NATIONAL HEALTH INSURANCE, 1978

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON HUMAN RESOURCES UNITED STATES SENATE

NINETY-FIFTH CONGRESS

SECOND SESSION

ON

EXAMINATION ON THE SOARING PRICE OF MEDICAL AND HOSPITAL COST AND WHY WE SHOULD HAVE A NATIONAL HEALTH INSURANCE PROGRAM TO MEET THE HUMAN NEEDS OF THIS NATION

Part 1

OCTOBER 9, 10, AND 13, 1978, WASHINGTON, D.C.

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NATIONAL HEALTH INSURANCE, 1978

MONDAY, OCTOBER 9, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH,
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:10 a.m. in room 4232, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Kennedy.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. We will come to order.

National health insurance: Few ideas have been the subject of more national debate and less congressional action.

Over the years one by one, every industrialized nation in the world except the United States and South Africa has debated and adopted a national health insurance program. Yet the human and economic need for such a program is as compelling in the United States today as it was in any country that has adopted national health insurance. And the need grows each day.

The economics of the situation are truly frightening. Everyone today agrees that health care costs are out of control. This rampant inflation takes its toll everywhere—on Federal budgets where the percentage of the Federal dollar spent on health has risen from 4.3 percent in 1963 to 12.7 percent this year; on State budgets where medicaid costs have become the single most rapidly escalating cost; on corporations, which pay more and more each year for health benefits; on the American family, which must pay $2,115 today and $3,500 in 1983, for benefits which cost $533 in 1963; on the elderly, who pay more for their care today out of their own pockets than the year medicare was implemented.

Hospital costs are so out of control that usually rational people talk about establishing a 12-percent hospital inflation rate as a public policy objective to control costs. There is something fundamentally wrong when the best one can hope for is to "limit" hospital inflation to 12 percent. It is astonishing that even that unacceptable target would save $30 billion over the next 5 years. But such is the case in an area where costs are increasing at the rate of $1 million per hour.

The Nation as a whole will spend $252 billion in 1981 on health care, and that money will pour into a system without cost controls, without quality controls, with uneven access to care and without prospects for improvement.

National health insurance is the last, best chance to halt this staggering economic waste. Costs containment is at the very heart of the health insurance debate.

Every American family knows what it means to live within a budget. It is time the American health care system learned to live within a budget. The proposal I introduced last week imposes such a budget. Under this approach, all health care costs will be prospectively budgeted. The American people will no longer have to hand a national blank check over to the health care industry. No other program to guarantee comprehensive benefits to all Americans will cost less than this proposal. In fact, once cost containment takes effect, the Nation will pay less for health care under national health insurance than if the current nonsystem is left unchecked. That is a fundamental point. The choice is not, as opponents would have us believe, between an expensive new program or no program at all. The choice is between comprehensive benefits for all Americans in a system with cost controls at every level or a continuation of the current patchwork system, with millions and millions of Americans denied care and costs continuing out of control.

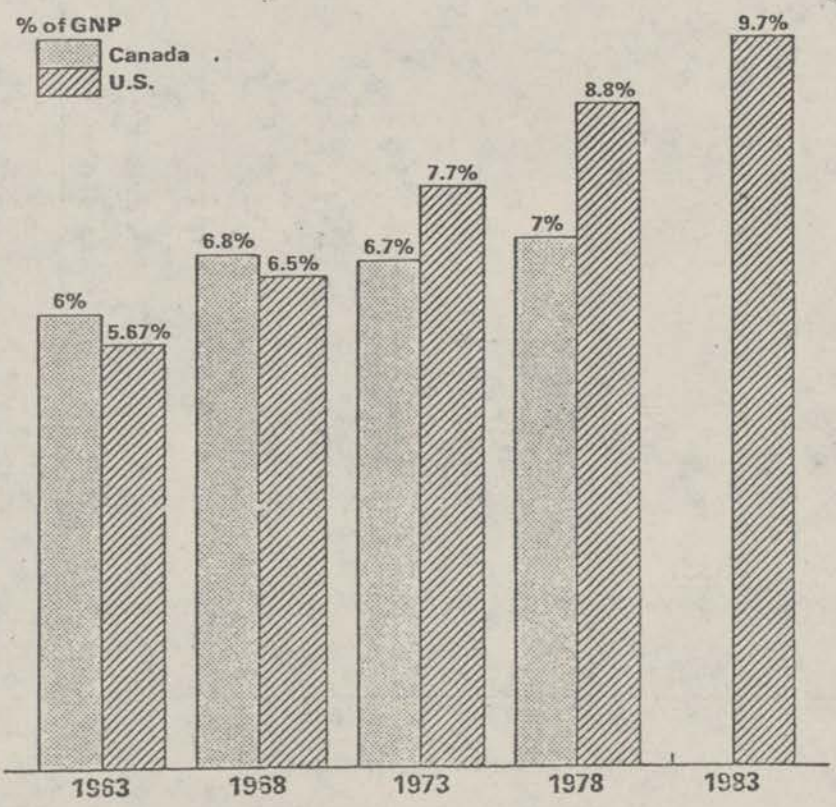
I think these charts that we have at our hearing this morning are quite revealing on this particular point.

At this point in the record we will include the various charts themselves.

[The charts referred to follow:]

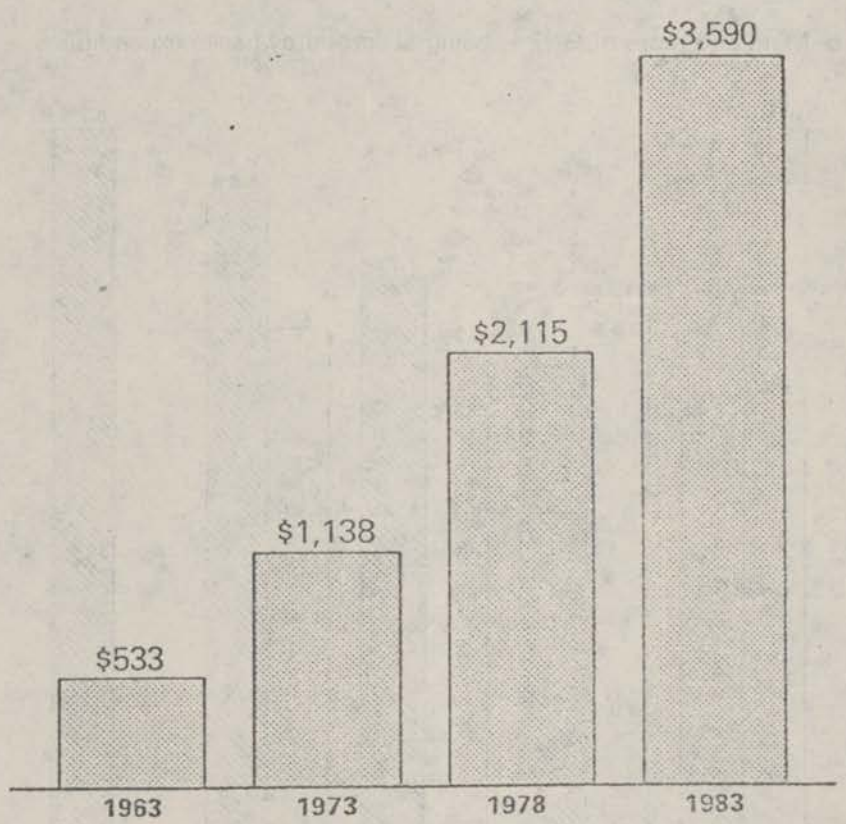
Health Care Costs are Rising

- Health costs will consume 8.8% of GNP this year
- Costs almost double every five years
- More and more of GNP is being absorbed by health expenditures



Total and % GNP for Health Services

Health Care Cost Increases: The Family

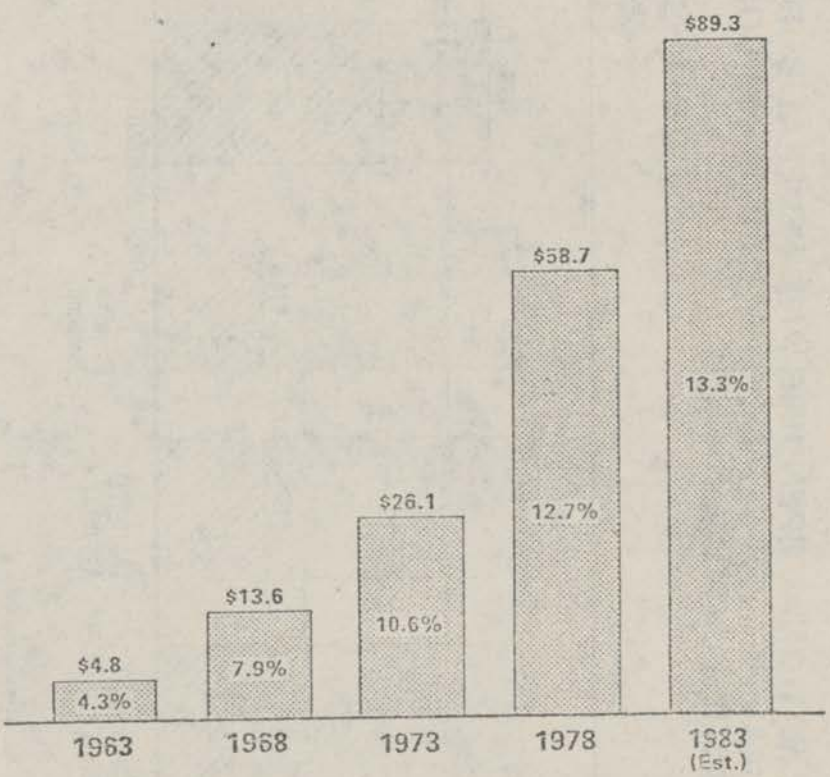


Family of Four

Average Costs of Health Care

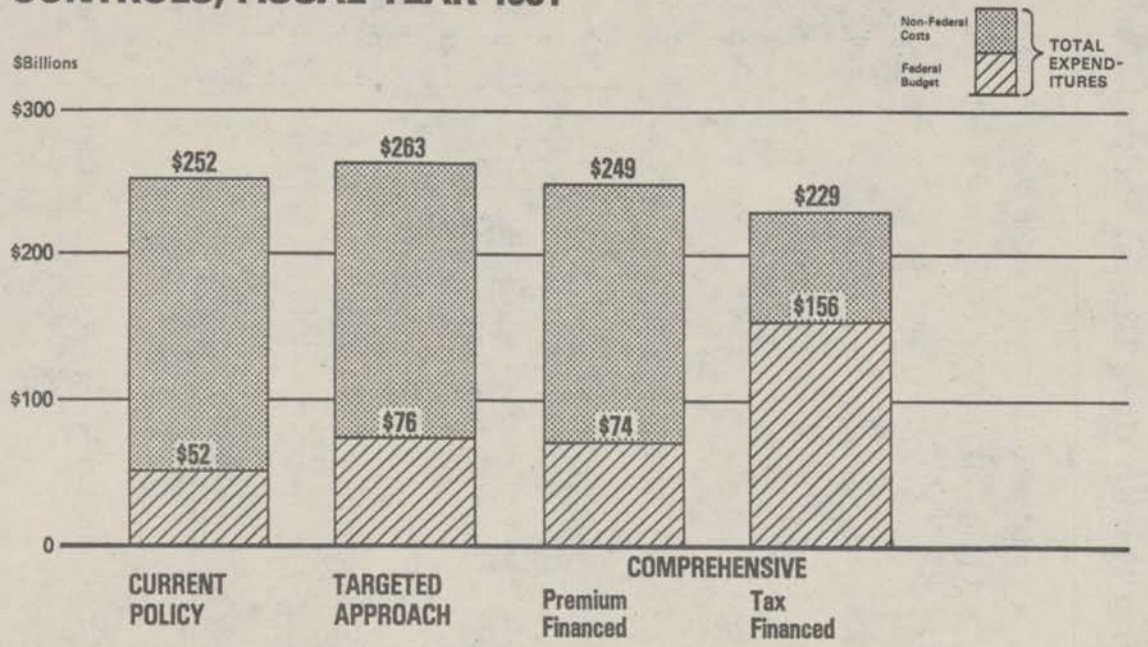
Rising Health Care Costs: Federal Budget

- Imposes an increasing burden on the Federal budget
- Diminishes ability of Federal funds to be used for other, pressing needs



Total and Percent of Federal Budget Spent on Health
(Dollar figures in Billions)

TOTAL NATIONAL SPENDING AND FEDERAL BUDGET COSTS, PERSONAL HEALTH SERVICES WITH STRONG COST CONTROLS, FISCAL YEAR 1981



Estimates by the Congressional Budget Office

Senator KENNEDY. This morning we will hear from our witnesses, our friends from Canada, who have experienced a national health insurance program for the period of the last 10 years and comparable situations from families in the United States.

I think one of the most dramatic facts is the flow chart that shows the total expenditures of health care in the United States versus a country, our neighbor, a country that we have such close relations with in so many different ways, and see how in Canada represented by the yellow that they have effectively been able to stabilize their health expenditures from 1968, 6.8 percent, to 1978 at 7 percent. That is two-tenths of 1 percent with national insurance.

The United States has continually gone up in 1968 from 6.5 percent to 8.8 percent in 1978, and 9.7 percent in 1983.

These figures are the Congressional Budget Office figures that do not favor one program over another.

This shows in the United States a family of four, they are increasing average costs of health care, and the enormous progression in terms of cost far exceeding the inflation rate.

This chart is very interesting because it shows how health is taking more and more out of the Federal budget, increasing percentage of the Federal budget and still going out of control.

These charts here are interesting and dramatic because this particular line which shows what the United States will spend in health care if we do nothing, and current policy without any health insurance program at all; $253 billion by 1982 if we do nothing at all.

Targeted approach would be catastrophic, which is normally considered to be catastrophic approach, and the third column, the premium-financed approach, and the fourth which would have been comprehensive program of the old S. 3.

Heavy reliance through the budget, but less and less in terms of the non-Federal costs.

But all these charts indicate that it is absolutely essential that we get the kinds of effective cost containment and cost controls, or these explosions of costs are basically going to bankrupt the people of our Nation as well as put enormous pressures on those which are underserved, the poorest and the neediest, to cut back even more on their programs.

I think this presents at least the financial aspects of our health care crisis, and the necessity for an effective kind of cost containment.

I believe the economics of the situation make a compelling case for a national health insurance program.

But even more compelling—even more compelling—is the case that will be made here today—the countless human tragedy; the needless personal anguish caused millions of Americans who simply can't afford adequate health care. I wish all Americans would be with us in this hearing room this morning. I know they would be moved by what we will see and hear; by the injustice of it; by the outrage of it; by the inhumanity of it.

Today we will see what health insurance means to families. We will hear from six families from Canada, where they have comprehensive health insurance, and six families from the United States. Some of our witnesses are poor, some are middle class; some are from rural areas, others urban; some have had series of illnesses, others have

had catastrophic expenses; some of the patients described are children, others are senior citizens. They represent a cross section of American and Canadian life.

If these families don't make the case for national health insurance, then no one can. If these differences between the United States and Canada don't move the people of this Nation, then nothing can; if the cost containment already achieved in Canada doesn't convince us that we can protect our people and our economy, then nothing can.

National health insurance is about people's lives. It is about the quality of life at times of greatest emotional stress. How a Nation cares for its sick is a measure of its humanity and its humanity is a measure of its greatness.

At this point I would like to included in the record an introductory statement issued by me outlining a new national health insurance program.

[The statement referred to follows:]

STATEMENT OF SENATOR EDWARD M. KENNEDY

ON INTRODUCTION OF A NEW NATIONAL HEALTH INSURANCE OUTLINE

I am pleased to make public today an outline of a significant new national health insurance program, prepared by the Committee for National Health Insurance in collaboration with my office.

It is nearly ten years since CNHI was formed. Its goal was and is to achieve high quality health care for all Americans as a matter of right, within a system that brings runaway health costs under control.

Many aspects of American life have changed since CNHI was formed in 1968. Many of these changes have been positive and have enriched the quality of life for millions of Americans. But in one area -- the health area -- the crisis which was just emerging in 1968 has grown seriously worse. The major reason has been the runaway escalation of health care costs.

This rampant inflation takes its toll everywhere -- on Federal budgets where the percentage of the Federal dollar spent on health has risen from 4.3% in 1963 to 12.7% this year; on state budgets where Medicaid costs have become the single most rapidly escalating cost; on corporations which pay more and more each year for health benefits; on the American family which must pay $2115 today, and $3590 in 1983 for benefits which cost $533 in 1963; on the elderly, who pay more for their care today out of their own pocket than the year Medicare was implemented.

Hospital costs are so out of control that usually rational people talk about establishing a 12% hospital inflation rate as a public policy objective to control costs. There is something fundamentally wrong when the best one can hope for is to "limit" hospital inflation to 12%. It is astonishing that even that unacceptable target would save 30 billion dollars over the next 5 years. But such is the case in an area where costs are increasing at the rate of 1 million dollars per hour.

The nation as a whole will spend 252 billion dollars in 1981 on health care and that money will pour into a system without cost controls, without quality controls, with uneven access to care and without any prospects for improvement.

In fact 26 million Americans still have no insurance coverage whatsoever. 19 million more have minimal, and totally inadequate coverage. And 51 million Americans live in areas without sufficient access to health care.

We must face the hard reality. The current non-system of medical care is a failure. If left unchecked, that failure will become a disaster -- a disaster which will destroy federal and state budgets, seriously injure the economy, cause countless human tragedies, and in my opinion, create a citizens revolt that will pale the current concern over taxes. Make no mistake about it.

There is a growing grass roots constituency, represented by CNHI, which cares deeply about this issue, and which will make itself increasingly felt in the months ahead. The senior citizens, church groups, and working men and women of this country are ready to move. Their ranks will be swelled, I believe, by the middle class which will see it's premiums rising and its benefits falling because of inflation. This coalition for national health insurance will have to be reckoned with.

Every American family knows what it means to live within a budget. It is time the American health care system learned to live within a budget. The proposal I am making public today imposes such a budget. No other program to guarantee comprehensive benefits to all Americans will cost less than this proposal. In fact, once cost containment takes effect the nation will pay less for health care than if the current non-system is left unchecked.

I see national health insurance as the last, best chance of bringing the health care system under control. It is more than a financing method. It is a system that will allow the nation to budget its health care expenses prospectively and then live within it; it is a system that will provide incentives for alternative, less costly delivery models -- such as HMOs - it is a system which will enable, through progressive reimbursement policies, an emphasis on prevention of disease, of increasing individual responsibility for maintaining health; it is a system in which one can improve the quality of care.

Next week the health subcommittee will begin oversight hearings on this proposal. We will hold hearings in Washington and around the country. Our goal is to begin a serious, intensive national debate. On the basis of what is learned, a legislative proposal will be developed, to be introduced early next session.

There are those who say we can't afford national health insurance. If there is one thing that is clear it is that we literally can't afford not to have it. I believe the economics of the situation, if nothing else, will help assure that the next Congress will be known as the health insurance congress.

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HEALTH CARE FOR ALL AMERICANS

INTRODUCTION

The purpose of this plan is to create a national health insurance program which will:

1. Make comprehensive health services available to all Americans.
2. Control runaway health care costs through a prospective budgeting system.
3. Allow a significant role for a publicly regulated private insurance system.
4. Promote system reforms to emphasize preventive medicine and encourage the development of alternative delivery systems such as HMOs.
5. Enhance the quality of care.
6. Ensure adequate compensation for health care providers.
7. Provide protection against catastrophic costs.
8. Assure full public accountability of all aspects of the plan and its operations and consumer participation in its development and administration.

THE PROGRAM

Universal Coverage

The program will provide for everyone in the country to be covered for comprehensive service benefits, including preventive health care services and catastrophic costs of illness.

The universal coverage will be assured as follows:

For the employed, self-employed and other individuals, there will be mandated benefits. Employers will be responsible for the major share of the health insurance costs of their employees and dependents.

For the poor and unemployed, the Federal Government will pay the costs.

For the elderly, Medicare will be upgraded to provide more comprehensive benefits.

Comprehensive Benefits

The mandated benefits will provide full coverage for in-patient services, physicians' services in and out of hospital, home health services, x-rays, and lab tests. Costs of catastrophic illness will be fully covered since there will be no arbitrary nonmedical limits on number of hospital days or physician visits. Preventive care for all members of the population will be actively encouraged and fully covered.

Specified mental health benefits will be included. Future benefits to be phased in will include prescription drugs (to be covered at the outset for the elderly) and other professional services.

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Immediate Cost Containment

Immediately upon enactment, the legislation will impose overall revenue and expenditure limits on hospitals and revenue limits on physician services. Budget caps will be used to restrain current rates of increase in these services. Protection for the wages of nonsupervisory employees will be assured.

When benefits begin two years following enactment, prospective budgeting of hospital and physician expenditures will become the principal method of cost control.

Budgeting Costs

In advance of each fiscal year of benefits, negotiations between representatives of hospitals and doctors, on the one hand, and the Public Authority, private insurers and health maintenance organizations on the other, will determine hospital budgets and schedules of payment of physician fees. Future increases in health care costs will not be permitted to exceed rises in the costs of other goods and services.

Providers will not be allowed to charge patients additional amounts above those that are negotiated in the budgetary process.

National, areawide and state budgets for health services and medical care will set maximum levels of expenditures.

Public Authority

Universal coverage will be assured through a bipartisan federal Public Authority (PA) whose members will be appointed by the President, subject to Senate confirmation. Not less than one-half of the members will be consumer representatives. Most Americans will be insured by a PA-certified and regulated insurer or HMO which is a member of a consortium of (1) insurance companies, (2) nonprofit health service plans, or (3) federally qualified health maintenance organization of their choice.

The PA will regulate and oversee the operations of the certified insurers and consortia and will consolidate the administration of Medicare, a federalized Medicaid program and several other existing federal programs. Its major objectives will be to assure universal coverage through the combination of public and private programs, control the rapidly escalating costs of medical care, and to effect major reforms in the provision of health care by bringing private and public financing into conformity with the goals of the legislation. It will also design national strategies for the expenditure of resource development funds in conjunction with existing agencies established in the health care planning legislation. The PA will establish standards such as assuring open enrollment, guidelines for mandated coverage, and procedures to assure adequate payment to providers. The Public Authority will also certify insurers to participate in the program, monitor their activities and recertify them on an annual basis. The Authority will publish rules and regulations for the guidance of provider reimbursement policies and for utilization review and quality assurance programs.

State Authorities

The Public Authority will contract with each state and territory to establish State Authorities (SAs) as agents of the federal agency to implement national policy. Programs such as state rate review agencies, health systems agencies, and professional standards review organizations, will be used to the maximum extent possible consistent with the objectives of the program.

The SA's bipartisan members will be nominated by the State Governor and approved by the PA. Consumers will comprise not less than one-half of the membership, in addition to representatives of the state and local governments and providers.

The State Authority, along with its certified insurers, will negotiate with hospital representatives to establish institutional budgets. Consumers, including employer and employee representatives, will also be involved in this process. Hospitals will be grouped into various categories (i.e., teaching/nonteaching, nonprofit community/proprietary, bed size, patient mix, etc.). No insurance carrier will be permitted to reimburse a hospital above the negotiated amounts, nor will the hospital be permitted to charge rates exceeding the approved amounts. Consistent with the system of prospective budgeting with caps, alternative ways of reimbursing providers will be given careful scrutiny in the coming months.

Similarly, the SAs, along with certified insurers, will negotiate with physician representatives and approved HMOs to establish fee schedules and other levels of payment for physician services based on per capita amounts, fee-for-time, stipends, salary and other approved methods. Fee schedules will be designed toward equalizing differences in rates of physician reimbursement for the same illness or category of service, and to encourage more primary care physicians, particularly in medically underserved areas.

Every resident of the United States will be issued a health insurance card.

If a patient receives medical care without proof of health insurance coverage, the provider will bill the State Authority, which will be responsible for determining the source of payment to be used for the individual.

In the event no certified carrier or HMO is available in an area, the State Agency will offer the mandated health insurance coverage to all residents in the area.

The Insurance Industry

Private health insurance companies or Blue Cross/Blue Shield plans, in order to participate in the national health insurance program, will require federal certification and to be included as a member of either the commercial carrier or Blue Cross/Blue Shield consortium. Continuation of federal certification will be subject to each company satisfying the following:

1. Provide for the enrollment of all group members, or individuals, without regard to age, sex, occupation, race, prior medical history, current health status, employment, marital status, or source of premium payment;

2. Conduct an annual open enrollment season designed to provide the opportunity for new applicants to join the health insurance program;

3. Be a member of a consortium;

4. Not require the purchase of other forms of business or personal insurance as a condition for enrollment in the health insurance program;

5. Price and advertise the mandated health insurance benefits separately from other forms of insurance;

6. Offer uniform, comprehensive insurance benefits at earnings-based premiums equal to or below the maximum set by the Public Authority without experience rating;

7. Provide only those other forms of medical insurance or disability income benefits which do not duplicate or conflict with the uniform health insurance benefits offered by the federal program;

8. Reimburse health care providers (both institutional and professional) for all services covered by the uniform comprehensive benefits, and at fees and rates not to exceed those established in negotiation with the providers and approved by the State Authority;

9. Adhere to the standards set by the Public Authority regarding claims and quality review criteria, interpretation of benefits, customer service, advertising and other matters;

10. Issue identification cards to all enrollees which guarantee payment for the mandated benefits at established fees and/or reimbursement rates to all participating providers; such cards will not identify the source of premium financing;

11. Utilize only standardized and State Authority-approved insurance policies that do not contain unjust, unfair, inequitable, misleading and/or deceptive language or encourage misrepresentation;

12. Utilize only standardized and approved claim forms designed for uniformity, clarity, and easy use for review and benefit reimbursement under the mandated program;

13. Collect data and report on utilizations and costs to the State Authority as required by the Public Authority;

14. Implement methodologies to assure that patient diagnosis and length of hospital stay are consistent and that quality of care is maintained;

15. Refrain from gathering and exchanging information and data on prior medical histories of individuals enrolled, or making application to enroll, in the mandated program;

16. Obtain approval of State Authority for all advertising material for mandated benefits;

17. Allow the Public Authority or its designee access to financial and management records as they pertain to the administration of the mandated benefits package;

18. Include a clause extending coverage for at least 30 days after employment termination;

19. Assure uniform charges;

20. Develop medical care profiles on treatment provided and facilities used to rapidly detect any minimizations or excesses which would conflict with the rendering of quality care and the efficient delivery of medical services.

Insurance Consortia

Specific responsibilities of each consortium will be the following:

1. To represent their member companies by participating with the Public Authority, which will establish premium rates based on anticipated expenditures for the forthcoming year;

2. To participate, on behalf of their member representatives, with provider representatives and State Authorities in all prospective rate and utilization review negotiations of physician payment and hospital budgets;

3. To serve as a management vehicle to redistribute excess employer/employee contributions to member carriers, requiring additional payments;

4. To serve as the source of carrier reinsurance in the event of revenue shortfalls because of adverse selection or catastrophe;

5. To review and approve carrier marketing material prior to distribution. Individual insurers will continue to market directly, but only with material approved by the consortium and the State Authorities;

6. To administer a placement service for individuals failing to select a carrier or to be allocated among carriers by the State Authority;

7. To organize, through their members, an administrative appeals procedure to resolve subscriber/provider/insurer disputes. The first review can be performed by the carrier, the second review by the consortium, and the third review by the State Authority;

8. To monitor, separate from direct federal surveillance, its members' satisfying federal qualification requirements;

9. To develop an accounting, research and evaluation component to collect and analyze cost data for its members, and for data reporting to the State and Public Authorities as essential elements in effective administration and control;

10. To furnish technical assistance to its members in the areas of administration, provider reimbursement and systems reforms.

Health Maintenance Organizations

HMOs and other nontraditional forms of health care delivery will be fully supported. Special provisions will be made for neighborhood health centers, community mental health centers, half-way houses and other organized methods of delivering health care. Programs which are useful in reaching underserved populations, including those in inner cities, rural America and migrant labor areas, will be covered.

The HMOs will be full participants in budget negotiations for institutions to be served by their enrollees and will receive full compensation for covered in-patient and out-patient services furnished in an institution operated by the HMO itself.

Since HMOs are expected to maintain their lower rates of hospitalization as compared with other types of insurers, the HMOs will be able to provide services beyond those mandated by the comprehensive benefits program and thus compete successfully with traditional forms of organization and delivery.

Financing

Financing will be effected through a combination of employer/employee contributions, and federal general revenue support for the poor and unemployed, and for improvement of the Medicare program. The self-employed and other individuals not covered by employer

groups will purchase coverage at group rates through a certified insurer or qualified HMO.

Earnings-based premiums will be established. This means a premium based on employers' total payrolls, of which the employees may be charged up to 25 percent, the exact amount of each employee's payment being determined in accordance with his or her wages. There may be contractual arrangements for employers to pay the total premium. In the case of the self-employed and the nonemployed, there will be a premium based on the individual's earned and/or nonearned income.

The earnings-based premium on employers will allow those whose employees' pay is lower than the average for the entire community to purchase good health insurance at less than what would be their experience-rated premium under our present system. It will mean that employers whose payrolls are higher than the average for the entire community will pay a larger amount, but no more in relation to payroll than other employers. Low- and high-wage employees will be similarly affected.

Thus, a company with lower-paid employees will pay less than a company with the same number of higher-paid employees. For example, if a five percent earnings-based premium is used, a firm paying average wages of $20,000 will pay $1,000 for health benefits for employees and eligible dependents (less up to 25 percent as the employees' share), while a firm with average wages of $10,000 per year will pay only $500 (less up to 25 percent as the employees' share). Federal subsidies will limit new costs to employers to a small percentage of payroll during the early years of the program.

Because the employer's contribution is based on employee salaries and wages rather than on the individual employer's cost of providing coverage, the costs of hiring low-wage employees will not be proportionately higher than for high-wage employees, and there will be no disincentive to hire part-time workers, those with high health risks, or those with eligible dependents. Migrant workers, seasonal employees, and others who have fallen between the cracks of other programs will be automatically covered -- at the same premium percentage of their salaries and wages -- without onerous premiums being imposed on their employers.

Companies which enjoy a lower-than-average rate for health insurance based on their experience (because they have healthier-than-average employees) currently save on taxes (health insurance as a deduction against their corporate income tax liability). Under the earnings-based premium, they will continue to save on taxes but will enjoy no premium reduction because others in the community may have a higher experience rate.

Paying for the Poor and the Unemployed

The program will provide for quality care for all under one system. The poor and the unemployed Americans will be insured for the same benefits as the employed. They will have the same choices of insurer or HMO as the employed. Costs of the short-term unemployed will be covered by a provision requiring thirty days' coverage for laid-off employees under employer plans. The long-term unemployed and the poor will be an on-budget cost to the Federal Government; but both in terms of identification and in levels of payment, the status of these groups will be indistinguishable from others.

Preliminary calculations indicate that the net impact on the federal budget will be tolerable.

Competition Between Consortia and Among Insurers and HMOs

Certified insurers and qualified HMOs will know what premium they will be entitled to receive for each person or family covered. Their incentives will be to control costs, be efficient, and offer competitive supplementary benefits, but not to compete on "risks."

Many employers will provide additional health benefits and other lines of insurance as benefits. With the mandated benefit package of the national health insurance program as a base to build upon, the insurers and HMOs will be expected to compete vigorously to attract new groups and for the self-employed, the poor and the unemployed. The HMOs will be highly competitive on the basis of their greater scope of benefits offered and lower costs of hospitalization.

Existing Employer-Employee Arrangements

An employer will not be relieved, by national health insurance, of any existing contractual or other obligation to provide or pay for health services to his employees. If an employer's cost under an existing contract exceeds what he would be required to pay to finance the mandated package, he could, as a result of negotiations with his employees, apply the excess to their cost of the mandated benefits and other services not covered by the legislation.

Provision will also be made for those organizations which self-insure to continue their individual programs. In cooperation with these organizations, the national health insurance program will develop arrangements for their participation which will conform to the overall goals and objectives of the national program.

Equalization and Reinsurance Program

Equalization and reinsurance funds will be established within each consortium and among consortia to counter balance individual member companies, service plans and HMOs. The funds will assure that no consortium member will be able to profit by selecting risks and that no consortium will engage in adverse selection in relation to other consortia. The pooling arrangements of these funds will be based on well-established insurance practices. Another fund will transfer payment for costs of treatment of out-of-area enrollees.

Unforeseen medical costs, such as those resulting from natural disasters, will be protected by these funds.

Administrative Costs

There will be provisions to limit to predetermined levels of administrative costs in both the public and private component parts of the program.

The costs of administering the federal and state public functions as well as private administrative costs will be strictly monitored and will be minimized through federal regulation.

Preventive Medicine and Health Promotion

The program will provide payment for services to prevent illness and to detect disease at an early stage. It will be designed to encourage health education of enrollees in all consortia-member companies, plans or HMOs.

Coverage for the provision of specific preventive services will be included, such as immunization and hypertension detection and follow-up.

The preventive medicine and health promotion aspects of this program for personal health services will dovetail with other programs developed as a national strategy for prevention-oriented, environmental, community and personal health practices.

Resources Development

A resources development fund will be established to stimulate development of services for population groups for whom access to services is presently denied or severely limited. The fund will also support a nationwide program of demonstration projects for the development of services designed to assist the elderly and chronically ill to remain in their own homes rather than to be institutionalized.

Consumer and Provider Advisory Councils

A National Health Insurance Advisory Council will be appointed. It will consist of providers of health care services and consumers of such services. The latter, who will have no financial interest in the furnishing of health services, will be a majority.

The National Health Insurance Advisory Council will assure similar representation at all levels of public authority involved in the program. It will advise the federal Public Authority on matters of general policy in the administration of the program, in the formulation of regulations, and in the performance of the PA's functions generally. It will also maintain a continuing study of the operations of the program with particular attention to utilization of health services, with a view to recommending any changes in benefits or administration.

The State Authorities will maintain similarly composed Advisory Councils.

The Advisory Councils will appoint professional and technical committees as they deem necessary to advise them with respect to the various classes of covered and prospectively covered services.

Net On-Budget Cost of the Plan*

Fiscal Year	Amount in Billions
1978	$14.1
1981	18.8
1983	21.7

*This is the net impact on the budget of providing mandated personal health services to the poor, the unemployed and upgrading the Medicare program. Benefits include in-patient hospital care services, physician services in-hospital, out-of-hospital and office visits, preventive care, and protection against catastrophic costs.

In addition to the on-budget costs for mandated services, it would be necessary for the Federal Government to provide subsidies to small employers and employees in low-waged industries. The DHEW has estimated that the magnitude of this subsidy will be in the area of $5 billion.

Providing drugs for the elderly would add $2.6 billion to the cost of the plan in 1978; $3.5 billion in 1981; and $4.1 billion in 1983.

Senator KENNEDY. We will now receive for the record a statement by Senator Javits who was unable to be present for this hearing.

[Senator Javits' statement follows:]

STATEMENT OF SENATOR JAVITS

Senator JAVITS. Mr. Chairman, my interest in and support of a national health program dates back to my earliest days in the U.S. Congress. In 1949, I introduced my first national health coverage bill and have worked toward the enactment of a comprehensive, national health program ever since. The opening of these hearings signals to me, to the health community, and, I believe, to the entire country the beginning of a new, revitalized effort which I am hopeful will result in the achievement of this long-sought-after goal.

Today tragic deficiencies plague our health care delivery system deficiencies which make the enactment of a national health insurance program of paramount importance. Consider, for example, the following statistics:

Approximately 50 million people—roughly one-quarter of our entire population—live in areas of the country which suffer from a shortage of personal health care services. In such places, physicians, other health professionals, and health care facilities are either in short supply or sometimes are virtually nonexistent.

The cost of health care has risen astronomically, causing severe financial hardship for many of our citizens. Since 1963, the total health care bill for the Nation has risen from $32.4 billion to $183 billion. Since 1968 the average cost of a hospital stay has risen from $469 to $1,543.

Twenty-four million Americans have no health insurance, another 18 million have inadequate insurance, and 88 million have no insurance against very large medical bills.

Our country can no longer continue to accept a health care system so riddled with deficiencies that millions of Americans are denied access to its benefits.

I believe the 96th Congress can and should become known as the "national health" Congress. To that end, it is clearly important that the debate on this issue begin now, in time for the forthcoming local, State, and National elections.

In addition, I believe it is time for the Congress to reform its committee structure in order to develop a more rational approach for the consideration of national health policy issues, particularly national health insurance. In my opinion, to divide issues relating to the financing, regulation, and delivery of health care services among four committees of the Congress is counterproductive to the achievement of rational health policies. Earlier this year, I introduced Senate Concurrent Resolution 100—a bill to establish a Joint House/Senate Committee on National Health Policy. This joint committee would combine the jurisdictions of the respective health subcommittees of the House Interstate and Foreign Commerce Committee and Ways and Means Committee and the Senate Human Resources and Finance Committee into one joint committee.

Under my proposal, the joint committee would have exclusive jurisdiction over all bills and resolutions relating to the development and

implementation of a national health insurance program. I feel it is time for the Congress to get its health policymaking house in order; I believe that my proposal is an appropriate mechanism for accomplishing this objective. I plan to reintroduce this measure at the beginning of the next Congress, and will work for its consideration and enactment.

I will not comment at this time on the proposal which is the subject of these hearings and which was developed under Senator Kennedy's leadership.

I pledge actively to support efforts to enact a national health insurance program in the 96th Congress. I hope the witnesses this week will provide us practical solutions to the many difficult issues that face the Congress in its consideration of national health insurance.

Finally, as you know, I am the author of S. 370, the National Health Insurance for Mothers and Children Act. It is my intention to introduce a revised national health insurance bill at the beginning of the next Congress. This bill will be based upon a phased-in program to inaugurate the national health program which begins with coverage of mothers and children. My reason for reintroducing this measure is to contribute further to the options available to the President and the Congress when NHI becomes the focus of serious and critical debate next year.

Senator KENNEDY. Today, this committee of the Congress begins the first serious congressional debate on national health insurance. It will last for many months. It will be carried to very part of this Nation. We will listen to all sides, to all viewpoints. And in the next Congress, it is my hope to report a bill from this committee that will, within a system that controls costs and improves quality, provide comprehensive benefits for all Americans.

We want to particularly thank our Canadian friends for being with us today.

I understand it is a holiday in Canada. Today is the Canadian Thanksgiving Day, and so we appreciate especially your willingness to be with us today and separated from your families.

Of course, here we are celebrating Columbus Day.

We have a Federal holiday in the United States as well.

Thanksgiving is a very special day in the United States, as I know it is in Canada, so we especially appreciate your willingness to be with us today.

I want to also acknowledge just the presence in our committee room of Mrs. Jay, Mrs. Peter Jay, wife of the Ambassador from Great Britain, to the United States. She has enormous interest in health policy and has spoken and shared the experience of Great Britain with us in various articles.

She is a person who has extraordinary comprehension of the system in her country and has been enormously, I think, informative for people. We are delighted to have Mrs. Jay.

We have representatives of families from three Canadian Provinces. We have Mr. and Mrs. Griffin, of Toronto. We are glad to have you here.

We have Mr. and Mrs. Ervin, from Saskatoon, Saskatchewan.

Mr. Leonard Hurst, of Windsor, Ontario.

Mr. and Mrs. Polewzuck, Montreal, Quebec; Mr. and Mrs. Gosling, of Martlack, Saskatchewan; and Mrs. Andrew Wilsack, of Hamilton, Ontario.

I want to thank you.

We are pleased to have American families from six States.

Mrs. Fred Sheagley, of Kokomo, Ind.

Mrs. Mary Cihak, of McGrath, Minn.

Mr. and Mrs. Corbett, of Newton, Mass.

Mr. and Mrs. Howell, Smokey Hollow, Ga. They are not here. Mr. Howell took ill last evening, which is some indication, I suppose of the currency of the—of some of the problems. We hope Mrs. Howell be with us a little later this morning. She is trying to get up here.

But in any event, we will hear their story.

Mr. and Mrs. Churchill, of Louisville, Ky.

And Mrs. Elizabeth Wolfe, Cincinnati, Ohio.

Perhaps if we could start with Mrs. Sheagley and Mrs. Wilsack.

Mrs. Sheagley is from Kokomo, Ind.; and Mrs. Wilsack is from Hamilton, Quebec.

They are both low-income families. Mr. Sheagley and Mr. Wilsack both are associated with auto repair shops.

Mrs. Sheagley, if we could talk with you first. We are interested in learning a little bit about yourself and we would like to get some feel from the families so I will just ask a few questions.

We hope that all of you will feel as relaxed as you possibly can.

We want to hear about your own story in your own words.

I think it is always difficult. I do not think anyone really talks too much about their own illuess or sickness and feel that they want to share these experiences. I am sure the families here this morning have that as a viewpoint.

I think as you can understand, we are in the process of learning and we are in the process of attempting to learn from your own experience so we can try and fashion a policy to help others.

Mrs. Sheagley, what kind of house do you live in?

Tell us a little bit about the number of children.

STATEMENT OF MRS. FRED SHEAGLEY, KOKOMO, IND.

Mrs. SHEAGLEY. We live in a garden trailer. It is 10 by 52 foot. We have two bedrooms. We use a hide-a-bed, too, to accommodate my three children, my husband, and myself.

I have two retarded children that go to special schools. In the past I have had about 20 surgeries with no hospitalization. I have filed for different things to get help and nothing has been given us.

Senator KENNEDY. As I understand it, you have two retarded children, is that correct?

Mrs. SHEAGLEY. That is correct.

Senator KENNEDY. And a third daughter who has some difficulty in school?

Mrs. SHEAGLEY. She is a low-graded learner.

Senator KENNEDY. Where are your retarded children now?

Mrs. SHEAGLEY. My retarded children stay with us. They go to school in the daytime. It is where they have work. They train them for

a special type of work. It is Buena Vista, and they do a tremendous amount of work there.

Senator KENNEDY. Has this been a burden on you?

Mrs. SHEAGLEY. Very much.

Senator KENNEDY. Financially?

Mrs. SHEAGLEY. Very.

Senator KENNEDY. What sort of burden has it been on you?

Mrs. SHEAGLEY. We are right now in the process of having to file bankruptcy due to the medical expenses, low income, and we just cannot afford to keep everything going.

Senator KENNEDY. What sort of medical expenses do you have besides the retarded children?

