

Finally, the medical profession has been allowed to indulge its predictable preference for excluding nonphysicians from decision- and profit-making roles in the industry. By claiming that an ethical principle is involved, the profession has successfully excluded entrepreneurs capable of introducing organizational innovations into the system. The result is a system that is essentially unmanaged and disorganized, again with the consequence that it has failed massively to deliver needed care.

The lesson from this experience is that it was not the market but a combination of legislative and professional restraints that has blocked the delivery of health care resources when and where they were needed. The conclusion should argue for directing attention to the elimination of these restraints and the recreation of a functioning market system.

II. MONOPOLY, ALREADY WIDESPREAD IN HEALTH CARE DELIVERY, WOULD BE FOSTERED, STRENGTHENED, AND EXTENDED BY SOME PROPOSALS—A POLICY OF ENCOURAGING COMPETITION AND PREVENTING MONOPOLY (WITH INTENSIVE SUPERVISION TO ASSURE QUALITY OF CARE) SHOULD BE EXPLICITLY ADOPTED

The health services industry features a high degree of monopoly power. Hospitals of course enjoy monopoly power by reason of their small numbers in particular geographic areas. Less obviously, each fee-for-service physician "monopolizes" in an important sense the market represented by his individual patients, whose medical ignorance, dependency, and willingness to pay, when coupled with doctors' agreement among themselves not to advertise or otherwise compete for business, prevent them from exercising that degree of choice necessary to make a market function effectively. Much of this monopoly power is probably inevitable, resulting as it does from economies of scale in hospital operation and from professional and societal mores, and there is probably no likelihood that the industry's performance could be significantly improved by stimulating competition within the fee-for-service sector as it now exists.

In addition to being inevitable, some monopoly power in health care is not particularly objectionable. Most monopolistic hospitals are community or charitable enterprises whose wealth, including any monopoly "profits," are dedicated to public uses, and indeed monopolistic charges to paying patients have traditionally been used to subsidize unremunerative services, including free care for the poor. Similarly, the therapeutic importance of doctor-patient rapport may be great enough to justify the suppression of intra-professional criticism and de-emphasis of the commercial aspects of individual treatment situations. But the issue today is not whether monopoly, heretofore tolerated, should be stamped out but whether it should be fostered, strengthened, and extended. Many of the current proposals for altering the health care system tend to feature, according to the disposition of their proponents, either monopoly or a high degree of government control (or both) as a solution to existing problems, and it is a common assumption that the forthcoming policy choice must be between the lesser or some combination of these evils.

It is my view that, while some monopoly power is inevitable in health care and can be tolerated, it would be unfortunate to adopt policies that would foster monopoly by excluding competition either overtly or by consequence. Although monopoly power may be exercised by technically nonprofit providers, such monopolists have frequently slighted their patients' wishes, possess much weaker incentives to maximize efficiency than do their profit-making counterparts, and have shown a propensity to operate for the convenience and benefit of their managers and medical staff. It is noteworthy that latter-day radicals object to monopoly less for its mere profitability than for its dehumanizing aspect and the power it accumulates, suggesting that a monopolist's nonprofit status is no defense. See Health Policy Advisory, "The American Health Empire" (1970); Halberstam, "Liberal Thought, Radical Theory and Medical Practice," 284 N. Eng. J. Med. 1180 (1971). Health policy must recognize the legitimacy of these concerns and could do so by making the individual consumer, rather than the provider, sovereign. (Consumer collectives, incidentally, seem necessary only where there is no alternative but to confront monopoly with some kind of "countervailing power.")

The threat of increased monopoly in health services delivery may be difficult to resist because present circumstances make concentration and reduced com-

petition seem both logical and desirable. Not only has competition long been thought to be largely incompatible with the rendering of medical services, but recent recognition of the need to increase efficiency in health care now argues strongly for larger providers and for bringing the diverse components of the system under central control. Moreover, there is already in motion a potent vehicle of monopoly which is the more threatening because it has hitched itself to the widely accepted notion of "comprehensive health planning." Such planning is clearly needed for the purpose of supervising and coordinating the health investments of the public and eleemosynary sectors to prevent redundant, extravagant, or even corrupt expenditures, but this purpose does not justify the current tendency to extend planning to include private-sector investments and to give the planning agencies the power to prevent market entry wherever a "need" is not demonstrated to their satisfaction. (See, e.g., 1971 N. C. Sess. Laws ch. 1164; H.R. 1 § 221.) Unfortunately, "planning" is being silently metamorphosed into protectionist regulation for the benefit of incumbent providers. The planning agencies themselves have already reached the status, which all regulatory agencies may be dated to attain, of being the captive of the establishment they are expected to regulate.

Of course, as things now stand, community hospitals are indeed excessively vulnerable to competition, in part because their rate structures do not reflect the costs of their various services but more fundamentally because they bear a considerable financial burden in serving the poor, much of which must be covered by monopolistic charges to paying patients. Health insurance helps to spread these latter charges and prevents the monopolistic-charity model from being a totally irrational and inequitable way for society to absorb the cost of caring for the poor, but reliance on this model requires protective legislation and forfeits the benefits obtainable from preserving the threat of new entry.

Provision of medical care for the poor is not fundamentally incompatible with a more completitive health care marketplace. Thus, the Administration's proposals would pursue the more attractive route of providing the poor with adequate insurance coverage rather than subsidizing the providers of care by direct public grants or through award of monopolistic privileges. Of course, measures to improve disadvantaged citizens' ability to pay for care may reflect compassion for hard-pressed providers more than concern for the deprived poor themselves, but at least that compassion should not be carried to the extent of relieving providers of both the need to treat some nonpaying patients and the threat of competition. There is a real danger that the process of legislating protectionism will be completed at just about the time that the chief justification for it is largely removed.

Because of the serious implications of monopoly for efficiency, cost, and consumer rights—subjects that must be primary concerns of Congress—a policy of encouraging competition wherever possible and of limiting monopoly power should be explicitly adopted. The role of the antitrust laws should be recognized and endorsed, and it would be extremely helpful if Congress through this Committee would acknowledge the Sherman Act's applicability, without stint, to nonprofit, seemingly noncommercial instrumentabilities as well as the appropriateness of antitrust enforcement to maintain competition in this industry even in the face of inconsistent state law. Gradually it is coming to be recognized that distinctions between profitmaking enterprises (many of them managed by persons other than their proprietors) and nonprofit institutions (also often managed by persons capable of selfishly maximizing something other than achievement of the organization's stated objectives) are in many ways specious. No field cries out more loudly than does health care for policies embodying recognition of this fact and of the need for careful fostering of competition opportunities as a means of improving overall performance.

III. IF HEALTH MAINTENANCE ORGANIZATIONS ARE PERMITTED TO DEVELOP WITHOUT SUBSTANTIAL LEGISLATIVE OR REGULATORY RESTRCTIONS, THEY WILL STIMULATE MORE EFFECTIVE COMPETITION IN HEALTH CARE DELIVERY AND SHOULD SUBSTANTIALLY IMPROVE THE PERFORMANCE OF THE ENTIRE HEALTH CARE SYSTEM

It is wrong to say, as many have, that the Administration's program is unlikely to bring about needed basic changes in the health care system. In my view, it has the potential for being, with only minor changes, truly revolutionary. The primary condition that must be satisfied is that HMO entry not be made materially more difficult than it has to be.

My expectation that allowing free entry for HMOs can improve the performance of the entire health care industry rests, first of all, on HMO's ability to impose, almost for the first time, a needed cost constraint on physicians in caring for their patients. By discouraging overutilization and realizing other efficiencies, HMO's will be able to quote a lower price than do health insurers for the same benefits or to give more coverage for the same price. Such competition would introduce unprecedented but essential pressure to control costs in the insured-fee-for-service sector, and health insurers and professional groups would be driven to institute at least a mild form of peer or other review calculated to reach the most substantial abuses and thereby to lower insurance premiums.

For the foregoing reasons, the extent of HMOs' actual penetration of the market in terms of subscribers enrolled will not directly measure HMO's overall value to consumers, and indeed consumers may continue in large numbers to prefer fee-for-service care even at a higher price. Nevertheless, an available substitute, even if it is perceived to be somewhat inferior, can impose an effective check on the exercise of monopoly power, resulting in lower prices and greater efficiency than would otherwise prevail. Thus, even if HMO-type care should appear inferior in some respect to fee-for-service medicine, it still has a vitally important market function to perform. No evidence suggests that any loss in essential quality can be anticipated that would outweigh or even approach the substantial benefits that can be expected to flow from infusing HMOs into the health care system.

I have tested these expectations against the possibility that monopolistic HMOs will emerge and so dominate the market as to deprive the public of the benefits which I have predicted will accrue. I find little reason to fear this result so long as proprietary HMOs are permitted to function and no requirements of minimum size and no unreasonable financial requirements are introduced. Accomplishment of the goal of facilitating HMO entry will require that state laws be expressly rendered inapplicable to HMOs that meet minimal federal requirements. This and other specific entry-facilitating measures are discusssed under point IV below.

A specific and most important danger is that fee-for-service doctors, operating through local medical societies and community hospitals which they effectively control, may themselves create HMOs and thereby head off independent HMO development. Whether this would be a substantial danger with the Administration's total program in effect (especially NHISA with an unrestricted HMO option for all employees), I am not sure, but many local medical societies are responding to the HMO threat by the creation of "medical care foundations," society-sponsored HMOs which are expressly designed to pre-empt the field against plans not under the profession's control. I have argued in the "Law and Contemporary Problems" article that the foundations may violate section 1 of the Sherman Act. At the very least, medical societies and monopolistic hospitals should be barred, by antitrust action if not by statute, from HMO formation if they have the effect, or adopt policies designed to have the effect, of preventing competitive HMO development. It is most important to prevent the provision of HMO-type care from being dominated, directly or indirectly, by persons—whether in the medical societies or in the medical schools—who lack a total commitment to its maximum development, not merely as a stopgap to forestall competition or government control or as a social welfare agency to serve the disadvantaged but as a serious contender for the role of family doctor for all Americans.