Mrs. SHEAGLEY. I, myself, am an epileptic and I have had 20 surgeries in the past, ended up in the hospital about every 3 to 6 months. I also right now am in the process of going to Indianapolis for treatment, for epilepsy thyroid, and a number of other things.

This I go to about every 3 months, and it is an expense just to go down there with a car that was really given to us by my husband's boss.

Senator KENNEDY. What is your income, your family's income?

Mrs. SHEAGLEY. Our family income, my husband makes about $500 a month. We do get some assistance for the mentally retarded children.

Senator KENNEDY. What would this be?

Mrs. SHEAGLEY. That is $177 a month.

Senator KENNEDY. So about $677 a month?

Mrs. SHEAGLEY. Right.

Senator KENNEDY. How do you allocate that between your covering these expenses?

Mrs. SHEAGLEY. We, of course, have our lights and fuel, trailer payment, lot rent, our gas for our car expenses, clothing, and so forth for the children.

Senator KENNEDY. Your income does not cover all your expenses, does it?

Mrs. SHEAGLEY. No, sir.

Senator KENNEDY. So how have you been able to pay your hospital bills?

Mrs. SHEAGLEY. We have not been able to pay them.

Senator KENNEDY. Were your bills ever turned over to a collection agency?

Mrs. SHEAGLEY. Yes.

Senator KENNEDY. What happened?

Mrs. SHEAGLEY. We do get harassing letters and this leads to me having seizures very much of the time, because I get very depressed and the doctors do not want me under tension, but it is there.

Senator KENNEDY. What are your medical expenses now?

Mrs. SHEAGLEY. Our medical expenses are in the thousands, probably $17,000.

Senator KENNEDY. What has it meant to you and Mr. Sheagley being unable to get medical coverage and still confronted with a vast array of medical problems?

How do you feel about that?

Mrs. SHEAGLEY. We are very said because we have not been able to give our children normal—like normal people give to their children. and to do things.

Our home is not really like we would like for it to be. We are very cramped in our small trailer. But I have wanted to make do.

Senator KENNEDY. Mrs. Wilsack, how many children do you have?

STATEMENT OF MRS. ANDREW WILSACK, HAMILTON, ONTARIO

Mrs. WILSACK. Ten.

Senator KENNEDY. How many grandchildren?

Mrs. WILSACK. Seven.

Senator KENNEDY. How much money did Mr. Wilsack make in the repair shop?

Mrs. WILSACK. $110 a week.

Senator KENNEDY. $110 a week?

Mrs. WILSACK. Yes.

Senator KENNEDY. That is about $540—it is almost identical; is it not?

What kind of medical problem does Mr. Wilsack have?

Mrs. WILSACK. He has had two heart operations, a brain operation, and a gallstone operation within 11 years.

Senator KENNEDY. That was a heart valve surgery?

Mrs. WILSACK. Both of them.

Senator KENNEDY. And surgery for a blood clot and then another heart operation; is that right?

Mrs. WILSACK. Yes, 3 years ago.

Senator KENNEDY. Have you had medical problems?

Mrs. WILSACK. Yes, sir.

Senator KENNEDY. What sort of medical problems do you have?

Mrs. WILSACK. A series of operations.

Senator KENNEDY. Could you tell us a little bit of the type of medical problems you had?

Mrs. WILSACK. Well, I had gallstones and a hysterectomy, caesarean, and I have got arthritis and an ulcer.

Senator KENNEDY. You are from Hamilton, Ontario?

How did you pay for these?

Mrs. WILSACK. I did not pay for them. We did not pay for them. Ontario OHIP did.

Senator KENNEDY. Maybe you could tell us just a little bit about it. After you got out of the hospital, where you were treated in these areas, you did not receive a bill?

Mrs. WILSACK. No, sir.

Senator KENNEDY. Did your husband receive any bills?

Mrs. WILSACK. No, sir.

Senator KENNEDY. So all of your expenses were covered by the health care program, Canadian and Provincial together; is that correct?

Mrs. WILSACK. Yes.

Senator KENNEDY. What has it meant to you to know you can get medical treatment free from the fear of not being able to pay?

Mrs. WILSACK. It really feels good.

Senator KENNEDY. Do you think the service is worthwhile?

Mrs. WILSACK. Yes, sir, I sure do.

Senator KENNEDY. Has it made any difference in terms of your own children, being able to do more things with your own children because it has not been a drain on your own family budget?

Mrs. WILSACK. Yes.

Senator KENNEDY. We heard Mrs. Sheagley talk about the limitations of being able to do things with their children like other families could do because they are so pressed for every cent in order to try and cover their medical bills.

You are able to still enjoy the good life with them?

Mrs. WILSACK. Yes, sir.

Senator KENNEDY. So I think we really see here where the husbands are working in virtually comparable employment in the United States and Canada.

Your husband has retired; is that right, Mrs. Wilsack?

Mrs. WILSACK. Yes, sir. He is on pension.

Senator KENNEDY. Heart condition, and it is essentially the same, with children, and there have been serious medical burdens on both of the families, extremely serious, and Mrs. Sheagley has got $12,000 outstanding in medical debt—it is $12,000 medical debt?

Mrs. SHEAGLEY. Yes.

Senator KENNEDY. Mrs. Wilsack, you do not have any?

Mrs. WILSACK. No, sir.

Senator KENNEDY. Mrs. Cihak, as I understand it, you are from McGrath, Minn., and work on a farm; is that correct?

STATEMENT OF MRS. MARY CIHAK, McGRATH, MINN.

Mrs. CIHAK. Yes.

Senator KENNEDY. Could you tell us a little bit about the kind of farm you have?

Mrs. CIHAK. Well, it is a 700-acre farm altogether. We do not have all the land ourselves.

Senator KENNEDY. You rent the farm; is that right?

Mrs. CIHAK. Yes.

Senator KENNEDY. How many children do you have?

Mrs. CIHAK. Altogether we have six, at the present time.

We had seven up until the first of July of this year and our little girl passed away quite suddenly.

Senator KENNEDY. Do any of your other children have medical problems?

Mrs. CIHAK. We have three sons with a very rare type of cerebral palsy.

Senator KENNEDY. Tony has cerebral palsy?

Mrs. CIHAK. Yes. He is our youngest.

Senator KENNEDY. He has cerebral palsy and he stays in a wheelchair; is that right?

Mrs. CIHAK. Yes.

Senator KENNEDY. Has he required much hospitalization?

Mr. CIHAK. At times he requires hospitalization for infections. If he needs any dental work, he has to be put in a hospital for dental work.

Senator KENNEDY. He had flu; didn't he?

Mrs. CIHAK. He had flu last December, and after we put him in the hospital he got staph infection while at the hospital. He had to spend 6 weeks in the hospital and lost the use of his hand because of it.

Senator KENNEDY. What kind of health has Mr. Cihak had?

Mrs. CIHAK. Well, for the past 2 years now he has at different times suffered from severe headaches and depression. He has not been able to hold a regular job because of this so I have gone to work.

Senator KENNEDY. Does he have high blood pressure?

Mrs. CIHAK. Yes, he does.

Senator KENNEDY. Do you work?

Mrs. CIHAK. Yes, I do.

Senator KENNEDY. With all the problems, what kind of medical insurance have you had?

Mrs. CIHAK. We have not had any medical insurance up until the first of this month, and this will be covered by the plant where I work.

I think it is a Metropolitan type of insurance.

Senator KENNEDY. You have got hospitals and doctors' bills worth how much, approximately?

Mrs. CIHAK. Anywhere from $20,000 to $50,000.

Senator KENNEDY. What kind of income do you have?

Mrs. CIHAK. Well, I make a little over $500 at my job.

Senator KENNEDY. $500 a month?

Mrs. CIHAK. Over that. I do not know exactly how much, We have just gotten a raise.

Senator KENNEDY. Nothing wrong with that; is there?

Mrs. CIHAK. No. My son collects SSI, $189 a month.

Senator KENNEDY. Can you cover all these medical expenses with this income?

Mrs. CIHAK. No. No way.

Senator KENNEDY. So what happens?

Mrs. CIHAK. So we have quite a few bills piled up that we have not been able to pay.

Senator KENNEDY. Are you reaching a point where if you earn anymore money you will lose your SSI payments?

Mrs. CIHAK. Yes.

Senator KENNEDY. What kind of advice are you getting?

Mrs. CIHAK. Nothing at the present time.

Senator Kennedy. Have you had any difficulty getting medical insurance?

Mrs. CIHAK. Well, yes.

We had applied for medical insurance with different companies. We have children, well, because of the syndrome they will turn us down.

Senator KENNEDY. When they hear about the disease they turn you down?

Mrs. CIHAK. Yes.

These children get progressively worse.

Their mental ability ranges from normal to very low normal, but their physical abilities tend to deplete, they get worse physically.

Senator KENNEDY. What you are saying is that actually the medical needs increase?

Mrs. CIHAK. Yes, as they get older.

Senator KENNEDY. And when the insurance companies become aware of this, you find that you just cannot get the coverage you need?

Mrs. CIHAK. Right.

Senator KENNEDY. Do you find this is also a drain on you, I mean, is it difficult to cope with this kind of problem?

Mrs. CIHAK. Certainly it is.

Senator KENNEDY. It has been for your family?

Mrs. CIHAK. Over many years, yes. I really believe it is part of my husband's problem, with his headaches.

Senator KENNEDY. The pressure and tension?

Mrs. CIHAK. Yes.

Senator KENNEDY. Mrs. Gosling, do you live on a farm?

STATEMENT OF MR. AND MRS. RUPERT GOSLING, MARTLACK, SASKATCHEWAN

Mrs. GOSLING. Yes, we do.

Senator KENNEDY. Tell us where is that?

Mrs. GOSLING. It is west of Moose Jaw, if you know where Moose Jaw is.

I do not suppose you know where Moose Jaw is.

Senator KENNEDY. How many acres or what type of farm do you have?

Mrs. GOSLING. About 2,000 acres, and we have mixed farming. We have cattle and grain.

Senator KENNEDY. How many children do you have?

Mrs. GOSLING. We have two children.

Senator KENNEDY. Are they in good health?

Mrs. GOSLING. Yes; very good health.

Senator KENNEDY. What kind of problems have you had?

Mrs. GOSLING. Well, until 2 years ago my health was quite good, and then I started having problems and the surgery proved that I had cancer.

So, for the last 2 years I have been in and out of hospitals every several months.

Senator KENNEDY. You had radiation treatment?

Mrs. GOSLING. Yes.

Senator KENNEDY. You have required frequent hospitalization?

Mrs. GOSLING. Yes.

Senator KENNEDY. Are these expensive treatments?

Mrs. GOSLING. No; they are not in Saskatchewan; no, they are not.

Senator KENNEDY. Well, they may be expensive treatments, but they have not cost you; is that right?

Mrs. GOSLING. No; they are not any cost to us at all.

We have no expenses.

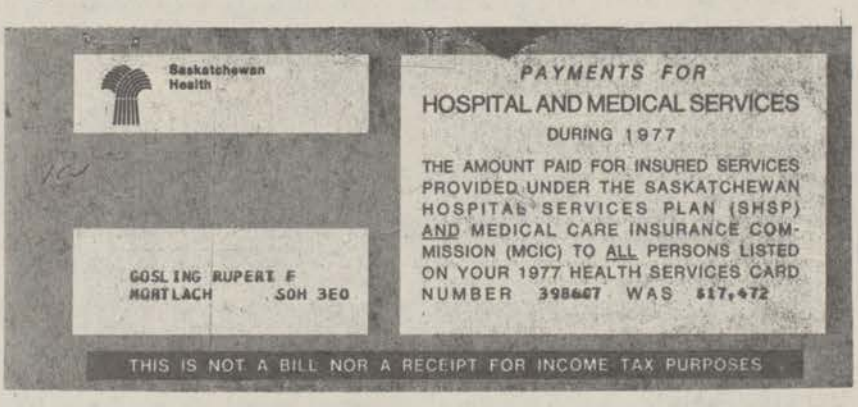
Senator KENNEDY. What do you think national health has meant to you and your ability to cope with your illness?

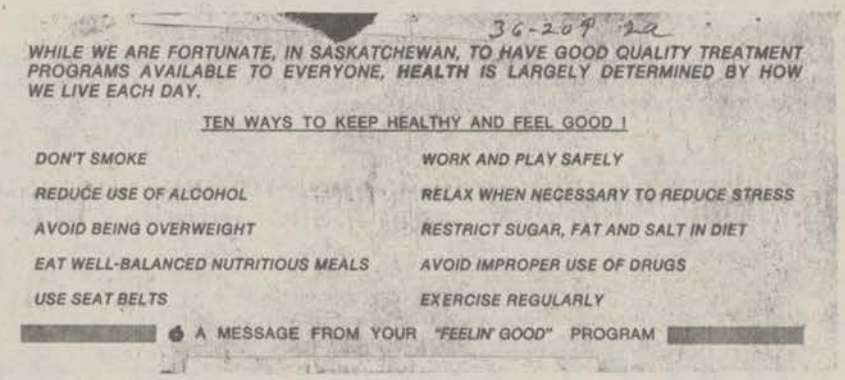
Mrs. GOSLING. I think the big thing is that in the past it certainly has been tremendous. But now with cancer the future is so uncertain, and

I think the assurance that you know you do not have to worry about the financial end of it because you have such a tremendous amount of worry other than this, and, besides, last year alone we received a bill, a slip from our government saying what they have paid out for this, and this would have cost $17,000 for 1 year.

Senator KENNEDY. I believe this is the bill [indicating].

[The bill referred to follows:]





Mrs. GOSLING. Yes; that is right.

Senator KENNEDY. It was sent to Rupert Gosling, and in this it says the amount paid for insurance services provided by Saskatchewan Hospital Service Plan, Medical Care Insurance—give your number—they indicate that it was $17,472.

Mrs. GOSLING. That is for 1 year.

Senator KENNEDY. That is for 1 year.

Those are the types of costs, expenses, that you would have had to pay, or your family would have had to pay, and that Mrs. Sheagley is indebted for.

This particular slip is from the health service to you indicating the amount that was paid by the health service for the treatments.

Mrs. GOSLING. This was actually the bill for two surgeries, and I was in the hospital for 5 months.

This is what is was for.

Senator KENNEDY. So, effectively, it has not cost you anything; is that correct?

Mrs. GOSLING. No; nothing at all.

Senator KENNEDY. I think the point you have raised here is of enormous importance. I think it has been mentioned by Mrs. Sheagley and Mrs. Cihak; that is, the freedom from the fear of these expenses.

Mrs. GOSLING. Yes.

Senator KENNEDY. You mentioned yourself contact with cancer is a difficult and enough burden for any family to have to endure, but having additional kinds of fear of medical expenses have to be enormously burdensome.

Is this not what you are telling us, Mrs. Sheagley and Mrs. Cihak, earlier?

Mrs. SHEAGLEY. Yes.

Mrs. CIHAK. Yes.

Senator KENNEDY. About this constant fear that bothered Mr. Cihak and that you feel is a source of a good deal of his headaches and other factors?

Mrs. CIHAK. Can I say something?

Senator KENNEDY. Yet, I think an interesting thing is even though they made that kind of bill, they have been, as we can see from these charts up here, have been able to control costs, too, in this area. So they were both able to meet the human aspects of it and also the economic aspects of it, too.

Mrs. GOSLING. Could I mention something else, Senator?

I would just like to say that I have been in a lot of our hospitals in Saskatchewan. I think that our nursing and our doctors' care is absolutely tremendous.

Senator KENNEDY. That is a good point.

Mrs. GOSLING. It really is.

Senator KENNEDY. That is an interesting point on the quality issue.

You do not feel that with this kind of service some have had that it gets impersonal?

Mrs. GOSLING. No. I have been extremely ill over the last couple of years, and you know many times the doctors and nurses have done things, sort of personal things, above the call of duty, really, and this has happened to me many, many times.

I just will never forget the things that people have done.

When you are ill, little things mean so much.

Senator KENNEDY. Well, is there any advice you can give your friends and neighbors in the United States about this similar kind of program in the United States?

Mrs. GOSLING. Well, I certainly hope that you can do something to implement it here because it is tremendous. It really is.

Senator KENNEDY. Maybe on this point, Mrs. Wilsak, did you find the services in the hospitals to your satisfaction, too?

Mrs. WILSACK. Yes; I did.

Senator KENNEDY. Personalization, at least treating people with humane care and attention?

Mrs. WILSACK. Yes.

Senator KENNEDY. Mrs. Corbett, from Massachusetts, perhaps you can tell us a little bit, if you do not mind—the next two families we

will talk with are the Corbetts and the Polewzucks, and they are basically what we consider middle-income families with children who have exactly the same medical condition, spinal byfica.

Mr. Corbett is also here.

Mrs. Polewzuck is from Montreal, Quebec.

We will start, Mrs. Corbett, with you.

Would you give us some idea of the general income level of your family and where your husband works?

STATEMENT OF MR. AND MRS. DANIEL CORBETT, NEWTON, MASS.

Mrs. CORBETT. My husband, right now, is working, and he makes $21,300 yearly.

Senator KENNEDY. Where does he work?

Mrs. CORBETT. For the Federal Government in Massachusetts.

Senator KENNEDY. How many children do you have?

Mrs. CORBETT. Four.

Senator KENNEDY. You did have some medical problems with your oldest boy, is that correct?

Mrs. CORBETT. Yes.

Senator KENNEDY. Do you want to describe them for us?

Mrs. CORBETT. He was born with spinal byfica, which is supposed to be the second most crippling disease, now, and it is an opening in the base of the spine, which causes paralysis from that point down.

He was hospitalized when he was born for 6 weeks, and it was touch and go whether he would live.

Senator KENNEDY. Now he requires a good deal of attention, is that correct?

Mrs. CORBETT. Once a month at Mylo Clinic, it is called, children's hospital.

Senator KENNEDY. Is it easy to care for him?

Describe a little bit about the kind of care he receives.

Mrs. CORBETT. I have to empty his bladder every 3 hours manually.

If this does not work, then he will require more operations on his bladder.

Senator KENNEDY. So it takes a good deal of attention?

Mrs. CORBETT. Yes; plus therapy that is required.

Senator KENNEDY. As I understand, initially you had some insurance coverage, did you not?

Mrs. CORBETT. We have good insurance.

My husband has the highest option he is allowed now. He was out of work.

Senator KENNEDY. Initially you had some insurance?

Mrs. CORBETT. Yes.

Senator KENNEDY. What did that cover?

Did it cover therapy?

Mrs. CORBETT. No, Senator. I did not know it when they had taken my card number, and I thought it was being covered, and it was not until I began to receive the bills that I realized it was not being covered.

Senator KENNEDY. That is when he worked at his other job?

Mrs. CORBETT. Yes.

Senator KENNEDY. And he was unemployed for a brief period of time?

Mrs. CORBETT. Yes.

Senator KENNEDY. He is now working for GSA.

Now we are talking about the coverage you had in the first job.

That did not cover the therapy?

Mrs. CORBETT. No; it didn't.

I had to stop taking him when the bills started to come in, and I learned how to do it myself.

Senator KENNEDY. Tell us about it. This is the therapy that was not covered, even when you had insurance, is that right?

Mrs. CORBETT. Yes.

Senator KENNEDY. That was taking him to the center. How often? How frequent?

Mrs. CORBETT. Once a week, every Friday.

Senator KENNEDY. What was the cost, approximately?

Mrs. CORBETT. About $30 each week.

Senator KENNEDY. Each week. And you did not have the resources to cover that week after week after week?

Mrs. CORBETT. As I said, I thought it was being covered. There are so many things that you think are being covered by insurance, and until you receive the bill, they are not covered.

Senator KENNEDY. What other kinds of expenses did you incur for the boy?

Mrs. CORBETT. The trips now that I'm supposed to take each month, there are a great many monthly trips, and then you are there all day long. Sometimes we have left at 7 in the morning and we did not get home until 3 and you are just standing in line waiting, waiting, waiting.

He has special clothes, special braces. He has been in a cast for 13 weeks, on a frame that you have to rent. It is too expensive to buy.

Senator KENNEDY. Do you have any unpaid bills?

What is the general cost, how would you round it out?

Mrs. CORBETT. Right now, I am not covered by insurance.

I can put my hand on $2,000. About that.

Senator KENNEDY. That is in spite of the coverage that you had before——

Mrs. CORBETT. Yes, Senator.

Senator KENNEDY. Have you had to face collection agencies?

Mrs. CORBETT. Yes, Senator.

Senator KENNEDY. What is that like? Pretty grim experience?

Mrs. CORBETT. Yes. I have tried to make arrangements that I will pay them $10, and I will let them know that I am planning on paying them.

My husband believes that if doctors do jobs, they should be paid, and we try to as soon as we can. But if there are so many coming in, it is a balancing act of which one is going to get paid.

Senator KENNEDY. You have $22,000 income.

The median income is $13,000 in the United States. Even with that and highest coverage, highest option coverage, as I understand it, you have still got $2,000—you are facing a collection agency.

Do you find this puts other pressures on other family needs like food and other factors?

Mrs. CORBETT. Definitely.

Senator KENNEDY. What is your budget for today, say for a week?

Mrs. CORBETT. I've tried to keep it to a minimum, about $50, but I have gone down with $10 sometimes and put back $11 if I had paid too many bills. I pay my bills first.

Senator KENNEDY. Pay your bills first. That is exactly what we would like to do with Health.

Has this had an impact, just a fear?

We always tragically are looking at these things in dollars and cents and charts too often.

Mrs. CORBETT. I know if children get sick, I hesitate bringing them to the doctor.

Senator KENNEDY. Why?

Mrs. CORBETT. Because I'm afraid of more bills.

Senator KENNEDY. So you have got four children and they have to be pretty sick before you take them down?

Mrs. CORBETT. Yes. I know that one time the doctor said one child was having a convulsion and the doctor said put the child in the hospital. I said, can I take care of her? And he gave me something to watch for and said the child needs to go right now, and I put the child in the hospital and I cried. I though we were going to be wiped out for the rest of our lives.

I know that Martin had six doctors when he was born and only one doctor was covered by insurance.

The doctor that did the operation itself.

Senator KENNEDY. Do you have have any money put away or saved at all?

Mrs. CORBETT. I keep hoping I might someday.

Senator KENNEDY. I understand you needed some prothesis before your son went to school?

Mrs. CORBETT. Yes. He is on crutches and his first pair I had paid $15. He broke them the day before school started. I said with inflation, maybe they are up to $30. When I went to get them, they were up to $50, only had the $30 at that time, and I got them, but it took 4 weeks.

Senator KENNEDY. Four weeks?

Mrs. CORBETT. Yes.

Senator KENNEDY. Mrs. Polewzuck, how many children have you had?

STATEMENT OF MR. AND MRS. RICHARD POLEWZUCK, MONTREAL, QUEBEC

Mrs. POLEWZUCK. I have had three, but I have two now.

Senator KENNEDY. Two of them were born with spinal byfica?

Mrs. POLEWZUCK. Yes.

One of them tragically died.

Senator KENNEDY. Did they require expensive operations?

Mrs. POLEWZUCK. Yes, my 6-year-old, she has had eight major surgeries.

Senator KENNEDY. Eight major surgeries?

Mrs. POLEWZUCK. And hospitalizations in between.

Senator KENNEDY. And hospitalizations?

Mrs. POLEWZUCK. Yes.

She has had three sets of lung lead braces and cane. She has had extensive therapy and the youngest one that died, she had five major

operations. She was hospitalized twice for bronchial pneumonia. She had extensive therapy and we did not pay a penny.

Senator KENNEDY. How have you been able to meet the enormous expenses of the medical needs of your family?

Mrs. POLEWZUCK. There were no expenses. Everything was covered by medicare.

Senator KENNEDY. All of it covered?

Mrs. POLEWZUCK. Everything.

Senator KENNEDY. Operations?

Mrs. POLEWZUCK. Operations, braces. You can go to the best neurosurgeon in Montreal at the Royal Victoria Hospital, one of the best, and they have the best neurosurgeons there and she was operated on there, and we did not pay a penny. Everything. We had 24-hour nursing and it was covered.

Senator KENNEDY. Mrs. Corbett, you were telling us you had to have your children kept at home, is that right?

Mrs. CORBETT. Right.

Senator KENNEDY. You had 24-hour nursing?

Mrs. POLEWZUCK. Nursing, when she had pneumonia.

There was a nurse in the private room, 24 hours, with all the machines and we never got a bill. We just got a statement from the hospital stating the cost, but that was all.

Senator KENNEDY. And the therapy, too. You were able to get therapy?

Mrs. POLEWZUCK. My 6-year-old now, she is getting her cast off, she got it off yesterday. She is going to be in the hospital for therapy. She will undergo extensive therapy so she has to stay in.

It is about 2 hours a day every day, and she will come home in about a week, and then I will bring her twice a week in for therapy.

Senator KENNEDY. That is covered, as well?

Mrs. POLEWZUCK. Yes.

Senator KENNEDY. What has it meant to you?

You listened to Mrs. Corbett with the same condition you had. She is in debt. She has to worry about bill collectors. She has had to deny herself even medical care. You have been able, with two children with the same problem, and have not had to worry about medical expenses, not have had enormously difficult hard times obviously, emotional strain, but at least you have not had to worry about expenses, medical expenses.

Mrs. POLEWZUCK. No; my daughter was born in 1973.

Medicare had been in for 3 years. I was a little bit naive. I just took it for granted. It took me awhile to think not everybody has it. You can really go broke. A lot of the surgery is not life and death, but without it she would be in a wheelchair.

It has meant a lot that she could lead a more normal life.

Senator KENNEDY. Are you satisfied with the care you have received.

Mrs. POLEWZUCK. Yes.

If you are not satisfied, if you are not happy with your doctor, there are hospital boards you can complain to, and you can change without a reason.

You can just take your daughter and change hospitals.

Senator KENNEDY. Are your neighbors satisfied with it?

Mr. POLEWZUCK. Oh, yes, very.

Senator KENNEDY. You would recommend it then?

Mrs. POLEWZUCK. Oh, yes. It is a preventive measure, too, because you will not wait until your child is so severely ill that it is near death before you do bring it to a doctor and yourself. You go when you are not well.

Senator KENNEDY. That is important, I would think.

Mrs. Corbett was telling us about when the child is sick, she just waits because she knows that there is going to be additional kinds of expenses.

But you do not feel that kind of restraint for taking your child down?

Mrs. POLEWZUCK. No; a lot of people say it will be abused, that people will be running to the doctor for every little thing. But I do not believe in that because who likes to go to a doctor, sit in an office, and go to a clinic?

It is good to have it. It should be there if you need it.

Senator KENNEDY. That is a good point.

Most people either want to be back with the families, working, whatever. They do not want to be taking up a lot of extra time. We have found that to be the case.

I am interested in from various studies in the fact that you make that point.

Do you think that the money you pay in taxes is worth it in this case?

Mrs. POLEWZUCK. Yes.

We have bills, like we get an invoice from the hospital. Between the two children, it comes to $50,000.

Senator KENNEDY. What about you, Mrs. Gosling?

Do you think the money you pay in taxes is getting the dollars' value?

That would be kind of a loaded question in this country.

Mrs. GOSLING. Yes; there is no doubt about it at all.

It simply is a lifesaver mentally, and in every way. Because some things you can do without, but if your health breaks down, you have to have medical care.

You have no choice.

Senator KENNEDY. Mr. and Mrs. Churchill, of Louisville, Ky., and Mr. and Mrs. Ervin, Saskatchewan.

Mr. Churchill, perhaps you will tell us a little bit about where you work.

STATEMENT OF MR. AND MRS. ED CHURCHILL, LOUISVILLE, KY.

Mr. CHURCHILL. Yes, Senator.

I am sales promotion manager for B. F. Spirits, Ltd.

Senator KENNEDY. Just give us approximately what your income is.

Mr. CHURCHILL. Around $21,600.

Senator KENNEDY. Do you have a 23-year-old son who has some medical problem?

Mr. CHURCHILL. That is true.

Senator KENNEDY. Describe the problems for us.

Mr. CHURCHILL. My son has a condition called Krome's disease, for which he recently had major surgery.

Five years ago he had the same type of operation, which at that time my wife and I were both working, and our insurance covered all of the expenses.

Now, there is a situation where he is 23 years old and unable to—so far has been unable to maintain a regular job, and the surgery he has just had we committed ourselves to pay it.

We are the parents and he is living at home with us. But we were told that there are programs available that would help to subsidize some of this expense and/or completely take care of it due to the fact that he is an adult, and he could not any longer be considered as dependent, at least so far as he has not, because he has small jobs last year, which he is unable to keep, and his income put him in the bracket where we could not declare him as a dependent.

So our main reason for being here today is to speak for him in the event that what is going to happen if something happens to us, how does a person like this survive in this country today, who is unable to work regularly and continuously gets these expensive bills?

This is something he is not going to get rid of. It is going to come back, and he is going to continuously have to have surgery.

Senator KENNEDY. Before age 21, he was covered?

Mr. CHURCHILL. That is true.

Senator KENNEDY. After he reached 21, he is not?

Mr. CHURCHILL. That is true.

Senator KENNEDY. It is extraordinary about a health care system that treats somebody one way up until a certain birthday and then another way after they reach a certain birthday.

Mr. CHURCHILL. That is true, after they become an adult.

Senator KENNEDY. It does not make sense.

Have you tried getting coverage for him?

Mr. CHURCHILL. Yes; we applied through the billing office at Johns Hopkins Hospital, about 6 weeks ago, we applied for social security, which we were told that he is not eligible for because he has not worked long enough to get a certain amount of points or whatever that is.

So it was suggested to the doctors that we apply for SSI which we did when we went back to Louisville, and that is pending now. We had to pass the buck type of thing until we got in touch with some people we know through SSI, so that is pending now.

We do not know if it is going—if he is going to qualify or not.

Senator KENNEDY. How many unpaid bills do you have?

Mr. CHURCHILL. Well, we have regular household bills that we have.

Senator KENNEDY. Medical.

Mr. CHURCHILL. Medical bills, we have a little over $6,000 from Johns Hopkins. That is not counting the surgery fees from the surgeons. That was just for Johns Hopkins, and we said that we would pay it when we could pay it—when we signed my son out, we were asked how we were going to pay the bill or was he going to pay the bill.

We are the parents, and we know his bills have to be paid, so we committed to pay the bill eventually, which is around $100 a month.

My main interest is what happens to people in this particular category which does not have help or what is going to happen if something

should happen in the future that the man or woman like my son—well, what would happen? He is an American citizen, does he get help or are there programs? What does he do?

Senator KENNEDY. You mentioned to us he was out in California. Did he go out there?

Mr. CHURCHILL. Yes.

Senator KENNEDY. As I understand, there was one hospital—well, do you want to tell us that story?

They required or asked you for a deposit.

Mr. CHURCHILL. That was Johns Hopkins.

They asked me for $3,000 deposit.

Senator KENNEDY. $3,000 deposit?

Mr. CHURCHILL. Yes.

Senator KENNEDY. Is that what you did, you just laughed or cried?

Mr. CHURCHILL. I laughed and asked for the supervisor.

I knew somebody was saying something wrong to me. We did make a $200 deposit.

Senator KENNEDY. Mrs. Ervin, you have a son, is that right?

STATEMENT OF MR. AND MRS. LAVERNE D. ERVIN, SASKATOON, SASKATCHEWAN

Mrs. ERVIN. That is right.

Senator KENNEDY. What kind of medical problem does he have?

Mrs. ERVIN. Born with calcium deficiency and a lot of allergies.

When he was 20 months old, we took him in for an inoculation for red measles, then, because there was an outbreak, and we had lost a child previously with red measles, so we were told.

When he was inoculated, it caused a reaction, and he had 107° temperature for a week, causing brain damage and such and there were convulsions, of course. Since that time, he has been in and out of various hospitals, under doctors' care constantly.

At the present time he is in a nursing home just four blocks from our home, fortunately.

Senator KENNEDY. As I understand it, your family's income is about $22,000, is that correct?

Mrs. ERVIN. A little more than that.

Senator KENNEDY. Just about the same, though.

Mrs. ERVIN. Right.

Senator KENNEDY. How much did it cost in Montreal Neurological Institute?

Mrs. ERVIN. When we took him to Montreal, it was about 7 years ago. It was $95 a day coverage for the hospital, plus the doctors. He was in there from the middle of July until the middle of October. It was around $6,800.

Senator KENNEDY. What did you pay?

Mrs. ERVIN. When we thought we were going to be responsible for that, but it was all taken over and covered between the Quebec government and Saskatchewan government.

Senator KENNEDY. So you paid nothing?

Mrs. ERVIN. We paid nothing; other than our expenses and return trip and such.

Senator KENNEDY. Going back and forth?

Mrs. ERVIN. Right.

Senator KENNEDY. Where is your son now?

Mrs. ERVIN. As I mentioned, he was put in a hospital in a school for the retarded and he was there for 6 years and we had hoped by putting him in there—it was recommended by the doctors—we had hoped they would curb the seizures he was having. He would have as many as 50 to 100 a day, and then when he was going downhill so badly they decided they should put him in a terminal home and it is within 4 blocks of our own home.

It has proved very good.

Senator KENNEDY. Who pays for that?

Mrs. ERVIN. The Government covers all costs.

Senator KENNEDY. Do you know what the value of the services for the last year, for example, did you get one of those little bills——

Mrs. ERVIN. Yes; we got a statement last year, and I was so overwhelmed when I saw it that I did write a letter to the Government. It cost $25,000 last year. He was in and out of comas several times, which required hospitalization and care on top of the nursing home care.

Senator KENNEDY. What did you pay again?

Mrs. ERVIN. We paid absolutely nothing.

Senator KENNEDY. You wrote a letter to the Government?

Mrs. ERVIN. I wrote a letter to the Provincial government because I thought we had taken it for granted for so many years, this health coverage, and when I saw that it was more than my husband's take-home pay for 1 year, and this could continue—there has only been one doctor who ever gave us a life expectancy and she said 16 years. So it could go on indefinitely.

Senator KENNEDY. You wrote to the Government expressing appreciation?

Mrs. ERVIN. Right.

Senator KENNEDY. I do not know when the last time a person wrote to the Government in this country expressing appreciation.

Mrs. ERVIN. I think it was a first for them, too.

Senator KENNEDY. Seriously, in terms of the kind of attention that they have given to you, I mean the nurses and doctors, you have been satisfied?

Mrs. ERVIN. It has just been great, really.

The thing is, when we brought Steve to Saskatoon, he was 10 years of age, weighed 40 pounds, and in a wheelchair, getting water with an eye dropper. He is 13 years of age now and he weighs 120 pounds and he is 5 foot 5, and he is enjoying life as best he can.

Senator KENNEDY. Are your neighbors and friends—do they feel as you do about the system in Canada?

Mrs. ERVIN. I think everybody there is just so happy to have it. They do not mind the extra taxes and such because they know in an emergency, as in our case, it could happen to anybody, this sort of expense. I think everybody is quite willing to pay their taxes if you have got this coverage.

Senator KENNEDY. You feel you are getting services for the taxes that you pay?

Mrs. ERVIN. Definitely.

As I mentioned, we do have really superior health care in the province.

Senator KENNEDY. Whatever you feel you are paying in taxes, you feel you are getting your dollars' worth?

Mrs. ERVIN. We most definitely are.

Sentaor KENNEDY. Do you agree with that Mrs. Gosling?

Mrs. GOSLING. Yes.

Senator KENNEDY. We will go to Mrs. Wolfe and the Griffins, representing our elderly population.

Mrs. Wolfe is from Cincinnati, Ohio, and Mr. and Mrs. Griffin, Toronto.

I think it is time that we started with the Canadians first.

Perhaps we will just start off with Mrs. Griffin, from Toronto. We are glad to have you here.

Perhaps you can tell us how old you are.

STATEMENT OF MR. AND MRS. WALTER GRIFFIN, TORONTO, ONTARIO

Mrs. GRIFFIN. I am 74 and my husband is 82.

Senator KENNEDY. That is Mr. Griffin right behind you?

Mrs. GRIFFIN. Yes.

Senator KENNEDY. Mr. Griffin, we are glad to have you here.

Mr. GRIFFIN. Thank you very much.

Senator KENNEDY. What kind of medical problems has your husband had?

Mrs. GRIFFIN. He has had a good many.

Do you want me to go into it?

Senator KENNEDY. I hope that maybe we can talk a little bit about it.

You lived in Canada before health insurance and after health insurance, is that correct?

Mrs. GRIFFIN. That is correct, yes.

Senator KENNEDY. We are a little interested in your impressions before and after, I think that is kind of important, too, as people who have lived in Canada under two different kinds of systems, what your own reactions to those different issues were.

Do you remember about 30 years ago when Mr. Griffin had an ulcer?

Mrs. GRIFFIN. Yes, I do.

Senator KENNEDY. An ulcer operation.

At this time Canada was not under health insurance.

Maybe you could tell us what happened then?

Mrs. GRIFFIN. He had an operation for an ulcer.

Senator KENNEDY. This is 30 years ago?

Mrs. GRIFFIN. It has been past 30 years ago.

Senator KENNEDY. Past 30 years?

Mrs. GRIFFIN. Yes. I would say 35 years. It is going way back.

Senator KENNEDY. At that time there was no national health insurance in Canada?

Mrs. GRIFFIN. No.

Senator KENNEDY. What kind of coverage did you have then?

Mrs. GRIFFIN. If I recall, not very much, if we had any at all. I do not know, it is so far back.

Senator KENNEDY. Did your husband have other kinds of medical problems before health insurance in Canada?

Mrs. GRIFFIN. Before 35 years ago?

Senator KENNEDY. Before the passage of the health insurance in Canada, a number of years ago, did he have other health problems?

Mrs. GRIFFIN. Yes, he has had a great many.

Senator KENNEDY. A great many. Were you able to meet the expenses and the costs of those medical——

Mrs. GRIFFIN. Well, the ulcer alone, the surgery was $500. We tried our best to pay a little each month, $5 or $10, whatever we could, and I believe this went on for about a year, and it got to the stage—I guess the doctor felt that we were trying, so there were no more bills. I guess after so long, I do not think they carry it on, I do not know, so long as you were trying.

Senator KENNEDY. You did have a problem, as I understand, 35 years ago, before health insurance, where you had these operations and you had medical needs and you were being hard pressed to pay them if I understand that?

Mrs. GRIFFIN. That is right.

Senator KENNEDY. Now, there is a different situation, since you have passed health insurance in Canada. Have you had any medical problems since health insurance was passed?

Mrs. GRIFFIN. Oh, yes.

Senator KENNEDY. Your husband has had a heart attack?

Mrs. GRIFFIN. Before that heart attack, since this health problem was passed, the health bill, he had a nervous breakdown, and he had a nervous breakdown caused from a hernia operation, and he had also an operation in previous years before that for a gallbladder and hernia, too.

Senator KENNEDY. When was that, now?

Mrs. GRIFFIN. The gallbladder and hernia—let me see—a good many years back.

Senator KENNEDY. Before health insurance?

Mrs. GRIFFIN. That is right.

Senator KENNEDY. You had a lot of medical expenses, did you?

Mrs. GRIFFIN. Yes, we did.

Senator KENNEDY. How did you pay for those?

Mrs. GRIFFIN. We just had to pay what we could, just a little at a time, and do what we could.

Senator KENNEDY. Recently has he had illness or sickness?

Mrs. GRIFFIN. Yes, he has.

Senator KENNEDY. How recently, in the last few years? The last 2 or 3 years?

Mrs. GRIFFIN. Yes.

Senator KENNEDY. What sort of illnesses or sickness did he have in the past 2 or 3 years?

Mrs. GRIFFIN. He had another hernia.

Senator KENNEDY. Another hernia?

Mrs. GRIFFIN. Yes.

Senator KENNEDY. Did you receive any bills from the one?

Mrs. GRIFFIN. No; those bills there [indicating]—one heart attack that he had last year, but he had two heart attacks last year.

Senator KENNEDY. Two heart attacks?

Mrs. GRIFFIN. Yes.

Senator KENNEDY. This is for one of them?

[The bill referred to follows:]

DATE	NAME OF PAYOR	CHEQUE	CASH	CHEQUES	SUNDRY	RECEIPT NO.	NAME OF PATIENT OR DESCRIPTION
Aug 7/72	W. Griffin			2		58734	

MOUNT SINAI HOSPITAL

RECEIPT

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FORM MS 178

NORFLEX TORONTO

Ontario Health Insurance Benefits

Your Ontario Health Insurance Plan (OHIP) has been billed the following amount for your hospital stay:

W. Griffin — Patient's name

$332.20 — Amount

This amount represents your use of STANDARD WARD hospital services. It includes all basic hospital charges, but excludes extra charges (if any)for semi - private or private accommodation, and special services (if any) not covered by OHIP.

Ontario Health Insurance Plan

Ministry of Health
Ontario

FOR INFORMATION ONLY—
NOT AN INVOICE
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Points to remember about your Health Insurance

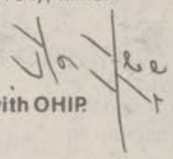
Separate premiums are required when dependent children marry, reach age 21 or get a full-time job. Application forms are available at hospitals, banks and OHIP offices.

The family premium must be paid to cover married couples. Tell your group — or, if you pay premiums directly, notify your local OHIP office.

If you stop paying premiums through a group, carefully follow the instructions on the back of the Certificate of Payment (Form 104), which your group is required to give you.

Always keep your Health Insurance certificate handy.

Always quote your Health Insurance number when dealing with OHIP.



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Mrs. GRIFFIN. That is one. They did not give me the other bill. They just gave me the discharge bill, but that was the first time, the first heart attack.

Senator KENNEDY. This was for the heart attack.

On this it says $3,325. It says at the bottom "For information only, not an invoice, not a receipt, and not for tax deduction."

Mrs. GRIFFIN. No, it did not cost us anything at all.

Senator KENNEDY. It did not cost you anything?

Mrs. GRIFFIN. No; the same when he was in in December.

Senator KENNEDY. You lived under the old program and this program?

Mrs. GRIFFIN. That is correct. Yes.

Senator KENNEDY. Which one do you prefer?

Mrs. GRIFFIN. I prefer this one by all means. If I had had to pay nearly $6,000 in a year on an old age pension check, I do not think I could have done it.

Senator KENNEDY. Well, there many senior citizens in this country, Mrs. Griffin, that are hard pressed.

Mrs. GRIFFIN. I am sure there must be.

Senator KENNEDY. That paid for medication and other kinds of services and medicare, their retirement only pays 40 percent.

Mrs. GRIFFIN. I really do not know how they get by.

Senator KENNEDY. A lot of them do not get by, that is the tragedy.

Mrs. GRIFFIN. You could not possibly. I know with my husband and I, if we had not had that coverage, and I have a heart attack condition, too, with the care I am getting and with what my husband has been getting, he still now goes to a heart specialist every 6 months,

and he is under a heart specialist care, and you know what a specialist would cost, a heart specialist, if you have to go to one for a consultation.

Senator KENNEDY. You take the number of people even in the United States that have heart attacks, illness and disease, probably the No. 1 killer, so the fact that people having this kind of expense, I mean, $3,325, and the American people that are affected by illness, by heart illness and disease and sickness, and that are getting bills similar to that is——

Mrs. GRIFFIN. It is sad.

Senator KENNEDY. It is not the exception, it is too frequent obviously.

Mrs. GRIFFIN. Yes.

Senator KENNEDY. They are very heavily burdened by it.

But in your situation you get this bill that says, "Paid in full." Effectively, that is what it says.

Mrs. GRIFFIN. That is right.

All I had to pay for was the phone.

Senator KENNEDY. The phone?

Mrs. GRIFFIN. Yes. They even cut the phone bill down because at the time when my husband went in, he had a virus in his ear or an infection, whatever he had, and he had to go to an ear specialist there in the hospital, so he could not just use the phone. When he did use it, it was only a couple of times, and I just stated when I was paying the phone bill that it was too bad that he could not talk to me or in fact I could not speak to him on the phone because—to call in to him. The lady asked me, well, how much I thought was reasonable.

I said, well, I would leave it up to her. So I think I only paid $2.50 for the phone. That was for 2 weeks in his room because he was in intensive care for a week.

Senator KENNEDY. You mean they negotiated to you what they were going to charge?

Mrs. GRIFFIN. That is true. That is the truth, they did.

I did not ask for that favor, she gave it to me.

Senator KENNEDY. You thought you were fairly treated, did you think, on the charge for the whole hospital for the phone?

Mrs. GRIFFIN. She told me what the phone bill was, and I would have to pay it because that did not go with that and I just said that it was too bad that I could not talk to the husband on the phone and I was not able to go down to see him.

She cut the phone down and I thought that was very nice of her and I would have to say like this lady said, that the care my husband got was just wonderful. The doctors were wonderful, too.

I do not believe my husband would be here today if it was not for the care that he had received from the Mount Sinai Hospital and the doctors.

Senator KENNEDY. So not only has it relieved you of the financial worry, but you think you are getting good service, too?

Mrs. GRIFFIN. That is right, because with my condition, too, it relieves the worry from me, at least it does not aggravate me too much anyway because if I had that pressure to pay the bill, I just could not do it. That is all. It is bad enough just to keep your home going when you are on a limited income.

Senator KENNEDY. That point has been mentioned time and again, and that is the mental strain, the burden, that people have about fear of the expenses.

Mrs. GRIFFIN. You do, because you feel you are obligated to pay what you can and you can only do so much.

You worry, where am I going to get the money. That can be aggravating. My husband had a nervous breakdown, and I really believe that caused a lot of problems going back those years before, worrying about how we are going to pay things.

Senator KENNEDY. Nobody in Canada really has to worry about that?

Mrs. GRIFFIN. They do not. I think it is the most wonderful thing that anyone can ever have. I sincerely hope that you folks will be able to have your bill passed.

Senator KENNEDY. I do, too.

Mrs. Wolfe, would you tell us how old you are?

STATEMENT OF MRS. ELIZABETH WOLFE, CINCINNATI, OHIO

Mrs. WOLFE. I am 68. I will be 69 in January.

Senator KENNEDY. Are you a widow?

Mrs. WOLFE. Yes, I have been a widow since January 1962.

Senator KENNEDY. What job did your husband have?

Mrs. WOLFE. He was a high ranking executive, ended up losing his job as a matter of corporate politics, almost immediately after his 50th birthday, and simultaneously with the diagnosis that he had generalized atherosclerosis.

Senator KENNEDY. He had a good income?

Mrs. WOLFE. In those days, Senator, there was such competition for middle management jobs that even though my husband had responsibility for a staff of 37 people with a very fine corporation, his highest compensation was only $16,000.

Senator KENNEDY. You have two children?

Mrs. WOLFE. Yes.

Senator KENNEDY. Did they both go through college?

Mrs. WOLFE. I put them both through college.

Senator KENNEDY. Did you work?

Mrs. WOLFE. Yes, sir.

Senator KENNEDY. What kind of medical problems did you encounter?

Maybe you could start with 1968.

Mrs. WOLFE. I managed to hold up pretty well until 1968. Just about Thanksgiving of 1968 I fell and ruptured the optical muscle that supports the eye, and had to have first corrective eye surgery in order to avoid multiple vision.

Then I went to Chicago because my children were in that area to start my affiliation with a different brokerage house. I was financial consultant at the time. Starting out in the business advising middle-income people to plan for retirement and old age.

I was also licensed by the FCC, NASD, and insurance departments of the States of California, Illinois, as a life and health insurance agency, strictly commission. I could not generate, having just mentioned the move to Chicago, sufficient income to maintain myself, and I had to go back into legal work, and in spite of all my experience, I had to start at a beginner salary.

The insurance group that I worked for moved its home office from Chicago to an outlying suburb. I was considered too old to be eligible for the transfer. I started developing a hobby of breaking bones.

Senator KENNEDY. You were covered with some form of insurance?

Mrs. WOLFE. Yes, for a period of time.

When my job with the insurance company terminated in 1971, I carried Blue Cross as an individual, and then when my medical problem really started, Blue Cross canceled me for too many claims.

Senator KENNEDY. As you mentioned other medical complications, did you try to get Blue Cross to continue?

Mrs. WOLFE. I could not possibly afford it. I could not possibly afford it because of my present health record.

Senator KENNEDY. Could not afford the premium?

Mrs. WOLFE. I could not possibly afford the premium.

Senator KENNEDY. They raised the premium?

Mrs. WOLFE. Yes.

When I was still able to get it before I had so many health problems, the premium was already $30 a month. Now that I am on social security and medicare, even if I had a good health record, the premiums would be approximately $40 a month. On my social security income, and you have a figure there, Senator, I cannot possibly afford that.

Senator KENNEDY. What medical problems have you had since 1972?

Mrs. WOLFE. In 1972, May 1——

Senator KENNEDY. Just briefly summarize.

Mrs. WOLFE. I entered a hospital for diagnosis as to whether or not we could do anything about my gastric problem. After 11 weeks of examination, they did an operation for an esophageal hernia. It was not a success. I was in the hospital until October—May 1 to October 29. I convalesced at Women's Club.

Two months later I broke one hip. About 3 months after that, they did a second operation for the same hernia of the esophagus problem. The following year I fractured the other hip. The fracture never united completely. I have been walking with a cane since.

We are now in the process of testing when will I be ready for a third operation. They have put me through preliminary testing at the cost of over $2,000 for each series of tests so far this year. Since medicare does not furnish copies to the recipient of what the bills are, and I only get the figures as to what my 20 percent should be, I would estimate so far the billing to medicare this year has been $10,000 at least, and surgery is now scheduled, a very high risk, at least 6 hours, for November 11.

Senator KENNEDY. Has this drained off, these medical expenses, drained off your assets?

Mrs WOLFE. Totally.

My only income is social security.

Senator KENNEDY. Did you have a small savings?

Mrs. WOLFE. I have no savings account. I am fortunate if I can maintain a balance in my senior citizens checking account of $30.

Senator KENNEDY. What kind of condition were you in before all these medical expenses financially, were you at least comfortable?

Mrs. WOLFE. I was a financial consultant on planning.

Senator KENNEDY. You are a financial consultant?

Mrs. WOLFE. Yes.

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Senator KENNEDY. Before all these medical expenses you were at least able to have a comfortable existence?

Mrs. WOLFE. I had estimated that with social security, drawing 6 percent on my investments, that I would have an income of about $750 a month, and that I would have an earning capacity of at least $25,000 a year as a financial consultant.

Now those savings have effectively been wiped out. Everything is gone.

Senator KENNEDY. How do you get along?

Are you concerned about future types of medical bills?

Mrs. WOLFE. Yes, sir.

I have a shoebox full of duns.

Senator KENNEDY. For what?

Mrs. WOLFE. Duns, d-u-n-s.

I have two hospitals and one optician putting my balances——

Senator KENNEDY. Tell us what the duns are.

Mrs. WOLFE. Harassment.

Senator KENNEDY. Harassment?

Mrs. WOLFE. Yes, harassment. Such things as why don't you pay your share?

Obviously you are dishonest and did not want to pay for your eyeglasses.

Senator KENNEDY. You have two shoeboxes full of those kinds of notices from collection agencies?

Mrs. WOLFE. Yes.

Senator KENNEDY. You would be able to, would you not?

Mrs. WOLFE. Senator, I'm a proud person and I am an aggressive person. You have some history of my background. I have great earning capacity. I'm restricted as you know, with what I could earn by social security. I am restricted by my health condition as to what kind of work I can do. Just about a year ago I was fortunate enough to be in touch with a pilot program administered in the State of Ohio under the Older Americans Act.

The requirements to get this employment, one must be 55, preference to people over the age of 60. Maximum working hours to be compensated for 20 hours a week at $2.80 an hour. And income from all sources under $3,000.

Senator KENNEDY. I think there is quite a difference between your experience and Mrs. Griffin's.

Mrs. WOLFE. Yes, there is. It does not add to my peace of mind to know this is going to be a very high risk surgery. It does not give me any comfort that no undertaker will tell me what is the cheapest kind of funeral I can arrange unless I can guarantee the funeral will be paid for.

It does not make me very happy that when the project manager where I live learned that I had this invitation, he gave me a notice of eviction.

Senator KENNEDY. Gave you a notice of eviction?

Mrs. WOLFE. Of eviction.

My housekeeping does not meet with their standards.

Senator KENNEDY. You think these medical tragedies during your life have been really the principal problem in terms of unraveling of your own financial situation——

Mrs. WOLFE. Yes.

Senator KENNEDY. And the kind of tensions——

Mrs. WOLFE. Psychological.

Senator KENNEDY. Psychological problem?

Mrs. WOLFE. It is terrific.

Senator KENNEDY. We have heard Mrs. Griffin say that with all of the expenses, you do not feel that you have this problem, do you——

Mrs. GRIFFIN. No, I certainly do not, Senator.

Senator KENNEDY. You are obviously concerned about future health and well-being, but you are not as concerned as I understand——

Mrs. GRIFFIN. No, I am not, I have peace of mind.

Senator KENNEDY. Mrs. Wolfe, do you have peace of mind?

Mrs. WOLFE. No, I do not.

Senator KENNEDY. That, again, is part of the real issue in terms of health insurance. We are again always talking about charts and figures, but I do not know how you quantify this and put a dollar value on it.

It seems to me in this country we ought to be able to relieve people of this kind of mental anguish.

Mrs. WOLFE. May I make an unsolicited comment?

I live in a low-income integrated housing project under HUD. It is a high crime area. We have no supermarket within 3 miles. We have no restaurant. I have to walk downstairs six or seven or eight steps to reach any ground level and coping with a cane, there is a heavy door. We have no congregate mills. We have facilities that are not being utilized. The greatest problem we senior citizens—68 percent of the senior citizens in our area have incomes under $6,000 a year. The majority are black or Appalachian. Our average widow has an income of under $4,000 a year, and living in this environment, I am well aware of the problems of the senior citizens.

The greatest fear is that we will outlive—those who have resources—that they will outlive the resources and have to become medicaid patients. I have been in the best hospitals, and I have been in hospitals and nursing homes under medicare and medicaid, and there is a tremendous difference in the services rendered.

Senator KENNEDY. On that point, have you found any differences in the Canadian experience; you mentioned before, Mrs. Polewzuck, you go from one hospital to another—did you find this difference between services from one hospital to another?

Mrs. POLEWZUCK. No.

Senator KENNEDY. You generally get good services?

Mrs. POLEWZUCK. They treat you like a consumer if you are not happy—you are the consumer, and if you are not happy with the doctor, you do not feel is being truthful with you, or doing what you want him to do, you go to another doctor, and you can go to another hospital where you report him through the medical board.

Senator KENNEDY. Mrs. Wolfe was sort of commenting on the different kinds of levels of service in terms of more financial resources or less, but you do not find such real distinction?

Mrs. POLEWZUCK. No. You can go to the best specialist; if you want to see a specialist, you go to a specialist. You do not need a referral. You go to your specialist.

Senator KENNEDY. The next are the Howells and the Hursts.

Mrs. Howell, from Smokey Hollow, is unable to be here; and Mr. Hurst is from Windsor, Ontario.

I will ask the staff assistant that worked on this to give us the Howells' story, and then we will hear from the Hursts if we could.

Mr. Sheridan.

Mr. SHERIDAN. Mr. and Mrs. Howell live in a small black community called Smokey Hollow, near Tate, Ga., up in the northwest mountains. They live in a two-room shack, really, with wood-burning stove, and Mr. Howell has severe hypertension, and kidneys have been damaged.

He was on medicaid but he started receiving social security, and when he started getting social security, which amounted to $220 a month, he lost the medicaid because the limit in the State of Georgia for medicaid is $189. In other words, if you make more than $189 a month, you are not eligible for medicaid.

Then he tried to go to the doctor to treat his hypertension. The doctor would not see him because he did not have any money, he did not have medicaid. The legal services group in the—in Gainesville, Ga., interceded on his behalf and finally persuaded the State agency to pay the doctor's bill, so he got to go to the doctor. When he went to the doctor, the condition was so serious that the doctor sent him immediately to the hospital in Atlanta, where he was treated for a number of weeks.

He then returned to Smokey Hollow. Now he is in Smokey Hollow, and he and his wife were to have been here this morning, but last night he took a turn for the worse, and his wife is now trying to get him in the hospital.

His condition has been worsening.

He does not have medication he needs. He is not getting the treatment he needs. In addition, they have a 15-year-old with him, and she was getting $66 a month under medicaid for her treatment of her teeth. Her teeth were all rotten, and the dentist set up a program to remove all of her teeth, and replace them with dentures.

In the middle of the process, when most of her teeth were removed, and, of course, no dentures were yet available, the medicaid stopped and the dental treatment stopped. So that is where that stands. The girl has few teeth in her mouth, no dentures, and no prospects of that situation improving.

In addition to that, one of the grandchildren, they have a program in the State of Georgia for malnutrition, and one of the grandchildren had symptoms of malnutrition, so he was under the program and started to improve, and when he reached a certain point of improvement, they took him off the program because the program was for people with malnutrition. He went back to Smokey Hollow, and he now again has malnutrition.

That basically is the story of the Howells.

Senator KENNEDY. They stopped treating the daughter, is that correct?

Mr. SHERIDAN. As soon as there was no medicaid.

Senator KENNEDY. Did she have some of her teeth taken out?

Mr. SHERIDAN. She had most of her teeth taken out, she had very few teeth, and she does not have the dentures yet, of course.

Senator KENNEDY. So effectively she lost the medicaid, really, by the SSI?

Mr. SHERIDAN. Yes; as soon as the social security started, he lost medicaid.

Senator KENNEDY. We will hear from Mr. Hurst.

Both of these families have hypertension.

Mr. Hurst, how old are you and how many children do you have?

STATEMENT OF LEONARD HURST, WINDSOR, ONTARIO

Mr. HURST. I am 45 and I have 10 children.

Senator KENNEDY. When did you find out that you had hypertension?

Mr. HURST. In 1954, when I was in the Royal Canadian Navy.

Senator KENNEDY. The Royal Navy, and you were discharged from the Navy because of hypertension; is that right?

Mr. HURST. That is correct.

Senator KENNEDY. You have worked for the Chrysler Co.?

Mr. HURST. At the present time.

Senator KENNEDY. Have you had hospitalization for your medical condition?

Mr. HURST. Yes.

Senator KENNEDY. Pardon me?

Mr. HURST. Yes; I have.

Senator KENNEDY. How frequently?

Mr. HURST. Three or four times a year.

Senator KENNEDY. For how many days?

Mr. HURST. Different times, sometimes at the end of 3 months, 2 months, 30 days.

Senator KENNEDY. You have been in and out of the United States, have you not?

Mr. HURST. That is correct, sir.

Senator KENNEDY. You have been hospitalized in California?

Mr. HURST. Yes, sir.

Senator KENNEDY. For what reason?

Mr. HURST. For high blood pressure. I was hit by a car in Detroit, Mich. My legs were busted, fractured, and I was in a cast up to my waistline. I went to California—well, I'm ahead of myself—I was in Detroit and I went for X-rays and they did not find any fractures or anything in my bones, in my legs; and I went to California and went to the Martin Luther King Hospital, and that is when they found I had fractured legs.

I was in the hospital there approximately about a week; that is, the Martin Luther King Hospital. Then my blood pressure went up, and all this pain and suffering I had with my leg, and I went into Foxhill Hospital.

Senator KENNEDY. Where?

Mr. HURST. Foxhill Hospital in Los Angeles.

Senator KENNEDY. About how many different hospitals have you been into in the United States, do you think, approximately?

Mr. HURST. Five.

Senator KENNEDY. Five different hospitals?

You are a Canadian citizen; is that right?

Mr. HURST. Right.

Senator KENNEDY. Who paid for your medical treatment in the United States?

Mr. HURST. OHIP, Ontario Hospitals.

Senator KENNEDY. That is Ontario Hospital insurance program?

Mr. HURST. That is correct, sir.

Senator KENNEDY. So the Canadian programs paid for your medical expenses while you were hospitalized here in the United States?

Mr. HURST. That is correct.

Senator KENNEDY. All five different hospitals and all the other times you have been hospitalized here in the United States?

Mr. HURST. Yes, sir.

Senator KENNEDY. They pay all of your medical expenses?

Mr. HURST. Yes, sir.

Senator KENNEDY. Do you know how much they paid in Los Angeles or how much they paid the doctor?

Mr. HURST. In the Martin Luther King Hospital I believe it was a little over $1,000. For Foxhill Hospital, it was between $2,000 and $3,000, about $2,800 or $3,000. The doctor in Foxhill Hospital ran about $700 or $800.

It was all paid by the insurance company.

Senator KENNEDY. Somebody who was in the next bed over in any of these hospitals may very well not be getting hospitalization covered.

How do you feel about the Canadian system?

Mr. HURST. Very good. It takes a lot of worry off your mind. In my case, I never know when I would be struck down with this high blood pressure again, sir.

Senator KENNEDY. Let me see if there is some summary result that we might make here. I would like to inquire of our Canadian friends, speaking for yourselves and really for your neighbors, is there any one of you who is not satisfied or grateful or pleased with the system of national health insurance in Canada at this time that you know?

I do not know whether I can put in your record that you all shook your heads, but maybe your smiles can be indicated. I think you have commented on it. I gather from what you said already that you are satisfied, well satisfied with it, and no one questions any kind of system cannot be strengthened, but the essential aspects of it you are all satisfied with, that you feel you are getting your tax dollars value from the system.

Do you all agree?

You would not like to see it repealed?

What about it, Mrs. Griffin, would you like to go back to the old days?

Mrs. GRIFFIN. No. I certainly would not.

I would probably end up with a nervous breakdown. I say no, I certainly would not. I would probably end up with a nervous breakdown.

Senator KENNEDY. Would you have any guidance to your counterparts in the United States?

Mrs. GRIFFIN. I say, work hard for it.

Senator KENNEDY. You would say, work hard for it?

Mrs. GRIFFIN. Yes, work hard for it. Keep trying.

Senator KENNEDY. What about the others? Mrs. Gosling?

Mrs. GOSLING. Yes.

Mrs. WILSACK. Yes.

Senator KENNEDY. Do you think it is worthwhile for your counterparts in the United States to try to have both farm families and people who work in plants and factories, elderly people this morning, which are representing the group, do you think your counterparts in the United States ought to work for the type of health program that you have encountered?

Mrs. WILSACK. Yes, they should.

Senator KENNEDY. What would you do to a political leader who would try to take it away from you, Mrs. Gosling?

Mrs. GOSLING. Get rid of him.

They would not do that up there. It would be political suicide.

Senator KENNEDY. I asked the staff a question here and maybe you could comment on it.

Do you represent different political views?

I do not know whether you have different viewpoints about supporting different types of systems. The point I would be interested in is whether no matter what the political spectrum, whether all the political parties in Canada basically support the same kind of system?

Could you tell us, Mrs. Gosling, just on knowledge, general knowledge?

Mrs. GOSLING. I am going to mention something, one government put on a deterrent fee and this meant that when you went to the doctor, you paid a minimal amount, and the rest was paid by the government actually, and when the election time came around, this government lost very drastically. I think it speaks for itself.

Senator KENNEDY. For our American understanding, are there any political leaders or political parties in Canada that do not basically support this type of program?

Mrs. GOSLING. Oh, no.

Senator KENNEDY. They are all in general support of it?

Mrs. GOSLING. Yes; I think definitely.

Senator KENNEDY. It is basically a nonpartisan issue?

Mr. GOSLING. Yes.

Senator KENNEDY. Liberal or conservative?

Mr. GOSLING. Yes.

Senator KENNEDY. One of the problems that we know you have to be concerned with, and our Americans are concerned with, is the problem of inflation.

The increased cost of things, whatever arguments—food, energy, and health costs. But even with the problem of inflation, you still feel satisfied that you are getting your dollars value?

Mr. GOSLING. Yes.

I think one problem that has come up in Saskatchewan, sometimes you have a waiting period to get a bed. You cannot always get into the hospital immediately. I think this is one thing that has happened. They said inflation, just in the last few years, but I do not think it is as serious a problem.

Senator KENNEDY. Let me ask our American friends here if they have any kind of reaction to listening to this story here from the Canadian experience, if they have any reactions on it.

Mrs. Corbett?

Mrs. CORBETT. I know that everybody does and we really need some help financially. My husband makes a good salary. We cannot enjoy it. It is all just going to doctors bills. I am not alone. Many people feel this way. We need something.

Senator KENNEDY. Are you impressed by the fact that our friends from Canada are both warmly endorsing their type of a system, that it has relieved the families from the kind of medical expenses that I think each of you have testified about this morning, and also effectively have paid the bills and have done it within a system where they have been able to limit cost controls generally in terms of the economy?

Everyone is worried about runaway inflation, and if we get national health insurance, whether you really have a program that can limit costs.

Do you think at least from what you have heard that some form of national health insurance can certainly relieve you from the kind of fears that you have about meeting your medical needs for your children?

Mrs. CORBETT. I would like to say I would jump and scream if we ever got it. We need it desperately.

There is an awful lot of guilt that you are not being a good mother or a good parent, that you cannot do it. I know I would be grateful to all those who did work for it. We are grateful to be asked today to explain our side, that it is so needed.

Senator KENNEDY. Mrs. Cihak.

Mrs. CIHAK. Yes; it would be greatly appreciated if this bill would go through. It is a dirty shame that American people have to work all their lives and have one medical tragedy wipe out everything.

Senator KENNEDY. There is the fear of another one, too, I suppose.

Mrs. CIHAK. Yes.

Senator KENNEDY. We heard this morning that it is not just one, but Mrs. Wolfe talked about it, a series, the fear of any other kinds of additional illnesses and the fear of not being able to provide for children now, giving them the continued kind of treatment and support——

Mrs. CIHAK. Yes.

Senator KENNEDY. And Mrs. Sheagley, what do you think?

You have been listening to your Canadian counterparts, and do you feel they have something going up there?

Mrs. SHEAGLEY. I really think that they have got something going, and I for one would like to share in what they do have going, because I would like to be a better mother, and have some of the pressures taken off of me, because as a mother with retarded children, I need to be patient and understanding, and some of the bills we do have in medical expenses, they would be taken off of me. I would have more patience to give my two retarded children, a little more love and understanding that they need.

So I definitely think that it is a great idea.

Senator KENNEDY. All right.

Is there anyone else?

I think these statements have really said it.

Mrs. WOLFE. I would like to say I think that it is sad commentary that after my husband and I scrimped and saved and paid our taxes all these years, we made sacrifices and my son was a Marine officer, that now in my old age I am condemned to exist in poverty, living at below poverty levels.

Seven dollars is the minimum cost for going to a clinic. I have been in clinics sometimes eight times in 1 month. If I stop and have soup and a sandwich, after waiting 6 hours to be seen by my doctor, the bills runs even higher. Medicare being given our senior citizens is bandage medical treatment. You never know what doctor you are going to see.

You have the feel there is never any interest in you. It is a hardship to get to the clinics. Medical transportation is one of our greatest needs. We need reassurance that some doctor cares that we are still existing, and as long as we are existing we should be treated like human beings and not doped into a stupor.

Senator KENNEDY. Mr. Churchill, you have listened as well.

Do you have any comments?

Mr. CHURCHILL. Senator, I think we have a good program in this country, but I think they drastically need improving, and hopefully through your bill that some attention will be put on these types of things. I also think that through these programs we do have that some effort or better effort should be made that older people that are able to get help on their own, to look into these programs, also the younger people that qualify for these types of things, I think workers in certain areas where bucks are continually passed, should be looked into where a person that qualities should not have to go through harassment of bills, looking for someone to help them to apply for different things that we do have.

Senator KENNEDY. We are enormously grateful to our friends from Canada coming here.

Mrs. GRIFFIN. Could I have a mike and make a comment?

This last heart attack that Mr. Griffin had, it occurred at 4 o'clock in the morning. I was in the house and I got on the phone and I called and I called the police. In return they got an ambulance. Now, they had Mr. Griffin into the hospital before you could look around.

Everything was taken care of when he got into the hospital, which was very important in a case like that. Being prompt and getting there is important. It did not cost me for that ambulance.

I did not have to pay.

I thought I would mention that. It does not sound like very much, but I just wanted to show the care we get.

Senator KENNEDY. I think that the testimony we have heard in this panel this morning probably illustrates as clearly and as forcefully as could be illustrated, the need for the health program.

It was done in human terms. The health insurance program is based in the very same fundamental principles which I believe in so deeply in terms of its universality. It reaches out into rural areas, farm areas, as well as within the cities, in terms of comprehensiveness. It fits into all different kinds of illnesses and sicknesses, whether it is children, senior citizens, whether it is a continuing kind of medical need of the average family.

Hospitalization and patient care, medication, it covers those. It covers all Canadians and it is comprehensive. Inhospitalization and outpatient. It is done in a very humane way.

We have heard that spoken so eloquently in each of our witnesses this morning from their own friends and neighbors that they feel the same way about the system.

Mrs. Polewzuck mentioned he can go to another hospital or another doctor. There are all kinds of procedures. They feel they are getting good services. They are getting good quality. They feel they are getting good quality. It is very powerful message that you are giving to us, that you feel free of the burden of financial illness and disease. No one can be ever free from the fear of potential illness or disease, but you feel free from that financial burden that wipes out the family, that Mrs. Wolfe and others have talked about.

Just absolutely changes and alters and in some of the instances attacks the dignity and self-respect of an individual.

You do not have that fear because of the financial aspect of it. You feel relieved of it. You have done all of that within a system supported by the central authority in terms of what is being paid for, a lesser percentagewise than our friends in the United States.

It is holding, It is holding. It is cost effective, as they say. Those are the statistics, the figures that have been assembled, not by myself, a strong advocate of health insurance, but the Congressional Budget Office, Canadian Government figures, our own evaluations that were made by individuals who were not advocating any particular form—you are doing it efficiently and effectively from the cost effective point of view.

I think our final point, as I hear our Canadians, is that there is not a politician nor a political leader or political party that wants to go back from where you are in terms of health insurance.

That ought to be something that is not lost as well.

At the time when we can see where political leaders will jump out in front of any kind of movement or citizens concern on this issue here, that virtually uniformly across the political spectrum it is not a partisan issue, but supported by those of different political spectrums as it should be, because we are talking basically about how people are going to treat each other.

That should not define an ideology, whether someone is one political belief or another. It is basically human decency and humanity.

On the other side we have listened to our American citizens and friends who have been virtually, I think, most importantly have commented on their own sense of loss of being able to provide for loved ones.

I think this is what is really the message, I found most revealing this morning. The parents being concerned about not being able to do things that they want for their children or for their loved ones, because of a system where financial aspects are barricaded, a system which in too many instances individuals have been served at a cost of their own self-respect and dignity, a system which is widely out of control in terms of finances of it, and in a system where those that have been touched by serious health needs, continue to have that sense of fear every day of their lives, every night, that their child may get sick or ill and they will not be able to provide for them.

Mrs. Corbett tells us about middle income people, people who tell us about their children being sick and they wonder whether it is $50 sick, or $75 sick, because that is what it is going to cost, not having the resources for the crutches.

I just paid my son's prothesis bill, $1,600. Teddy has prothesis, $1,600 this year. He goes through one a year. I do not know how a family—Mrs. Corbett is talking about $50 for crutches. I am fortunate to have had the financial security to be able to afford it. Only part of the tragedy is that Congress looks out after itself pretty well.

As I have often said in different parts of the country, if we give to the American people what we have done for ourselves in Congress and the Senate of the United States, we would be a long way down the road toward not—not all the way down, but a long way down the road toward meeting health care needs.

So I hope that any American citizen, when they hear these pious comments and speeches from those coming back home after the Congress—about health care and health insurance, that the families are going to demand why they look out after themselves and not look out after them in this area.

It is a deeper kind of problem. We are going to be needing all the help from various groups in our country, doctors and others, to try to deal with this problem.

We want to deal with it. We started on this issue just on comprehensive programs 8 years ago and it will continue on and as long as I am in the Senate or until we pass it—I do not think there is a family in this country that has not been touched by health problems.

I just see in my own family, I have a retarded sister, and I was in a plane accident, 7 months in the hospital. I had the very best that you could possibly have. We were obviously able to afford it.

My father was sick for 7 years with a heart illness at home and again we were able to afford it. No questions that we ever got the very best in those that have the resources.

But we are committed to trying to relieve the American people of the fear of the financial burden. We are committed to seeing that when they get health care, that they are going to get the best that we can possibly fashion. We are committed to insisting that we do it at a cost the people can afford to pay.

I would hope that the taxpayers of this country listening to the taxpayers of Canada who indicated they feel very strongly that in this area of public policy they are getting their dollars' value, and I think I have stated correctly your position on it.

And that message should not be lost.

We want to thank all of you very much this morning, and we have one more important witness at the conclusion of this panel, so we will just recess for a moment or two, just to permit you to leave the table.

We want to thank you very much.

We will recess for about a minute and a half and permit our witnesses to leave the table, and then we will continue with our hearing.

[Recess.]

Senator KENNEDY. All right, we will be back in order now. We will hear from Mr. and Mrs. Frank Mooney from Philadelphia. Christopher Wall is also here. All right. Can we start now?

STATEMENTS OF MR. AND MRS. FRANK MOONEY, WEST CHESTER, PA.; CHRISTOPHER J. WALL, AUDUBON PARK, N.J.; AND MRS. ROSE ESHLEMAN AND DAUGHTER LIL, NOTTINGHAM, PA., A PANEL

Mr. MOONEY. My name is Frank Mooney and I am from Philadelphia. And to my left is my wife, Kathleen. To my right is Christopher Wall, and obviously the extreme right is Mrs. Rose Eshleman and her daughter Lil.

We represent a very small group from Philadelphia and we have been waiting an awfully long time to have some time to talk with your committee. We started our journey at 4 a.m., so we are very anxious to talk.

What we represent is a group of very concerned parents that have children on respirators, and I would like to briefly outline our problem and switch to Mr. Wall and outline his.

We have a 1-year-old baby, Jason Mooney, who has an extremely rare disease called Werdnig-Hoffman, also known as progressive infantile spinal muscular activity. It is a disease that occurs in 1 child out of 200,000. It is a terminal disease. The child has a longevity of no more than 2 to 3 years. The child is dependent on a respirator to breathe, and it is quite obvious it is our decision to maintain and prolong his life on a respirator.

Mr. WALL. My name is Christopher Wall and I am from Aubudon Park, N.J., and my son's case is quite unique from the other parents that appeared here today. The fact that my son 3 years ago was born with one of the rarest heart defects, known as Ectopia Cortis, his heart was permeated outside of his chest.

Due to this fact, he needed ventilation. The uniqueness of his situation is at the time I was unemployed, and I am solely dependent on Government agencies to maintain moneys to maintain my son's health. At the present time, after a 3-year hospital stay, the hospital bill is $600,000. To maintain my son at home, it will cost an annual dollar figure of $50,000. The problem that I face is, as long as my son is in the hospital, all his medical bills will be covered. Once my son was released from the hospital 3 weeks ago—I am working in a timeframe of approximately 1 year that services would be provided—at that time, when that year is up, I am faced with one of two alternatives. I am either to return my son to the hospital where he will remain forever, or I was told I could go on welfare and my son would be paid for.

Now, in my particular case, my son is not solely dependent on his machine. He is on the machine for periods of 12 hours, 14 hours, and he can stay off the machine the remainder of the day. And without this machine he cannot survive. But this machine is a means to my son ultimately being healthy as any other child. But I will ultimately be deprived of my son at home because I do not have the funds myself and there is no Federal agencies that provide for such care. I have dealt with the Social Security Administration and with the Department of health in New Jersey. I fall in a category in the Social Security Administration of two parents and one eligible child under 18 years old, a family income not exceeding $1,600 a month. Anyone

that would have to live on this means would again be near the poverty dollar level.

That is all I have to say.

Mrs. ESHLEMAN. I would liketo say that I am self-employed and if I made some profit I would lose it. I have a full-time baby because I have her on a respirator, and I have had her on that for 4 years. I expect it much longer.

I would like to work and contribute to society. Thank you.

Mr. WALL. Senator, we have prepared a short paper here. May I?

Senator KENNEDY. Surely.

Mr. WALL. To the members of the committee: Reference ventilated children.

We would like to thank the committee for the opportunity to appear and give testimony concerning the problems we face as parents of ventilated children.

Before going any further, we feel it is necessary to define what is meant by a ventilator. A ventilator is a machine which artificially breathes for the child. Dependence on the machine—the amount of time a child must spend on the machine—varies with each case. The children are attached to the ventilator by means of a tube leading from the machine to a tracheostomy, an opening in the threat through which air passes into the lungs. The medical history of each child is unique, and many different disease processes and birth defects are involved. Ventilation is the common factor in each situation.

There are numerous problems involved in the care of these children, particularly in the area of financial support and coordination of home care. Areas of financial support involve two sectors, public and private. The private sector includes insurance companies and organizations, such as the March of Dimes, Society for Crippled Children, and the National Industries for the Severely Handicapped.

Private insurance coverage varies with each family, but always involves a ceiling amount. When that limit is reached, coverage ends and cannot be reinstated. Help has been sought from numerous private agencies, but no financial aid has been found. Our group has contacted 27 such organizations. Those who responded, although sympathetic to our situation, were unable to provide financial assistance because our children do not fit their eligibility requirements.

When insurance coverage ceases, the family must turn to public agencies for assistance. Under the existing Social Security Administration laws governing our situation, all medical expenses incurred during hospitalization will be covered through medicaid and each State's respective crippled children's disabled unit program.

When we choose home care for our children, our eligibility for both of the above-mentioned programs ends; unless our earned income falls below the Social Security Administration's 1977 figures, the earned income of a family of five, including one child eligible for assistance, must fall below $994 per month. In addition, the unearned income of the child—that is, trust funds, interest on savings accounts and U.S. savings bonds, support payments—must be less than $662.30 a month. Both requirements must be met for eligibility. A family must be near impoverished levels to meet these standards.

The question is now raised, which is more practical from a financial standpoint, home care or hospitalization? Jerry DeMartini, 2

years old, of Woodlyn, Pa., has been home since December 1977 at a cost of $4,500 a month. This includes all supplies, equipment, and 24-hour duty private nursing. Compare this to $12,300 per month in an institution at Government expense. This $12,300 does not include doctor's fees. This figure is three times as much as home care. This situation is an example of private health insurance being quickly exhausted. Every parent who has brought his child home has averaged 60- to 70-percent savings in medical-care costs.

Even though it is financially more practical to care for the child at home, when the private funds are exhausted and the public funds are not available, the parents are faced with two alternatives to insure the health of their child. They may institutionalize the child permanently or be forced to go on public assistance if the parents choose home care for their child. Both methods would satisfy the financial need necessary to maintain the health of the child, but no parent should have to choose either of these alternatives to secure needed moneys.

In addition to the obvious financial benefit, we feel home care provides the optimum setting for the child to reach his maximum potential. As parents, we look at the total child and are concerned with their physical, emotional, social, and spiritual well-being. The children receive the necessary physical care both by his parents and private-duty nurses.

The other aspects of care at home are clearly superior to institutional care. The children develop socially and emotionally as they respond to the love shown them by family and friends in a warm secure environment. Unfortunately, it is difficult today to coordinate home care for the children. There is a scarcity of qualified private-duty personnel willing to provide home care, and there is no central agency through which we can locate and purchase needed supplies. The formidable task without any support takes up large amounts of time and energy that should be devoted to the child's care.

A more complete explanation of our problem is not possible at this time, so we have attempted to give only a general overview to familiarize you with our situation. It is obvious that change is necessary.

Today, our small group represents only the start of a growing concern. In time, with the ever-expanding medical and technical knowledge in this field, there will be a large number of children needing such care across the country. But even this small group of children represents a huge amount of financing necessary for adequate care. As their numbers increase, these children have the potential to drain the budget of any existing program, public or private. We feel it is important at this time to recognize the shortcomings of these programs, and make a concerted effort to modify existing programs and extend services to include the needs of ventilated children at home.

Thank you very much.

[The following material was received for the record:]

PRIVATE AGENCIES CONTACTED FOR ASSISTANCE

New Jersey Blue Cross and Blue Shield, (Non-group), P.O. Box 1330, Newark, N.J. 07101.

American Lung Association, 311 S. Juniper St., Philadelphia, Pa.

Muscular Dystrophy Association, 810 Seventh Ave., New York, N.Y. 10019.

Easter Seal Treatment Center, 56 W. Lancaster Ave., Downingtown, Pa.

National Easter Seal Society for Crippled Children, 300 Main Street, Orange, N.J.
National Foundation of the March of Dimes, 1732 Chestnut St., Philadelphia, Pa.
Society for Crippled Children and Adults, 3955 Conshohocken Ave., Philadelphia, Pa.
National Multiple Sclerosis Society, 1015 Chestnut St., Philadelphia, Pa.
Chester County Medical Society, 808 Valley Forge Rd., Phoenixville, Pa. 19460.
The American Physiological Society, 9650 Rockville Pike, Bethesda, Md. 20014.
National Council of Jewish Women, 1601 Walnut St., Suite 1124–25, Philadelphia, Pa. 19103.
National Easter Seal Society, 2023 West Ogden Ave., Chicago, Ill. 60612.
American Red Cross, 930 Avenue of the State, Chester, Pa.
Health Systems Agency of South Western Pennsylvania, 1616 Walnut St., Philadelphia, Pa.
National Industries for the Severely Handicaped, 4350 E.W. Highway, Bethesda, Md.
National Institute of Health-Research Center, and Fund Raising, 9000 Rockville Pike, Bethesda, Md.
The Lynch Home for Special Children, 205 Krewson Terrace, Willow Grove, Pa.
American Medical Association, 535 North Dearborn St., Chicago, Ill.
The Salvation Army, 110 E. Market St., Box 115, West Chester, Pa.
Campbell Soup Fund, Campbell Place, Camden, N.J.
Parkhill Memorial Trust for Crippled Children, The Blind & Incurable, c/o South Jersey National Bank, 600 Kings Highway, Cherry Hill, N.J.
Catholic Social Service of Delaware County, 711 Avenue of the States, Chester, Pa.
National Genetics Foundation, Inc., 9 West Fifty-seventh St., New York, N.Y.

Mr. MOONEY. If I can just say a few more words.

In this country today there are children and there are adults that are on kidney dialysis machines. The cost of those machines and the maintenance, the upkeep is being subsidized by the Federal and/or State Government. We feel that there is definite discrimination at this juncture with respiratory dependent children, and we are not trying to get into a moral issue here today. We are getting into the financing, financial aspects of the problem that we have, and although our children's diseases vary, we all have been exposed to tremendous emotional problems as well as the financial burden. And we feel that the emotional problems are enough to handle, and we do not need the financial burden.

Once the insurance is exhausted, you are on your own. There has been no help at all.

I think it is about time that children on respirators be viewed as normal children in the capacity that they are. They are mentally growing, intellectually prospering young children, and they should not be discriminated against because they need a respirator to help them support breathing.

So we really want to make a concerted effort and it is a shame that we could not all have the opportunity to talk and explain our personal situations earlier. But I think the overview of this statement should give you an idea of the tremendous problems that we are facing and, unlike the two groups that appeared prior to us, we are talking big numbers here. We are talking an awful lot of money. At the current time, our child, for example, is costing $8,500 a month to stay in an acute care facility.

The hospital wants to get rid of us because our child is considered chronic. But there is no chronic care facility that wants Jason. If we bring Jason home, it will cost approximately $3,500 to $4,000. So we, as parents, are trying to reduce costs by bringing our children home, but we feel it is about time that we get some support.

I think discrimination has been—has certainly been there with these children, and it is time that they be recognized. They are a small minority right now. But medical science keeps going ahead, and they provide for equipment to help our children and, all of a sudden, the money runs out. People say, well, we are sorry we cannot help you. We are sympathetic, we are empathetic, but we cannot help you. Why do you not try going to this agency first or this agency, and you get jerked around so long and we are all tired of being frustrated.

We could go on for a long time. Do you have any questions or other members of the committee?

Senator KENNEDY. You said it very well. I think you made the case very powerfully. You pointed out about how it is an increase of the problem rather than a decrease with medical science. Of course, it comes, I would imagine, at a very—at a time of your life after you just got married, just got started, just beginning to try to come to grips with the challenges of life, young people having their families, developing their families, and suddenly this kind of both emotional and financial burden as well, because it is the parents of the children who do not have a long life expectancy. The emotional problems, as you very well pointed out, I mean I am sure beyond, when you add to those the financial burdens as well, they have to be interrelated, I think. So just make it—it is just extraordinary to deal with.

Even as you pointed out, trying to do it less costly by bringing them home, you get in that fearful spiral where it will wipe out your savings, you have to qualify for medicaid.