IV. CERTAIN LEGISLATIVE STEPS, MOST OF THEM CONTEMPLATED IN THE ADMINISTRATION'S PROGRAM, ARE NEEDED TO ASSURE THAT MAXIMUM BENEFITS ARE OBTAINED FROM HEALTH MAINTENANCE ORGANIZATION DEVELOPMENT

Enactment of the Administration's health care proposals would greatly strengthen the basis for relying on the market to improve the health care system's performance. A broadened health insurance plan for the poor, universal health insurance with an HMO option for everyone, and general encouragement of HMO development should expand consumer choice, restore some vigor to price and service competition in health care, and increase provider cost-consciousness throughout the system, all with generally favorable implications for the quality of care. Congress, attracted by the combination of a reasonable likelihood of meaningful change and the essential conservatism of a market-oriented approach, may well find the Administration's program to its liking.

The Administration's program could be improved, however, by the changes which I am about to suggest. All of these changes are directed toward creating a truly dynamic market place and the conditions for optimum HMO development.

Declaration of a Legislative Purpose To Maximize HMO Entry Opportunities

In view of the overriding importance of preserving opportunities for HMO entry, Congress should declare, either in legislation or in legislative history, that the law shall be administered with a view to this objective. Specification of the relevance of antitrust law and policy would be helpful in this regard.

Congress and this Committee should recognize that ease of entry not only enlarges opportunities for entrepreneurs interested in HMO formation but supplies a beneficial restraining influence on sellers already operating in the market. Thus, a market populated by only a few sellers may yet behave competitively, in part because sellers recognize not only their existing rivals but also the risk that other sellers will appear if prices rise, or quality of service sinks, to a level making entry appear attractive. For these reasons, preservation of such "potential competition"—which might come from HMOs operating in adjoining areas, employers interested in cheaper care for their employees, or indigenous fee-for-service physicians—should be an important policy consideration.

Overriding State Laws Restricting HMO Development

Section 401(a) of H.R. 7741 would prevent state laws from being applied to prohibit operation of an HMO which had contracted with the Secretary of HEW to care for FHIP beneficiaries. Desiring only to expand the scope of this provision, I propose the following language as a seubstitute:

"Any health maintenance organization (or organization proposing to become a health maintenance organization) which makes an agreement with the Secretary of Health, Education, and Welfare to provide services for which payment may be made pursuant to part B of title VI of the Social Security Act shall comply with such requirements as the Secretary may include in such agreement or in regulations in order to secure efficient and economical provision of services of high quality and to carry out the other purposes of this section. No State law or regulation shall be deemed (i) to prohibit the incorporation of such an organization or the provision by it of the services contemplated under such an agreement, or (ii) otherwise to apply to such services except to the extent that such law or regulation would not be inconsistent with the terms of the agreement or with the Secretary's regulations issued pursuant to this subsection."

This language would permit an HMO to escape restrictions in state law during the organizational, planning, and developmental stages as well as in its operations. The text also indicates that the Secretary will be concerned with quality of care, which is the consideration ostensibly underlying the states' restrictive measures.

I think that the chances of a successful constitutional challenge to such a provision would be extremely small.

Lifting Entry Restrictions Imposed in the Name of "Planning"

Section 221 of H.R. 1, as reported by this Committee and passed by the House of Representatives, appears to confer on state authorities the power effectively to control all major new public and private investments in health facilities, including HMOs, and to prevent all new construction for which they are not satisfied that a "need," as they define it, exists. Experience in other regulated industries tells us that "need" in such circumstances is almost always defined with an eye to possible adverse effects on other providers of the service, indicating that legislation of this kind invariably protects existing providers from competition and explaining why it is regularly sponsored by them.

While this Committee has no present occasion to reconsider the provision referred to, I deem it extremely important that the Committee at this time recognize the destructive impact of the provision on the functioning of a health care marketplace. It is to be hoped that the Senate will delete at least those parts of section 221 which extend its coverage to HMOs, and that this Committees delegates to the House-Senate conference will seize the opportunity to rectify what I regard as a most serious error. Although, as I noted earler, the arguments supporting legislation of this kind are extremely persuasive on their face, I hope that the Committee will reconsider its judgment now that it has had an opportunity to recognize its full implications.

Elimination of a Minimum Size Requirement

Some but not all of the Administration's bills contain a requirement that an HMO have 10,000 enrollees as a minimum. This requirement, which appears in H.R. 7741, would seriously inhibit entry and should be eliminated. The ability of smaller HMOs to survive, perhaps by dint of characteristics other than rigorous efficiency, should be tested in the marketplace and not in legislative halls.

Clarification of the Mandatory HMO Option Under NHISA

The proposed National Health Insurance Standards Act in section 101 of H.R. 7741 does not make it clear that employees would be entitled to choose among all the available HMOs in the community and would not be bound by the employer's election of a single HMO to which their participation would be transferable at their option. Clarification is needed to assure that each employee will have, in effect, a voucher entitling him to enter the marketplace in search of the kind of HMO care that appeals to him most. Only such arrangement would permit significant competition among HMOs and would prevent pre-emption of employment groups by medical care foundations or other HMOs dominated by doctors dedicated to preserving fee-for-service medicine.