Mr. MOONEY. What savings?

I am sure we are all in the same position.

Senator KENNEDY. So that is when you try, both from the loving point of view of looking after the child, do it in a more cost-effective way, and be caught in the downward spiral. I suppose any concerns that you bring the child home in order to give more love and attention and to do it more lower cost factor, you also have concerns when you get her back in a hospital. The kinds of pressures, if you get a patient out of the hospital, because of the chronic nature of the problem. You have just pointed out just extraordinarily important aspects of human need and health needs in this country. At least the financial burdens that you are under, that you have described here would be relieved under health insurance at this point.

I think that would be a substantial—and from what we heard, be done at a level where at least you know that they are getting good health care, the children, and that is important.

Obviously the emotional kind of attention, loving, you know, that is going to—that would remain with the parents, but I think they are trying to deal with that as best they can.

This other kind of burden, too, is just unreal.

Mr. WALL. Senator, may I give just one thought a minute?

Senator KENNEDY. Yes.

Mr. WALL. I think it is important to mention that the children that are on the ventilators, not all of them are chronic. The ventilator is a means of making them healthy, and in my son's case, it is only a matter of time that he will be able to rid himself of this machine and live a normal life.

But because I do not have the means to do that, he may be forced to be institutionalized until his health is at a point where he no longer needs that machine. The doctors have told me it may be a year, 2 years, maybe 4 years. I do not feel, as a parent, that I should have to have my family split and one institutionalized because I do not have the funds to pay for this child.

Senator KENNEDY. You know, the fragmentation of both services, reimbursement mechanisms which have to be dealt with, I mean that is why it is necessary to deal with it in this comprehensive way. That is what effectively the reimbursement mechanism—reimburses hospital facilities and not the home facility. All kinds of standards of qualifications. It is an absolutely fragmented system, and what has happened is, and it is pointed out in instance after instance, you pointed out in your situation where these groups fall through the cracks in our health care systems, and unless you get underpaid then you are going to find out that we fall through the cracks. The case that you make is a powerful extremely heart rending and compelling one.

I can tell you that the approach that we are strongly supporting, it would meet the financial aspects of it, and the quality aspects of the tragedy that you are faced with, and I think that would make some difference to you in this case.

If there are no other comments, I thank you very much, and we will recess until 9 o'clock, tomorrow morning.

[Whereupon, at 11:45 a.m., the subcommittee recessed, to reconvene at 9 a.m., Tuesday, October 10, 1978.]

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NATIONAL HEALTH INSURANCE, 1978

TUESDAY, OCTOBER 10, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH,
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:08 a.m. in room 4232 Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy and Chafee.

Senator KENNEDY. We will come to order.

As our first witness this morning, we have Mr. Meany, president of the AFL–CIO, and Mr. Fraser, president of UAW. We look forward to hearing from both of them.

We want to say how delighted we are to have the rest of the members of the panel. Over a period of years we have had the opportunity to work very closely in trying to fashion a health care program and system that is going to meet the human needs of the people of this Nation. The panel that is here today, and those that follow, will speak for the working people of this Nation; for those that live in rural areas; those that speak about health care as an important and moral issue; those that speak for our senior citizens, who perhaps more than any other group in our society have been touched by the failure of our current health care system, have been extremely constructive in trying to make recommendations on how to deal with this issue.

I do not intend to comment on the very powerful testimony we had yesterday. We have limited time. I think it is good to get started with our hearing.

STATEMENT OF GEORGE MEANY, PRESIDENT, AFL–CIO, AND DOUGLAS A. FRASER, PRESIDENT, INTERNATIONAL UNION OF UNITED AUTOMOBILE, AEROSPACE, AND AGRICULTURE IMPLEMENT WORKERS OF AMERICA

Mr. MEANY. Thank you, Mr. Chairman. The AFL–CIO welcomes this opportunity, Senator, to testify in support of the proposed Health Care for All Americans Act—the framework of which was worked out in close consultation between your staff, the Committee for National Health Insurance, and the AFL–CIO.

While actual legislation will not be completed until a later date, the detailed framework you have made public can well serve as the basis for informed public debate on the issues.

We believe it is vital that this debate be started before the November election, since no issue facing the next Congress will have a greater impact on the lives of more Americans than national health insurance.

Indeed, public debate up to now has provided the supporters of comprehensive and universal national health insurance with an opportunity to make refinements in the health security program. As a result, objections which have been raised to portions of that program have been dealt with—but without sacrificing the essential principles which must be met to achieve genuine national health insurance.

Before discussing the individual provisions of the Health Care for All Americans Act, permit me to sum up the reasons why the AFL–CIO contends that action on national health insurance is mandatory in the next Congress:

The medical care situation in the United States is a disaster waiting to happen. Costs are escalating out of hand. Quality is deteriorating, because of cost pressures. There is too much surgery, too many hospital beds, too much expensive and wasted equipment, and too many people still not receiving adequate care.

This, then, is the dimension of the problem:

In fiscal 1977 Americans spent $163 billion on health care needs—that is $737 for every man, woman and child, or 8.8 percent of the gross national product.

Ten years ago, the Nation apent $48 billion or 6.2 percent of the GNP.

By 1985, a conservative projection is that a total $430 billion will be spent on health care, or about 10 percent of the projected GNP. That is how much this Nation will be spending for inadequate health care if genuine national health insurance is not enacted at the earliest possible date.

Escalating health care costs will have a similar effect on the Federal budget. In fiscal year 1977, the total Federal Government expenditure for personal health services was $40 billion, excluding medical research and construction. By 1985, the cost to the Federal Government is estimated to rise to $98 billion.

The main reason for escalating costs is the way in which the health care industry is organized and the method of paying hospitals and doctors.

Hospitals and other health care institutions are paid on a cost-plus basis by Blue Cross, commercial insurance, medicare and medicaid. Cost-plus payments are an invitation to inefficiency and waste. Physicians are paid on the basis of usual and customary fees—nothing more than average of fees that the physicians themselves establish. The patient has little to say as to how much medical care he or she will receive, and, therefore, is probably the last person who could exert any restraint on health care costs.

It is the physician who recommends hospitalization for the patient, selects the hospital and determines the length of the hospital stay. The physician also recommends surgery—too often unnecessary; the doctors decide what tests, X-rays and drugs the patient requires—again, too often ordering more than are necessary.

Just about the only decision the patient makes is whether or not to see a doctor in the first instance. In no other industry does the supplier have such absolute control over demand.

The need for medical care is not fixed; rather, it is indefinitely expandable. Why should doctors give their patient a multiphasic screening test for $35 when an executive-type physical examination for $500 can be performed—provided, of course, the patient can pay for it? Why should a physician order $50 worth of tests when he can order tests costing $250? The patient—overwhelmed by the technology and understandably totally reliant on the doctor's judgment—rarely objects. And what about equipment? Should new expensive equipment be purchased without evaluation of its effectiveness?

Increased expenditures for physical examinations, for tests and for medical equipment have not necessarily improved the quality of care. Rather, many Americans receive—and pay for—more elaborate medical care without any evaluation of the need for such elaborate, expensive care.

It is clear, therefore, that a solution to the complex health care problem in this country must meet the following points:

A comprehensive single standard of benefits.
Universal coverage.
Access to health care as a matter of right.
Incentives for reform of the delivery system.
Built-in quality controls.
Effective cost controls.
Minimum administrative overhead cost.
Equitable and progressive financing.
Strong consumer representation.

Indeed, Mr. Chairman, those are the principles for national health insurance to which the AFL-CIO has been committed for many, many years. To this list, I would add just one: that the program contain a specific timetable for implementation to assure the American people that national health insurance will not become an empty promise.

The health care for all Americans which you have proposed meets each of these criteria.

The program would provide for a single and mandated standard of benefits.

Assuming enactment in 1979, payments for services will begin in 1983. Initially, these services will be covered: inpatient and outpatient hospital care, physician services in and out of the hospital, preventive services and protection against catastrophic costs. In addition, medicare benefits would be expanded to cover drugs, and the deductibles and copayments under medicare would be eliminated. In 1985, benefits would be expanded to include drugs and nursing home care for the rest of the population.

And, at the same time, many Americans receive either no medical care or far less than the care they really need.

The program would assure universal coverage. A public authority would be established to assure universal coverage. It would administer medicare, a partial medicaid program and other Federal programs. Three consortia would be established for the private sector. Blue Cross and Blue Shield would form one consortium, the commercial insurers another and health maintenance organizations the third. Individual insurance companies and individual Blue Cross and Blue Shield plans would be subject to certification, monitoring and recertification requirements established by Federal law. HMO's would continue to be

regulated under the Health Maintenance Organization Act. These three consortia would operate on both a national and State level.

All employes, all self-employed persons and certain nonemployed persons would be required to pay premiums. The Federal Government would pay the premiums for the poor and the unemployed.

Access to health care as a matter of right would be assured.

Every beneficiary would have an entitlement card that would not disclose the source of his or her premium payment.

Incentives for reform of the delivery system are provided. A health resources development fund would promote health maintenance organizations and also support demonstration projects for the development of services designed to assist the elderly and chronically ill to remain in their own homes at less cost than if they had to be institutionalized.

A national quality control commission would develop quality standards. State authorities would be required to implement these quality standards as a condition of participation in the program.

There would be effective cost controls through a budget for all health expenditures.

This budget would then be allocated to the State authorities. Provider budgets would be based on past expenditure patterns, anticipated shifts in population, estimated rates of inflation, and adjustments to reflect additional resources development or elimination of unnecessary facilities.

Administrative cost savings would be achieved. The cost of processing claims with deductible and coinsurance provisions would be eliminated. There would be no income or means tests and significantly reduced marketing costs, since all insurers would be marketing the same basic health benefits package.

Financing would be equitable and progressive.

Financing of the program would be through a combination of employer-employee premiums and Federal general revenue support for the poor and the unemployed. The self-employed would purchase coverage through a certified Blue Cross or Blue Shield plan or insurance company or a qualified HMO.

The premiums would be earnings-based. Employer premiums would be based on total payroll. Employee premiums would be based on individual earnings. For the self-employed, the premiums would be based on the individual's earned and unearned income. For small business, the premium rates would be subsidized.

Thus, most of the cost of the program would not be placed on the budget. Initially, the costs to the Federal budget for the poor and unemployed, most of whom do not now have coverage, and the small employer subsidies would be more than the Federal Government is now spending for health services. But, as cost controls become effective, the net cost to the Federal Government—the difference between the cost of health care under national health insurance and what it would cost if no program is enacted—would be signficantly lower.

Strong consumer participation in the administration of the program is assured. A majority of the members of the Federal public authority and of the State authorities would be consumers.

All benefits would be phased in by 1985. Thus, each of the principles the AFL–CIO believes is essential for a national health insurance pro-

gram have been met. While many details and specifications are yet to be worked out, the AFL–CIO endorses the framework and pledges its total cooperation in working on the details of a final bill.

Mr. Chairman, the AFL–CIO was frankly disappointed by President Carter's retreat on the principles that will guide development of his administration's national health insurance legislation.

Based on the promise made by President Carter on April 16, 1976, during a speech to the Student National Medical Association, we believed that he would provide the leadership needed for early enactment of a national health program. We believed his program would restrain medical costs, enhance the quality of health care and make adequate health care a basic right of every American. Obviously our belief was misplaced.

The principles recently announced by the White House were late in formulation, restricted in scope, inadequate to meet the needs of the American people, and vague as to implementation. We are also distressed that the administration failed to understand the need to present a detailed program in time for national debate during the 1978 election campaign. We appreciate your understanding of this need, Mr. Chairman, and the fact that these hearings do start that national debate.

Since the election of President Carter, the labor movement has sought to cooperate with the administration in developing a national health insurance program. In the spirit of compromise and cooperation, we were willing to accept various modifications in the national health security proposal we have advocated for several years.

These modifications, however, would have preserved the principle of providing comprehensive and universal health care coverage for every American through a fixed timetable laid out in a single piece of legislation. Indeed, the Health Care for All Americans Act, which we endorse today, accomplishes that.

Instead, the Carter administration proposes a piecemeal approach, without a specific timetable, thus making the principle of universal and comprehensive coverage meaningless. For supporters of national health insurance, enactment of a single, phased-in program promises to be a difficult but achieveable legislative fight, but enacting several different pieces of legislation spread out over several Congresses would be an impossible task.

Placing conditions, such as inflationary or budgetary concerns, on the enactment of every additional stage of a national health program is an incitement to continued inflation in medical costs. The same special interests which are trying to scuttle effective hospital cost containment legislation—doctors, insurance companies, and hospitals—are opponents of a genuine national health insurance program.

The potential for sabotaging future stages of a national health program, through continued medical cost inflation, gives these opponents additional financial incentives to continue and intensify their inflationary practices.

It is no wonder that the Health Insurance Association of America, the American Hospital Association, Blue Cross-Blue Shield, and the chamber of commerce immediately hailed the administration program.

The Health Care for All Americans Act is not an "if-maybe-perhaps" bill. It contains a specific timetable for implementation.

For our part, we will ask every candiate for the House and Senate to support both the framework and the legislation that will be developed. We hope that the President will reconsider his position and join the overwhelming majority of Americans whom every poll has shown support national health insurance.

No social issue has a higher priority than enactment of national health insurance. With the execption of the racist regime of South Africa, the United States is alone among industrialized nations without a national health program. The American people have been forced to endure inadequate, inappropriate, and high-cost medical care as a result.

Our goal is to make decent health care a right of all Americans, and we will not be deterred in our efforts to achieve that goal.

For all these reasons, Mr. Chairman, we support your proposal and will do everything we legally and legitimately can do to insure its passage in the next Congress.

Senator KENNEDY. Thank you, Mr. Meany.

I believe we will hear from Mr. Fraser and then I have some questions.

Mr. FRASER. Thank you, Mr. Chairman.

Mr. MEANY. Anything I have forgotten, I am sure he will say.

Mr. FRASER. I do not think you left anything out.

I appreciate this opportunity to appear before your committee. I come here with two or three hats today—first, as president of the million and a half UAW members; and also as Chairman of the Health Security Action Council, and as Chairman of the Committee for National Health Insurance. In the latter capacity, I am indebted to the distinguished group of health care experts under the leadership of Dr. I. S. Falk, and thankful for the input from your staff and consultation with your staff in developing this new proposal. I think we have all the essential elements of a program that is worthy of the consideration of Congress.

I think what the committee of experts has done is fashioned a plan that meets the need for universal access to quality health care, at costs that are not excessive.

Now Mr. Meany covered basically the same ground that we cover in our statement. I would like to file our statement and make a few extemporaneous remarks.

Senator KENNEDY. It will be printed in the record.

Mr. FRASER. The committee of experts of the CNHI are going to continue working on the text of legislation. The plan that is before the committee is preliminary. It is not complete. Certainly the debate can begin. I believe this debate concerns the most important piece of social legislation since the enactment of the Social Security Act. I submit, Mr. Chairman, that Congress must act soon. The medical care system is out of control. Mr. Meany mentioned $163 billion we spend last year. It will be $183 billion this year. And then according to HEW, it will be the horrendous amount of $323 billion by 1983. That is a crushing economic burden the American people cannot accept. One out of eight Federal dollars is spent on health care, and that amounted to $59 billion in 1978.

Lou Harris recently conducted a poll and was asking the American citizens to respond to their greatest concerns. Of the 21 concerns that were listed, their fourth greatest concern was the cost and delivery of medical care.

What we are doing is subsidizing waste and inefficiency. Just let me give you a few words about our perspective in negotiations.

We had a strike at Ford Motor Co. in 1976. One of the reasons for the strike certainly was the whole question of the cost of medical care. In each of the last several negotiations, the employers, who pay all the premiums under most of our contracts, have made a demand that the members share in the cost of the premiums. Now that is not a very enchanting proposition for the members of our union. And I can predict that when we go into negotiations in 1979 that the corporations with whom we deal will make a demand upon our union that the members assume half of the cost of the premiums.

We will fight them off on that position, and they will have a backup position; and that backup position will be that maybe it is too much to ask to pay some of the current premiums, but we want the members of your union to pay half of the future premium increases that are absolutely inevitable during the life of the agreement.

To give you the dimensions of what we are talking about in terms of economics of collective bargaining, the family health insurance premium for a Chrysler worker in the State of Michigan today amounts to 6 weeks' wages. To put it another way, again using the Chrysler example, the premium paid by Chrysler in the State of Michigan for family coverage for hospital, surgical, medical, and drugs (this does not include vision, hearing, and dental programs—they are separate programs) now comes to $167 a month. We have annual adjustments, and the next adjustment period will be February 1, 1979, and it is absolutely predictable that it is going to be an increase from that $167 by 10 or 15 percent.

It is very interesting to use the Chrysler example because it is the only one of the Big Three that has an international agreement. We have one agreement that covers both the workers of the United States and workers in Canada. And in Canada the Chrysler workers there get better and more complete coverage then they do in the United States and yet the premiums that the Chrysler Corp. pays in Canada are not $167 a month, but $33 a month.

Every year that Congress fails to act, the cost of medical care is just going to become more oppressive.

Now for those that argue, well, why are we so concerned that the employers are paying the cost of the premiums. That is nonsense in terms of the real world of collective bargaining, because if the employer is paying $1 an hour for health insurance premiums; that means that is $1 an hour you cannot negotiate for higher pensions, more wages, more holidays, and all of the other benefits that workers enjoy.

Now we are fortunate, the members of our union, because we have better coverage than most of the people in our country. Most people have less coverage than we, and some people unfortunately have no coverage at all. I would hope that Congress would view this whole issue with a sense of urgency when the new session begins in January 1979.

The costs are not the only problem, in terms of the current system. There also is the quality of medical care. We have a two-class health care system in our country. One out of every three black mothers have no prenatal care. Babies that are born of poor families are twice as likely to die before their first birth date than babies born in middle income families.

There is no health education, illness prevention system in this country that is worthy of its name. There are 51 million Americans who live in areas where there are insufficient services. There is poor distribution of doctors, particularly in the inner city and rural areas. Just to point out a couple examples. In San Francisco, Washington, D.C., and Boston, there are 600 physicians for each 100,000 population.

In Newark, there are 60 for each 100,000. Not 600. In Mississippi and South Dakota there are fewer than 100 for every 100,000 population. We have specialists and super specialist physicians coming out of our ears. They now constitute 65 percent of all the doctors in our country, and that is a trend that is accelerating. I do not know where we are going to wind up in a few years. We will have very, very few general practitioners.

It has been mentioned in some areas, hospital beds are in oversupply and there are shortages in other areas, because there is just no organization in the delivery of health care. There is insufficient support for HMO's and other innovative forms of health care delivery.

And there is inefficiency in health payment methods; 14 cents of every insurance premium dollar goes to administrative expenses and profit. It is here again constructive to look at Canada. Their administrative costs are only 2.3 percent. If you could just apply that percentage of administrative cost to the past year, we would have saved $5 billion in this country in health care.

Now let me elaborate on the matter that Mr. Meany touched upon. We had hoped frankly that we would be debating and testifying on a national health insurance bill that was advanced and advocated by the administration. I can tell you that it reflects no lack of effort on our part that that day did not come to pass. In meetings that went for weeks and months we sought a common ground, and we thought we were really preparing with the administration a national health insurance program with which we would agree.

It was not because we did not compromise or modify our position. For example, a very difficult one for the labor movement was to make what we frankly thought was a concession of having a role for the private insurer in the plan. It was very difficult for us to do. But in an effort to seek compromise with the administration, we agreed to that.

The administration proposal is timid and uncertain. It does not provide for prospective budgeting. I do not believe you can have effective cost control without prospective budgeting.

It also provides for coinsurance and deductibles, and that really does not reduce costs. Every single study that I have seen shows it does not reduce costs. It just transfers costs onto the back of the consumer. And then from our point of view, from the U.A.W. point of view, the most important disagreement with this administration is their interpretation of what phasing means.

Now when we were talking with the administration, we had in mind that we could not enact national health insurance in 1979 and have it apply to all the 217 million American people, and all of its segments, by 1980. We knew there had to be a phasing-in period. I do not know if we ever got down to specific time limits or time frames. But in the back of my mind I would have agreed to a phasing of 5 or 6 years, as long as we enacted the program as a single entity first with specific implementation dates for each of the elements of the health insurance program.

It was not until about 3 or 4 days before the administration announced its program that I heard the new interpretation of phasing. As Mr. Meany points out, their interpretation of phasing is, you take one segment of the Health Insurance Act, present that to Congress, hopefully get it enacted; and one year later you come back with a different segment of the program, and 18 months later, a third one, and a fourth one, and a fifth one. Any person who views the political scene in America realistically knows that when this debate finally takes place in Congress, hopefully next year, it is going to be one of the most difficult legislative fights that has ever confronted Congress. And to propose that you must conduct that war two or three or four or five times is unthinkable. It is a political impossibility.

So we decided that we are going to go forward without the administration. And a committee of CNHI and HSAC unanimously adopted the program that you now have before you. I think that program does protect the basic principles of universal coverage, comprehensive care, quality control, and cost containment.

Let me expand for a moment on cost containment because there are charges by those who really are not interested in a sound national health insurance program to charge that cost containment really means the rationing of health care.

Nothing could be further from the truth. Again it is instructive to look at other democracies in the world who have effective cost containment. I know I sometimes have difficulty in making this relevant to our membership. Germany is sort of remote to them. In addition to this, Germany's health security program was enacted in Bismarck's days in the latter part of the last century, 1890 or 1892. The Scandinavian countries certainly are good models, as is the United Kingdom. But I think it is most instructive to look at our closest neighbor; from our office in Detroit you just look across the river a short span of half a mile, and there is Canada. We have 140,000 members in Canada, and I think what we should do is look at how their system works and compare with the system that really is nonexistent in the United States.

Cost containment to us means reallocations of services. It means stopping duplication and waste. It means that every hospital should not be allowed to purchase a CAT scanner, regardless of need, but as a status symbol. We have three times as many open heart surgery centers than we need.

I belong to a prepaid group plan in Detroit, the Metro Health Plan. Many of our members belong to the Metro Health Plan, while others are enrolled in Blue Cross-Blue Shield on a fee-for-service basis. We have members in California that use Blue Cross-Blue Shield and others that use Kaiser Permanente.

In the prepaid plans, we have more complete coverage and, I believe, better health care. But that is sort of, I suppose, subjective; and perhaps we should look at how the systems perform for our members. I am comparing apples and apples. Our members were in a prepaid program and those members who are not, the same age groupings, the same ethnic backgrounds, the same sex distribution.

Both in Detroit and Kaiser Permanente, two things are obvious. We have fewer hospital days per 1,000 subscribers—one-half, only 50 percent as many hospital days per 1,000 subscribers in the prepaid system.

Secondly, only one-half of surgical procedures are performed in the prepaid plan. That is not only shocking waste, it seems to me, but it is absolutely hazardous and dangerous to the patient because of all of these unnecessary surgical procedures.

I have submitted with the statement, Mr. Chairman, our cost estimates, the committee's cost estimates, of the plan that is before you. Our technical committee is going to continue to refine the plan, think more about prospective budgeting and how that should be handled in detail, and the kind and form of subsidies to the poor and small employers.

Let me conclude by saying that I think that the Congress of the United States really owes some action to the American people.

The Democratic Party platform that was adopted in 1976, as you know, calls for national health insurance based upon universal and comprehensive coverage. President Carter in a speech that Mr. Meany referred to, a speech to the black medical students on Good Friday, 1976, set forth a series of principles upon which a sound national health insurance program can be built, and I agree they were sound principles. I just wish the administration had stayed with them. The Republican Party platform, incidentally, and interestingly, calls for health care coverage for all Americans with access to care at affordable costs.

Their difference with national health insurance was that they objected to all of the funds coming from taxpayers. Well, we have even met that objection now in our new plan. There is really no further excuse for delay, and there is no disagreement, evidently, in principle that we should have a national health insurance program. The only thing that is lacking, it seems to me, is the commitment.

Thank you.

[The prepared statement of Mr. Fraser follows:]

October 10, 1978
Washington, D. C.

Statement by

Douglas A. Fraser
President
International Union UAW

and Chairman
Health Security Action Council

on

PRELIMINARY PLAN FOR THE HEALTH CARE FOR ALL AMERICANS ACT OF 1979

before

Subcommittee on Health and Scientific Research

U. S. Senate Committee on Human Resources

Mr. Chairman, we appreciate the opportunity to testify in support of the preliminary plan for a new national health insurance program which you have recently introduced. We speak in behalf of the coalition of citizens represented in the Health Security Action Council and the 5 million men, women and children in UAW families. I am accompanied this morning by Melvin A. Glasser, Director of the UAW Social Security Department, and Max Fine, Director of the Health Security Action Council.

This new proposal has been developed under the guidance of the distinguished group of health care experts chaired by Dr. I. S. Falk, who comprise the Committee for National Health Insurance Technical Committee. We owe them a debt of gratitude, as well as to your own staff who worked cooperatively with them. In our opinion, they have fashioned a realistic plan which will meet the needs of all of the American people for universal access to decent health services at costs which will not be excessive.

While the text of the actual legislation will not be completed until next year, the preliminary plan can and should begin an informed public discussion on the issues and lead to specific legislation in the next Congress.

We'd better act soon because the problems are almost overwhelming. Costs are completely out of control. They are nearly doubling every five years. According to the Carter Administration, they will reach $183 billion this year and increase to $323 billion in 1983, under current public and private programs.

One out of every eight federal dollars now goes for health care--$59 billion in 1978.

One out of every twelve dollars spent from our own family budgets now pays for hospital and medical costs and for private health insurance premiums and uncovered gaps in the insurance. So frightening to Americans is the fear of medical costs that controlling them is the fourth highest priority of Americans surveyed last month by Louis Harris. Among 21

national priorities listed, only general inflation, government spending and unemployment were selected as higher priorities.

Working Americans are being forced to subsidize tremendous amounts of waste and inefficiency in the health care system and its many financial institutions.

In each of the past two major negotiations in our Union the escalating costs of health care and the insistence of the employers on passing these costs on to our members has been a major factor in causing strikes. The same problem is being experienced by other unions across the country. Today the family health insurance premium for a Chrysler worker in Michigan is the equivalent of six weeks pay. In two years it will be eight weeks pay he will have to forgo to maintain his present benefits. This situation must be corrected.

We are not unique. The Administration tells us that an average family of four will spend $2,115 for health care this year -- and $3,590 in 1983. How can we go on like this?

We say it's time to call a halt to a system which assures runaway costs but not family security or national aspirations in health.

Every year that the Congress fails to act means higher costs of the eventual national program. The sooner they act, the greater the savings.

The reason is simple: national health insurance will impose cost controls which are not possible under our present grab-bag assortment of public and private insurance plans which reward greed but not efficiency.

That's why the 96th Congress must be the national health insurance Congress. And that's why the debate should be started now, before the November elections, so that the people can have an opportunity to determine the positions of those seeking election to the next Congress.

Every dollar of the $183 billion spent this year comes out of the pockets of the people. Some of the dollars are called premiums, some are taxes, some are called deductibles, exclusions and co-insurance. But they all come from the American people, and only a national health insurance plan of the type you are proposing, Mr. Chairman, will provide the leverage and the support to control the huge increases which are otherwise coming.

Costs are not the only problem. We must be equally concerned with what the American people get in terms of quality of health service for the money they pay. We have a two-class health care system in which the poor often receive substandard care and the health of minorities is a national disgrace. One out of every three black mothers do not receive pre-natal care, and babies in poor families are twice as likely to die before their first birthday than babies in middle income families.

A third problem is the failure of the system to provide for health education, illness prevention, early diagnosis of disease, and appropriate services for the chronically ill and elderly. Instead, there is over-emphasis of acute, episodic care.

A fourth problem is the fact that 51 million Americans live in areas without sufficient health care services.

A fifth is the poor distribution of doctors. They are hardly to be found where most needed, such as the inner cities and rural areas, and they are densely clustered where least needed -- San Francisco, Washington, D. C., and Boston have more than 600 physicians per 100,000 people; Newark has 60; Mississippi and South Dakota less than 100.

A sixth problem is the increase in specialists and super-specialists which already represent 65 percent of all physicians, and the decrease in general practitioners and primary care specialists, to only 35 percent of physicians; and the relative number sliding downward each year.

A seventh problem is the over-supply of hospitals in many areas and the shortage in others. And a corollary of this problem is the under-supply of ambulatory care programs and the surplus of surgical suites and esoteric medical technology.

An eighth problem is the lack of real support and incentives for health maintenance organizations and other innovative forms of health care delivery.

A ninth problem is the failure of the system to be responsive to consumer needs -- services are not arranged according to the needs of the people who use them but of those who provide them.

A tenth problem is pervasive. This is the problem of the present payment methods -- the thousands of different insurance plans which encourage the overtreatment, under-service and inefficiency. Not to be overlooked is that nearly 14 cents out of every dollar subscribed for benefits

to the insurers is creamed off the top for administrative expenses and profits.

Mr. Chairman, we need look only to our northern neighbor, Canada, a country much like our own but not as wealthy, which has been able to achieve a successful national health insurance program. Most Canadians regard the Canadian national health insurance scheme as the major achievement of post-war Canada.

Even the American Medical Association's own newspaper recently conceded that Canadians from Montreal to Vancouver like their national health insurance system. Pollster Gallup found that 84 percent of Canadians listed national health insurance first among all government programs. I might add, not incidentally, that the administrative costs of the entire national health insurance system are only 2.3 percent of benefits--one-sixth of the private health insurance administrative expenses in this country. If our administrative costs were the same as Canada's, we would have reduced spending by over $5 billion last year due to this single savings.

We believe the preliminary Health Care For All Americans Act of 1979 will achieve many of the same goals as the Health Security program, which we have long supported, but with some changes in the administrative and payment mechanisms. The changes have been made in response to recommendations of those who favor it. The plan provides for universal and comprehensive coverage through public and private resources acting in concert, according to its specifications, to control costs and deal concurrently with each of the major problems in health care.

There are unique features of this plan, such as prospective budgeting of its costs, premiums related to wages and income, regulated insurers, and a Federal/State relationship in its overall administrative responsibilities. These we feel are responsive to the legitimate concerns of both major political parties.

The Democratic Party's national platform in 1976, in supporting universal and mandatory coverage under a national health insurance program, concurred with Jimmy Carter when he said that "a responsible national health insurance program will not require that the nation spend more than it is now spending on health services, nor will it intrude in any way into the present relationships between physician and patient."

The 1976 National Republican Convention Platform proposed that "every American should have access to quality health care at an affordable price," and was critical of financing such a program entirely through taxes which it said would increase government spending by more than $70 billion.

The preliminary plan for the Health Care For All Americans Act of 1979 has responded to both parties' concerns. It will not require that the nation spend more for health services; the nation will spend less. It will not intrude in any way into the doctor-patient relationship. It will not increase government spending by $70 billion.

Government spending for coverage of the new plan will be limited to the poor, the unemployed and the elderly.

The bulk of spending for health care will remain in the private sector. Every employer will provide coverage through a private insurer, and for those marginal employers who would otherwise incur onerous new costs, there will be federal subsidies.

If the total program was operative in 1978, new federal costs would be approximately $14.1 billion with an added subsidy of $5 billion for employers. Overall costs to the people would be billions less within a few years of the program than under the present system.

Mr. Chairman, we take this opportunity to call upon the political parties to act as responsibly as we have been in listening to them. If they mean what they say in their platforms, they can no longer use diversions and attacks on the Health Security program to avoid their responsibilities for supporting decent health care for all of the American people.

Our Technical Committee is continuing its work. Among the areas requiring further exploration and more detailed analyses are those of prospective budgeting, the wage and earnings related premium and the subsidies for the poor and for employers. We intend to pursue these matters with diligence and to make recommendations for a full and complete program based on the preliminary plan now before you.

I would like to augment your outline of the preliminary plan by including a brief description as part of my testimony.

Thank you very much.

HEALTH CARE FOR ALL AMERICANS ACT OF 1979 --- In Brief

UNIVERSAL COVERAGE -- Every resident of the United States will be covered by mandated health insurance plans, with federal financing of coverage for the poor, the unemployed and the aged.

COMPREHENSIVE BENEFITS -- There will be full coverage of inpatient hospital services, physicians' services in and out of hospital, home health services, x-rays, and lab tests. Costs of catastrophic illness will be covered since there will be no arbitrary non-medical limits on number of hospital days or physician visits. Medicare will be upgraded for the elderly and will also be covered for prescription drugs.

IMMEDIATE COST CONTROLS -- Upon enactment of the bill, budget caps will immediately be used to control hospital and physician costs. Wages of non-supervisory employees will be protected. When benefits begin two years later, prospective budgeting of hospital and physician expenditures will become the principal method of cost control.

BUDGETING COSTS -- Hospitals and doctors will be paid on the basis of pre-negotiated amounts. They will not be permitted to charge patients more than the insurance plan pays. National, area-wide and state budgets for health services will be set and any increases will be tightly controlled.

PUBLIC AUTHORITY -- The program will be administered by a federal Public Authority whose members will be appointed by the President, subject to Senate confirmation. A majority will be consumer representatives.

STATE AUTHORITIES -- The Public Authority will contract with each State and territory to establish State Authorities as agents of the federal authority in helping to implement the national health insurance program. A majority of the members of each State Authority will be consumer representatives.

INSURANCE PLANS and HMO CONSORTIA -- Most Americans will be insured by an insurer or health maintenance organization which is certified and regulated by the federal Public Authority. The insurer must be a member of a consortium of (1) insurance companies, (2) Blue Cross/Blue Shield plans, or (3) federally qualified health maintenance organizations.

MEDICARE -- The elderly and eligible disabled people will continue to be covered by Medicare which will be upgraded so that benefits will at least equal the privately-mandated benefits. Physicians will no longer bill Medicare patients but will be paid directly by the insurance plan. Prescription drugs will be covered for the elderly.

MEDICAID -- The poor and near-poor will be covered by the national health insurance plan for all mandated benefits. Medicaid will cover only those services such as long-term nursing home care which are not incorporated in the national health insurance program. State budgets will be relieved of over $4.5 billion in existing Medicaid costs.

HEALTH INSURANCE CARD -- Every resident of the United States will be issued a health insurance card. If a patient receives medical care without proof of health insurance coverage, the provider will bill the State Authority which will pay the bill and later determine the proper source of payment (one of the consortia or the federal Public Authority).

FEDERAL REGULATIONS -- In order to be included in the program, an insurer will require federal certification and will be subject to ongoing federal regulation. The effect of certification and regulation will be to eliminate such long-standing practices as

"risk selection" and discriminatory pricing, and to bring existing private insurance expenditures into conformity with public policy on cost controls and equity of benefits and financing.

FINANCING -- Employers will pay a premium related to total wages. The premium will cover the full costs of the covered benefits. The wage-related amount will mean that employers paying high wages will pay more for health insurance than employers paying low wages, although the rate will be the same. Unless other arrangements are made, employees may pay up to 25 percent of premium costs. This method of financing will relieve marginal employers of onerous premium costs and assure inclusion of migrant workers, part-time workers and other low-income working people and their families.

COSTS -- Total costs of health care will be less within a few years of the national health insurance program than they would be under current programs, because of the immediate and long-range cost controls applied. For example, total costs will be an estimated $361.6 billion in 1985 without national health insurance, and $330.6 billion, or $31.0 billion less with national health insurance. New on-budget costs for coverage of the poor and unemployed, and for improving Medicare, would be $14.1 billion in 1978 dollars.

QUALITY CONTROL -- A national quality control commission will develop quality standards. State Authorities will be required to implement these quality standards as a condition of participation in the program.

HEALTH MAINTENANCE ORGANIZATIONS -- HMO's and other non-traditional forms of health care delivery, such as neighborhood health centers, will be fully supported and their development encouraged through incentives.

COMPETITION -- Insurers and HMO's will compete for enrollees, but not by selecting "risks." They will know what premium they will be entitled to receive for each person or family covered. They will compete on the basis of administrative efficiency and for supplemental coverages.

EQUALIZATION AND REINSURANCE PROGRAM -- To assure that no consortium member will be able to profit by selecting risks, there will be equalization funds to counter-balance member companies and consortia. A reinsurance program will protect individual companies or plans against unforseen costly events.

EXISTING EMPLOYER-EMPLOYEE ARRANGEMENTS -- An employer will be obligated to maintain existing contractual or other arrangements for health benefits. If the employer's present costs exceed mandated premiums, the excess will be applied to other employee benefits subject to negotiation with employee representatives.

PREVENTIVE MEDICINE & HEALTH PROMOTION -- Services for the prevention and early detection of disease will be covered, including immunization and health education.

RESOURCE DEVELOPMENT -- A resources development fund will be used to improve services for underserved populations and to develop new services for the full population's changing needs, in particular for home care of the elderly and chronically ill.

CONSUMER AND PROVIDER ADVISORY COUNCILS -- A National Health Insurance Advisory Council and State Councils with consumer majorities, will advise federal and State Public Authorities on general policy, on the formulation of regulations and on the performance of the Authorities' ongoing functions. The Councils will have professional and technical staff as required and will recommend future changes in benefits or administration.

New Federal On-Budget Costs for Providing Benefits
under the Preliminary "Health Care for All Americans Act"

Population Group	FY 1978	FY 1981	FY 1983
		(Amounts in Billions)	
Medicare	$ 0.9	$ 1.3	$ 1.5
Medicaid	2.9	3.9	4.5
Long Term Unemployed and Persons with No Health Insurance	10.3	13.6	15.7
TOTALS	$ 14.1	$ 18.8	$ 21.7

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This is the amount of new money that would be added to the Federal Budget, in alternative fiscal years, to upgrade the Medicare program and provide the mandated benefit package to the poor and the unemployed. Benefits include inpatient hospital care services, physicians' services in hospital, out-of-hospital and office visits, preventive care and protection against catastrophic costs.

Providing drugs to the elderly who are chronically ill and/or HMO subscribers would add $2.6 billion to the cost of the plan in 1978; $3.5 billion in 1981; and $4.1 billion in 1983.

In addition to the on-budget costs for mandated services, it would be necessary for the Federal Government to provide subsidies to small employers and employers in low-wage industries. The Department of HEW has estimated that the magnitude of this subsidy will be in the area of $5 billion.

The estimates in this table are based on the assumption that the costs of mandated services be contained for two years prior to the time benefits begin. This table illustrates that the longer the enactment of the Health Care for All Americans Act is delayed the net increase in cost that must be borne by the Federal Treasury will be higher.

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Senator KENNEDY. Thank you very much, President Fraser and President Meany, for two excellent statements.

I would like to just take up with Mr. Fraser and Mr. Meany these negotiations that are coming up, and what they mean to the average worker, these escalated costs. Just develop that point for a moment, and then get some sense of your own feeling for how we can vocalize the American people on this issue.

Now, there are important national negotiations Mr. Fraser has mentioned, their negotiations. You have certainly some as well, President Meany, that will be coming on up. I thing it might be of some interest how this explosion of costs is really eating away from the wages of the average worker, and how this matter is going to continue to be a matter of a serious kind of negotiation, and how that is going to have an extraordinary impact on them as individuals and certainly on the economy.

We have talked about that, Mr. Fraser. I think this chart over here gives us at least up until 1974, an indication of how the employer/employee contribution of health benefits as a percent of wages and salaries has been going up dramatically. I would think that would be a matter of some concern to workers, is it not, particularly when the projections over the period of the next years are going to show that that is going up higher and higher [indicating].

Do workers understand that? I think the graphic illustration is that the UAW works 3 weeks for their health, and 6 weeks in the United States. I would just be interested in the whole range of different negotiations that are taking place and what this is going to mean for the workers.

Mr. MEANY. Senator, this is just one item. And as this chart indicates, it is an increasingly important item as time goes on, but it is one item that is laid on the table. There are all sorts of items which go into the collective bargaining agreement. Of course, if the employer is going to come along and take the position he has just got so much to give, and this keeps going up, it means that something else is going to suffer. Or if the administration comes along and says 7 percent, you know what I mean, that is all you are going to get, then again we are going to see something suffering in order to pay for this.

It is all a part of one great big bag.

But this to me is a very, very important part of it because if things get real bad for the American family, Senator, you do not have to buy one of Doug's cars; but if the boy gets sick or the girl gets sick, you have to go to a doctor. You have to try to get them well. This is part of what I would call the very essentials of life: There is medical care, you have to pay your rent, and you have to care for your family. And this is getting to the point where, as I said in my testimony, it is getting to be a real catastrophe.

Frankly, I do not know how much longer the American people will put up with this when they look across the border. I was very much intrigued by the testimony which I read about here yesterday. Of course, I knew about that, because the Secretary of the Canadian Labor Congress was down here a short time ago and gave us a real fill-in on that. I just wonder how long the American people are going to accept a program of health care which is unique in what we call the democratic

industrialized world. We are practically the only industrialized country outside of South Africa, and we do not like to be put in the same jug with South Africa, I will tell you that.

Canadians have national health insurance where people get their hospital and medical care, and they cannot tell us that they do not get good care. They do get good care. They get it in Israel, Sweden, all over the world.

I do not know how much longer the American people are going to take this. I do not know how much longer they are going to stand for it.

Senator KENNEDY. What about it, Mr. Fraser? The costs now are rising close to twice the national average—that is, health care costs over the Consumer Price Index—and this puts enormous pressures I would think in the negotiation. The worker is paying more and more of their average salary into this. What do you think we can do around the country to mobilize the American public on this issue?

Mr. FRASER. I know you would mobilize the auto workers, if they had to pay directly part of the premium, in a hurry. There would be a march on Washington.

Let me give you a couple figures of where we have come from in auto, and these are Ford Motor Co., figures. It would be duplicated in Chrysler, General Motors, the agriculture implement industry.

In 1965, the cost of health insurance per active employee was $331. In 1970, it leaped to $466. In 1975, it went up to approximately $1,500. In 1976, $1,700; 1977, $1,925. That is per employee. Now, unfortunately, I really do not think there is a full realization among the members of our union of the prohibitive costs, and maybe this comes from the fact that they never have to pay the premiums directly. They are all paid automatically by the employer. But if they would look at it in a way a negotiator has to look at it; that is, $1,925—they are not going to get in increased wages and pensions and other programs that the workers are interested in.

What we are going to do, frankly, is start a campaign to make certain that the workers realize the enormity of this problem and the amount of money that is taken from the negotiated settlement. That is what it amounts to, to pay for these benefits.

I would think that once we make them realize the enormity of the problem, I think they will be much, much more active in mobilizing for Congress to finally give this problem the kind of urgency that is so desperately needed.

Senator KENNEDY. Finally, Mr. Meany, on this issue, clearly the workers have an extraordinary stake, not only those that are organized, but working people all over this country. Are your unions ready to put their shoulder to the wheel and ask candidates about their positions on these issues and place this as the kind of high priority which I think——

Mr. MEANY. Without question, we are going ahead right now with that. Of course, what we have been waiting for, and what we had hoped, was that the President would come along with a bill. In fact, I thought we would have a bill in 1977, because he laid out all the principles in the early part of 1976, and as of now, we still do not have a bill. In fact, we did not get the principles until 2 months ago. And

frankly, we have been members of this committee of which Doug is now the chairman, the Committee for National Health Insurance, working with that committee for years; and when we had a President in the White House who was committed to this, we felt and were waiting and waiting, and as you know, we discussed this with the President last March, I believe, but now we have got at least a form of a bill. We will have a bill ready, and we will have the issue before the American people, and we are going to push it with every candidate who runs for Congress in this upcoming election.

Senator KENNEDY. Well, that is going to be both important and I think extremely encouraging to the millions of people here who do not have the coverage. We are going to look forward to working closely with you. We are enormously grateful for your testimony and for your support, and look forward to working with you. Thank you very much.

Our second panel will be James Sammons, executive vice president of the American Medical Association; and William C. Felch, M.D., chairman of AMA's Council on Legislation.

STATEMENT OF JAMES H. SAMMONS, M.D., EXECUTIVE VICE PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION, AND WILLIAM C. FELCH, M.D., CHAIRMAN, COUNCIL ON LEGISLATION, AMA, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR OF DEPARTMENT OF LEGISLATION, AMA, A PANEL

Dr. SAMMONS. Thank you, Mr. Chairman.

I am Dr. James H. Sammons, executive vice president of the American Medical Association. Participating in this presentation is William C. Felch, M.D., a physician in practice in Rye, N.Y., who is chairman of the AMA's Council on Legislation. Accompanying us is Harry N. Peterson, director of our Department of Legislation.

The American Medical Association is pleased to take part in these hearings on national health insurance. As you know, Mr. Chairman, this subject has been debated from time to time over an extended period with varying degrees of intensity—depending on a variety of factors—and the AMA has been an active participant throughout.

We share the sincere concern of proponents of NHI proposals that health care should be available to all persons. To this end the AMA has developed a bill, presently pending in this Congress as H.R. 1818 and S. 218 and known as the Comprehensive Health Care Insurance Act, to provide comprehensive and catastrophic coverage for all persons. Our legislation, based on longstanding principles for comprehensive health insurance adopted by our organization, is founded upon the strengths offered by our existing pluralistic health system. Its foundation is solidly based upon the successes of our entire health delivery system, allowing for future development and innovation.

The extended discussion on national health insurance which has taken place during the past years has been beneficial in many respects in analyzing the issues and in evaluating the impact upon society. The thrust and scope of national health insurance proposals have altered with changing circumstances.

During the long period of NHI debate, but particularly during this last decade, we have seen a number of significant changes take place

in our health system. To name a few: Marked increase in numbers of medical schools; significant expansion in number of medical graduates, with emphasis in primary care training; substantial increase in training of allied personnel; proliferation of medical facilities, affording easier access; development of sophisticated technology; wider distribution of medical personnel; expansion of Government-supported health programs; increased access to care by the disadvantaged; and wider coverage of private health insurance, including catastrophic coverage.

Thus while the debate has waned and waned, our health delivery system has shown steady improvements. This has been accomplished through the cooperative efforts of many, including both Government and the private sector.

Moreover, we have seen changes in approaches to national health insurance. It is important that flexibility be maintained in order to mold the program to meet current needs and demands. There is an increased awareness and concern on the part of those persons bearing responsibility in developing and implementing any program as to the magnitude of the problems involved. These problems certainly have been brought into sharper focus as a result of governmentally administered and controlled programs both here and abroad (for example, bearing on consideration by Congress of further Government programs is the recent revelation by the HEW Inspector General of some $7 billion waste in HEW programs, and evident in congressional consideration is also the groping—seemingly futile sense of frustration—of Congress to reach those problems with corrective measures).

Too, the changing economy has dictated shifting priorities in our national goals. We perceive the additional frustrations of Congress as it seeks to provide for a variety of programs within a restricted economy. The result has been for the most part a sharp rationing of dollars within existing programs and a curtailment in new programs. At the same time, nevertheless, the national deficit is still further expanded: In other words, Mr. Chairman, even though we heard—and continue to hear—solemn and sincere intentions to reach a balanced budget, and even though we find a more critical evaluation of dollars spent, we find that the Government has not been able to exist within a balanced budget.

Mr. Chairman, we all recognize that there are problems that exist in our health delivery system. Certainly the profession and the AMA are particularly aware of these. For example, with respect to legislative solutions, the American Medical Association has prepared a variety of bills for consideration by the Congress. Among these, to identify a few, are bills to strengthen and improve child immunization programs, expand maternal and child health care programs, fund preventive residency training programs, encourage Federal support for medical student loans and scholarships, protect the confidentiality of patients' medical records, improve rural health delivery, improve and strengthen our food and drug laws, increase drug labeling for patients, and improve local planning for health facilities. In addition, we have developed important model State legislation, for example, bills to encourage greater health education in our elementary and secondary school systems, provide for improved disciplinary procedures by State

medical boards, stimulate effective peer review, encourage expanded home health care services, and provide expanded patient information for clinical laboratory services, just to name a few. In addition, the association and profession are involved in and promote a host of other health improvement programs.

Deficiencies are being addressed by a variety of forms, public and private. For example, manpower shortages are being overcome. Surpluses, in fact, have been predicted for the near future by responsible Government officials, alternative delivery systems are under experimentation, new types of providers are being utilized on an increasing scale, greater health education is being carried on by many groups, preventive measures are being accentuated, and new public awareness of the impact of total environment upon health is being aroused. The AMA has taken an active role and has supported these activities.

It would be inadvisable to attempt to resolve all existing problems through adoption of any NHI bill. Major policy questions of such import should receive independent and thorough study on the merits.

But as we have said before on this subject in the course of this extended debate, notwithstanding present weaknesses there is a fuller realization and acknowledgement that this country's health care, under attack by many in the course of NHI debate, is indeed superior to any other in the world. This is certainly our stance, and we believe that. You, too, Mr. Chairman, would join in that conclusion based on your comments of yesterday.

Senator KENNEDY. Doctor, it certainly is true for the medical profession, and it certainly is for those of us who can afford it, and it certainly is for those who are covered with health insurance. But it certainly is not true for the 26 million Americans who have no health insurance or the 51 million Americans who live in underserved areas, or the millions of Americans who are inadequately covered, or the millions of Americans who suffer from over-surgery or over-utilization of drugs. It certainly is not for the elderly people down in Florida, the biggest retirement State in the country, who find out that less than half of the doctors are willing to take the usual and customary fees for services. It certainly is not for them, and I am not going to let you make a statement like that and let it go unchallenged because——

Dr. SAMMONS. I would like to challenge your statement.

Senator KENNEDY. It is not so. Sure, we have the best for those that can afford it. All of those that are on the top of the mountain, that are covered by comprehensive health. Sure, it is the best in the world for them. But there are a lot more people down in the valleys, and they were testifying at that table yesterday. You listen to Mary Corbett of Massachusetts talk about the health care, and you would not get that, Doctor.

Dr. SAMMONS. I would hope that the record is very clear that the people that were at this table yesterday are not the norm as far as coverage exists in this country; that those are unusual cases. Impressive though they may be, they account for a small percentage. I challenge your findings.

Senator KENNEDY. We will hear testimony for elderly people, for millions of elderly people, and we will find out whether they are the

norm, and we will listen to the ones representing the workers of this country and find out whether they are the norm.

Dr. SAMMONS. But Senator, those people yesterday, some of the problems they had are social welfare problems, and not merely medical problems.

Senator KENNEDY. You missed the point of yesterday's hearing, Doctor. You missed the point of yesterday's hearing. The point of yesterday's hearing is that there was not a person that appeared there that did not have the fear—the fear of being wiped out, the fear of their children being healthy today and finding some illness and sickness. It was not just the amount of medical bills, but it was the fear which exists in every mother and every parent in this country, that if their child is going to be sick, or their parent is going to be sick, that they are going to have those kinds of health care costs and not be able to afford it. It was the fear. That was one of the principle lessons of yesterday.

Dr. SAMMONS. Our bill would eliminate that fear, because our bill does in fact bring total health care to the American people, and it does it built on the strengths of the present system and present American way of life.

Senator KENNEDY. Your statement says, "This country's health care, under attack by many in the course of National Health Institute debate, is indeed superior to any other in the world. This is certainly our stance."

I am saying on that particular statement, when you have 51 million Americans living in unserved areas, and millions of Americans not covered—26 million Americans have no health insurance, equivalent to the populations of California, Oregon and Washington.

Dr. SAMMONS. I do not believe that figure is correct. You are including a great many groups in there that are not in fact without the sort of private coverage that is available. We would challenge the validity of that figure. That is exceptionally high.

Senator KENNEDY. I am sure you might challenge it. But it happens to be the figure that has been used for a number of years by HEW, by Republicans and Democrats alike on it. You might challenge it.

Dr. SAMMONS. We do, sir.

Senator KENNEDY. That is fine that you challenge it, but we will be listening to people who do not. I am not willing to accept that statement.

Dr. SAMMONS. I suggest to you, Senator—

Senator KENNEDY. We have got the very best, right in the Congress and the Senate of the United States, you bet we do; and the people that can afford the insurance have got the very best. You go to the cities of this country, urban areas, rural communities of this Nation, and ask other people, and you get an entirely different answer.

Dr. SAMMONS. Our bill would provide for those people. It has been before this Congress since 1970 in various forms, and it is still before this Congress. Our goal is the same as yours, and that is to reach the American people and our bill does so. I suggest to you, sir, that you can solve this problem very nicely by simply becoming a cosponsor of AMA's bill S. 218.

Senator KENNEDY. On that note we will recess while I go vote.

[Recess.]

Senator KENNEDY. Now, I cannot remember what happened when we recessed. Were you cosponsoring our bill or was I cosponsoring yours?

[Laughter.]

Dr. SAMMONS. I just invited you to cosponsor mine.

Senator KENNEDY. Maybe if we cosponsor each others, we will make some progress.

[Laughter.]

Senator KENNEDY. We appreciate everyone's willingness to move along. We want the substance of the testimony. We will do the best we can on all the questions of time, but we are moving along.

Dr. SAMMONS. I am sure our full statement will be a part of the record.

Senator KENNEDY. Sure.

Dr. SAMMONS. The great strengths in our system, Senator, are the ones that have to be used to build any national health insurance program. It is both reasonable and obvious that these aspects must be accentuated rather than adopt a new program suggested by some to impose a radically different system, with full Federal administration and control, upon our health system. Needed modifications must and can be accomplished without upheavals that would undermine or sacrifice the great strengths of our system which far outweigh any imperfections.

This leads us then to an evaluation of the program which you have just announced, Mr. Chairman.

Before getting into more detailed comments, however, let me characterize it generally by stating our recognition that certain changes from your former bill, S. 3, the Health Security Act, (for example, financing other than through the already overtaxed social security system, recognition of a roll for private insurance companies, continuation of insurance coverage for the unemployed, upgrading of medicare benefits), are beneficial. Regrettably, however, the overall changes have not been of sufficient extent and character to remove fundamental objections to the proposal. Nor have the changes been of sufficient magnitude and extent to effect a change from the basic character of S. 3.

In saying this, it is also recognized that we must deal with general narrative and, to an extent, conceptual language as contained in your statement on "Introduction of a New National Health Insurance Outline." We do not have legislative language which, of course, would be more definitive. Nevertheless, the description of the program is sufficiently clear to present a fully federally administered and controlled program radically restructuring our entire health care system.

Mr. Chairman, we do not find such a program to be in the interest of the citizens of this country.

At this time Dr. Felch will continue with the presentation of our statement.

Dr. FELCH. Mr. Chairman and members of the committee:

At the outset your program, Mr. Chairman, would immediately upon enactment impose strict controls both on hospitals and physicians through overall revenue and expenditure limits on hospitals and revenue limits on physicians. Those controls would remain for at least 2 years until other specific program controls took over.

Although described meagerly, this "cap" appears, as to hospitals, similar to the administration's hospital cost containment program that has been so hotly debated in this Congress. The deficiencies of this plan have so often been described that it would seem unnecessary to have to repeat them.

Manifest is the inherent unfairness of subjecting one industry to stringent cost controls without likewise controling the factors that affect the costs in that industry.

The great weakness in the logic of these "cap" programs is that they assume that health care inflation is generated almost totally by the industry and thus can be completely controlled by it. To control the revenues and expenditures of hospitals and physicians does not attack the causes of the inflationary spiral that affects all industries.

We also note that in establishing ceilings, nonsupervisory wages would not be subject to controls. It is unfair to single out one group of hospital employees for favorable treatment at the expense of others. Further, approximately 60 percent of all hospital expenses are for labor. Thus pressures for increases will continue.

Moreover, without legislation, the current Voluntary Effort, strongly supported by the AMA, has been highly successful in already meeting the goal of reducing the rate of increase in hospital expenditures.

Furthermore, we note that the newly proposed cost control program in the NHI "Outline" would go even farther than the administration's program and would impose "revenue limits on physician services." No further details are provided. This is aimed at placing a restriction on the earning capacity of physicians. Again, it is grossly inequitable to single out a segment of our society and economy for discriminatory controls. Mr. Chairman, this on its face would be objectionable.

Once the benefits under the program become effective, national maximum budget levels of expenditures for health care would be set together with similar maximum areawide and State budgets. These maximum levels would apply to health care and medical services.

Senator KENNEDY. At the top of page 9 you say:

> Moreover without legislation, the current Voluntary Effort, strongly supported by the AMA, has been highly successful in already meeting the goal of reducing the rate of hospital expenditures.

Of course that is not so.

Dr. SAMMONS. It is so.

Senator KENNEDY. That does not happen to be factually accurate. We know what if you take the most recent figures that we have, which are July and August of this year, it is 1.4 percent for July and 1.5 percent for August. That is annualized at 18 percent—18 percent. That is 2½ times the consumer price index. You are talking about Voluntary Effort—you are talking about bankrupting the American people on it—bankrupting them.

Dr. SAMMON. Not at all, Senator. That is inappropriate mathematics, to take 2 months and attempt to annualize. If you take the first eight months of this year, you will find that the overall reduction in the rate of escalation in the hospital sector is better than 2.8 percent, and the Voluntary Effort established a goal late last year of 2 percent a year.

Senator KENNEDY. To what level?

Dr. SAMMONS. We are down somewhere to the general order of 13 to 14 percent.

Senator KENNEDY. Somewhere in the general order of 14 percent?

Dr. SAMMONS. That is better than 19 percent that it has been.

Senator KENNEDY. With the upturn in July and August; 14 percent, which is double the consumer price index. You are talking about fairness in terms of control of a particular industry, fairness.

Dr. SAMMONS. That is inappropriate mathematics. It is predictable in July and August of any year there would be an upturn in hospital rate of expenditure because of the number of hospitals in this country that begin their fiscal year on July 1. If you take 8 months, it looks a great deal better and it is better.

Senator KENNEDY. You might be prepared to settle for 14 percent increase on it. I just do not see how the families of this country are going to be able to see that kind of escalation.

Dr. SAMMONS. We are not settling for that, Senator. The goal of voluntary effort is an additional 2 percent, which will bring it down to the rate of inflationary development in the cross national product.

Senator KENNEDY. Your goal is what?

Dr. SAMMONS. It is to match or better the rate of growth in the gross national product.

Senator KENNEDY. Twelve percent? Did you just state that is your goal?

Dr. SAMMONS. No.

Senator KENNEDY. What is your goal?

Dr. SAMMONS. Our goal is to match or better the true rate of growth of the gross national product by the end of 1979.

Senator KENNEDY. Which is what?

Dr. SAMMONS. At the present rate it is going to be about 11½ percent.

Senator KENNEDY. Well, 12 percent.

Dr. SAMMONS. That is the gross national product.

Senator KENNEDY. We are talking about inflation. Let us just in terms of people who can understand, the average person, the housewife. We have a whole range of people here representing workers talking about whether it is going to be 7 percent, 8 percent additional wages next year to offset expenses. You are stating your goal is either 11½ or 12 percent. Now can you tell us where, in States that have had this voluntary program, what the rate, for example, has been where you have had the voluntary program and what your track record is, and let us take States which have initiated cost containment and take their track record.

Dr. SAMMONS. I am sorry, Senator, I do not have those figures with me.

Senator KENNEDY. I think that is pretty important in evaluating whether these goals are effective, don't you think, Doctor?

Mr. PETERSON. I wonder if I might ask a question with respect to the cost containment amendment which is now being supported by yourself and Senator Nelson?

Senator KENNEDY. I will be glad to answer your question if you answer mine. You are here talking about how patently unfairly this legislation singles out a particular industry, manifests inherent un-

fairness of subjecting industry to stringent cost controls. Manifestly unfairly.

Dr. SAMMONS. That is right.

Senator KENNEDY. It is unfair, I think, to take money out of the pocket of the average worker at 12 percent, too, when they are getting 7 percent increase. We are talking about dealing with inflation. You say the voluntary sector is going to work in this area, so I say OK. Let us look at the States that have been going ahead with the voluntary and the States that have been going ahead with mandated and let us compare them.

Dr. SAMMONS. Let us compare nationally.

Senator KENNEDY. Can you answer the question?

Dr. SAMMONS. Ask the question again, Senator. It has been so long since, I have forgotten.

Senator KENNEDY. I will give it to you again.

Dr. SAMMONS. Yes. Go ahead.

Senator KENNEDY. Compare the States that have initiated voluntary programs and those States that have had cost control programs.

Dr. SAMMONS. I do not have those figures with me.

Senator KENNEDY. I just happen to have those figures.

Dr. SAMMONS. Fine.

Sneator KENNEDY. I would think it would be worthwhile in terms of talking about effectiveness of the voluntary program that you would have them, too.

The nine States that had mandatory programs had an average rate increase of total expense of 12 percent, and the voluntary programs had an average rate increase of 15.6 percent. States with no programs at all had an average increse of 15.8 percent. These are the first years of the cost containment programs, and I will include the list of the States, which I have here, in the record.

But the point is, and these are just States primarily that have just initiated cost containment programs—without any programs, 15.8. With voluntary programs, 15.6. Two tenths of 1 percent. And with the nine States that are mandatory, down to 12 percent.

Mr. PETERSON. Without going into all of the States, we will be glad to supply some figures for you.

Senator KENNEDY. We welcome them.

Mr. PETERSON. Recently a hospital study in your own State had indicated they were able to reach their reduction by virtue of the fact that many hospitals are not meeting their expenditures out of current revenues, but are dipping into capital and so forth.

So the question is: What is going into the reduction in order to meet requirements in those States?

Senator KENNEDY. I can tell you about my State. That is, we are not hearing complaints about the quality of care.

Dr. SAMMONS. You will, sooner or later.

Senator KENNEDY. I am glad you think we might. I am telling you now, you talk about effectiveness of your voluntary program, and I think the track record on that, at least, would question a great deal of confidence in its effectiveness.

Dr. SAMMONS. As I pointed out, Senator, this is 8 months into the first full year.

Mr. PETERSON. As I understand the proposal which you and Senator Nelson are now supporting, your goal as well is about 12 percent. I do not think we are very far off.

Senator KENNEDY. No, no, no, no, no. I will vote for that program, I will vote for it reluctantly, because I do think it is wrong to establish what is effectively almost twice the consumer price index. But I am satisfied at least that program is going to save the taxpayers about $30 billion that would not otherwise be saved.

I am glad to state my position. I welcome your comment on it and let us move ahead.

Dr. SAMMONS. My comment, sir, if you will just give the Voluntary Effort the time for another year, we will better that goal, because we are on our way to doing so now, in spite of the figure that you use.

Senator KENNEDY. Unfortunately, I think you have the votes on the Senate floor, so you will have an opportunity to see whether you can do it, and we will be back talking about it next year.

Dr. SAMMONS. I certainly hope you do not have the votes.

Dr. FELCH. This budgeting process, controlled through a new Federal agency called the Public Authority is at the heart of the program. You have made much of the fact in your opening remarks, Mr. Chairman, that the health system must learn to live within a budget. This on first reading may sound desirable, but the inescapable result of such a budget is rationing of health care.

Senator KENNEDY. I think that is a scare tactic of the most dangerous type, talking about rationing of health care. We have rationing today on the ability to pay. We have rationing of health care today which has effectively denied the people again that live in the cities and rural areas. We have rationing in all different aspects of the health care. We have rationing in terms of the assignment and the failure of assignment, people that are being denied, elderly people in different parts of our country. We have that kind of rationing. We heard nothing in our hearings yesterday from Canadian people that felt to any extent that they were—under the national health insurance program—that they were being rationed. You have rationing today. You have all types of rationing, and to suggest to involve that particular word with all its implications in terms of frightening the people, I do not really feel is either warranted or justified. I think quite frankly to the contrary, because of the denial of millions of Americans to be able to be covered, and receive quality health care, I think you have a form of rationing today.

Dr. FELCH. What we are concerned about is that budget controls sooner or later will end up requiring somebody to make decisions about who will not receive care.

Senator KENNEDY. The alternative to cost controls is no cost controls, and absolutely out-of-sight expenses. That is what we are talking about. That is the alternative. The people that have been dropped in many instances from coverage are increasing.

Dr. SAMMONS. There are solutions to those problems, Senator. There are solutions to the problems of people that do not have any coverage at all. Those solutions are very simple solutions, and one—which you have recognized at least in part in your proposal—is an exemption from the antitrust laws to allow the insurance industry to pool within States to accept the risk for those people who are uninsurable. The

fact that there are deficiencies in medicare and medicaid are problems which the Congress itself indeed should address and certainly can. An increasing percentage of the payment that the elderly in this country are paying for their health care is the result of percentage limits that are set by the Congress of the United States, not by the profession. There are ways that these serious deficiencies can be addressed. We share the concern with you, and in quite seriousness, Senator, our proposal does in fact provide comprehensive coverage for every American in the United States. There are mechanisms to accomplish that. But the fact is, when you impose income and expenditure limits in a situation dealing with health care of people whose illness cannot be turned on and off, sooner or later someone is going to have to be denied services.

Senator KENNEDY. They are being denied today, Doctor. Millions of elderly people that—the doctors who refuse to take medicare patients on the basis of usual and customary payments, and we will hear from real life situations on that. They are being rationed. That is up to the individual doctor.

Dr. SAMMONS. I am afraid you have your terms confused.

Senator KENNEDY. They are being denied that today. There is nothing in your bill, you want to talk about that, that is going to eliminate that. More than 50 percent of the physicians in the State of Florida refuse to take usual and customary assignment—refuse to take assignment.

Dr. SAMMONS. Your terms are confused. You have your terms confused, Senator.

Senator KENNEDY. I know what it means from listening to those people, that 50 percent refuse to take assignment.

Dr. SAMMONS. Those problems are administrative problems that are based on limits that have been set——

Senator KENNEDY. They are financial problems——

Dr. SAMMONS. Indeed they are.

Senator KENNEDY [continuing] Never for the doctors.

Dr. SAMMONS. There are solutions to those problems without imposing a rigid new system of health care and delivery in this country as has been proposed here. I think you will find, if you would carefully read our proposal, Senator, that we recognize and accept the fact that there are people who are for one reason or another not receiving care.

Those people can receive care and those problems can be corrected, but when you impose income and expenditure limits, you are going to impose rationing, whether we like the term or not. It is absolutely a fact that somebody for an arbitrary reason, correctible or incorrectible, and in that instance incorrectible, will be denied care.

Senator KENNEDY. You can say that, Dr. Sammons.

Dr. SAMMONS. It is true, Senator.

Senator KENNEDY. You can say it, but if you take a country that has now a national health insurance program, such as Canada, that has 84 percent of the Canadian people approving of it, 84 percent of the people approving of it, and not a single politician in Canada willing to go back to the old days, so to speak, not a politician is willing to do that; and to take your sort of generalities about what may or may not happen with this kind of change in the future, I do not think you are on strong ground.

Dr. SAMMONS. The costs in Canada are escalating. They are beginning to suffer some of the same problems which have been identified here. The comments that have been made this morning about relative cost in Canada simply do not take into account there is a matching payment between the Province government and the Federal Government. That is a tax. In Quebec they at least call it what it is. They simply identify it as a tax, because that is what it is.

Senator KENNEDY. No one suggested that people do not pay for it, no one has suggested that, Doctor. The figures we used yesterday are total expenditures, which include Province as well as what is paid by the Central Government.

Dr. SAMMONS. My point, Senator, is that we are perfectly willing and prepared to work with you and the members in resolving some of the presently existing problems. It is our sincere belief that they can be addressed, and they can be resolved without a restructuring of the system which we still contend provides the finest medical care in the world to the greatest number of people, and we are happy to do so. But your present proposal is simply a Federal restructuring of the system.

Mr. PETERSON. With respect to your statement that physicians in Florida are not accepting medicare patients on the basis of usual and customary fees, I want to point out that medicare does not pay usual and customary charges. There is a big difference between the assignment rate recognized under medicare and the usual and customary charge. So I think the record should be corrected to indicate that the difficulty under medicare is with assignment, and the percentiles, and the strict limitations that the medicare program has placed on the reimbursement mechanism.

Senator KENNEDY. We are going to hear testimony on it. I will ask Bill Hutton to respond on that question. Do you want to make one 15-second response on that?

Mr. HUTTON. Five seconds, nearly all the doctors who refuse assignments charge more than those who do not.

Senator KENNEDY. You did it in 5. We will hear from him.

Let us proceed.

Dr. FELCH. Families today know that when the budget runs out, as they do for so many in these inflationary days, rationing or doing without becomes necessary. If the health budget is to operate in the same way, as a ceiling on expenditures, how can this undesirable result be avoided? The American public should not be led to believe that the budget process will answer their health needs.

The point is, Mr. Chairman, we agree with you that health care costs must be kept in reasonable balance, but we urge the Congress not to fall into the cost containment trap—the belief that cost control is more important than the alleviation of human misery and suffering.

As a final note on this budget process, it would not be based on any proven experiences. Nor does the methodology or data exist on which it should be the subject of a national experiment. Too much is at stake for such risks. Mr. Chairman, we hope that you will take another hard look—or perhaps softer—look at this feature and reevaluate its impact on the American people. We think such methodology would prove disruptive and chaotic.

We have mentioned the Federal public authority to be created, with its members to be appointed on a bipartisan basis by the President. It would have full authority for regulating and controlling the entire program. While there is a role provided for a proposed State authority, these State authorities would only be agents of the Federal agency to implement national policy. Even the constituency of the State agency would be controlled by the Federal public authority. Moreover, in exercising any State role, that agency's authority would be through contract with the Federal authority. Experience has demonstrated the Federal domination exercised through that process.

Senator KENNEDY. You can keep saying it and maybe you will believe it. Complete Federal takeover. Those are sloganeering words, cliches, and if you want to keep stating, misrepresenting it, that is your prerogative. If you want to continue to perpetuate that kind of statement, about Federal takeover, and all other cliches, you are welcome to do so. But it is a misrepresentation. I will let it go along for a while, but I am not going to let you keep repeating it——

Dr. FELCH. We do not consider it a cliche. We consider it a real danger.

Dr. SAMMONS. We do not consider it a misstatement of fact. It is complete takeover by the Federal Government. All authority is vested in a Federal agency. The States are nothing but—they might as well be intermediaries, because they have no rights, as we understand the language which you put forward.

The whole process is a federally dominated and controlled one, including approval and allocation of budgets, including the total amount that will be expended. I do not know what else you could do if that is not Federal domination and control.

Senator KENNEDY. You can say it and repeat it, and keep stating it, but that is distorted reading of words and language, as well as intention. If you want greater detail, we can sit down and talk about it. You can say it all you want. It does not happen to be so.

You are free to put what characterization, but I am not going to let it go unchallenged. It is not accurate representation.

Dr. SAMMONS. Senator, if that is not your intent, may I very respectfully suggest that someone on your staff rewrite the document that was issued by your office on October 2 to clearly state your intent, because this document provides precisely for Federal control.

Senator KENNEDY. It doesn't either, so you reread it, and get somebody on the staff to reread it.

Dr. SAMMONS. We shall do so.

Senator KENNEDY. Good.

Dr. FELCH. The total Federal takeover of the health care system is inescapable under this program. This result is undesirable. In our opinion we do not think the American public will want its health care directed and controlled by the Federal Government. The history of federally run programs does not instill such trust and confidence as to support such action.

Turning to other features of the proposal, we note the stated intent to create a significant role for the insurance industry. Frankly, while there is certainly a role provided, insurance companies appear to be no more than regulated agents of the Federal public authority. The determination of the premium; its significance—merely a capitation rate—the absence of risk; the interrelationships among insurance companies,

consortia and HMO's; even the basic flow of funds—all these are unclear, but subject to Federal control. Further clarification is needed and basic questions need to be answered.

Similarly, with respect to the financing, more information is needed. As we stated, we note the change away from imposing an additional tax through the already beleaguered social security system. Nevertheless, the earnings-based premium—to be determined by the Federal public authority—appears to be similarly to a payroll tax and this needs further study and evaluation.

Other aspects of the program could be discussed such as the absence of coinsurance requirements. Coinsurance, as you know, is advocated by many as a restraint on overutilization. The time restraints of this hearing, however, preclude a discussion of all features of the program.

Mr. Chairman, in closing I want again to express our appreciation for being invited to express our views on your new outline for a national health insurance proposal. Understandably, since it is an outline, much needs to be added in order to present the full program. As we indicated, on the one hand we had difficulty in understanding important working elements of the program. On the other, it is apparent to us that we are speaking of a federally dominated program that would tear down our health care system rather than improve it.

We note that it is your intention to hold hearings around the country. We would recommend that sufficient details, if not a complete bill, be fashioned so that the public would be more completely informed in addressing a more specific proposal. As you know, the HEW Advisory Committee on National Health Insurance Issues recently held extensive hearings throughout the country and in Canada to receive views on national health insurance.

We have not gone into details of our own program—H.R. 1818 and S. 218—because of time limitations at this hearing. With your permission, Mr. Chairman, we submit for the record a copy of our testimony submitted on that proposal before the Department of HEW in October 1977. The program and its underlying principles are discussed in some detail, and we urge your careful review and consideration of our proposal.

We look forward, Mr. Chairman, to further opportunities to explore with you your proposal as your program becomes further developed.

We will be pleased at this time to answer questions which the committee may have.

Senator KENNEDY. We will include that in the record. We will have you back sometime to talk about your program.

Senator Chafee.

Senator CHAFEE. Mr. Chairman, I regret I have to go to a highway conference at 11 o'clock. I was sorry I couldn't be here early for this. I think it is worthwhile to get views of all groups and appreciate your coming and giving your thoughts. We look forward to further submissions and comments as you have them.

Dr. SAMMONS. Thank you very much, Mr. Chairman, Senator Chafee, members of the committee. We appreciate the opportunity. It is always nice to see you.

Senator KENNEDY. Thank you, Doctor. Nice to see you.

[The joint prepared statement of Dr. Sammons and Dr. Felch and material referred to follow:]

Statement

of the

AMERICAN MEDICAL ASSOCIATION

Before the

Subcommittee on Health and Scientific Research
Committee on Human Resources
United States Senate

on

National Health Insurance

by

James H. Sammons, M. D.

and

William C. Felch, M. D.

October 10, 1978

Mr. Chairman and Members of the Committee:

I am James H. Sammons, M. D., Executive Vice President of the American Medical Association. Participating in this presentation is William C. Felch, M.D., a physician in practice in Rye, New York, who is Chairman of the AMA's Council on Legislation. Accompanying us is Harry N. Peterson, Director of our Department of Legislation.

The American Medical Association is pleased to take part in these hearings on national health insurance. As you know, Mr. Chairman, this subject has been debated from time to time over an extended period with varying degrees of intensity -- depending on a variety of factors -- and the AMA has been an active participant throughout.

We share the sincere concern of proponents of NHI proposals that health care should be available to all persons. To this end the AMA has developed a bill -- presently pending in this Congress as H.R. 1818 and S. 218 and known as the Comprehensive Health Care Insurance Act -- to provide comprehensive and catastrophic coverage for all persons. Our legislation, based on longstanding principles for comprehensive health insurance adopted by our organization, is founded upon the strengths offered by our existing pluralistic health system. Its foundation is solidly based upon the successes of our entire health delivery system, allowing for future development and innovation.

The extended discussion on national health insurance which has taken place during the past years has been beneficial in many respects in analyzing the issues and in evaluating the impact upon society. The thrust and scope of national health insurance proposals have altered with changing circumstances.

During the long period of NHI debate -- but particularly during this last decade -- we have seen a number of significant changes take place in our health system. To name a few: marked increase in numbers of medical schools; significant expansion in number of medical graduates, with emphasis in primary care training; substantial increase in training of allied personnel; proliferation of medical facilities, affording easier access; development of sophisticated technology; wider distribution of medical personnel; expansion of government supported health programs; increased access to care by the disadvantaged; and wider coverage of private health

insurance, including catastrophic coverage. Thus while the debate has waxed and waned, our health delivery system has shown steady improvements. This has been accomplished through the cooperative efforts of many, including both government and the private sector.

Moreover, we have seen changes in approaches to national health insurance. It is important that flexibility be maintained in order to mold the program to meet current needs and demands. There is an increased awareness and concern on the part of those persons bearing responsibility in developing and implementing any program as to the magnitude of the problems involved. These problems certainly have been brought into sharper focus as a result of governmentally administered and controlled programs both here and abroad. (For example, bearing on consideration by Congress of further government programs is the recent revelation by the HEW Inspector General of some $7 billion waste in HEW programs, and evident in Congressional consideration is also the groping -- seemingly futile sense of frustration -- of Congress to reach those problems with corrective measures.)

Too, the changing economy has dictated shifting priorities in our national goals. We perceive the additional frustrations of Congress as it seeks to provide for a variety of programs within a restricted economy. The result has been for the most part a sharp rationing of dollars within existing programs and a curtailment in new programs. At the same time, nevertheless, the national deficit is still further expanded! In other words, Mr. Chairman, even though we heard -- and continue to hear -- solemn and sincere intentions to reach a balanced budget, and even though we find a

more critical evaluation of dollars spent, we find that the government has not been able to exist within a balanced budget.

Mr. Chairman, we all recognize that there are problems that exist in our health delivery system. Certainly the profession and the AMA are particularly aware of these. For example, with respect to legislative solutions, the American Medical Association has prepared a variety of bills for consideration by the Congress. Among these, to identify a few, are bills to strengthen and improve child immunization programs, expand maternal and child health care programs, fund preventive residency training programs, encourage federal support for medical student loans and scholarships, protect the confidentiality of patients' medical records, improve rural health delivery, improve and strengthen our food and drug laws, increase drug labeling for patients, and improve local planning for health facilities. In addition, we have developed important model state legislation, for example, bills to encourage greater health education in our elementary and secondary school systems, provide for improved disciplinary procedures by state medical boards, stimulate effective peer review, encourage expanded home health care services, and provide expanded patient information for clinical laboratory services, just to name a few. In addition, the Association and profession are involved in and promote a host of other health improvement programs.

Deficiencies are being addressed by a variety of forms, public and private. For example, manpower shortages are being overcome (surpluses, in fact, have been predicted for the near future by

responsible government officials), alternative delivery systems are under experimentation, new types of providers are being utilized on an increasing scale, greater health education is being carried on by many groups, preventive measures are being accentuated, and new public awareness of the impact of total environment upon health is being aroused. The AMA has taken an active role and has supported these activities.

It would be inadvisable to attempt to resolve all existing problems through adoption of any NHI bill. Major policy questions of such import should receive independent and thorough study on the merits.

But as we have said before on this subject in the course of this extended debate, notwithstanding present weaknesses there is a fuller realization and acknowledgement that this country's health care -- under attack by many in the course of NHI debate -- is indeed superior to any other in the world. This is certainly our stance, and we believe that you, too, Mr. Chairman, would join in that conclusion.

And frankly, it is because we have reached that level of preeminence in health care -- having done so without national health insurance -- that the medical profession must examine proposals for such programs with special vigilance. The profession rightfully guards very zealously the position our health system enjoys, and the profession will -- and must in the interest of the public -- resist its erosion.

Mr. Chairman, the great strengths in the health care system of this country are the ones which we believe it is most appropriate

upon which to build any program of national health insurance. It is both reasonable and obvious that these aspects must be accentuated rather than adopt a new program suggested by some to impose a radically different system, with full Federal administration and control, upon our health system. Needed modifications must and can be accomplished without upheavals that would undermine or sacrifice the great strengths of our system which far outweigh any imperfections.

This leads us then to an evaluation of the program which you have just announced, Mr. Chairman.

Before getting into more detailed comments, however, let me characterize it generally by stating our recognition that certain changes from your former bill, S. 3, the Health Security Act, (e.g., financing other than through the already overtaxed Social Security system, recognition of a role for private insurance companies, continuation of insurance coverage for the unemployed, upgrading of Medicare benefits), are beneficial. Regrettably, however, the overall changes have not been of sufficient extent and character to remove fundamental objections to the proposal. Nor have the changes been of sufficient magnitude and extent to effect a change from the basic character of S. 3.

In saying this, it is also recognized that we must deal with general narrative and, to an extent, conceptual language as contained in your statement on "Introduction of a New National Health Insurance Outline." We do not have legislative language which, of course, would be more definitive. Nevertheless, the

description of the program is sufficiently clear to present a fully Federally administered and controlled program radically restructuring our entire health care system.

Mr. Chairman, we do not find such a program to be in the interest of the citizens of this country.

At this time Doctor Felch will continue with the presentation of our statement.

Mr. Chairman and Members of the Committee:

At the outset your program, Mr. Chairman, would, immediately upon enactment, impose strict controls both on hospitals and physicians through overall revenue and expenditure limits on hospitals and revenue limits on physicians. These controls would remain for at least two years until other specified program controls took over.

Although described meagerly, this "cap" appears, as to hospitals, similar to the Administration's hospital cost containment program that has been so hotly debated in this Congress. The deficiencies of this plan have so often been described that it would seem unnecessary to have to repeat them.

Manifest is the inherent unfairness of subjecting one industry to stringent cost controls without likewise controlling the factors that affect the costs in that industry.

The great weakness in the logic of these "cap" programs is that they assume that health care inflation is generated almost totally by the industry and thus can be completely controlled by it. To control the revenues and expenditures of hospitals and physicians does not attack the causes of the inflationary spiral that affects all industries.

We also note that in establishing ceilings non-supervisory wages would not be subject to controls. It is unfair to single out one group of hospital employees for favorable treatment at the expense of others. Further, approximately 60 percent of all hospital expenses are for labor. Thus pressures for increases will continue.

Moreover without legislation, the current Voluntary Effort -- strongly supported by the AMA -- has been highly successful in already meeting the goal of reducing the rate of hospital expenditures.

Furthermore, we note that the newly proposed cost control program in the NHI "Outline" would go even farther than the Administration's program and would impose "revenue limits on physician services." No further details are provided. This is aimed at placing a restriction on the earning capacity of physicians. Again, it is grossly inequitable to single out a segment of our society and economy for discriminatory controls. Mr. Chairman, this on its face would be objectionable.

Once the benefits under the program become effective, national maximum budget levels of expenditures for health care would be set together with similar maximum areawide and state budgets. These maximum levels would apply to health care and medical services. Hospitals budgets and physician fee schedules would be negotiated annually.

This budgeting process, controlled through a new Federal Agency (called the "Public Authority") is at the heart of the program. You have made much of the fact in your opening remarks, Mr. Chairman,

that the health system must learn to live within a budget. This on first reading may sound desirable, but the inescapable result of such a budget is "rationing" of health care. Families today know that when the budget "runs out" -- as they do for so many in these inflationary days -- rationing or "doing without" becomes necessary. If the health budget is to operate in the same way, as a ceiling on expenditures, how can this undesirable result be avoided? The American public should not be led to believe that the "budget" process will answer their health needs.

The point is, Mr. Chairman, we agree with you that health care costs must be kept in reasonable balance, but we urge the Congress not to fall into the "cost containment trap" -- the belief that cost control is more important than the alleviation of human misery and suffering.

As a final note on this budget process, it would not be based on any proven experiences. Nor does the methodology or data exist on which it should be the subject of a national experiment. Too much is at stake for such risks. Mr. Chairman, we hope that you will take another hard (or perhaps softer) look at this feature and re-evaluate its impact on the American people. We think such methodology would prove disruptive and chaotic.

We have mentioned the Federal "Public Authority" to be created, with its members to be appointed on a "bipartisan" basis by the President. It would have full authority for regulating and controlling the entire program. While there is a role provided for a proposed "State Authority," these state authorities would only be

"agents of the federal agency to implement national policy." Even the constituency of the state agency would be controlled by the Federal "Public Authority." Moreover, in exercising any state role, that agency's authority would be through "contract" with the Federal Authority. Experience has demonstrated the Federal domination exercised through that process.

The total Federal takeover of the health care system is inescapable under this program. This result is undesirable. In our opinion we do not think the American public will want its health care directed and controlled by the Federal government. The history of Federally run programs does not instill such trust and confidence as to support such action.

Turning to other features of the proposal, we note the stated intent to create a significant role for the insurance industry. Frankly, while there is certainly a role provided, insurance companies appear to be no more than regulated agents of the Federal Public Authority. The determination of the "premium"; its significance (merely a capitation rate?); the absence of risk; the interrelationships among insurance companies, consortia and HMOs; even the basic flow of funds; -- all these are unclear, but subject to Federal control. Further clarification is needed and basic questions need to be answered.

Similarly, with respect to the financing, more information is needed. As we stated, we note the change away from imposing an additional tax through the already beleaguered Social Security system. Nevertheless, the "earnings-based premium" (to be determined

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by the Federal Public Authority) appears to be similar to a payroll tax and this needs further study and evaluation.

Other aspects of the program could be discussed such as the absence of co-insurance requirements. Co-insurance, as you know, is advocated by many as a restraint on overutilization. The time restraints of this hearing, however, preclude a discussion of all features of the program.