Clarification of the Membership Requirements

There is a technical problem in the articulation of the membership requirements for HMOs in H.R. 1 and H.R. 7741. In H.R. 1 it is sepcified that at least half of the enrollees must be under age 65, and under H.R. 7741 at least half of the HMOs enrollees are required to be neither FHIP- nor Medicaid-eligible. These definitions should be altered to integrate them in such a way that an HMO could not be constituted with nearly half of its enrollees covered by Medicare and most of the other half made up of FHIP and Medicaid beneficiaries. The purpose should be affirmatively to require the HMO to serve a substantial population of enrollees who are non-federally supported subscribers who have chosen the HMO over the other alternatives available to them, including health insurance. Such a membership requirement would provide added assurance of the quality of care provided and would guarantee that the beneficiaries of the federal program would not be segregated in HMOs serving only or primarily publicly supported persons. Moreover, the statutory limitations to be imposed in the HMOs profit rate in serving Medicare and FHIP beneficiaries require the presence of a substantial portion of non-federally supported individuals in each HMO.

The Role of Health Insurers

I see substantial merit in prohibiting health insurers from sponsoring HMOs. The more obvious reason is to avoid domination of the market by Blue Cross and Blue Shield, which might in some communities come to sell the bulk of the health insurance while also controlling the major HMO and reinsuring competing HMOs against excessive risks. Since Blue Cross and Blue Shield are widely accused of being operated in the interest of the medical establishment, the arguments against their extension into the HMO sector parallel the arguments against medical society sponsorship of prepayment plans: there is good reason to suspect that the Blues' HMOs would hang back rather than develop the full potential of the HMO concept and that avoidance of the establishment's discomfiture would be their primary raison d'etre.

A more subtle reason also supports excluding health insurers from HMO sponsorship. Health insurers must have a powerful financial stake in the survival of fee-for-service medicine if their efforts are to be directed, in a way they have never been before, to reducing costs and increasing efficiency in that sector of the market. As long as health insurers have enjoyed a protected position, they have been willing to confine themselves to paying the bills submitted, seldom disputing the amount of fees or the patient's need for the therapy or surgical procedure performed or the hospitalization ordered. The rise in medical costs has not hurt health insurers enough to enlist them in policing the providers, and the easier course has been to seek rate increases from regulatory agencies or experience-based rate adjustments from insured groups. The public has thus lost practically the entire benefit of health insurers' potential economizing influence over providers. While there are substantial limits to what insurers can achieve in this regard without undesirable interference with actual treatment, they are capable of more than they have achieved up to now and could be expected to maximize

their efforts only if they are not indifferent to whether patients choose health insurance or HMO care.

Exclusion of health insurers from HMO formation would of course cut off an important source of needed expertise and initiative. For example, no one else possesses in such abundance the actuarial data and techniques needed for HMO development. Nevertheless, insurers excluded from HMO formation might profitably enter the consulting business, or their actuaries might be hired away by HMO developers or consulting firms. Moreover, although health insurers possess large capital resources that one might wish to attract into HMO development, exclusion of such insurers might make HMO investments more attractive to an even larger pool of private capital. Even if HMO development were slightly slowed by exclusion of health insurers, the more important long-range goal of fostering vigorous competition would be furthered by the concomitant widening of entry opportunities.

A final matter to which attention should be given is the extension to health insurers of the requirements for open enrollment to which HMOs will be subject. In other words, health insurers, like HMOs, should not be allowed to decline applications on the ground of health. This requirement is necessitated by the need to protect the HMO sector from being overburdened by persons whose present health or history renders them uninsurable under the present system. Some such requirement is necessary if "community rating" and fair competition are to prevail.

Adequacy of Benefits of the FHIP Program

If the coverage of an insurance scheme for the poor is significantly restricted by unrealistic benefit limits, deductibles, and coinsurance, providers may hesitate to enroll the plan's beneficiaries because of the losses to be anticipated from defaults on bills rendered for services not covered. Federal payment of less than 100% of the cost of caring for the poor (after reasonable deductibles and copayments) would be merely a further subsidy for charitable providers and would exclude profit-conscious providers from participating in such care, The poor would continue to be barred from the medical care "mainstream."

Whether the benefits provided by the Administration's Family Health Insurance Plan (FHIP) would be adequate to prevent discrimination against its beneficiaries is something that I am not in a position to judge. But this Committee should make every effort to satisfy itself that such discrimination would not occur. The workability of a market-oriented system of health care depends heavily on the ability of poor persons to enter the marketplace.

Price Controls

Congress would be understandably reluctant to provide funds for health care for the poor if, as happened with Medicare, a large part of the public's investment would be lost in higher prices as the market sought to ration limited resources among the increased number of users of the system. Price controls may therefore appear desirable to prevent further enrichment of providers largely at government expense and continued denial of care to those whose circumstances, even with a government supplement for health care, would not permit them to bid effectively in the market against the more affluent. The existence at this time of price controls throughout the entire economy has provided an occasion for direct action with respect to the costs of medical care. With prices controlled. Congress should have less reason to be shrinking from adopting a truly adequate FHIP that would not result in discrimination against its beneficiaries.