Mr. Chairman, in closing I want again to express our appreciation for being invited to express our views on your new outline for a national health insurance proposal. Understandably, since it is an outline, much needs to be added in order to present the full program. As we indicated, on the one hand we had difficulty in understanding important working elements of the program. On the other, it is apparent that we are speaking of a Federally dominated program that would tear down our health care system rather than improve it.

We note that it is your intention to hold hearings around the country. We would recommend that sufficient details -- if not a complete bill -- be fashioned so that the public would be more completely informed in addressing a more specific proposal. As you know, the HEW Advisory Committee on National Health Insurance Issues recently held extensive hearings throughout the country and in Canada to receive views on national health insurance.

We have not gone into details of our own program (H.R. 1818 - S. 218) because of timelimitations at this hearing. With your permission, Mr. Chairman, we submit for the record a copy of our testimony submitted on that proposal before the Department of HEW

in October, 1977. The program and its underlying principles are discussed in some detail, and we urge your careful review and consideration of our proposal.

We look forward, Mr. Chairman, to further opportunities to explore with you your proposal as your program becomes further developed.

We will be pleased at this time to answer questions which the Committee may have.

COPY

Statement

of the

AMERICAN MEDICAL ASSOCIATION

Presented by

William C. Felch, M. D.

before the

Department of
Health, Education and Welfare

Re: National Health Insurance

October 4, 1977

Mr. Secretary:

I am William C. Felch, M. D., a physician in the private practice of internal medicine in Rye, New York, and I serve as Chairman of the Council on Legislation of the American Medical Association. With me today is Harry Rosen, a member of the AMA Legislative Department.

Mr. Secretary, we are pleased to have the opportunity to appear before you to express our views on national health insurance, which has been the subject of discussion in the public and private sectors of the nation extending over a long period of time.

This hearing marks increased Administration activities concerning NHI and augments the series of local public meetings being sponsored by the HEW regional offices throughout the nation in the development of national health insurance legislation for introduction in the Congress in the coming year. We also note other recent Administration legislative initiatives in anticipation of national health insurance.

National health insurance has also been the subject of hearings before various Committees and Subcommittees of the Congress, and we have appeared on many occasions to present our views at those hearings.

The views of the Association during those appearances are embodied in legislation that was developed by it as a result of extensive deliberations by the Association. Such legislation was first introduced in the Congress in 1970. The plan proposed by this legislation would make comprehensive health care available to all Americans through private insurance. Similar proposals, modified to meet changing needs, were introduced in each of the succeeding Congresses. The latest of these bills (H. R. 1818, S. 218), entitled "The Comprehensive Health Care Insurance Act of 1977", was introduced in the present Congress on January 13, 1977, and now has the sponsorship of 52 members of the House and Senate.

Objectives of NHI

Mr. Secretary, the AMA believes that one fundamental objective should be to make available to all individuals the benefits of our health care system. Any health care program, however, to best serve the American people, must be realistic in its objectives, manageable in its costs to individuals, to families and to the nation, and be as simple as possible in its administration. The present American health care system delivers more high-quality medical care to more people than any other system in any other nation in the history of the world.

The objectives we should strive to achieve with a national program for health insurance must be to assure continuation of the benefits of this system to all our citizens without impairing its quality or inhibiting its creative energy for continued innovation and improvement. This can best be

accomplished by building such a program on the many strengths of the present system. Ours is the finest health care system in the world and should not be put in jeopardy.

The issues regarding our health care delivery system are manifold and complex. Any national health insurance program will, of course, be related to many other health programs including, for example, manpower and other medical resource development and distribution.

These measures are of such individual magnitude, however, that although they are unquestionably related to comprehensive national health insurance, they require independent consideration. It would be inadvisable to attempt to resolve all of these pressing questions through the adoption of any NHI bill. Major policy questions of this import should receive independent and thorough study on the merits.

We do not support the suggestion that any single piece of legislation will rectify problems of the distribution of medical manpower, the allocation of resources, or the environmental and social ills which often are the source of illness and injury, and at the same time provide the basic assurance of comprehensive health care for all individuals.

The AMA has long supported legislation on specific areas, including national health service corps, health manpower education, health education, rural health, emergency medical services, air and water pollution, toxic substances, Indian health, and other legislation which appropriately address issues independent from national health insurance. We have also drafted legislation in several of these areas to assist Congress in its consideration and adoption of appropriate programs.

We recognize that the present system is not perfect. Further changes and improvements can be made, and in fact are continually being made. But any modifications must be accomplished without radical restructure that would undermine or sacrifice the great strengths of our system which far outweigh any imperfections. Adoption of a health insurance program will cause all of us to depend for vital health care on the program that Congress develops. Therefore, we cannot experiment needlessly; we cannot afford to have a program of such importance founder.

We believe, therefore, that the best way to assure that any health insurance program will be beneficial rather than harmful is to construct it in accordance with certain basic principles which reflect the essential strengths of our present successful system.

AMA Comprehensive Health Insurance Principles

Attached to this statement is a copy of the AMA principles which underlie the AMA proposal for comprehensive health insurance, as well as a copy of the AMA bill, and a summary of its provision. I should like at this time to expand on only certain of those principles and indicate briefly how the AMA bill exemplifies those principles.

Uniform and Comprehensive Benefits - One of the principles that must be adhered to is to assure that the program is comprehensive,both with respect to the population to be covered and the benefits to be provided. There are Americans who do not seek medical care because they have a concern over funds to pay for even basic care. Moreover, the ill fortune of major illness can cause economic ruin.

The needs thus presented are addressed and met in H. R. 1818 and S.218 by providing financial coverage for a broad range of basic medical care and by insuring all persons against the prospect of financial ruin as a result of long term or expensive illness.

In meeting the health care requirements of the population, the AMA proposal provides a broad range of benefits that includes all necessary hospital care, physician services in and out of the hospital, and home health services.

Realistic preventive care is also a part of this coverage, providing well-baby care, physical examination, immunization and inoculations, x-ray and laboratory work.

Also addressed is the need for protection against the costs of psychiatric treatment, both inpatient and outpatient. The program also provides a full range of dental care for children, as well as emergency dental care for all persons.

Equal benefits are provided for all--the same type of insurance protection is supplied for the employed and the non-employed; and supplemental insurance is made available to Medicare beneficiaries to bring Medicare benefits up to the health insurance level of our program.

The program provides, too, for continuation of coverage for the unemployed. Certainly our experience with the vagaries of our economy presents stark evidence of the need for such a provision in any NHI program we adopt.

Private Insurance - Another principle recognizes the need to build a viable program on the present successful system which is structured on private insurance. Private insurance is incorporated as one of the essential building blocks of H.R. 1818 and S. 218. Employer-employee health insurance already enjoys wide familiarity and acceptance. The present system of employer-employee group health insurance plans, which presently cover the vast majority of individuals, is retained and utilized. Under our bill, employers would make coverage of required benefits available to employees, and pay at least 65% of the cost. For the self-employed or the non-employed, coverage for the same benefits would also be available.

Administration - Another essential characteristic in a successful program is administration in the private sector. Experience clearly demonstrates that the American citizen, as both patient and taxpayer, would be ill-served by transferring the functions now performed by the private insurance system to a federally controlled and operated system.

There is real danger that operation by a federal bureaucracy could stifle the health care system under piles of paperwork and regulations,and become unresponsive to specific needs, lacking in innovation.

Recognizing the merits of private over federal administration, H. R. 1818 incorporates private insurance as the vehicle for administration.

Level of Federal Assistance - Insuring that federal financial assistance is provided on the basis of need is fundamental to an appropriate national program. If NHI is to have a long-term vitality and realistic program costs, it is imperative that federal resources be focused so that they provide most assistance for those who have the greatest need. This is essential considering the limitations of available government funds and the increasing competition for those funds to meet all national needs.

H. R. 1818 and S.218 carry out this principle by providing federal assistance on a graduated scale based on the income of the individual. For the poor, the subsidy would pay the full premium cost.

Financing - In utilizing a continuation of private insurance coverage, such as employer based coverage, much of the cost will remain in the private sector. This obviates the problems attendant with special tax financing. We are all aware of the enormous problems presently facing the Social Security Trust Fund and of the essentially regressive impact that "special" taxes, such as Social Security, have on individuals. Therefore, any federal assistance should be financed out of general revenues, not through a Social Security type tax.

H. R. 1818 and S. 218 follow that principle.

Freedom of Choice - Under H. R. 1818 and S.218 each individual would retain the basic right to choose his or her own form of health insurance coverage. He could also choose the method of delivery of health care service, whether through prepaid or fee-for-service, group practices, an HMO,or through a solo practitioner. Thus, he has the right to choose his own physician.

Medical care, to be most effective, must be acceptable to the recipient. It can best achieve that end by providing patients with maximum freedom to choose their own form of care.

Mr. Secretary, we again invite your consideration of all the principles enunciated by the AMA for health insurance, and attached to this statement. We have here highlighted only a few. As you will see from an examination of H. R. 1818 and S. 218 these principles are embodied in our comprehensive health insurance program.

Health Security Act (S.3)

Our excellent present system of health care would be radically restructured under some plans submitted to the Congress. One such plan, the Health Security Act, would entirely overturn the present system. Under that proposal the delivery of the nation's health care would be placed under the direction of a federal Health Security Board of five members. Professional and institutional providers would provide their services under contract with the federal government. All health services would be provided within the limits of a fixed annual budget established by the Board and financed by new social security taxes and matching general revenues. Federal bureaucracy would displace private insurance. We strongly oppose such a concept which would superimpose an untried and unproved system over that which has produced for the American people the finest health care in the world.

Limitations of NHI

Mr. Secretary, the degree of value that we as a people will reap from any national program for health insurance will be directly proportional to the degree of realism that goes into its creation. Thus, it is just as important to recognize what such a program cannot do as what it can do and to accept its limitations in presenting it to the American people.

Such a program will not result in dramatic improvement in certain health statistics, either in the short term or the long term. There is nothing in such a program, and virtually nothing that can be built into it, that will reduce death by homicide, suicide or auto accidents--the leading causes of death among American males under 40.

There is nothing in NHI that will induce Americans to stop smoking, prevent alcohol abuse, or eliminate pollution--all of which affect our health status.

Medical care is only one determinative factor in general well-being. No one should suffer unnecessarily for lack of access to quality medical care. Therefore, we believe a program of comprehensive health insurance should assure continued access, and we endorse this concept.

But let it be understood that any national health insurance program would not provide an all-encompassing magical answer to all health problems; there are limitations to what it can accomplish.

Conclusion

A realistic and beneficial NHI program can best be achieved, we believe, by adherence to the principles we have enumerated and which we are submitting as an attachment to our prepared statement along with our proposal, H.R. 1818 and S. 218.

In summary, H.R. 1818 and S. 218 would make health care available to all

Americans regardless of income. Comprehensive health coverage of basic and catastrophic costs of illness would provide a full range of hospital, physician and other health care needs, uniformly for all persons. This would be achieved without special or payroll taxes to finance the program.

For most individuals (and their families), the coverage would be provided through their employment, much as is done today, and total premium would be shared between employer and employee.

Government premium-sharing would be limited essentially to those in need. It would pay total premium for the poor, and it would pay part of the premium, on a graduated scale related to income, for persons who are unemployed or self-employed, or for supplemental coverage purchased by the elderly to bring their Medicare payments up to the level of the program's uniform comprehensive coverage.

This program would assure for all persons access to care provided under our present system of health care delivery. We commend this legislation for your favorable consideration.

Mr. Secretary, I would be pleased to answer any questions you may have.

AMA GUIDELINES FOR NATIONAL HEALTH INSURANCE UNDERLYING THE AMA BILL, H.R. 1818 and S. 218, "THE COMPREHENSIVE HEALTH CARE INSURANCE ACT OF 1977"

These are the key elements of the AMA guidelines for national health insurance, with a brief statement as to their incorporation in the AMA bill.

1. *Comprehensive Coverage for the Entire Population*

H.R. 1818 and S. 218 would provide comprehensive coverage for all--both basic and catastrophic benefits. Full hospitalization, both inpatient and outpatient, would be included in this comprehensive coverage, as well as full medical care, both in and out of hospital. All diagnostic, therapeutic and preventive care by or under the direction of a physician would be included. Skilled nursing facility care, home health services, full dental care for children, and emergency dental care would also be covered benefits.

2. *Premium Subsidy and Cost Sharing*

Premiums on insurance of the nonemployed, the self-employed and the elderly would be shared between the insured individual or family and the federal government based on income. For the poor, the premium would be paid in full. For others, as income rises, the federal assistance would diminish.

Coinsurance would be based on income, but an absolute dollar limit on coinsurance would apply to all. Low income individuals would pay no coinsurance.

3. *Varied Sources of Funding; Private and Public*

Provisions of the AMA bill recognize the need to rely upon the present widespread use of employer-provided health insurance. The primary thrust of H.R. 1818 and S. 218 is upon continuation of employment-based insurance funded in the private sector. The bill provides for employer-employee premium sharing, with the employer paying at least 65%.

Federal government financing would be limited primarily to subsidies on an income-related basis of the premium for the nonemployed, the self-employed and the elderly (as a supplement to Medicare benefits) and to tax assistance (for five years) to employers who experience increase in payroll costs as a result of the employment-based insurance requirement.

4. *Minimum Federal Dollars*

Federal participation would be limited essentially to assisting the poor and low-income individuals pay health insurance premiums.

5. *Minimum Federal Administration*

The AMA program would be administered primarily in the private sector through the use of private health insurance. While a Health Insurance Board (composed of a majority of health professionals) would establish minimum standards of qualification of insurers and insurance plans, State insurance departments would (as they do now) regulate private insurers.

- American Medical Association, Legislative Department, Public Affairs Division -

6. *Freedom of Choice*

The bill preserves freedom of choice by the patient and physician. It would provide for individual choice of coverage through a health insurance policy, Blue Cross/Blue Shield or other plan, or prepayment plan (including HMO), and for individual choice of physician. The physician's freedom is also preserved, including his choice of practice.

7. *Pluralism*

The AMA program builds upon the strengths of our pluralistic health care delivery system. It would utilize various modes of health care delivery, allowing for further development through innovation and experimentation.

8. *Preservation of Physician/Patient Relationship*

The program also preserves the integrity of the physician/patient relationship. It contains a general prohibition against federal interference in the practice of medicine. The individual freedoms of both physician and patient are maintained, as indicated above, with the individual physician exercising his own best judgment as to medical care and treatment needed for his patient.

9. *Continuity of Benefits*

The AMA bill establishes uniform benefit coverage for all persons.

As a further protection, the bill would provide for a continuation of the same insurance policy for an individual for 30 days after termination of employment (with 60 additional days if paid for by the individual). Moreover, while a person was covered by unemployment compensation (and to the end for the calendar year if not employed by then) he would be covered at government expense.

10. *No Social Security Financing*

There would be no Social Security financing. Basic financing would be in the private sector. Federal premium subsidies would be made from general revenues through credits against income tax or redemption of "certificates of entitlement."

11. *No Social Security Administration*

The Social Security Administration would not administer the new program. Overall program administration would be in the private sector and would be the primary responsibility of private insurance carriers, with premium assistance administered through the Federal tax laws.

12. *State Licensure and Certification*

The bill would continue present state responsibility for licensure and recognition or certification of health manpower.

13. *Quality Controls*

Rather than advocate a single inflexible method which may not be appropriate for many areas or situations, the bill would authorize the Health Insurance Board to develop appropriate mechanisms for quality review at time of implementation of the program.

14. *Cost Controls*

The bill addresses the complex issue of cost controls in several ways. It would require (in most cases) coinsurance on services. In addition, hospital reimbursement would be subject to acceptable formulae as determined and agreed on by hospitals and insurers thus including a variety of reimbursement methods including prospective reimbursement.

Medical service would be subject to usual, customary and reasonable levels of reimbursement and be subject to present private insurer programs of review.

Also, the Health Insurance Board would have authority to establish appropriate mechanisms for utilization review of services.

15. *Use of Private Insurance*

Coverage under the AMA bill would be furnished by private insurers on a risk and underwriting basis.

16. *Coordination of Benefits*

Benefits payable under any duplicate coverage would be coordinated to avoid duplication of payments.

17. *Separation of Medical and Institutional Components of Expense*

Identification of expenses according to classes of health care providers would be desirable to assess costs of the program.

January 18, 1977

January 17, 1977
H.R. 1818; S. 218
"Comprehensive Health Care
Insurance Act of 1977"

A BRIEF SUMMARY OF THE
AMA NATIONAL HEALTH INSURANCE PROPOSAL

The AMA program would make comprehensive private health insurance available to all persons, regardless of income. The benefits are comprehensively broad, covering full hospital care, full physician care (wherever provided, both in and out of the hospital), home health services, emergency care, lab and x-ray services, extended care services, etc. It would provide both basic and catastrophic coverage for costs of illness. The range of benefits embrace preventive, diagnostic and therapeutic services.

This protection would come through private health insurance. Most persons would receive this insurance through their employment. Their employers would be required to offer the full-benefit coverage to their employees and their families, and pay at least 65% of the premium--and many employers would no doubt continue the practice of paying more. The employee would pay any difference.

Low-income or unemployed persons would obtain the same full coverage from their own insurance companies, and the government would contribute toward the premium. The government would pay all of the insurance premium for the poor, and gradually less for others on a scale related to their incomes. As income increased, the federal assistance would diminish.

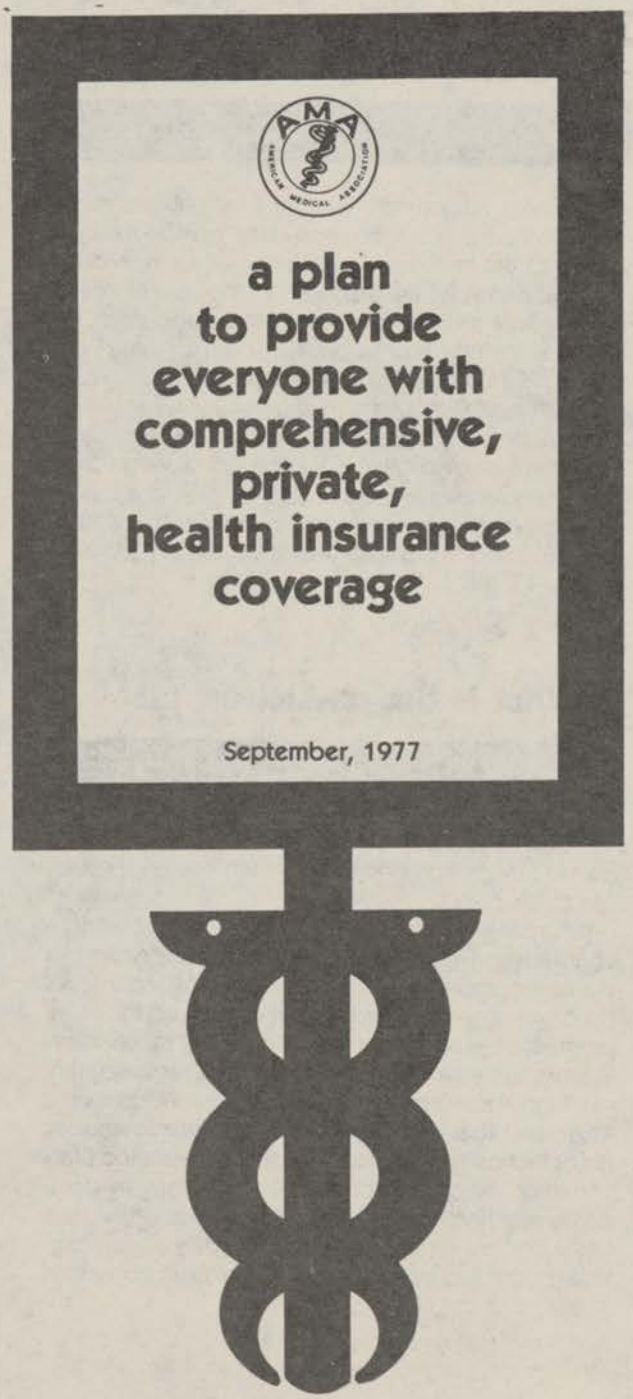
Elderly individuals would also be able to obtain private insurance to build up the level of their medicare benefits to the level of the full benefits program, and the government would pay for all or part of such insurance depending on the individual incomes.

There would be some coinsurance, to keep costs of the program down, except that the poor would pay nothing. Any coinsurance that an individual or family would have to pay in any year would be limited in relation to their income, but even this would be further limited by a fixed amount applicable to all persons. The limit on the amount any individual or family would have to pay in any year would assure against any economic hardships because of costly illness. There would be no deductible; benefits would begin immediately.

No special taxes would be needed to finance the program. Financial participation of the government would be very limited, and would come primarily as payment of premium for the poor and premium assistance for individuals or families with low incomes. As is true today, most of the premium for comprehensive health insurance protection would come from employee group insurance, and employers would pay the major part of that premium. Subsidies would be available to assist employers experiencing substantially increased costs.

Adoption of this program would assure continuation of the advantages of our system of health care and the quality of such care. The individual would choose his physician and the method under which he would receive his health care, and his insurance would provide him the full protection--both basic and catastrophic--he needs against the costs of illness.

- American Medical Association, Legislative Department, Public Affairs Division -


AMA
AMERICAN MEDICAL ASSOCIATION
a plan
to provide
everyone with
comprehensive,
private,
health insurance
coverage
September, 1977

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1. Why do physicians support comprehensive health insurance?

As the ones responsible for caring for patients every day, physicians know how essential quality medical care is to the health and well-being of an individual. They are also very much aware that the cost of health and medical care has become a financial burden for certain segments of our population. Even for those with substantial incomes, a long or serious illness can create serious financial problems.

These are the concerns that led physicians, through the American Medical Association, to develop their own comprehensive health insurance plan. It is called the Comprehensive Health Care Insurance Act of 1977 (H.R. 1818 and S. 218) and was introduced in Congress January 13, 1977.

2. What is the physicians' plan?

The plan is just as the title indicates—a program to extend private, comprehensive health insurance coverage to everyone.

In formulating the plan, the physicians established a **comprehensive list** of medical and health services that would be available to everyone, incorporated a set of principles to assure **quality care,** and based the entire program on a **sound, realistic financing mechanism.**

Integral to the plan is the belief that federal financial help should be provided to those who need it most, and that everyone should be free to choose his or her own physician and health insurance plan.

Further, physicians believe any program of comprehensive health insurance should be built on the best of the present system—a system which is already providing more and better health care to more people than in any other country.

3. How does the plan work?

The program would provide a complete package of benefits essential to good health care, as well as to protect against the cost of catastrophic illness—without limits.

Realistic preventive care benefits would also be included. Importantly, the plan is designed to keep red tape and bureaucracy to a minimum.

The actual health care protection would be furnished entirely by a private health insurance policy or plan. Coverage would be available through the present system of employer-employee group health insurance plans; or through a program for the self-employed and non-employed. Supplemental coverage would be available to those eligible for Medicare to raise the level of benefits to equal those of the physicians' plan. Individuals currently receiving Medicaid benefits would receive them through this new program.

Benefits

Under the physicians' plan, approved protection would have to provide payment of expenses for both basic and catastrophic health care needs. This would be true whether an individual participates in the employer-employee program, the program for the self-employed and non-employed, or the supplemental coverage for Medicare beneficiaries. All insurance plans offered would be approved by the respective states to assure that benefits met the comprehensive national standards.

Benefits for a 12-month period would have to include:

- 365 days of hospital inpatient care
- 100 days of inpatient care in a skilled nursing care facility
- all emergency and outpatient services
- all physician care (diagnostic, therapeutic, and preventive, regardless of where it is provided) and other health services

- all home health services
- all dental care for children
- emergency dental care for everyone
- ambulance service
- institutional and outpatient psychiatric care
- well-baby care
- immunization
- physical examinations
- x-ray and laboratory services
- anesthesiology services

Employer Coverage
Most people would receive their health care protection as they do now — through the current system of employer-employee group health insurance. The employer would be required to offer the insurance but participation by the employee would be voluntary. At least 65% of the health insurance cost would have to be paid by the employer, the rest would be paid by the employee. Financial assistance will be provided for small businesses.

Self-Employed, Non-Employed, and Medicare-Eligibles
Individuals or families in these categories could buy qualified health care insurance. The insurance plan would have to meet the established national standards of benefits and policy conditions. The federal government would contribute toward the cost of the policy according to the individual's or family's ability to pay. The amount for a given year is measured according to how much the individual or family paid in income tax the preceding year.

For example, a family of four earning $6,000 a year would pay no income tax. Therefore, the federal government would pay the entire cost of the health insurance premium.

For a family of four earning $7,000 a year, the income tax would be $133. The federal government would pay 86% of the cost of the family's health insurance premium.

For a family of four with an annual income of $11,300, the income tax would be $893. For this category (and any individual or family paying more than $891 income tax), the federal government would pay 10% of the cost of the family's health insurance premium.

The income tax figures as shown are based on 1976 IRS Tables.

The financial assistance would in the form of an income tax credit or a certificate to be given to the insurance company toward payment of the premium.

Unemployed

Unemployed persons, while eligible for federal or state unemployment compensation, would continue to be covered by their previous employer-sponsored insurance. Premiums would be paid by the federal government. If unemployment compensation expired before new employment, the government would continue to cover health insurance premiums for the rest of the year. At the beginning of the new calendar year, the individual would immediately be eligible for the non-employed subsidy program (described in previous paragraphs). Because of this provision, there would be no interruption in coverage.

Coinsurance

As with any program that offers as many benefits as the medical profession's plan, financial safeguards must be included, otherwise the program would be too expensive for the taxpayers to afford. In this program there would be cost-sharing in the form of coinsurance.

Although the amounts are small, cost-sharing between citizens and the government would help keep the total cost of the program at a reasonable level. It would help prevent policy holders from going to a physician "just because it's paid for" or entering a hospital "because it's more convenient."

Coinsurance would be 20% of the cost of all covered benefits, but not more than a specified ceiling limit

related to income. **The poor would pay no coinsurance.**

This coinsurance maximum (the most an individual or family would pay) would be equal to 10% of the individual or family income after a "coinsurance deduction" has been subtracted. The coinsurance deduction is figured according to family size. For example, the deduction is $4,200 for a family of four. So if a family of four earns $10,000, the coinsurance limit (or total cost) for a 12-month period would be $580, or 10% of $5,800 (salary of $10,000 minus deduction of $4,200). The family would not have to pay more than $580 for all of the medical services provided in that year, even if there were expenses of a catastrophic size.

In no case could coinsurance exceed $1,500 for an individual or $2,000 for a family, regardless of income.

As soon as a family or individual reaches the limit on coinsurance, the catastrophic portion of the plan would take over.

4. Will national health insurance really solve America's health problems?

Unfortunately, no—because many of America's health problems do not have purely medical solutions. Many of these problems can be solved only when our society commits itself to eliminating the root causes, such as poor housing and sanitation, malnutrition, smoking, lack of exercise. A basic and essential step in accomplishing this objective is the dissemination of good, sound health information to the public.

Over the years, America's physicians, through the AMA, have been deeply involved in health education. The AMA has on-going programs to educate the public about drug abuse, venereal disease, proper nutrition, and exercise.

The AMA is also working hard to increase the capability of our health care system by encouraging and supporting the expansion of the allied health professions

and increasing the number of physicians. The AMA is particularly gratified that the total enrollment in U.S. Medical Schools has increased from 32,500 in 1965 to 56,000 in 1976. An equally important development is the increasing number of medical students entering the primary care areas of family practice, internal medicine, obstetrics and gynecology, and pediatrics. In 1974, alone, 58% of the graduating students entered residency training in these areas.

The AMA has also been an active and positive force in the passage of constructive health and medical care legislation for the public. It has strongly supported such federal legislation as:

- maternal and child health programs
- protection of human beings in medical research
- drug abuse education
- medical devices safety standards
- cancer research
- assistance for allied health personnel, public health personnel and nurse training

In addition, the AMA has authored and introduced legislation:

- to develop community emergency medical services programs
- to improve rural health care delivery
- to upgrade health care for American Indians

Many years ago, physicians, themselves, pioneered peer review programs, and set up safeguards to ensure that all patients receive quality medical and health care.

Even though our present system provides more and better health care to more people than in any other country, physicians are aware that the American system is not perfect. And they are as concerned as anyone about its improvement. The Comprehensive Health Care Insurance Act is only one of many AMA programs demonstrating physicians' active campaign to improve health care and its delivery in America.

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Senator KENNEDY. Our next witness is Bill Hutton, executive director, National Council of Senior Citizens, representing 3½ million elderly Americans. He joined the council in 1961 as informaton director and became its executive director in 1965; and Cyril Brickfield, executive director of American Association of retired Persons, National Retired Teachers Association, combined membership of 12 million citizens.

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS; AND CYRIL F. BRICKFIELD, EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF RETIRED PERSONS AND NATIONAL RETIRED TEACHERS ASSOCIATION

Mr. HUTTON. You have my prepared testimony before you. In the interest of time, if I could submit it for the record; I prefer to make some brief observations and then be available for questions.

I just returned to Washington today, after spending several weeks listening to and talking to elderly Americans in conferences and conventions of State groups all across this Nation.

Let me tell you frankly, Senator, that the major problem on the minds of the senior citizens has little to do with proposition 13 or similar legislation. They fear cutbacks in essential services that could result in that kind of legislation. However, older people are not panicked by Howard Jarvis, but more and more they are deeply angered by skyrocketing costs of sickness care, the continuous ripoffs of medicare and medicaid by hospitals, by nursing homes, by doctors, and other health care providers.

And these people are resentful and ashamed that the Government of this great Nation, which they gave so much of their lives to build, seems unwilling or incapable of catching up with the l de industrial nations of Europe or with our undeveloped and underpopulated neighbor Canada to the north.

In moving away from the woefully wasteful and inefficient medical practice into the modern world of fully comprehensive health care, accessible to all, with preventive care serving as the major health insurance for future Americans, that is the way it should be.

In one senior citizens' convention after another, Senator, our older people are demanding fully comprehensive health care for themselves, for their children, and for their children's children.

I sense a growing development of righteous anger and militancy. They are militant because really they expected much more progress in the 13 years which have elapsed since enactment of the medicare program.

Last week in the convention center in Fresno, Calif., delegates of some 459 senior citizens clubs affiliated with our California Congress declared that unless the Congress enacted national health insurance soon, they were determinde to really put the pressure on their lawmakers and they tell me they are going to make Howard Jarvis seem like a pussycat.

Senator KENNEDY. Pussycat?

Mr. HUTTON. That is right, just like a pussycat. They can get very angry when they are aroused. They are slow to anger, but I can tell you they can really get steaming. They are steamed up by this program. Of course I was steamed up this morning by the usual reaction of the lemmings of the AMA who rush to the sea every time we have this type of hearing.

They lost in medicare. Although they outspent us by millions—they had a budget in the medicare program of $7 million in the year that I had a budget of $100,000 for the senior citizens, and we won, Mr. Chairman. We will win on this one, too. They will go down to defeat as they always do. They seem to enjoy it. Yet, somehow or other, they come up dripping with roses, like they did with the medicare program.

It is not really a medicare program; it is a doctor care program. It has taken very good care of the doctors.

Now regarding some of the statements which they made, I must say they rather turned my stomach. In every State I visit, I learn of proud but sick older people, who, as ill as they are, refuse to go to the doctor because they are too poor to put up the money for medicare deductibles. You know, that first day has gone up from $144 and $160 now. And they know that the doctor is going to put them through an operation and call in the surgeon. They have not got that one-fifth of the doctor's fees, the 20 percent of the surgeon fees. They know it will wipe out their meager savings.

What do they do? Many of them, they suffer in silence and too often they die in silence. That is the kind of thing that is going on across this country. You have just got to go out and talk. Why doesn't AMA, why don't AMA people, instead of coming here and having somebody write glorious testimony, why don't they go out and talk to the poor people? If they ask questions they would find out. But they know the answers. They know what answer they want. They raise this specter of rationing.

It is already rationed. Medicine is rationed by $10 and $20 bills, which the poor cannot afford. That is how medicine is rationed today. It seems to me——

Senator KENNEDY. What about assignment?

Mr. HUTTON. On assignment, it is already less than it was when medicare began. When medicare first began, it was about 60 percent. It is now down to about 48 percent.

Senator KENNEDY. Describe for the record briefly what does assignment mean?

Mr. HUTTON. When a doctor accepts assignment, it means that he will accept the Government payment of what they consider is reasonable, customary, and prevailing. That means it is the average of what all the doctors in that region would normally ask for. He is above average in most cases, so he says, "I don't want to take assignments."

Sometimes he will take assignment for a big case, where the patient probably cannot afford to pay the bill at all, where the patient is just simply too poor. He will accept Government money. But if the patient has got anything in the bank at all, if it is $100, he won't accept an assignment. This happens in every State, Senator.

Senator KENNEDY. What is happening? Is it more frequent now or less frequent than it was 5 years ago?

Mr. HUTTON. It is more frequent now than it was when medicare started. Fewer and fewer doctors are taking assignment. I would like to see us put into the law that they have got to accept assignment. In fact, I would like to even offer something to them.

Senator KENNEDY. As you know, it is in our outline.

Mr. HUTTON. Yes; it is. And I am grateful for that.

Mr. Chairman, we are grateful that this hearing is being held, because we think that the real debate on national health insurance can really be started here. I believe it is out there now. I can tell you all our clubs have been informed of the framework of your bill. We are going to see every one of the 435 Congressmen who are running for office, and the one-third of the Senate, and we will reach them all before November 7, and we are going to say to them, Where do you stand on this issue? And we are going to chase them pretty hard.

We are determined to take it to all those who are running for Congress just as we did for medicare. I can say this. I have never, in the 17 years I have been in this thing now, I have never seen the older people so disappointed about the failure of the administration to move, and I have never seen them so mad, so steamed up and so ready to go. I am sure you are going to get the support to pass this bill next year.

Senator KENNEDY. Mr. Brickfield.

Mr. BRICKFIELD. Thank you, Senator.

Senator, I have a rather lengthy statement, and I have a short statement. With your permission, I will even summarize my short statement for you.

Senator KENNEDY. We will include all the statements in the record.

Mr. BRICKFIELD. I represent the American Association of Retired Persons and the National Retired Teachers Association. These two have a combined membership of 12 million members. I think we can do an effective job in helping you and the committee in enacting a national health bill. The elderly are very much concerned. First of all, they have less money to go on. They are usually on low, fixed incomes.

Second, they are sicker more frequently, and when they are sick, they are sicker for longer periods of time. This brings about a great worry, because with skyrocketing cost, they find it harder and harder to meet their medical bills. We look upon medicare as something that needs to be improved by a national health insurance program that you have sponsored. We feel that the prime beneficiaries of medicare are not the elderly. The prime beneficiaries are the doctors and the hospitals and the insurance companies.

Senator KENNEDY. Why do you say that?

Mr. BRICKFIELD. Because the doctor really is the consumer. It is not the patient. As President Meany said here this morning, all the patient does is select the doctor. That is about it.

It is the doctor who selects the hospitals. Hospitals do not compete with each other. You go to the hospital where your doctor is affiliated. At best he is affiliated with one, possibly two hospitals. Then he goes into this defensive position, he is afraid of malpractice, whatever, he starts calling for all sorts of diagnostic tests and things of that nature. He decides how long you stay in the hospital, when you get out. Not only is he the gatekeeper as to who goes in, but most assuredly

he is the tolltaker of the money paid by the people today for health care.

I like that part of your bill that provides for competition—it provides competition among the carriers, the nonprofits, the profits, and the HMO's. This is what I think destroys the myth of the AMA people today when they try to say that, in the face of this competition, we have socialized medicine.

In addition to that, I would like to recognize what you have recognized, and all people have been talking about, Senator, for years. Good health care is a basic human right. I have not heard that before this year. There are those who say this: You have got it if you can afford it I suppose, being on top of the Hill. But the great mass of the people have no good health care.

Also we like the provisions that put in a great monitoring system, where you set up these public authorities, and you have consumer interest on the authorities to make sure that the people have a voice in the decisionmaking process.

Also, too, Senator, what your bill includes, and not too many people have emphasized, is the fact that in the past too much emphasis has been placed on direct medical assistance. More has to be done in the area of alternatives to medical care. More must be done in the area of social services, in the delivery of home health services, and in these alternative services that can supplement national health. And your bill does that.

Finally, I would like to just mention Great Britain has national health, and has had it for 30 years. But I think the important thing is they did all in 1 day.

They had the old system on July 4, 1948, and a brand new 100 percent new system on July 5, 1948. For those who say it has to be incrementally brought forth, and then only if certain conditions are met; that is not necessarily so.

Finally, I would say on behalf of our 12 million members and board of directors, NRTA and AARP have just adopted a massive program to go out to some 3,500 chapters that we have across the Nation, and some 2,000 teaching units to drum up support for a national health plan, so the elderly in the long run and all Americans can have a decent health care system, regardless of their age, and regardless of their ability to pay. And I thank you.

Senator KENNEDY. Thank you very much.

Both of your organizations, as I understand, support our statement of principles for having these hearings today, is that right?

Mr. HUTTON. Absolutely.

Senator KENNEDY. The smarter minds, so to speak, have said that health care and health care discussion is virtually dead in this country. I am wondering what you are bringing back from your people and what your organizations are prepared to do to try to bring this issue to the favorable consideration which you feel that it deserves?

Mr. HUTTON. Seven of our State conventions passed resolutions.

Senator KENNEDY. I hope they are prepared to do more than pass resolutions. Are they going to do more?

Mr. HUTTON. They are going to work on their Congressmen and Senators. This stuff is much stronger than I use in many cases. They

are very, very open about what they tell their Congressmen. They say that where the causes of the current health crisis have been studied and debated ever since President Truman, over 30 years ago, it still isn't here. This is the kind of stuff they are sending to their Congressmen and Senators.

I can say this, I want to add one thing about controlling costs. Controlling cost is not going to produce national medical care to people who need it. It is going to produce limitation of reimbursement to physicians who do not need it. That is why they are so mad, Senator.

Senator KENNEDY. What do you mean by that?

Mr. HUTTON. They know if you start controlling cost, you are going to reduce $63,000 after taxes which most doctors get. And they do not like that.

Senator KENNEDY. Mr. Brickfield.

Mr. BRICKFIELD. Well, you know, just before I go back, before I answer your question, Senator, about developing means to influence the legislation, I want to say that medicare first became the law of the land, it paid 80 percent of the doctor's fees and today, it only pays 55 percent of those fees. This is so because doctors refuse assignments or their fees go beyond what medicare reimburses. This puts a tremendous burden on the middle-income people and the elderly and the poor and near poor people and something must be done.

As to how to get the troops out to support this legislation, I have a network through which I can get an alert out to 50 States, 3,500 chapters, 2,000 units within 24 hours.

What we do is that we ask our people to get to the Senators in their home States and the Congressmen in their home districts.

You know, I come up to the Hill and I sit here, and I am a paid staff member, and sometimes I wait for an hour in a Senator's office to talk to him and sometimes he tells me to tell his administrative assistant. And I do not know whether I have him here or not.

But when I get back to him in the home district, he listens.

We do not support them with money or things like that, but we support the Members of Congress with our votes if we agree with them and we think they are right.

We think they should support national health insurance as outlined in your plan, and I think we can bring great pressure to bear to bring this about at the local level so that the results can be reflected here in Washington.

Mr. HUTTON. If I could add one thing. There are 23 million people over 65 in this country. Most of them are retired and living on reduced incomes. They feel this thing very badly.

There are another 20 million over 55. They include a lot of the hidden, unemployed and they, just as the others have difficulty. That is a total of 43 million people who are either retired and having problems or are contemplating retirement and are worried about the horrors of retirement, particularly the health horrors, so that they are really concerned about this. That is 43 million people.

Senator KENNEDY. But, Mr. Hutton, you heard Dr. Sammons say those figures about people not being covered or the insurance programs are inadequate that is not so. He said their studies show to the contrary on it.

What are you telling us?

Mr. HUTTON. I am telling you that their studies are either (1) just fabrications or (2) they do not go outside the staff on North Dearborn Street where the headquarters are to get their facts.

Senator KENNEDY. You say the real situation is different?

Mr. HUTTON. It is a lot different. Any member of the public will tell you if you just go out and talk to them.

Senator KENNEDY. OK. Thank you very much.

We appreciate your coming here. Your statements will be printed in their entirety.

Mr. HUTTON. Thank you.

[The prepared statements of Mr. Hutton and Mr. Brickfield follow:]

Testimony before the Senate Committee on Human Resources
Subcommittee on Health and Scientific Research
on
The National Health Insurance Act of 1979

Statement by
William R. Hutton, Executive Director
National Council of Senior Citizens
1511 K Street, N.W.
Washington, D. C.

October 10, 1978

Senator Kennedy and Members of the Subcommittee, I am William R. Hutton, Executive Director of the National Council of Senior Citizens. Our organization is comprised of 3,800 affiliated clubs and area and state councils representing over three and one-half million older Americans across the length and breadth of this country. We have appeared before Congressional committees innumerable times since 1961 to testify on the subject of pre-eminent importance to our constitutents--health care. We are pleased to be here today to add our voice in support of the proposed framework for the universal and comprehensive National Health Insurance Act of 1979.

In the early years, led by former Congressman Aime Forand of Rhode Island, the National Council came to Congress in hopes of fulfilling one dream of America's elderly--relief from the tremendous burden of health care costs. Four years after the founding of the National Council of Senior Citizens, after countless appearances on Capitol Hill, hundreds of demonstrations and a flexing of political muscle through the election process--Senior Power--a major portion of that dream was realized through an Act of Congress. Medicare was signed into law by President

Johnson who memorialized our efforts by stating that "without the help of the National Council of Senior Citizens, there would be no Medicare."

Despite the compromises made during the debate over Medicare and despite the significant shortcomings of the Medicare program, we believed then and we continue to believe to this day that Medicare has improved the quality of life of America's older citizens. There is no dollar amount that accurately reflects the sense of security an older person gains as a result of knowing that if he or she should become ill, the money will be there to pay for it.

Unfortunately, that sense of security has been eroded over the past decade. While Medicare continues to provide some insurance to the elderly against financial loss due to health care costs, its major benefits go to health care providers: It provides open-ended assurance of payment on a cost-plus basis for hospitals and doctors.

Medicare, despite the claims of its early opponents, has not brought us socialized medicine. Nor has Medicare handcuffed the hospitals or the doctors. To the contrary, Medicare has provided a public financing mechanism where none existed before. Medicare did ease access to the health care delivery system. But it did not change that system. Needed delivery reforms were and are still absent! The inclusion of deductibles, coinsurance and copayments, and the lack of a comprehensive benefit package has diminished its value to participants. Additionally, it has reinforced the incentives

in the health care delivery system for inefficiency in the use of health resources. Medicare's lack of impact on delivery reforms and cost-effective care was and continues to be its weakest point.

Finally, what was originally intended to be a simple financing mechanism, turned into a program so complicated that the intended benefactor often was lost in a morass of rules, regulations and paper shuffling. Beneficiaries are no longer even sure what is covered. Unfortunately, they have become increasingly aware of what is not covered.

After 12 years of experience, Medicare has failed to relieve the economic ruin and tragedy which inevitably accompanies unexpected ill health.

What does Medicare pay for today? On average, only 38 per cent of the health bill. For victims of stroke and major surgery patients, for example, coverage is likely to be far below average and financial catastrophe is a likely outcome in addition to the tragedy of catastrophic illness. Medicare has become a program which sets limits on protection instead of limiting the financial burden of older people.

Through the extraordinary increase in the deductible under Part A from $40.00 in 1966 to the recently announced figure of $160; the simultaneous escalation in coinsurance amounts, and the rise in the premium under Part B from $3.00 a month to $8.20 a month in the same time period, Medicare has become a program which limits access to health care and sick care.

Through the failure of the assignment procedure for reimbursement of physicians and the lack of any hospital cost controls, Medicare has become a program which contributes to the erosion of its own adequacy. It feeds inflation in the health care sector.

A close look at the flaws in the assignment mechanism provides a good example of a mistake that must not be repeated.

Briefly, the assignment procedure was created to provide a physician reimbursement mechanism with purported cost controls. Under the assignment system, a doctor accepts Medicare's customary, reasonable and prevailing charge as payment in full (less the deductible and coinsurance).

However, doctors are not obligated to accept assignment in order to treat a Medicare patient. By refusing assignment, a doctor instead of billing Medicare, bills the Medicare patient directly. As a consequence, three serious problems arise. First, in billing the patient directly, the burden of being reimbursed by Medicare falls directly on the patient. Second, the doctor is no longer constrained to limit his charges to HEW's "reasonable" rate. Third, that portion of the bill which is in excess of the reasonable charge not only must come out of the patient's pocket, but the reason that Medicare does not reimburse the full amount of the bill is also left unexplained. Thus, patients are left in the dark as to whether they are paying unusually high physician rates or for uncovered services.

While it is implied that the physician and the patient can agree between themselves as to the method of payment, the fact is that the patient has no bargaining power in a situation where presumably the assignment method is discussed. The reality of the situation is that the physician can determine the method of reimbursement which is to be used.

Furthermore, the physician can make that decision with respect to every Medicare patient he sees and force direct billing in one case and assignment in another. He can even use the direct billing method with respect to one episode and the assignment method in another with the same patient.

Studies, such as those conducted by the Triangle Research Institute and the Robert Nathan Associates, show that, in general, doctors force the assignment method where there is a risk of collection. Consequently, it is more likely to be used in cases where the bill is large. Therefore, the assignment system far from being a cost containment apparatus is in reality a collection mechanism with the government as a collection agent.

But the problem does not end here. More and more doctors are refusing assignment altogether. Currently, less than half the physicians treating Medicare patients are accepting assignment.

The problems outlined above are not limited to the assignment procedure. The lack of universality, uniformity, comprehensiveness and the ultimate lack of effective cost control as witnessed in the assignment system are flaws which show up throughout the Medicare program.

It is this experience with Medicare--the nation's largest public health insurance operation--which we draw upon in hopes that it will make self-evident to the Congress the elements of a national health plan that will not duplicate in the future the mistakes of the past.

Senator Kennedy, as you are aware, the National Council has supported your efforts and those of the Committee for National Health Insurance for ten years. NCSC and the more than three and one-half million seniors we represent has had as its number one priority the enactment of National Health Security--reconfirmed as late as our National Convention in June 1978.

We supported National Health Security because it was unique among the many National Health Insurance proposals. It met the six major criteria by which health care proposals should be evaluated:

(1) universality of coverage;

(2) comprehensiveness and uniformity of benefits;

(3) reform of health care delivery;

(4) adherence to social insurance principles in administration and financing;

(5) effective cost and quality controls, and

(6) strong consumer representation.

We are equally supportive of the framework for National Health Security's successor--The National Health Insurance Act of 1979. The basic design appears consistent with the principles that our experience indicates are of overriding importance.

The National Health Insurance Act of 1979 adequately protects the social entitlement principle long endorsed by the National Council. Universality of coverage accompanied by a single uniform entitlement card will insure equal access and equal treatment for all at the point of service delivery regardless of the source of payment.

While the financing of the National Health Insurance Act of 1979 will be primarily off the federal budget, the basic right of all Americans to receive high quality health care is unchanged from the Health Security program.

Although Medicare will be retained in name under the National Health Insurance Act of 1979, the proposed framework does contain systematic changes in the coverage, reimbursement practices and cost and quality controls in the delivery system so that the present inadequacies in Medicare are significantly altered and improved.

Specifically, NCSC applauds the decision to discard the onerous deductibles and coinsurance provisions of Medicare. To seniors, the deductibles have presented an unnecessary burden and all too often

a barrier to adequate health care. Similarly, the coinsurance provisions of Medicare have become intolerable as the total cost of a day in a hospital or a visit to a doctor has steadily increased.

Without cost-sharing, the National Health Insurance Act of 1979 could achieve a breakthrough in guaranteeing health care as a right by assuring that appropriate levels of care will be available to all citizens. We believe the administrative efficiencies which would result from the elimination of deductibles, co-payments and coinsurance will, on balance, effect a saving to the system, both in dollar terms and in terms of more efficient use of medical resources and better health.

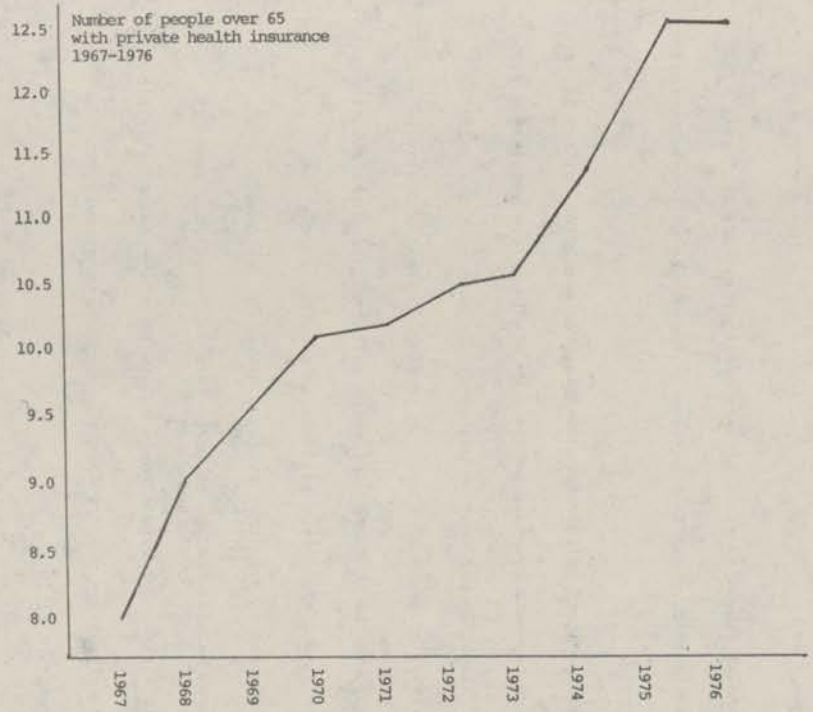
As delighted as we are to see the elimination of the cost-sharing mechanisms of Medicare, our members will be equally pleased by the long overdue reform of the current reimbursement system. The framework for the National Health Insurance Act of 1979 which prohibits providers from charging patients additional amounts above those that are negotiated in the budgetary process, obviates the need for a physician assignment procedure which has so plagued the Medicare program since its inception. In addition, prohibitions against direct billing of the patient eliminates unnecessary and costly administrative operations. At the same time, it relieves the patient from needlessly complicated paperwork and the frequent need to pay a bill prior to reimbursement.

The National Council of Senior Citizens is also happy to be able to tell its constituents that seniors will no longer feel

pressured to deal with the insurance industry in their traditional role as underwriters to the extent that they are forced to today. Private supplementary "Medigap" coverage will not be required to cover financial gaps that no longer exist.

With the steadily declining ability of Medicare to meet the increasing high cost of health care for the aged, many older people have turned to the private health insurance market for increased financial protection. In 1974, Medicare paid only 62 per cent of older people's hospital bills, and only 52 per cent of covered physicians' bills. It paid nothing for their out-of-hospital prescription drugs and medical devices, and next to nothing (3.3 per cent) for nursing home expenses. Yet even with the advent of so-called "Medigap" policies, out-of-pocket expenditures by the elderly have continued to rise.

The growing reliance of older people on private health insurance over the past ten years is graphically demonstrated in the attached table. The table indicates that the number of people over 65 years of age who purchased one or more private health insurance policies rose from slightly over eight million persons in 1967 to over twelve and one-half million persons by 1976--an increase of over fifty per cent participation. (The increase in the over 65 population was less than four per cent.) Unfortunately, the table says nothing about the rise in dollar outlays for private supplemental insurance. Our guess is that



Source: Health Insurance Institute and Health Insurance Association of America; Source Book of Health Insurance Data for the years 1967-1976

the increase in expenditures on private health insurance is likely to be even more dramatic than the increase in the number of people buying such insurance.

Today, "Medigap" policies account for over a billion dollars in private premium payments by older people. No single policy completely fills the gaps. Almost 25 per cent of policyholders have multiple policies which duplicate coverage to a greater or lesser extent. The average loss-payment ratio of the "Medigap" insurance carriers (i.e., the relationship between the number of dollars paid out in benefits to the number of dollars collected in premiums) averages around 50 per cent.

For most people, Medigap coverage is a "bad-buy," but lack of coverage is a risk most people can't afford to take--whether it's a bad buy or not! For those who are "lucky" enough to be paupers or near-paupers, Medicaid fills the gap.

Certainly, the message is clear. Liberalization of Medicare to "fill the gaps" by removing deductibles and coinsurance and by adding in-home care to avoid unnecessary and high-cost hospitalization or long-term institutionalization will be cost-effective. The money is now being spent in the private market capriciously and wastefully. A rational National Health Insurance system with built-in cost controls is a far more efficient way to "fill the gaps."

Senator Kennedy, members of the Committee, as the debate on National Health Insurance progresses, you can be sure the Council will actively press for and testify on behalf of the proposed measures.

TESTIMONY BY

CYRIL F. BRICKFIELD

EXECUTIVE DIRECTOR

OF THE

NATIONAL RETIRED TEACHERS ASSOCIATION

AND THE

AMERICAN ASSOCIATION OF RETIRED PERSONS

IN SUPPORT OF

THE NATIONAL HEALTH INSURANCE ACT OF 1979

TUESDAY, OCTOBER 10, 1978

Mr. Chairman and members of the Subcommittee on Health and Scientific Research:

My name is Cyril F. Brickfield and I am Executive Director of the National Retired Teachers Association and the American Association of retired Persons.

Our Associations, Mr. Chairman, have a combined membership of 12 million -- about one fourth of the American population over the age of 55. They are of every race, economic status, ethnic origin, occupation and political belief. Most are retired. Some are not.

Amid their diversity they share in common a minimum age of 55.

And they commonly share with the rest of the population a desparate need for quality health care at affordable prices.

Their need, however, is uncommonly intense for two simple reasons:

* Their average income is less than half of what they received during their working years. (Indeed, one-fourth of all Americans age 65 and over are classified as poor, or near-poor.); and
* They are sick more often -- and for longer periods -- than younger people.

This combination of reduced income and ill-health makes the elderly especially vulnerable to the skyrocketing costs of our present chaotic, uncontrolled, wasteful health care system.

No one designed the present system to be thus. Surely no one -- nor any group -- would purposefully design a system in which older Americans -- those most in need of quality, affordable care -- would be denied its access. And yet that is increasingly the truth of our present system.

It is time for this nation to admit that our noble intentions have been overcome by our ignoble impulses.

Medicare was a nobly-intentioned effort to meet the health care needs of the elderly. And we have supported it -- and sought to improve it -- over the years. But it has become

more a part of the problem than a partial solution.

Beyond its failure to meet the needs of the elderly -- a failure already well-documented by your committee--it has become a principal cause of the rampant inflation throughout the health care industry.

Its main beneficiaries today are not the elderly for whom it was designed, but the doctors, hospitals and insurance companies who have made the subjects of our good intentions the objects of their search for income and profits.

Instead of Medicare, it should be called "Semicare."

Or perhaps even more appropriately "Doctorcare," for the system has served no group so well as the nation's physicians. Last year alone their fees increased 50 percent more than other consumer prices. Since 1950 their fees have risen 43 percent faster per year than non-medical-care costs. The median income of physicians in 1976 was $63,000.

As presently designed, Medicare makes doctors both the gatekeepers of access to health care and the tolltakers for its expenses. They control absolutely the supply and can influence assuredly the demand.

Their allies are both the hospitals--which compete more for status through expensive, redundant equipment than for improved service---and insurance companies, which have created any array of confusing, wasteful, duplicative---profitable---

supplemental coverages.

In no way do we mean to imply that Medicare has been a total failure. But perhaps its greatest success will be the lessons learned---and applied---in creating a better system.

We are here today to commend your efforts---and those of the Committee for National Health Insurance and the growing coalition of supporters---to create a new, workable design for a comprehensive national health care system. And we are here to lend our wholehearted support to that effort.

Clearly piecemeal approaches have not worked. And as every other major country of the world has learned, they will not work. Required is a comprehensive national health insurance program, and we believe, Senator Kennedy, that your detailed proposal for the National Health Act of 1979 provides the basic foundation for building such a program.

We followed with great interest your attempts to develop a partnership with the Carter Administration in pursuit of this goal. And we fully agree with you that the implementation guidelines recently announced are unacceptable.

This new health care system is too vital to admit of "trigger mechanisms" that would abort its progress for economic reasons unrelated to the system itself.

If "triggers" be needed, let them be attached to other, less-vital programs that might stand in the way of meeting this need.

We are particularly pleased that your proposal includes five fundamental elements which we consider essential to any national health insurance program.

First, because your proposal defines health care as a basic human right and provides universal coverage and comprehensive benefits, it fulfills the requirements of a truly national health insurance program.

Second, your proposal wisely provides choices among competing modes of delivery within the overall system, with minimum standards. We heartily endorse the provisions which:

* Support the development of Health Maintenance Organizations, neighborhood health centers, community mental health centers and other methods of health care delivery;
* Promote competition among commercial insurance carriers, Blue Cross/Blue Shield, and the HMO's on the basis of supplemental services; and
* Provide incentives for efficiency and savings in administrative expenses by rewarding those providers with lower costs and penalizing those with higher costs.

I think it is important, Mr. Chairman, to emphasize these provisions to anyone who might be fooled by those spreading the lie that the National Health Insurance Act of 1979 is so-called "socialized medicine."

Through its encouragement of competition among providers of health care, your proposal is far more uniquely American and far more consistent with free enterprise than our present system of "monopolized medicine" -- a system in which service suppliers are largely unrestrained by the traditional American marketplace characteristics of price competition, quality comparisons, truth in labeling, full disclosure, and informed consumer choice.

Third, your proposal will contain costs not only by limits on national, regional and state budgets and by negotiated payment schedules, but also by means of constraints upon the providers of such service through utilization and quality reviews. Flagrant escalation of health care costs in recent years has not been the fault of patients or of their increased demand for services. The government and the providers bear the blame for our fiscal crisis in medicine. We stress this point before those who argue that cost containment should be excluded from national health insurance and those who would have us believe that copayments, deductibles and other financial disincentives to patient utilization should be included in national health

insurance.

Fourth, the program recognizes the necessity for assuring public accountability by requiring a predominance of consumers on the proposed Public Authority, all State Authorities, and the National Health Insurance Advisory Council.

This provision would not create another distant unaccountable "bureaucracy," as some opponents will claim. To the contrary, it is a bold, innovative step toward putting responsibility back in the hands of the people.

This provision for participatory democractic administration of national health insurance may well prove to be the single most important element in its ultimate success. In fact, it may portend an exciting new era of citizen management of and responsibility for public programs.

Fifth, the proposal seeks to enhance the quality of care and ethical practice. Besides the lack of cost restraints, the absence of effective quality controls is the most conspicuous failing of our current health care system.

To correct this deficiency, we urge the dissemination of objective, scientific information to health professionals; the review of medical and prescribing practices by outside professionals and laymen; continuing education requirements for all health professionals; and an array of licensing reforms. Rational medical practice is not only essential to patient protection,

it is also a prime factor in keeping down costs.

Finally, Mr. Chairman, in recognition of the increasing aging population and its special concerns, we urge you to consider these recommendations:

Older Americans need a medical system with health professionals trained to deal with the clinical, preventive, remedial and social aspects of health and disease affecting the elderly.

They need a reduction in institutionalization accompanied by increased resources of congregate housing, homemaker and home health services, non-institutional licensed practitioners, and neighborhood-based ambulatory geriatric clinics. They also need prescription drugs, mental health care, eyeglasses, hearing aids, dental treatment and dentures, podiatry, and ambulance and other transportation service.

To those who would dismiss these objectives as excessive or impossible, we point out that Great Britain's much misunderstood and misrepresented National Health Service provides all of these services. It does so for an elderly population which is 50 per cent larger in proportion to its entire population than our own. And it does so as part of a total health care cost which in 1976 was only 5.8 per cent of its Gross National Product, compared to U.S. health expenditures of 8.6 per cent

of our GNP.

Senator Kennedy, your proposal applies lessons learned and preserves what is good in American health care while correcting its deficiencies and insufficiencies.

Still there are many in our country who question whether we need or can afford national health insurance.

We believe our nation can no longer afford not to enact national health insurance.

And we fully expect that when this goal is firmly achieved, it will assume an historical significance comparable to that of the Social Security program in enhancing the quality of American life.

Already our Associations' Boards of Directors have approved plans for massive educational, grass-roots advocacy efforts in pursuit of this goal.

We value your leadership in this effort, and that of your committee. And we look forward to working with you in the coming months to help you and our country make universal and comprehensive health care a reality.

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Senator KENNEDY. Our next witness is William E. Ryan, senior executive vice president of the Blue Cross and Blue Shield Associations of Chicago.

STATEMENT OF WILLIAM E. RYAN, SENIOR EXECUTIVE VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATIONS

Mr. RYAN. Good morning, Mr. Chairman.

I am William E. Ryan, senior executive vice president of the Blue Cross and Blue Shield Associations. On behalf of the associations, I wish to thank the subcommittee for the opportunity to comment on the outline of the proposed National Health Insurance Act of 1979.

Senator, our perspective on this proposal is that of an organization which provides privately underwritten health-care coverage for more than 83 million Americans, and which serves another 26 million under Government programs. Our experience gives us an understanding of the needs of our subscribers and an appreciation of the complex nature of health-care financing.

We have had only a few days to study the outline. I'm sure it was not your intention in the document to articulate the detailed mechanism by which the goals of the proposed legislation would be achieved. Accordingly, my comments represent an initial reaction to the broad principles we perceived represented in the proposal. Many of those principles are principles we have espoused in previous testimony. Blue Cross and Blue Shield are committed to translating into public policy such common principles as improving access to care, building on the experience of existing private sector carriers and other institutions, and using a proper mix of private and Government financing.

Certainly, the stated goals of your proposal are laudable. I believe, however, that they can be achieved only if the costs are not excessive, there is sufficient thought given to future implications and there is a broad public and private commitment.

At the risk of stating the obvious, it won't be easy. There are difficulties. We've encountered them in working toward the same goals over the years. I think we can be of help in locating and bypassing many of those problems.

As I comment on some of the major features of the proposal, I will raise some questions that must be answered ultimately if this proposal is to result in action which meets its own stated goals.

Broadly, those questions center on the control of costs, incentives for innovation, financing, and preservation of the best features of competition within the private sector.

The proposed program calls for universal coverage and comprehensive benefits. We support these principles so long as there remains room for carriers to devise distinctive and competitive programs which offer consumers freedom to exercise choice.

The program recognizes the need for cost control and a budgetary process. Cost containment is an important objective. The issue is how to achieve it. When no other alternatives were available, we favored some form of mandated controls to limit increased cost and bed additions, but our experience so far with the voluntary effort indicates that it deserves full support. We are dedicated to the promise of the voluntary effort and we want to give it every opportunity to succeed,

especially since caps are often measures which historically have been inflationary.

Prospective budgeting and rate setting are main features of the proposed program. We favor negotiated rates established between individual carriers and providers where possible. Regulated rates on a countrywide basis could stifle initiative, sanctify the present system, and over time be more rather than less costly.

The area of "setting" hospital budgets and physician fee schedules raises obvious questions. How do the public authority, insurers, HMO's, hospitals and doctors get together on this? How do we create such a mechanism without infusing it with adversary relationships which would prove counterproductive in the end? Does the proposal equate physician "revenues" with physician "fees" and thus perhaps inject disincentives for increased physician productivity?

We have questions about the role of the public authority and the State authority. The health-care system today is changing, and for the better. We're seeing innovation in delivery systems; a shift from expensive care in inpatient facilities to less expensive ambulatory programs, and a new emphasis on prevention rather than cure. We want to see more similar changes. Tighter Federal regulation inappropriately placed may discharge that kind of innovation. In principle, we see the role of the Federal Government as one of setting goals, establishing guidelines, and enforcing certain standards. We see implementation as the role of the States, following Federal guidelines.

Senator KENNEDY. That certainly is our goal. It is interesting to me that you can read the same words and come up with exactly what we are trying to do and others read those words and come up with such a different interpretation.

Mr. RYAN. I think we felt it was more of an intervention through Federal mechanism than what we previously recommended. Over a period of time there have been guidelines. If the State doesn't follow them, then it becomes an obligation somewhere else.

With respect to State regulation, we question any move that would further narrow the legitimate elements of competition. Experience has shown that any regulation that unduly restricts individual consumer choice and stifles innovation is counterproductive.

We support the endorsement in the proposal for HMO's. Blue Cross and Blue Shield plans have sponsored more alternative delivery systems than anyone else and, obviously, we believe they are valuable. While they are not a panacea, enchancing all available alternatives will prevent an arbitrary narrowing of the system.

Many of our traditional delivery systems work well and shouldn't be discouraged, and a variety of new ones in addition to HMO's should be supported. However, it is not clear how HMO's and other alternate delivery systems are to operate and be regulated vis-a-vis the two consortia envisioned in the proposal.

We also see the need for caution in this area so as not to discourage or preclude the development of new delivery or financing systems. Let's not rule out the possibility that a better way exists. There should be room within the framework of this or any future national program to give someone the opportunity and incentive to create a better alternative.

We are pleased to see this proposal suggest private financing for those who can afford it. Special attention will have to be paid to the temporarily unemployed and those for one reason or another on marginal incomes.

I am not commenting at length about the specific concept of an earnings-based premium because it is a new one and I don't fully understand all of its implications. It appears to be administratively complex. We see some potential loopholes. On the surface, for example, there appears to be an incentive for some employers to lay off certain employees and subcontract the services provided by those employees. But, again I am going to say, we don't fully understand the device. An analysis of the short- and long-term social and economic effects of this aspect of the program would be needed.

How accounts are rated needs to be explained. Because an employer's premium rate is apparently unaffected by his group experience under your proposal, he may very well have little incentive to initiate health education, fitness or other positive health programs in the workplace. Lately, we've seen a great deal of interest by some of the largest corporations in the country in such programs. We wonder if they will continue if the employer has less incentive to help keep his employees healthy?

My final area of brief comment is competition, and the impact of it on certain forms of regulation I perceived intended in this proposal. There appears to be an emphasis on competition within the area of retention of premium dollars for administrative costs and reserves. I would like to point out that limiting such retentions beyond a certain point, whether by regulation or through the demands of competition, will limit the ability of the carrier to undertake such programs as cost containment, innovative delivery mechanisms, or programs to improve the quality of care.

Additionally, focusing too tightly on administrative costs ignore the fact that they account for only about 10 percent of the premium dollar, and that the greatest potential for savings lies in the other 90-plus percent.

I believe a good deal of additional thought should be given to the concept of equalization. If I understand the proposal correctly, there would be a provision for a transfer of funds among consortia to counterbalance losses. If this is true, then there is certainly a severe disincentive for each of the consortia to operate in a competitive and efficient manner.

An additional question with respect to competition is what to do with self-insurance arrangements. They don't seem to fit into the regulatory pattern outlined, yet they are an element in health care financing today. One of the principles in the proposal is the absence of risk selection, but as currently outlined there appears to be a major incentive for all "good risk" groups to self-insure. To implement that principle, self-insurance programs must be subject to the same provisions that govern commercial insurers and Blue Cross and Blue Shield plans.

How the various elements of the program are implemented is of paramount importance. In recent years, it has been demonstrated that major changes cannot be implemented successfully without undue in-

flationary impact. The adjustment of supply and demand should be staged with overall objectives clearly in mind. In this context, our first priority should be the low-income groups, some of whom lack adequate protection and access to care.

Blue Cross and Blue Shield plans have more experience than any other organization, public or private, in the financing of health care in this country. We share a good many of your principles and goals. To the extent that they correspond with our own, we'd like to help realize them. We do have questions, however, and we'd like to share them with you in greater detail.

Thank you again for the opportunity to comment on this outlined legislation. I'll be happy to address any questions you might have.

Senator KENNEDY. Thank you very much. I think this is a very constructive comment and it raises a number of issues on which we are going to need a good deal of assistance.

On the top of page 3, you talk about creating such a mechanism without infusing it with adversary relationships which would prove counterproductive in the end.

There are a number of different items that are going to take a good deal of thought and attention and your organization has a breadth of experience on these, so we look forward to getting your opinion.

Your comment has been very constructive.

Let me ask why is it in the Blue Cross interests to get a handle on the costs?

Mr. RYAN. Mr. Kennedy, we operate in a very competitive field. Over a period of 45 years, we have tried to represent our subscribers by having them gain access to health care. We were purchasing medical care for those subscribers at the best rate possible and still giving those subscribers and the American public access to health care by taking away the financial obstacles.

We are as concerned as anybody else in this country by the increased costs and the escalation of costs because it raises questions and problems in the minds of our subscribers.

We feel that on their behalf as well as in consideration of our own competitive situation we must work hard as far as cost containment. We probably innovated 15 or 20 various programs both in the hospital environment and with the physicians in this country so that we could have such an impact. We have been criticized. People say what about the track record with costs going up the way they are? Have you been successful?

As a matter of fact, we have. We can demonstrate it both institutionally and professionally.

Senator KENNEDY. What is the increase cost in your premiums?

Mr. RYAN. Well, Senator, when we talk about our premiums, we are talking about individually experience-rated groups. On the average, I am presuming that the last 4 or 5 years has been——

Senator KENNEDY. That is enormously important, you understand.

Mr. RYAN. Surely. Obviously our rates reflect two things: They reflect the cost of the care, either institutional or professional. If I could, I would almost put the emphasis on the side of utilization of care, both institutional and professional. We have seen over the last 10 years the increases that you and Government employees have experienced in the Federal employee program.

A great deal of that is as a result of general inflation, but also costs have risen as a result of increased use and increased demand. I think we have to address the whole idea of supply and demand.

If you place a whole new comprehensive program into effect immediately, we are going to have the same result we had at the inception of medicare and the same result we got when we expanded medicare to nursing homes. You have this flood of demand which outstrips the supply and then you find yourself with the question of increased costs and utilization. These are the things that Blue Cross-Blue Shield are concerned with.

Senator KENNEDY. Thank you very much.

Mr. RYAN. Thank you, sir.

Senator KENNEDY. Our last panel consists of William P. Thompson, stated clerk, General Assembly, United Presbyterian Church in the United States of America, and president of the National Council of Churches of Christ; Rabbi Richard S. Sternberger, director, Mid-Atlantic Council, Union of American Hebrew Congregations; and the Reverend Monsignor Francis J. Lally, secretary, Department of Social Development and World Peace, United States Catholic Conference.

Before we get started, there is a vote, and I will just go over and vote quickly and come back.

We will recess for about 5 minutes and then resume.

[A brief recess was taken.]

Senator KENNEDY. Come to order.

William P. Thompson.

STATEMENTS OF WILLIAM P. THOMPSON, STATED CLERK, GENERAL ASSEMBLY, UNITED PRESBYTERIAN CHURCH IN THE UNITED STATES OF AMERICA, PRESIDENT OF NATIONAL COUNCIL OF CHURCHES OF CHRIST; AND RABBI RICHARD S. STERNBERGER, DIRECTOR, MID-ATLANTIC COUNCIL, UNION OF AMERICAN HEBREW CONGREGATIONS; AND REV. MSGR. FRANCIS J. LALLY, SECRETARY, DEPARTMENT OF SOCIAL DEVELOPMENT AND WORLD PEACE, UNITED STATES CATHOLIC CONFERENCE

Mr. THOMPSON. Mr. Chairman, as you have indicated, my name is William P. Thompson. I am stated clerk of the General Assembly of the United Presbyterian Church in the United States of America, and I currently serve as president of the National Council of Churches of Christ in the United States of America.

I am joined this morning by Rabbi Richard S. Sternberger, director of the Mid-Atlantic Council of the Union of American Hebrew Congregations.

In presenting testimony to the subcommittee today each of us speaks for the policies of his own governing body and in my case, that is the General Assembly of the United Presbyterian Church in the United States of America.

In 1971, the general assembly of my church adopted a policy statement entitled, "Toward a National Public Policy for the Organization and Delivery of Health Services."

A subsequent general assembly received a policy statement which was adopted by the appropriate administrative body responsible for such services entitled, "Health Ministries and the Church."

Also in preparing this testimony, we have been guided by a policy statement of the Inter-Religious Coalition on Health Care which includes representatives of Catholic, Jewish, and Protestant organizations. That statement is entitled, "The Need For a New Health Care Policy in the United States."

I ask that these three documents be made a part of the record.

Senator KENNEDY. They will be made a part of the record.

[The material referred to follows:]

THE NEED FOR A NEW HEALTH CARE POLICY IN THE UNITED STATES

A Statement of the
Interreligious Task Force on Health Care

Representatives of:
Jewish
Roman Catholic
and Protestant
organizations

September, 1972

FOREWORD

In June 1971 a group of staff people responsible for services and social action in the area of health and welfare from several religious groups was convened by the National Council of Churches to discuss mutual concerns about health care in the United States.

At that time each organization was at some stage in the process of developing or implementing a policy statement on health care in the United States. Religious organizations are concerned about the wholeness of persons as children of God and therefore about their physical and mental health. For this reason the emergence of health care as an urgent national concern confronted religious groups with an imperative to care and to act.

Without losing sight of the crucial importance of human problems affecting health—such as pollution, hunger, poverty, and war, and of ethical issues arising out of new biomedical technology—this statement will be directed to the provision of personal health care. This choice is made because of the imminence of federal legislation dealing with this subject.

Our regular meeting served to keep us informed about the content and process of policy development in our respective organizations and steps being taken to implement policies.

In order to test the extent of agreement among us, Edward Krill of the U.S. Catholic Conference very generously agreed to formulate a composite statement based on positions already adopted by our organizations. While we expected general agreement on the nature and extent of the problem, we were encouraged to find that there was also substantial agreement on the goals toward which efforts at solution should be directed.

It seemed feasible, therefore, to attempt to prepare a document which would represent the best judgment of members of the Task Force. While this document draws heavily on policy statements of several organizations, it does not speak for our respective organizations. Rather, its purpose is to speak *to* members of our organizations, particularly to those who influence decision-making in churches, synagogues, health and welfare agencies, and in communities. Members of the Task Force are committed generally to the point of view expressed here and we believe that it is consistent with policies of religious organizations which have adopted policy positions on health care.

A RELIGIOUS PERSPECTIVE

Our vision, illuminated by the Judeo-Christian understanding of history, sees that God's holy purpose is for mankind to be of worth and to be well, to be healthy and to nurture health for one another. The vision of faith sees the present reality in the light of what might be. Pain that is unavoidable can be accepted but ill-health that we have the knowledge and resources to avoid is intolerable. We acknowledge a commitment under God, to exercise public compassion and justice for all people of our land and to increase the well-being of all.

The pivotal issue, underlying discussions of all proposals for national health programs, deals with an emerging social philosophy regarding health care. This philosophy affirms that the availability of good health care is a right, to be enjoyed by all citizens—rather than a privilege to be limited by considerations of race, religion, political belief, or economic or social conditions. Therefore, our goal is that each person receive sufficient health care of good quality as a right and as a recognition of the dignity of man.

In an affluent society the provision of adequate health care is feasible. Therefore, unimpeded access to it should be a legal right of all citizens, a corollary to the right to life itself. The responsibility for fulfilling this right rests with both the individual and society.

We recognize that we are each involved in self-health care, in mutual health care in our primary social groups and in supporting health care services at home and abroad. What happens to our neighbors' health happens to us. An epidemic knows no political or economic or social boundaries. Residents of Keokuk or Chicago suffer ravages of Hong Kong flu just as residents of Asian cities and hamlets.

The development and preservation of good health requires a national commitment with well defined purposes and explicit goals. We believe that health care in the United States, though now substantially an endeavor of private and independent sectors, cannot be left to private resources and private initiatives alone. We believe the general public has direct responsibilities for designing and developing a comprehensive, publicly-oriented national health policy, which will make real the rights of individuals and the responsibilities of society.

The development of a comprehensive, morally defensible health care policy in the United States is not solely the responsibility of health care providers, whose knowledge and skill and art make superior health care possible for many. Our whole society gives priority to the production and consumption of goods, to profit-making and the defense of wealth, neglecting basic human needs. Therefore, all members of this society share responsibility for determining what objectives and priorities should be in health care.

Health Care Crisis

President Nixon, in July of 1969, said, "We face a massive crisis in this area (of health care) and unless action is taken, both administratively and legislatively, to meet that crisis . . . we will have a breakdown in our medical care system which could have consequences affecting millions of people throughout this country."

In 1971 the report of the Citizens Board of Inquiry into Health Services for Americans stated (inter alia):

"Americans are angry and frustrated about health services. . . . The anger is intense. It springs from frustration with efforts to obtain health services from doctors, hospitals, health departments and a host of programs and agencies that are involved with the delivery of health care. Anger also comes from exasperation that conspicuous deficiencies are met by a succession of studies and, at best, ineffectual efforts at reform. Let there be no mistake. The anger is well-founded. The deficiencies are real."[1]

Dr. Herman E. Hilleboe, in the 11th Bronfman Lecture to the American Public Health Association attributes to the late Walter Reuther speaking in 1968 the following: ". . . thirty million Americans live in poverty even though we have a Gross National Product of one thousand billion dollars. Let's face it; the poor are shut out of affluent society. Few other aspects of American life than health display a greater gap between promise and performance—reason enough for a high priority for health. The American consumers are subsidizing a non-system that fails to deal with basic health needs at a cost of two-and-one-half times the general price level. No amount of mental or moral gymnastics or clever Madison Avenue public relations can hide the ugly facts about the failure of our health system."[2]

Although the United States spends a larger percentage of its Gross National Product and more money per person on health care than any other nation, we are slipping in our ranking among the nations on key health indexes. Since 1950 we have gone from first to seventh in maternal mortality, from seventh to fourteenth in infant mortality, and presently rank eighteenth in male life expectancy. In 1970 white infant mortality declined, while non-white infant mortality, nearly twice that of whites, rose significantly. Non-white mothers die four to five times as often in childbirth. A poor person is four times as likely to die by age 35. Clearly, Americans are not getting the health care they have a right to expect.

Specific Problems

1. *Shortages, misuse, and maldistribution of personnel and facilities*

There is inequitable distribution of health care resources, severe short-

ages of some kinds of health care personnel, and lack of medical facilities in many communities. Important sectors of the community are not able to obtain adequate health services; these groups include the poor, people in rural areas, and in recent years they increasingly include middle-income families. There are severe manpower shortages in the health service fields: primary care physicians, nurses, technicians and supportive services. The number of physicians providing *primary patient care* has decreased from 103 per 100,000 population in 1950 to 90 in 1971, although there is an increase in the number of physicians in all forms of service and the total number per 100,000. Moreover, health professionals are not equitably distributed geographically. In California there is a practicing physician for every 625 persons, twice as many as in seven other states. There are over 100 counties in the United States with no physician. Urban ghettos have lost most access to personal physician care.

Inadequacies in health care are not entirely due to a shortage of facilities and professional personnel. There is inefficient utilization of personnel and facilities that do exist.

2. *Costs and financing*

a) Spiraling costs have placed adequate medical care beyond the grasp not only of 45 million persons below or near the poverty line but also of many middle-income families. The cost of health care has been rising much more rapidly than other items in the consumer price index. In terms of 1967 dollars, for example, food that cost $74.50 in 1950 cost $119.20 in 1971. The total bill for personal health care for Americans (combining private and public payments) rose from $12.1 billion in 1950 to $26.4 billion in 1960 to $75 billion in 1971.[3]

One factor in inflating costs is lack of coordination and planning in acquisition of expensive equipment. One study[4] showed that almost one-third of those hospitals with expensive open-heart surgery facilities had not used them in a year. Unless there are adequate mechanisms to control the factors producing higher costs, larger and larger segments of our population will not be able to afford medical care.

b) Financing—There is no comprehensive system for financing health care in the United States, one which equitably distributes costs. There are many governmental and private systems, each reaching a segment of the population with varying degrees of effectiveness. During the decade of the 1960's approximately one-third of consumer health expenditures were met by health insurance.[5] One program, Medicaid, designed to provide care to the medically indigent failed to do so to a substantial extent. An HEW Task Force on Medicaid and Related Programs in 1970 reported: "only about one-third of the 30 to 40 million indigent and medically indigent who could potentially be covered (by Medicaid) will in fact receive services . . .", "the cost of covering less than one third has exceeded earlier estimates of the cost of covering the whole medically deprived population."[6]

Especially vulnerable in the under age 65 population are 13% not covered by hospitalization insurance, 20% without surgical insurance, and 57% who have no insurance to cover visits to doctor's offices or home calls by physicians. Insurance policies are designed with the company's rather than the consumer's interest in mind.[7] In 1969, 17 cents out of every dollar paid to an insurance company in health insurance premiums were retained for operating expenses, additions to reserves and profits. The comparable figure for Blue Cross-Blue Shield plans was 4 cents.[8] The cost of administration of public programs from fiscal 1968-1971 was 2.6% of total expenditures.[9]

Policy-holders in private insurance companies, including Blue Cross and Blue Shield, are unprotected or under-protected when they most need help: when they face extraordinary medical expenses or when they seek preventive care to avoid future expenses. This distorts priorities of care and interferes with effective functioning of the health care system.

3. *Inadequacies in the delivery system*

Health services are fragmented, with wide gaps in service, failing to provide continuity of care. This is particularly true when the patient may require attention by his family physician, one or more specialists including surgeons, convalescent care, and post-hospital follow-up care. Even a person with substantial resources now has trouble making effective use of a fragmented system. A low-income person finds it well-nigh impossible.

The current emphasis in medical care is on treatment of crisis illnesses, with relatively limited attention to "health maintenance" which would include prevention, early detection, and treatment during the initial phase of the illness.

Many factors contribute to denials of health care: inability to pay, distance from resources, discrimination based on race or ethnicity, place of residence, and ignorance regarding rights. Treatment of disease for a fee has all too often preoccupied providers to the neglect of health promotion and prevention of illness.

4. *Lack of controls for assuring quality care*

There are substantial variations in the quality of medical care. One is impelled to conclude that existing mechanisms are inadequate to assure quality control at reasonable cost, particularly for health services given outside a medical institution. Hospitals have medical reviews by peer groups, supervision by chiefs of staff, or other internal controls. The effectiveness of these controls varies widely and in many cases is seriously deficient.

For patients outside a hospital, controls tend to be limited to consultation or malpractice suits. There is no unified control system, but rather an agglomeration of relatively independent, self-regulating and diverse enterprisers and enterprises. The accreditation of hospitals, for example, is carried out by the Joint Commission on Accreditation of Hospitals, which is mainly supported by and controlled by The American College

of Physicians, American College of Surgeons, the American Hospital Association, and the American Medical Association. All four are organizations of providers. The Joint Commission itself has no effective voice of consumers in its policy-making and standard-setting decisions. Blue Cross Associations, which are supported by its subscribers, are governed by Boards of Directors consisting mostly of health service providers or their representatives.

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These problems are individually identifiable but interrelated. They reflect the fact that there is no national health policy that provides for the development, organization and delivery of comprehensive health care. In the absence of such a policy, unified goals and coordinated plans for meeting the nation's health needs do not exist. What is needed first is a national policy, which is based on the interrelatedness of relevant factors and which in turn furnishes the basis for a comprehensive health-care plan.

The following principles and recommendations are presented in an attempt to indicate some bases for such a plan.

FOOTNOTES

1. "Heal Yourself" Report of the Citizens Board of Inquiry Into Health Services for Americans, Frontispiece (University of North Carolina).
2. Hilleboe. H. E., M.D. "Preventing Future Shock", American Journal of Public Health, Feb., 1972, pg. 140.
3. Social Security Bulletin, U.S. Department of Health, Education and Welfare, Sept., 1971, pg. 52.
4. H.E.W. White Paper: "Towards a Comprehensive Health Policy for the '70s" (May, 1971).
5. "Why Health Security," Committee of National Health Insurance, July 7, 1970, pg. 19.
6. U.S. Department of Health, Education and Welfare, Office of the Secretary, Report of the Task Force on Medicaid and Related Programs, June, 1970, pg. 2.
7. "Heal Yourself" op. cit., pg. 24.
8. Social Security Bulletin, H.E.W., Feb., 1971, pg. 17.
9. Social Security Bulletin, H.E.W., Jan., 1972, pg. 9-11.

PRINCIPLES AND IMPLEMENTING RECOMMENDATIONS

I. The World Health Organization has stated:

> Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being

without distinction of race, religion, political belief, or economic and social conditions.