In the context of a freeze on medical costs, I would suggest that any controls on HMO charges should be limited to the kind proposed for government payments to HMOs in the Medicare amendments and the proposed FHIP program, namely a premium ceiling of 95% of the actuarially determined cost of caring for the HMO's patient population in the fee-for-service sector. An attractive byproduct of leaving HMOs free to earn profits within this leberal constraint might be substantially increased attractiveness to physicians of HMO employment as providing both a relative haven from government control and a better opportunity for increasing earnings. Such increased incentives for HMO organization under a system of frozen fee-for-service prices would speed the realization of efficiencies and the needed reallocation of resources and should assist in making possible the eventual end of price controls.

SUMMARY

I. Contrary to common assertion, the market for health services has not "failed." Rather it has been prevented from functioning effectively by legislative and other restraints that have curtailed the supply of manpower and inhibited organizational innovations and efficiencies, particularly with respect to plans featuring provider prepayment. Because the market has not been proved incapable, primary attention should be given to eliminating restraints and recreating a functioning market system.

11. Monopoly power in health care, even though often possessed by nonprofit institutions, has serious adverse implications for efficiency, cost, and consumer rights, suggesting the need for policies to encourage actual and potential competition and to limit monopoly. A degree of monopoly power is probably inevitable in health services and can be tolerated, but special attention should be given to framing policies that do not foster, strengthen, or extend such power.

III. Health maintenance organizations, by virtue of certain efficiencies, can offer benefits for a lower price than can health insurers. The competition they provide should contribute to improved performance by the entire health care industry. To prevent monopolistic developments, policies should be framed to facilitate HMO entry and encourage competition.

IV. The Administration's package of proposals promises to work needed basic changes in the health care system, with beneficial effects on the cost, availability, and quality of care. In order to ensure maximum benefits, the following specific measures require attention:

(1) Congress should expressly declare a policy of maximizing HMO entry opportunities.

(2) Congress should expressly override state laws restrictive of HMO development.

(3) HMOs should be freed of most restrictions imposed by local "health planning" agencies, which have a serious tendency to foster monopoly by protecting incumbent providers against competition.

(4) HMOs should not be subjected to a minimum size requirement.

(5) The mandatory HMO option under NHISA should be clarified to maximize HMO opportunities.

(6) Certain HMO membership requirements should be clarified to assure that each HMO will be required to attract a substantial proportion of self-supporting enrollees in competition with other providers.

(7) Health insurers should be barred from organizing HMOs in order to prevent their domination of the market and to cause them to direct their attention to controlling fee-for-service costs.

(8) Health insurers should be subject to open enrollment requirements similar to those applicable to HMOs.

(9) FHIP benefits should be made sufficient to prevent the plan's beneficiaries from being discriminated against because of their inability to pay for services not covered.

(10) Congress should take advantage of the current price controls to enact the Administration's FHIP with substantial benefits and should allow HMOs to function under a liberal price ceiling likely to make HMO formation attractive.

Mr. GIBBONS. Prof. Lowell S. Levin, Society for Public Health Education. Would you come forward, please.

STATEMENT OF LOWELL S. LEVIN, ED. D., M.P.H., THE SOCIETY FOR PUBLIC HEALTH EDUCATION, INC.; ACCOMPANIED BY MRS. CAROLYN McCALL

SUMMARY

The Society for Public Health Education, a national professional association, presents a position in favor of a national, universal health insurance program. Within the context of general support for such a program, the Society gives special emphasis to the need for health education as a specific, funded benefit.

A rationale for educational benefits is given, including the expected contribution of such benefits to the reduction of human factors failures in the health

delivery system. Examples are given as suggestive of a broad potential for health education in national health insurance. Specific criteria for educational components are listed and recommendations are made for implementing development and proving of appropriate health education techniques.

The Society for Public Health Education states its availability to advise in technical design of educational components for inclusion in a benefits package.

RECOMMENDATIONS

The Society for Public Health Education recommends:

1. Approval of national health insurance, universal in coverage and eligibility and providing preventive, curative and rehabilitative benefits.
2. Inclusion of education of the consumer, patient and provider as a specified, funded, benefit.
3. Constitution of an office of health education in the U.S. Department of Health, Education, and Welfare.

Professor LEVIN. I would like to be joined in this testimony by my colleague and coauthor of this statement, Mrs. Carolyn McCall, who recently was the health planning consultant to the Seattle model cities program.

Mr. GIBBONS. We are glad to have you here. We welcome you to the table.

Professor LEVIN. Mr. Chairman, and members of the committee, I am Lowell S. Levin, associate professor of public health, Department of Epidemiology and Public Health, Yale University School of Medicine, New Haven, Conn. My testimony today is on behalf of the Society for Public Health Education, Inc., with headquarters in San Francisco.

The Society for Public Health Education is a national association of 680 individuals with professional interests and expertise in promoting, through education, better health practices both by the consumers of health care and by those who provide health care. In addition to setting standards for the education and training of public and community health educators and developing continuing education for practioners of health education, the society publishes a professional journal, Health Education Monographs, and Abstracts of relevant journals.

By the way, I left copies of all these materials at the staff office.

The society through its national committees and its 13 regional chapters, reaching from Boston to North Carolina to Hawaii, works closely with and through governmental and voluntary health groups, community health groups and health services programs to enhance the effectiveness of preventive and curative health efforts.

POSITION ON NATIONAL HEALTH INSURANCE

Those of us in public health who have worked to achieve more efficient and effective utilization of health resources cannot escape recognizing the overwhelming negative impact of the financial barrer to health care. All levels of society and all age groups are affected. We are faced with the fact that the often devastating costs of medical care are not calculated to encourage an individual's use of the care system in ways that will contribute to early detection and the lessening of disability. Indeed, the reverse is true. Our present limited sickness-payment system of financing encourages episodic, crisis medicine, with gaping holes in comprehensiveness and continuity.

Frankly, we believe that we have gone just about as far as we can go in encouraging preventive health behavior on the part of consumers and of providers until we have a nationwide health insurance coverage that takes the money factor out of the consumer's decision to seek or the provider's decision to deliver health care.

The Society for Public Health Education, through a unanimous vote of its membership at the annual meeting in Minneapolis earlier this month, has gone on record as being firmly and strongly in support of a national health insurance program with universality of eligibility and coverage, with no restrictions as to age, sex, citizenship, residence, ethnic group, income or employment status or the nature of the health need.

We are prepared to support an insurance plan that embodies this characteristic of universality and covers all manner of recognized medical services for prevention, cure, and rehabilitation; provides and maintains standards of quality; involves consumers together with providers in the process of planning and evaluating effectiveness; and insures public knowledge of program operations.

It is these essential criteria upon which our recommendations for enhancing the effectiveness of any national health insurance program rest. We are convinced that the adoption of these criteria will make it possible to operate free of constraints which erode our ability to have a significant impact on matters of efficient and effective utilization. Any approach of national health insurance that is exclusively geared to removing the economic barriers to care and omits these above design criteria loses any leverage for improving the quality of use. The United States must adopt a plan which gives a fighting chance to prevent disease and illness, to reduce inordinate dependence on health resources, to develop individual responsibility for health maintenance, and to tailor care to the needs and expectations of the consumer and of the provider.

Beyond removal of economic barriers the human factor is the central issue. Patterns of consumer and provider behavior are firmly established. Change in values and attitudes regarding the use or the provision of health resources will require a mandate and a purposeful set of plans, benefits, and sanctions for education of all involved.

EXAMPLES OF HEALTH EDUCATION IN HEALTH CARE

The members of the Society for Public Health Education are particularly experienced in dealing with the human factors aspect of health—that is, in dealing with motivation, behavior, learning, and communication. We are interested, for example, in solving such problems as patient delay in seeking medical care, unnecessary readmission to hospital for the same condition, patient inability to use health services appropriately, breakdowns in communication and motivation resulting in patient failure to follow orders or to take medications, unnecessary delay in patient recovery, and the like.

Let us take a look at some examples of the need for health education to reduce costs and preserve health, and some examples of actual impact of health education on utilization of health care.

Admittedly, gentlemen, I selected these from among many choices, and again I have included in my materials to the committee staff a variety of other research activities that you might want to review.

In 1969 the Department of Health, Education, and Welfare Task Force on Health Manpower pointed out that practically all deaths from cervical cancers could be prevented, and hospital and medical costs for women with this condition be reduced by half, that is, reduced from $2,000 to $1,000 per patient, if women had regular Pap smear tests. Although the knowledge has been available since 1928, cervical cancer continues to kill 8,300 women annually and to require nearly a million days of hospital care each year. Only 1 in 4 women 20 years of age or over has a Pap smear each year.

A second exmple from the same DHEW report: About 95 percent of recurrences of rheumatic fever, along with resulting heart damage and deaths, could be prevented through preventive, regular doses of penicillin or other antibiotic. Although we have known how to prevent recurrences of rheumatic fever since 1943, rheumatic fever and rheumatic heart disease continue to kill nearly 18,000 persons annually and require more than a million days of hospital care each year. Only one in 20 persons who have had rheumatic fever receives medication.

Who needs health education in such situations? Professionals do in terms of appropriate screening and prescribing; patients do in terms of motivation and understanding; families do in terms of support and reenforcement; and those in control of health planning and financing do in terms of making service available and acceptable.

A number of projects have been reported which show the impact of education on the hospitalization of patients with congestive heart failure. In Dade County, Fla., a study was made of two groups of patients with congestive heart failure. After hospital discharge one group received nursing visits with a strong educational component; the other group did not. The group receiving education required substantially fewer days of hospitalization—332 days—than the group receiving no special educational services, 521 days.

In Loma Linda, Calif., patients in the study group which received intensive "educational care," as it was termed, were far less likely to have to return to the hospital than a comparison group which did not receive educational service. Sixty-one of the 69 study patients were able to stay out of the hospital over a 1-year period. Only 38 out of 66 patients who did not receive "educational care" were able to stay out of the hospital. In other words, three times as many of the "uneducated" had to return to hospital.

A study at St. Peter's hospital in New Brunswick, N.J., showed that of a group of 50 patients with congestive heart failure, 23—almost half—had to return to hospital for a total of 600 bed-days. After undergoing a program of education and counseling, only six had to be rehospitalized for a total of 148 bed-days. Because of the progressive nature of this condition, hospitalization cannot be eliminated, but this amount of reduction in the most costly aspect of care is clearly worthwhile.

INFORMATION AND CONSULTATION OFFERED

Various other examples could be cited showing the impact of education on prevention, cure, or rehabilitation, but in the limited time

available, I shall not cite others. The Society for Public Health Education has available to you here today other examples of research and demonstration which suggest the potential that educational approaches have in reducing unnecessary human suffering and in reducing the waste of scarce health resources.

Additional documentation and technical consultation is available from the society to this committee or to any agency of Government designated to pursue these matters.

ESTABLISHMENT OF FEDERAL OFFICE OF HEALTH EDUCATION

It is our contention that a health education benefit component be incorporated in the total health care benefit package included in any legislation to be passed by the Congress. In order to establish a focal point for leadership in developing these educational benefits, we recommend that the Department of Health, Education, and Welfare constitute an Office of Health Education to be charged with identifying and testing techniques and procedures of health education which hold most promise.

THE EDUCATIONAL COMPONENT IN NATIONAL HEALTH INSURANCE

Educational techniques selected for inclusion as a benefit in national health insurance must be those which can be made available universally and which can be easily and efficiently used by personnel possessing highly variable levels of educational skill and experience. Training costs in the use of new educational devices must be minimal in terms of time and money. Supervision and evaluation of the educational service also must conform to practicalities in the most modest health care setting. And, finally, the educational benefits component must have the potential for growth and variation appropriate to a given locale, clientele or situation.

There is time here only to give one example of a specific type of educational technique, that is, "a patient educational diagnosis and treatment plan." The idea is simple—it calls for a brief, structured interview of the patient at the time when the medical diagnosis is made. It is an inquiry into a patient's knowledge and concerns about the diagnosis and proposed treatment plan. Such information, incorporated as part of the patient's medical record, becomes the basis for a tailored explanation of what is required, and how well the patient understands the proposed regimen.

Most importantly, the educational diagnosis fixes responsibility for the educational effort and guides the steps required for that patient to play his own role in regaining and preserving his health. Furthermore, such a device fits comfortably into the overall well-established pattern of clinical evaluation, diagnosis, and treatment.

EDUCATIONAL TECHNIQUES: ARE THEY READY?

Techniques such as patient educational diagnosis, like many other devices, have been limited in their application to a handful of scattered

demonstrations. Much more needs to be done to test their efficiency, but further trials must be set with a particular operation and goal in mind. The methods must be tested within the costing and other constraints of a national health insurance program.

While it is clear that further development is necessary, it is equally clear that we need not start from scratch. We must begin now to cull the best that is available and consider a variety of pilot efforts within the context of existing health legislation, particularly medicare. Specific proposals in this regard have been made to the Congress in the past, several from the Department of Health, Education, and Welfare. Now there is a new urgency. We simply cannot afford in hard dollars-and-cents terms to move into the arena of blanket national health insurance coverage without the machinery—largely educational—to reduce wastage both of resources and human lives.

Now is the time to be frankly pragmatic. If it works, let's get on with it.

Let's take a fresh look at some of the existing results of patient education programs such as those in New Jersey, California, Florida, and elsewhere. Certainly, there is a sufficient basis in our present experience to have confidence in the belief that patient education, in an organizational arrangement which is supportive to its use, can reduce the short- and long-run costs of health care. Standing pat would mean that we are willing to live with a situation where, for example, 30 percent of patients fail to follow their doctor's orders for reasons which must include failure to understand the importance of the prescribed regimen and for failure of the regimen to take into account the full story of the patient's situation.

SPECIFIC RECOMMENDATIONS

On behalf of the Society for Public Health Education, I would like respectfully to place before you our recommendation that a national health insurance program be enacted with the characteristics of universality described in the body of this statement; and that such a program fund an educational benefit with fixed responsibilities to:

1. Acquaint the public with the availability, benefits, and limitations of the program;
2. Insure continuous public knowledge of and participation in the planning, operation, and evaluation of the program;
3. Encourage the appropriate use of national insurance benefits in order to reduce length of stay in hospital, repeated unnecessary admissions for the same diagnosis, and failure to comply with medical advice;
4. Help patients achieve and maintain appropriate levels of self-sufficiency in personal health;
5. Assist all elements in the provider system to learn from patients as well as to teach them; and
6. Establish a patient feedback mechanism to help in spotting communications breakdowns and to contribute ideas to enhance effectiveness.

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CONGRESSIONAL LEADERSHIP

For many years, the Congress of the United States has profoundly influenced the level of health in this country by taking leadership to set standards. Before the First World War, the Congress in establishing the childrens bureau created a mechanism to formulate health standards for women and children.

During the mid-1930's the Congress established matching grants to States for crippled childrens programs which were required to meet standards for personnel, fiscal accountability, and program. Today we make a plea that the Congress continue this tradition of setting standards for whatever program of national health care funding is adopted.

May I repeat the society's sincere wish to be of service in advising in the technical design and testing of the educational component we believe is so crucial to the success and economic viability of a national health insurance program. Thank you.

APPENDIX

NATIONAL HEALTH PROGRAM GUIDELINES OF THE SOCIETY FOR PUBLIC HEALTH EDUCATION, INC.

We believe that health is a basic human right. In order to preserve and improve the health of the people of our Nation, we believe that government, at its several levels, should create "a program that assures universal access to comphehensive and continuous health services of high quality, and in a manner that is efficient and economical." (Burns, Eveline M., "A Critical Review of National Health Insurance Proposals," HSMA Health Reports, vol. 2, Feb. 1971, p. 111.) Such a program should also have the following characteristics:

1. Appropriate education of patients within the categories of comprehensive services which include prevention, diagnosis, treatment, and rehabilitation;
2. Consumers and providers participating equally in planning and in determining philosophy, administrative structure, and procedures;
3. Consumers, their elected representatives, and health professionals sharing in the continuous review of services rendered;
4. Universality of eligibility and coverage with no restrictions as to age, sex, citizenship, residence, ethnic group, income or employment status, or the nature of health condition, whether or not preexisting;
5. Equality of benefits available to all regradless of ability to pay;
6. Education of patients to develop appropriate utilization patterns, enhance participation in decisionmaking, motivate patients toward accepted health practices; and education of health professionals and other providers to develop the sensitivity, knowledge, and skill to communicate effectively with consumers.
7. Education of both school age and adult population in prevention, health maintenance, and appropriate use of services.

(The following was supplied to the committee:)

SUPPLEMENT TO TESTIMONY OF THE SOCIETY FOR PUBLIC HEALTH EDUCATION

1. MEMBERSHIP ROSTER AND OFFICERS

2. RESEARCH AND DEMONSTRATIONS

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2. Klein, Susan F., "Toward a Framework for Evaluating Health Education Activities of a Family Planning Program," *A.J.P.H.*, Vol. 61, No. 6, June 1971, pp 1096–1109

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Mr. BYRNES. Thank you very much.

Mrs. MCCALL. Mr. Chairman, could I speak on a question raised earlier by Mr. Pettis, and one raised earlier by Mr. Corman?

Mr. Pettis raised a question about making the medical school training more efficient, and there was some discussion of techniques of doing this. I would like to mention to you, Mr. Pettis, that at the University of Washington, which is a regional medical school in the sense it is the only one in that part of the Northwest, a system has been developed by which students may take some of their years of their medical training in their home universities, for example, in Alaska, Montana, in Idaho. They may take their first year at home, come into the University of Washington for some of the laboratory medical science training, go back to their home, and return again. So for every class you have in the university the idea is you will also have a class outside of the university. This concurrent use of different kinds of facilities will in fact, if it works as intended, mean that more students are graduated, and that is an idea that might be duplicated elsewhere.

The other question raised is the question having to do with costs.

Mr. Corman mentioned that according to the figures submitted to the committee for comprehensive health care, the costs run something like $1,200 per family per year. I would hope this committee is going to hear, and if you are not, to see to it that you do hear a representative from the Group Health Corp. of Puget Sound, an organization that is 27 years old and has 145,000 patients. It gives comprehensive health care. They own their own hospital, and their area clinics. Their costs run between $500 and $600 per family of four per year.

This coverage is complete. It includes catastrophic illness, it includes mental health benefits, and it includes all of the ordinary medical health care one would expect except for dentistry. When I was working in the project in model cities, a prepaid health care project, half of our patients were being taken care of by group health and half through Blue Cross/Blue Shield mechanisms.

There was something better than a $20 per month per family spread for identical benefits from these two sets of providers.

Group Health makes its savings largely because of the emphasis on prevention; the fact they use a drug formulary, and use generic drugs, the least expensive; and the fact that many procedures are done out of hospital, that in the ordinary situation are done in hospital. For example, many procedures for which one is hospitalized the night before and run through a battery of laboratory tests use up to 2 hospital days. This is done on an outpatient basis in this program because the physical facilities are so arranged that the procedures can be done immediately adjacent to the hospital.

If there is difficulty, the patient can be hospitalized and for most patients there is no difficulty. Group health as a prepayment mechanism budgets to control costs. So there is now this organization that has existed for 27 years and that demonstrates you can do comprehensive health care at reasonable costs.

Mr. BYRNES. I understand they are testifying Monday.

Mr. CORMAN. That figure I referred to was one given us by the insurance industry, that would be the cost for a comprehensive policy.

Thank you very much.

The hearing is adjourned. We will be in session Monday at 10 a.m.

(Whereupon the hearing was adjourned at 2:10 p.m., until 10 a.m., Monday, November 1, 1971.)

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