Programs in the United States for financing and delivering health care should meet this standard.

II. Since health care systems vitally affect everybody, rich and poor, they must be accountable therefore to the general public at all levels of policy formulation and administration. Consumers (i.e. non-providers) of health care must have a primary role in defining goals and establishing guiding policies of the system.

1. Local communities should be empowered, under a national health policy, to define goals and to obtain services they need. Responsibility should be vested in a community health care policy-making body which will be composed in such a way that the dominant voice in decision-making shall be that of consumer representatives. These representatives should be accountable to organizations of people who do not derive any part of their income from provision of health care or the health industry.
2. Professional judgments and responsibility of physicians for diagnosis and treatment of individual patients should be assured.
3. Patients' right of choice among alternative providers and treatment plans should be protected.
4. There should be systematic efforts to develop an informed public that has increasing competence to make wise decisions and to create systems conducive to personal and corporate health.
5. The national health care system should provide for flexibility and pluralism in policy-making organizations to allow for regional differences and local self-determination of health priorities, for changing consumer demands and provider services.

III. The Health Care System should be comprehensive with respect to services and facilities provided and to participation of all relevant groups in planning and administration.

1. The following personal health services are essential and should be made available to all people in the United States:

   a) ready access to primary health care and ready referral for preventive and curative services, without exclusion.
   b) Emergency care.
   c) Hospital inpatient and outpatient services, clinic service for diagnosis and acute short-term care for both physical and mental illness.
   d) Long-term hospitalization or other extended care in facilities which provide nursing, therapeutic and rehabilitative services for both physical and mental illness.
   e) Dental care.
   f) Prescribed drugs.

g) Home health services, outreach and intake service, including transportation, nutrition consultation, personal and family health education, medical social services, physical therapy.
h) Family planning services. (It is to be understood that such services should protect the voluntariness of parents and that abortion is not considered a method of birth control. Moreover, the rights of health care personnel to refuse cooperation in family planning efforts should be respected.)

2. There should be comprehensive, coordinated planning and administration of health care, with publicly disciplined participation of practitioners and support personnel (such as health technicians, paraprofessionals, volunteers, etc.) to provide for maximum appropriate utilization of neighborhood ambulatory care units, general hospitals, medical research and teaching centers, and other specialized formal and folk resources, and to achieve functional cohesion.
3. Provision should be made for continuity in keeping and using medical and social records.
4. There should be appropriate community action to stimulate and develop competence for self-care and mutual primary group care.
5. New incentives should be developed to increase the availability and integration of health practitioners with diversified competence and for local comprehensive community care programs.
6. Physical and mental health programs should be integrated.
7. Provision should be made for regional health structures providing and appropriately relating essential research, training, specialized services, primary ambulatory care, hospitalization, preventive and health promotion programs.
8. Isolated persons and small communities should be provided all needed regular services through local health care units with transportation furnished to enable persons to have services of specialists and specialized facilities when they are needed. Such communities should have effective voice in deciding how the full range of services should be made available to them.
9. The quality of services should be controlled through organized and objectively administered consumer and professional medical evaluations. These mechanisms should include an effective form of peer group review, with adequate input from consumers and other non-professionals.

IV. Funds to support the health care system should be secured through means that are fair and equitable. Social insurance principles which spread the risk among a large population should be operative. Funding devices which discourage good personal health practices essential to health maintenance and preventive care should be avoided.

1. A National Health Fund should be established and maintained at

the optimum level by taxes levied according to ability to pay.

2. Direct payment to providers for health services at the time care is given should not be required of the individual patient or his family, except as there is ability and desire to secure services beyond the comprehensive quality care available to all people covered by the National Health Fund. If it is deemed necessary to provide for deductibles (i.e. payment by patient of a stated sum toward each service utilization) in the years of transition to a national health insurance system, the amount should be reasonable and consistent with ability to pay.

V. The health care delivery system should be designed to implement the principle that health care is a right to which every person is entitled.

1. There should be state, regional, or community health authorities, each serving a population large enough to require all the facilities and personnel for comprehensive health care, but small enough to enable communities through individuals and representative groups to design and control their delivery system.
2. Each state or regional health agency must arrange for the provision of essential personal health care to all people in its jurisdiction, using whatever agencies for service delivery and methods of payment will most effectively meet these needs. Federal guidelines shall provide incentives to support programs of prevention and early diagnosis and to assure essential services to isolated individuals and small communities.
3. The national health authority shall require that mechanisms and procedures shall be established in each state or region to assure that both quality of care shall be maintained and the circumstances of delivery shall be acceptable to the people served.
4. In selection of staff and in provision of services all forms of discrimination shall be eliminated: of race, creed, ethnic background, sex and age. Staff able to speak the language of consumers of the service should be provided.

VI. All necessary components for the provision of health care shall be planned for and adequately supported.

1. *Manpower.* There shall be effective utilization of all types of health manpower: professional, paraprofessional and non-professional. In areas where some types are in short supply, provision should be made for professional education, technical training of additional persons, or relocation of an existing surplus from elsewhere by providing appropriate incentives and career opportunities. This will involve:

   a) Making an inventory of existing health manpower as to number, types of competences, and location;
   b) Identifying shortages and surpluses, maldistribution and inefficient use of manpower;

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c) Improving and making better use of educational resources already available and, when necessary, creating new educational programs to fill shortages in health personnel;
d) Eliminating shortages caused by limited access to professional education;
e) Utilizing health personnel from other countries with due concern for the health needs of the countries from which they come.

2. *Research.* A certain proportion of the National Health Fund should be earmarked for research into causes and cures for diseases threatening the health of Americans and for studies to explore more effective methods of delivering health care. The national health agency should contract with national, state, or local agencies or institutions for stipulated research projects, according to a national plan based on information from all regions of the country, from all professional health disciplines, and from consumers representing all economic and ethnic groups.
3. *Facilities.* The development of facilities for provision of health services should reflect community-determined needs for services. This will call for health planning agencies (cf. II above) at local, regional, and national levels which are given responsibility and authority to do the following:

a) review service programs of all health providers in their areas;
b) determine needs for service independently of existing service patterns;
c) make public the information about differences between needs and services;
d) formulate a plan for facilities and services which will functionally correlate facilities, services, and needs.

Role for Churches and Synagogues

Members of the Task Force believe that churches and synagogues, specifically because they are religious organizations, have a responsibility to participate in the great national debate on changes in the health care delivery system. Human rights and the dignity of persons are ill-served by much of the present health establishment. This is a violation of moral principles and calls for thoughtful and determined action on the part of organizations.

Our Judeo-Christian faiths are founded on convictions about man as well as convictions about God. These convictions must be made relevant by working for a program of legislation which will make possible the physical and mental health of the people of the United States, and by working with others in achieving the same goal for all people.

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THE NEED FOR A NEW HEALTH CARE POLICY

A Suggested Bibliography

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HEALTH POLICY

A Statement of the 183rd General Assembly (1971) of the United Presbyterian Church

TOWARD A NATIONAL PUBLIC POLICY FOR THE ORGANIZATION AND DELIVERY OF HEALTH SERVICES

Introduction

"I have come that men may have life, and may have it in all its fullness."
John 10:10 (NEB).

A. **Our vision,** illuminated by the Judaeo-Christian understanding of history, sees that God's holy purpose is for mankind to be of worth and be well, and to be in health and nurturing health for one another, in institutions and with the whole world. In faith our vision sees both the promise and the present realities and faces up to ill health and its causes, because it knows a well-being, a life in which we share despite disabilities and illness. We acknowledge a commitment under God, to exercise public compassion and justice for all citizens of our land, and therefore, to increase the public well-being.

We know health is a mutual enterprise, "everybody's business." We recognize that as Presbyterians we are each involved in self health care, in mutual health care in our primary social groups and in supporting health care services at home and abroad among and for our neighbors. What happens to our neighbors' health happens to us. We are all involved directly and indirectly in meeting health care needs, just as significantly as we are each consumers of health care. By the same participation, we are each both shapers of societal and governmental policies concerning health care and recipients of the fruits of those policies.

In the face of those mutual responsibilities, we confess mutual culpability for the fractured and ailing condition of health care delivery in our nation, today, and for the shortsightedness of our nation in failing to participate appropriately in the development of effective health care for all the peoples of the earth.

We do rejoice in the care and devotion, the art and skill of a growing company of health care providers, as we rejoice in the explosion of medical science and technology, and in the innovative institutional and systemic efforts that lead toward a more effective delivery of health care.

B. **We find** that our society is giving highest priority to the production and consumption of goods and to profit-making and to the defense of wealth to the neglect of basic human needs including health.

President Nixon, in July of 1969, said, "We face a massive crisis in this area (of health care) and unless action is taken, both administratively and legislatively, to meet that crisis within the next two to three years, we will have a breakdown in our medical care system which could have consequences affecting millions of people throughout this country."

Fortune, in January, 1970, described the crisis: "American medicine, the pride of the nation for many years, stands now on the brink of chaos."

The worsening health care crisis is characterized by the continuing lack of a comprehensive national health policy and program reflected in inequitable distribution of health care resources, severe shortages of health care personnel, lack of medical facilities, spiraling unbearable costs for services, and an inadequate definition of health care for our time.

National Priorities and Health Policy

A. **We believe** that good health is one of the nation's most valuable resources, important not only to the well-being of individuals but also to the nation. The development and preservation of good health requires a national commitment with well defined purposes and explicit goals. We believe that health care, though now predominantly an endeavor of private and independent sectors, cannot be left to private resources and private initiatives alone. We believe the general public has direct responsibilities in redesigning and developing a comprehensive, publicly-oriented national health policy.

B. **We find** that there is no national health policy that provides for the development of the organization and delivery of comprehensive health care. In the absence of such a policy, unified goals and coordinated plans for meeting our nation's health needs do not exist. The confusion over goals is the major obstacle to an effective system of organization and delivery of quality health care. It is crucial, therefore, that there be a national policy to guide the restructuring of responsibility and accountability within the health care enterprise.

C. **Therefore, we recommend that:**

1. There be developed a national policy leading to a comprehensive system of health care which shall:
   a. Be accountable to the general public;
   b. Make all services and benefits available to all persons in the United States;
   c. Be administered by a single national health agency with power to enforce standards to provide the highest quality health care possible.
2. The purview of the national health agency include, within the full range of public, private and voluntary health facilities, service and agencies:
   a. Health promotion, health maintenance, prevention of illness, diagnosis and treatment of disease, and rehabilitation;
   b. Research and planning:
   c. Manpower development and deployment;
   d. Financing;
   e. Evaluation and assessment of needs and services, and recommendations for improvement and their implementation;
   f. Optimum development of each phase of daily activities, such as school and place of work, as the setting for health care.

Process of Accountability in the Health Care System

A. **We believe** that health care is everybody's business, a mutual enterprise. Health care must be accountable to and under the control of the general public with decentralization of authority to make it responsive to the needs and desires of local communities and effective in providing consumer care.

Of paramount importance in the development and implementation of public health policies is the involvement of the consumer community. The involvements of the consumer stems not only from his self-interest in sharing the benefits of health sciences, technology and skills, but also from a concern for the right of all men to adequate health care based on need rather than on the ability to pay as the present system requires.

New frontiers in health care should develop a system that will achieve participation of all segments of society in defining objectives and priorities, guiding change and development in health care resources and services, and in surveillance of the performance and responsiveness of the health care system.

B. **We find** no unified control system, but rather an agglomeration of relatively independent, self-regulating and diverse enterprisers and enterprises. Some are harmfully competitive, and almost none is effectively accountable to the general public and consumers of health services. There are current vested interest groups that resist redefining purposes and goals. The consumer must help redirect policies and procedures. Therefore, the empowerment of consumer groups as a distinct element in policy-making and program development is essential. Otherwise, the current arrangements for delivering health care will continue to be dysfunctional. We will continue to have a shortage and improper utilization and maldistribution of health personnel and facilities, and we will continue to have costs spiraling beyond the reach of the vast majority of people.

C. **Therefore, we recommend that:**

1. The complex issue of health and health care be redefined as a public issue, affecting rich and poor alike, rather than a professional and management problem to be solved by a few, whether in public or private capacities;
2. The organization and delivery of medical and other health services be directly accountable to the general public at all levels of policy formulation, determination, and administration;
3. Local consumer groups be empowered, under a national health policy, to define goals and obtain what they need, as well as to check and balance the providers of health care services;
4. There by systematic efforts to develop an informed public that has increasing competence to make wise decisions and to create systems conducive to personal and corporate health;
5. Quality control of services delivered be established through organized and objectively administered consumer and professional medical evaluation;
6. There be flexibility and pluralism in the policy-making organization of the system to allow for regional differences and changing definitions of consumer demands and provider services;
7. There be established national guarantees and mechanisms for the execution of policy to protect the right of the patient and physician to make free decisions about medical treatment.

The Delivery of Health Services

A. **We believe** that the value of persons requires that each person have full access to essential services without regard to ability to pay and on terms that enhance the dignity of individuals. We believe that the needs of the whole person must be addressed in the context of his whole milieu. We understand such care to include attention to physical and dental, mental, social and environmental needs. We believe that only with a continuity of personal relationships in a health providing community and a continuity of access through comprehensive health services will adequate care be achieved. We believe that an understanding of what a person can do individually and in his primary social group to promote and protect his own health has high priority for developmental assistance. We believe that personal and local self-determination of health priorities is necessary for the proper correlation of needs and resources.

B. **We find** our medical system to be preoccupied with disease and crisis care, which is costly in lives, social relationships, and money. A recent study showed that almost one-third of those hospitals with expensive open heart surgery facilities had not used these in a year. We find that although the United States spends a larger percentage of its Gross National Product and more money per person on health care than any other nation, we are slipping in our ranking among the nations on key health indexes. Since 1950 we have gone from first to seventh in maternal mortality, from seventh to fourteenth in infant mortality, and presently rank eighteenth in male life expectancy. An inequality exists and is growing in our country. Last year white infant mortality declined, while non-white infant mortality, nearly twice that of whites, rose significantly. Non-white mothers die four to five times as often in childbirth. A poor person is four times as likely to die by age 35. And the National Urban Coalition, supported by data from the Social Security Administration, states that spiraling medical costs have placed adequate medical care beyond the grasp of at least 45 million persons below or near the Census Bureau's poverty line.

We find that people are not receiving the care they need. Specialized practitioners and specialized facilities have focused on isolated conditions with services that leave unattended the other commonplace acute and chronic individual and family disorders, much less their causes. Inability to pay, distance from resources, discrimination regarding race and ethnicity, place of residence, and ignorance regarding rights have all contributed toward denying health care that is a rightful human heritage. Treatment of disease for a fee has all too often preoccupied the providers to the neglect of health promotion and prevention of illness. We also find that available services are fragmented and uncoordinated, and often perilously concentrated in some locals.

C. **Therefore, we recommend that:**

1. Comprehensive health care for all persons include at least these elements: aid in growth and development, nutrition, prevention of illness, periodic diagnostic evaluation, treatment of disease, extended and home nursing care, rehabilitation, long term care for chronic disorders, and the appropriate social and economic provisions to make these feasible in the life of a person and his household;
2. There be comprehensive, coordinated planning and administration of health care with publicly disciplined participation of practitioners, support personnel such as health aid technicians, paraprofessionals, volunteers,

etc., neighborhood ambulatory care units, general hospitals, medical research and teaching centers, and other specialized, formal and folk resources to maximize the appropriate utilization of each and to achieve functional cohesion;

3. There be appropriate community action to stimulate and develop competence for self-care and mutual primary group health care;
4. New incentives be developed to further the availability or group practice by health practitioners with diversified competencies for local community comprehensive care;
5. State laws prohibiting group practice be repealed;
6. Group practice units be linked with hospitals and other back-up units to offer prepaid, health promotion-oriented care on a per capita basis;
7. Physical and mental health programs be integrated;
8. Regionalization of the system be established with each region providing and appropriately relating essential research, training, specialized back-up services, primary ambulatory care, hospitalization, preventive and health promotion programs;
9. Health care units be established as needed to serve isolated persons as well as local communities with provision for community self-determination of priorities and full care guaranteed all community residents;
10. Appropriate programs be instituted to stimulate optimum local community development of health care.

Personnel Resources for Health Care

A. **We believe** that the recruitment, preparation, and utilization of health manpower deserve high priority. Responsible management and efficient delivery of quality health care requires competent health professionals and allied personnel, well-distributed, and optimally utilized. Health careers should assure opportunity to exercise humanitarian and social responsibility, and provide both lateral and vertical career mobility. Opportunities must be open equally to all regardless of age, race, sex, or ethnic origin.

Practitioners must be able and encouraged to keep abreast of new knowledge, technology, and delivery systems. They must participate in continuing research and improvement of their professions, and must be adequately remunerated with due regard to their usefulness and personal need. And they must be accountable to the general public and the consumer community they serve.

B. **We find** that there is a serious shortage of health personnel and no rational system to develop and employ adequate manpower, nor to assure maximum utilization and appropriate development. The U.S. Public Health Service estimates that we face current shortages totalling 481,000 including 48,000 doctors, 17,000 dentists, 150,000 nurses, 105,000 environmental health specialists, and 161,000 other health professionals. By 1980, this personnel shortage will probably climb to an estimated 775,000, yet approximately 15,000 applicants are annually rejected from medical schools, primarily by lack of space. We import 8,000 doctors a year, mostly from underdeveloped countries, who need them even more than we do; and still there are 11,000 hospital residencies unfilled. Because of migration of doctors to the suburbs, doctor shortages are most acute in the areas of greatest need--the central cities and remote rural areas.

While extraordinary efforts must be made to significantly increase the number of doctors, the increased use of allied professionals and paraprofessionals (many already trained in the military, peace corps, etc.,) offers a means of improving and expanding health care more rapidly and more adequately than by increasing the number of doctors alone.

Intelligent planning and action is needed now not only because of the present shortage of manpower but, also, because of the expanding number of health occupations, problems of accreditation, deficiencies in educational programs, and the requirements of future programs to provide essential health care.

C. **Therefore, we recommend that:**

There be a national health agency to formulate and administer public policy such as to:

1. Determine how the medical personnel resources of the nation might best be apportioned and related to develop programs to assure the just distribution of such personnel through voluntary choice;
2. Establish guidelines for expanding, organizing, and utilizing the supply of health manpower, including all levels of needed knowledge and skill;
3. Foster the creation of new health careers and new training resources for assistants and aids;
4. Provide functional, national licensure criteria for all health occupations:
   a. Facilitating unrestricted opportunities for career enlargement and advancement;
   b. Facilitating geograpnical mobility within the nation;
   c. Fostering optimal use of time in preparatory education and facilitating early placement.
5. Develop criteria and establish programs to encourage educational institutions to:
   a. Extend their capability to develop qualified health personnel for all categories of need in sufficient number to meet current and future demands;
   b. Increase enrollment and training in health professions and occupations;
   c. provide continuing education and training for health personnel and opportunities for career mobility;
   d. Stimulate through incentives and other means the recruitment for health professions and occupations from sections of the population that have been excluded because of economic or racial barriers or because of masculine or feminine discrimination.
6. Develop new educational institutions in areas where they can be of most service to people needing health care.

Financing Health Services

A. **We believe** each citizen should be eligible for comprehensive and continuous health services regardless of his ability to pay. Such universal coverage implies universal participation in the financing of that care. We believe that the public should get full value for the investments made in health care. We believe the economic arrangements should favor promotion of health and prevention of illness. We believe that the economic rewards in the health care system should be so distributed as to compensate all workers equitably, to promote equitable distribution of health resources among the population, and to cause optimum collaboration among health agencies.

B. **We find** that there are formidable and sometimes insuperable financial barriers to adequate medical services and health care for large numbers of people in the United States. Spiraling costs of such services, which continue to skyrocket at a rate of increase approximately two and one-half times faster than the general price index, threaten to exclude even larger numbers.

Money alone cannot be the answer, particularly if it is used to support the present fragmented nonsystem of delivering health care services. The present arrangement of financing is not adequate to achieve the objective of establishing a unified, coordinated system capable of increasing availability and continuity of care and enhancing its quality, promoting health and preventive medicine as well as the treatment of illness, improving the utilization and effectiveness of all services, and strengthening personnel and financial controls to restrain the escalating costs while providing fair compensation for those providing the knowledge, service, goods,and facilities.

The creation of a viable system and improved financing must take place simultaneously and in parallel.

C. **Therefore, we recommend that:**

1. There be such public investment in financing health care services that every person may be assured quality comprehensive health care, independently of an ability to pay, and without discrimination because of economic status, color, sex, religion, or political affiliation;
2. Public financing be utilized simultaneously both to facilitate access of every person to essential health care and to create a rational, well organized, economical, and balanced health care system designed to service all persons adequately;
3. A national health agency be empowered to provide leadership in developing and progressively refining objectives, standards, and methods of financing health care, and to regulate the financial operations of the health care system, so that appropriate economics may be realized and accountability to the consumer communities assured.

Enabling Health Services

In the face of the current health crisis, our Lord's concern for the health of all persons confronts us with an immediate urgency. His was a spirit that reached out alike to the leper and the centurion's son, that they might recover wholeness.

A new level of commitment and involvement is required of the Christian community today if we are to be faithful to the example of our Lord's healing ministry.

The varied legislative proposals, which are now before the Congress, dealing with the crisis in health suggest new health care opportunities for many persons. But the wide divergency of possible application demands a greater level of public determination in order to assure a system of comprehensive health care that serves God's purpose for all persons.

Therefore, the 183rd General Assembly (1971):

1. Calls upon all boards, agencies, judicatories, and members of the United Presbyterian Church to initiate and vigorously support actions affirming the recommendations of this statement.

2. Requests the appropriate agencies of the church to provide resources that will help United Presbyterians to deal knowledgeably and constructively with problems of health care and medical services.

3. Urges federal, state, and local governments to take prompt action to affirm, through appropriate legislative and administrative action, the right of all persons to full access to comprehensive health care without regard to ability to pay, and on terms specifically accountable to the public.

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Health Ministries and The Church

THE PROGRAM AGENCY

The United Presbyterian Church in the U. S. A.

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Preface

The Presbyterian Church has a long and memorable history in medical missions. Responding to the biblical injunction to heal the sick, the early mission boards found an acceptance of medical mission in many countries otherwise closed to Western missionaries. The names and deeds of famous medical personnel and hospitals in Asia, Africa, and Latin America are a permanent part of our early history in spreading the Gospel to lands previously unreached.

As the world and human societies have changed through the past 150 years of mission involvement, so has our mission strategy in health ministries. Governments have assumed a primary responsibility for medical education and for determination of hospital standards. At the same time there has developed an increasing awareness of the limitation of the specialized hospital in providing for basic health needs of poor rural areas of the world. A growing concern to help people meet their own basic sanitation, food, and primary health needs has brought health mission into closer contact with community development efforts.

As a result, the Program Agency, acting for the UPCUSA in mission, established a task force from many areas of health care to help it restudy the strategy of health missions during the next ten to twenty years. After eighteen months of study and discussion, the following report evolved and was adopted by the Board of the Program Agency as its guideline for the future in health mission at its regular meeting in October 1977.

C. William Metcalf MD

C. William Metcalf, M. D.
President, Program Agency, UPCUSA

Recommendation and Conclusions

The Board of the Program Agency approved the recommendation that emphasis and priority in the health ministries of the church be given to:

A. Basic health services reaching to communities, supported by community organization, involving new types of health personnel linked to supporting capabilities in the health care system.

1. The development and improvement of basic health services accessible to all is an immediate priority.
2. Programs of community organization and education, primarily developing out of the community, are needed to begin, strengthen and sustain basic health services.
3. New types of health personnel and new roles for them in training workers and providing services should be strongly emphasized.
4. New and expanded responsibilities for hospitals in providing outreach and support services for community health programs should be encouraged.

B. The development of the unique capabilities of the church in restoring and maintaining health, in the broadest sense, of individuals, families and communities.

1. Church congregations need to recognize and develop their unique ministry in health.
2. The church in all its structures should continue and increase its role as advocate in health matters with a concern for equity, justice, and the preservation of human values.
3. The church needs to continue and advance its involvement where human value questions exist and arise.
4. The church should continue and increase its ecumenical approach in health ministry, and also continue consultations with health organizations in the public sector from the community to the world level.

Introduction

The changes that are occurring in the health field are seen to have significant bearing upon the health mission of the church. In fact, the extent and character of these changes compel thoughtful consideration of how best to proceed in health mission. While the changes occurring clearly impose mounting difficulties in continuing health ministry in ways which have served in the past, they also create new and greater need for the church's witness and influence in the health care of people in this and other nations. Not only does this pose new challenge to the church, it presents significant opportunity for renewal and revitalization of the church's health mission. This calls for the development of new and innovative dimensions in health ministry involving the unique potential of the church as a supporting community, reinforcing individuals in the attainment, maintenance and restoration of health. It calls for health program strategies which are sensitive to the culture and developmental status of local areas and which increasingly utilize local resources, with emphasis on developing the capabilities and self-determination of the areas served. In short, effective health mission in the changing world, both at home and abroad, entails new and modified approaches, adjustments in orientation and style, and redirection of priorities and resources.

The Theological Mandate for Ministry in Health

The church's involvement in health care and services is its response to a mandate of the Gospel. God's will, as revealed in Jesus Christ, is clearly for the wholeness and health of the Children of God both in this life and the life to come. That is what the biblical concept of salvation clearly implies.

The Bible knows nothing of a truncated salvation in which people's souls can be saved and their bodies neglected. Human beings are regarded as unitary beings whose souls and bodies are one. For this reason, the Christian faith focuses not on the immortality of the soul, but on the resurrection of the body. For this reason also, Jesus' ministry of healing was not merely a "spiritual" exercise. The lame were to walk, the blind to see, and the poor were to hear good news. Jesus' ministry was directed toward the good health of humankind not only in a hoped for hereafter, but here and now. This also is the ministry of the church.

It is quite possible to view life differently. If being human is only a biological existence, the control of genetic structures is open to all kinds of arbitrary experimentation, simply on the basis of biological interest. If a person is only an economic animal, the focus on this center in one's life will jeopardize existence the moment one loses the promise of productivity. If a person is only a political animal, the interests of state have an absolute right to define the boundaries of one's existence.

We have not so learned Christ. People are living souls. God has breathed into them the breath of life. They are born and they die to celebrate the mystery of that miracle. Procreation which neglects the possibility and centrality of that celebration, and simply sanctions all breeding, has lost sight of the center.

Health care in the biblical mandate means the positive support of the promise of life. Health care is a theological matter involving spiritual, physical, and social factors because the biblical vision sees not only healthy individuals but a celebrating and healing community in the present and coming kingdom. In fact, the healthy individual is the person whose life is significant and meaningful insofar as it becomes a contribution to the ultimate fulfillment of life in God's Kingdom. Life lived to the glory of God is life lived for the coming of that kingdom—hence the care of life means concern for and participation in the promise for a full life for all—the care and healing of society. Individual life and death finds its meaning in

that total vision—a theo-centric and not ego-centric vision.

The implications of this basic insight are clear. It is not enough for the church to be concerned that individual bodies are protected and their life span extended, it is not enough that individuals find wholeness and meaning for themselves. It is the calling of the church to minister to "life together," to promote the communion of humankind to the glory of God. Such social concern is signified in the central sacrament of the Christian community—the Lord's Supper.

Health care has to do therefore with the nurture of individuals *and* society of which they are a part from promise to fulfillment by pursuing the biblical vision of the fullness of life of the God who created us. The church is called to something more than the amelioration of suffering in times of crisis (though that too is its task). It is called to the promotion of health and well-being in the broadest possible scale, for the love of life, and not the fear of death, is the church's primary and empowering motive.

Trends in Health Problems and Opportunities for the Church

Health, sickness, and death are matters of constant concern to the human race. Throughout the world there are debilitating diseases of many forms, infections, malnutrition (even in affluent countries), accidents, degenerative diseases and conditions, mental illness and a variety of causes of unnecessary afflictions and death at all ages.

There are a number of ways by which societies have responded to the threats to health. There seems to have always been a family or folk medicine which frequently has a religious aspect. Societies have greatly conditioned people's conduct, eating habits, travel, and have developed various instrumentalities and patterns of dealing with health needs. Health professions have emerged, hospitals and other institutions have been established, knowledge and technology have been advanced through research, and special educational systems for health workers have been developed. The interventions that can be made in disease patterns by inoculations, drug therapies, operations, and other capabilities of modern medicine are widely known and increasingly used in most areas of the world.

However, there are many problems involved in the system which society has developed to provide for health needs, and an adequate response to human illness is restricted in many ways. In broad perspective, the basic one is ineffectiveness in dealing with the root causes of health problems because of lack of understanding and many other factors. Poverty, inadequate living conditions, infested or contaminated environments, large and poorly spaced families, ignorance of the needs of sanitation, poor and insufficient food, unhealthy life styles, and personal values or socially determined behaviors, all with inherently unhealthy factors, are some of the root causes of illness, suffering, and death that are neglected as priorities of the health enterprise here and abroad. In addition, the effectiveness of health care systems in meeting human need is hampered severely by other inadequacies. Limited resources in money, personnel, and facilities frustrate health services; commonly there is maldistribution of resources which adds further to inability to serve needs effectively and equitably; inefficiencies in planning and organization, in educating, monitoring and evaluating lead to inadequate performance; and there is resistance to needed change and to correction of deficiencies where powerful vested interest is advantaged by the status-quo—all these contribute to health systems in both rich and poor nations that are lacking in sensitivity, responsiveness, efficiency, and ability to accomplish the purposes which they exist to serve.

Around the world human suffering is immense. The great majority of people in the world have no access to modern health care; simple diseases untreated lead to chronic sickness and an early death for large numbers of people; malnutrition reaps an extensive harvest of human lives; unhealthy environments, life styles, working conditions, and cultural attitudes and responses to health problems contribute continually to suffering, depression, and death.

The greatest hope in fundamental widespread reduction of this problem with its overwhelming dimensions is seen to lie in the new awareness of causal factors related to sickness and health. There is now a growing understanding world-wide of the importance of placing greater attention and emphasis on the root causes of health problems. New knowledge and skills have been developed that lead to reduction of disease and its toll. The place of social and family planning is increasingly accepted. There has been a heightened awareness of the need for balance between medical care in its hospital-based, disease-oriented form and other forms of health care in which the individual, the family, and the community have the major and

essential role in attacking environmental, social, and behavioral causes of sickness and death.

This new awareness leads to the importance of developing health services that reach to and are based in communities. Implied in this are new types of community-based health workers who are able to educate people and provide care in simple matters of health care and prevention, who are competent in basic maternal and child care, who can recognize and advise regarding environmental hazards and nutritional deficiencies, who can enlist the support of the community through community organization and education, and who are linked to a support system beyond the community both for guidance and referral. These basic health workers need the acceptance of the community, an awareness of the community culture, an ability to integrate modern medicine and traditional folk medicine in simple forms, and skills at making needed change.

New roles for health personnel are also needed beyond the community level. Community programs need effective supporting services which can be provided by personnel based at health centers and hospitals. There must also be regional managers, planners and practitioners who, in effect, do for the region what a basic health care worker does for the community. Hospitals and hospital-based staff can be a source of leadership for area-wide programs, of services upon referral of complex illness, and of training and supervision for a wide range of health personnel.

New relationships among various types of health personnel at all levels and of health personnel with the public are implied in these new directions. Instead of health workers functioning independently, there is a possibility of teams providing care. In place of a traditional separation between providers and consumers and unilateral responsibilities, there are implied factors of mutual responsibilities of providers and individuals, families and community, of coordination among community, regional, and national levels in collaborative planning, of ecumenical relations in the broad sense between churches and public and private agencies, and multinational approaches as being necessary for world health.

For the church committed to meeting spiritual and physical needs of people there have been many factors that already have brought changes in the patterns of ministry which traditionally were hospital-based, doctor-oriented service functioning in isolation and independently from other churches and governments. Rising costs of care and difficulties in recruiting trained personnel have been factors in change. But also there have been political and social de-

velopments in the independence of nations, the importance placed on self-determination, and, in many areas, nationalization of health personnel and services, all of which necessitate changes in the church's role and approach in health ministries. In addition, the church has been accumulating experience in new modes of providing health care and has become aware of the importance of the role of the congregation in support and healing and also of the place of the church in helping to deal with social, ethical, and theological issues in the changing conditions and technical capabilities of health care.

There is then a challenge to the church to become more fully involved in the new problems related to health care in a suffering world. There is the need for the church to respond to problems and trends, assess the resources it has available, identify the style and place for effective engagement, know the allies with whom it can work, and with enthusiasm and vigor to present its witness.

In the premises and direction seen for health ministry, this report does not differentiate specially between the health ministry in more developed and less developed countries. The problems in a broad sense are remarkably similar perhaps because the needs of humanity are consistent. Nor does this report in its recommendations seek to become specific either with regard to health care institutions or the specific responsibilities of local and regional or ecumenical church bodies. There will be urgent local specific matters that will vary from town to town and country to country. Leprosy or clean water may be the focus and concern and action in one area, in another it may be drug use, teenage pregnancies, or environmental contamination. At various places and times the national and regional church may be involved in studies and support of national health insurance or of the problems of poverty or international engagements; other church groupings might be assisting in a broadly based educational program on nutrition, child care, agricultural development, family planning or the education and supervision of basic health workers.

But while the report and its recommendations are spelled out in broad terms, applicability to these specifics and numerous others is implied. It is expected that the church in its various groupings will respond to its mandate of the Gospel and identify the tasks most suitable for its place and its capabilities.

Recommendation for the Church's Health Ministry

In light of the preceding sections on the theological mandate and the discussion of health-related problems and opportunities, the Health Advisory Committee recommends that emphasis and priority in the health ministry of the church at home and abroad be given to:

A. Basic health services reaching to communities, supported by community organization, involving new types of health personnel linked to supporting capabilities in the health care system.

1. Basic health services.

Proposition: Despite all the advances in medical knowledge and medical technology, unmet health needs remain and people in all parts of the world have yet to be reached. Especially is this true among the poor. New systems of health care which include basic health services can make a great contribution to the well-being of people if the appropriate plans for health care are made, education in preventive health measures developed, and easy access to frequently needed health care provided. A number of models which demonstrate these facts are in existence that could, with adaptation, be useful in guiding developments in other settings.

Substantiation: It is estimated that, in developing countries, 80 percent of the people do not have access to modern health care. Traditional wisdom and traditional medicine are there; but many of the simple facts of sanitation, nutrition, and reproduction are not known. Increasing population creates its own tragedy in a vicious cycle of famine and death. Those who survive are often the victims of continuous poverty and chronic disease and seek to produce more children so that at least one will live to maturity and be some support for the parents later. "The absolute poor are severely deprived human beings struggling to survive in a set of squalid and degraded circumstances almost beyond the power of our sophisticated imagination and privileged circumstances to conceive." . . . "Malnutrition saps their energy, stunts their bodies and shortens their lives. Illiteracy darkens their minds and forecloses their futures. Simple preventable diseases maim and kill their children. Squalor and ugliness pollute and poison their surroundings." (McNamara, R. S., *Address*

to the Board of Governors, World Bank, Washington, D. C., 1976, pp. 5, 35)

The World Health Organization (WHO) has just initiated a special program of research into several tropical diseases. The magnitude of these and other problems almost defeats the imagination; diarrhea kills between five and eighteen million children a year; one billion people live in areas where malaria is endemic; sleeping sickness is a permanent risk to thirty-five million people south of the Sahara; Chagas' disease affects ten million people in Latin America; two hundred and ninety million people are affected by filariasis.

The knowledge of how to bring great relief to the masses of the world's poor is available. The main need is to bring the knowledge to where the diseases are. During the last few years, new ways of doing this have been tried in pilot settings with success. A number of church organizations and others have been involved in village health care employing new types of basic health workers, who are generally resident in the community, chosen by the community, and specially trained for a few weeks or months for their roles. Some of these have been reported in *Health by the People* by K. W. Newell (W.H.O. 1975). Additional descriptions of such health services have been published in *Contact* (Christian Medical Commission) and also in *Here's How: Health Education by Extension* by Ronald and Edith Seaton.

Such basic health workers provide the point of access to the health care system. Basic health workers, involved as they are in community life and activity, can work directly with the root causes of disease.

Since they are often part-time and may be volunteers, they constitute a limited economic burden to the health care effort. The problems of poverty, infested or contaminated environments, large and poorly-spaced families, ignorance of sanitation, poor and insufficient food, unhealthy life styles and unhealthy socially determined activities are matters which the basic health workers can present to the community for action and assist in the education which is needed for individual and community understanding. Basic health workers provide preventive, curative, and rehabilitative care but also a link to supporting health care services for referral of more difficult problems.

Conclusion: THE DEVELOPMENT AND IMPROVEMENT OF BASIC HEALTH SERVICES ACCESSIBLE TO ALL IS AN IMMEDIATE PRIORITY.

2. Community organization and education.

Proposition: In conjunction with the first priority of providing basic health services, another immediate need is to promote good health practices and to educate people with regard to adequate nutrition, sanitation, and family planning. Integral to all this is the need to assist in community organization and the economic and social development of the poor in rural or urban situations. Even in more developed and affluent communities the importance of education in relation to the diseases of the time must be emphasized. Education and social development for rich and poor imply a change of life style by which disease is prevented.

Substantiation: Where the new types of basic health care services have been introduced most successfully, community organization and education have been conducted simultaneously.

One of the key factors in a reduction of the infant death rate is the adequate feeding of both the mother and child. In a rural setting this means a knowledge of nutrition and an adequate food supply produced by local agriculture to provide a nutritious diet. This in turn implies the introduction of improved farming methods, often using new types of seeds or crops and adequate water. Skills, new knowledge of social involvement, and appropriate community action are needed. In urban settings the needs differ but the problems are similar.

Also, in all countries there are social, cultural, economic, and ecological factors which are determinants in the health or sickness of the people of that country or region. Community involvement, education, awareness, and action are necessary for change in order to deal with the root causes of disease.

Conclusion: PROGRAMS OF COMMUNITY ORGANIZATION AND EDUCATION, PRIMARILY DEVELOPING OUT OF THE COMMUNITY, ARE NEEDED TO BEGIN, STRENGTHEN, AND SUSTAIN BASIC HEALTH SERVICES.

3. Health personnel.

Proposition: With the growing recognition of the many types of service that are needed for effectiveness of health care systems, the need of new types of health personnel is great particularly for those personnel who are engaged in basic health services.

Substantiation: The place of doctors and nurses in the hospital setting is well known. The churches are well experienced in training and deploying professionals to provide health service. However, more and more the responsibility for the training function is being taken up by the governments of countries in their health services. Less well known is the way to select, train and maintain people in the structures of community health programs. Governments are also seeking ways to educate and maintain such health workers upon whom rest the tasks of day to day education of the public for prevention as well as caring for basic health needs. In various countries councils of churches have become involved in assisting government programs that are in beginning stages, in encouraging groups in the public sector to develop such programs, or in supporting demonstration programs on their own. In all these cases, the selection of health leaders who can identify directly with the people they seek to serve, their adequate training for the specific tasks they are given, and the provision of necessary supplies and support systems are of great importance.

Conclusion: NEW TYPES OF HEALTH PERSONNEL AND NEW ROLES FOR THEM IN TRAINING WORKERS AND IN PROVIDING SERVICES SHOULD BE STRONGLY EMPHASIZED.

4. Responsibilities for hospitals.

Proposition: Established hospitals can serve as a base for the development of community health programs in their district or neighborhood. While hospitals are involved with the inpatient care of serious illness, they can serve in a broader role through operation or linkage with other types of health care such as outlying clinics, which are oriented to providing primary care, in order to meet health needs not requiring hospitalization, to provide emphasis on prevention, continuity and accessibility, and to support basic health workers with back-up services.

Substantiation: Hospitals form an important part of any health system. They are required for care of difficult cases of illness. In a rational health care system, services of a simple nature are performed at the community level, more complex cases may be sent to a health center, and cases that are not able to be treated adequately there are sent to the hospital. The hospital has a dual role in providing medical care: namely, to provide primary care in its immedi-

ate vicinity and to provide referral care in support of basic services in a broader area. In further support of basic health services, the hospital accepts or shares responsibility for the staffing of health centers and community-based programs for the training and supervision of community health care workers.

Hospitals and related schools for the education of doctors and nurses have been moving towards a community orientation at various centers around the world. A number of hospitals which are supported by the missionary work of the United Presbyterian Church are doing so.

An important aspect of this emphasis is concerned with the development of basic health workers and the orientation of other health personnel—physicians, nurses, paramedical, and auxiliary personnel—toward development and support of community-based programs. This is where the need for health personnel is the greatest. This is where the greatest gap exists between the health needs of people and the health system. There is need for health personnel to train people who will work as rural or urban community workers to promote and provide health knowledge and services in their communities. One of the main tasks for present health personnel is to provide education and support for these new types of health workers.

Conclusion: NEW AND EXPANDED RESPONSIBILITIES FOR HOSPITALS IN PROVIDING OUTREACH AND SUPPORT SERVICES FOR COMMUNITY HEALTH PROGRAMS SHOULD BE STRONGLY ENCOURAGED.

B. The development of the unique capabilities of the church in restoring and maintaining health, in the broadest sense, of individuals, families and communities.

1. The congregation's ministry in health.

Proposition: The congregation is the place where the people of faith gather and receive their communion together. In a very meaningful way, this is also the place where "wholeness" is received, shared, and understood. The renewal of the congregation as an agency in the ministry of health is of immediate importance.

Substantiation: The congregation has been described as having a central place in the health ministry of the church because it is a fellowship of love, a fellowship of worship, a fellowship of reconciliation, and a fellowship of prayer. These four elements of the congregation's life—love, worship, reconciliation and prayer—are profound forces for reinforcement and restoration of the health and the well being of the person.

In the spiritual vacuum of the present world and of our own society, the church has powerful, spiritual gifts that provide a supportive community to the lonely, reinforcement to individuals and families in anxiety, tension, and need, education to persons concerning their well being, and a perspective on life and death that gives direction, comfort, and support to people of all ages. The congregation can extend its healing influence beyond its own members.

Conclusion: CHURCH CONGREGATIONS NEED TO RECOGNIZE AND DEVELOP THEIR UNIQUE MINISTRY IN HEALTH.

2. The church as advocate in health policy.

Proposition: There is continuing need for advocacy in areas dealing with social and public health policy and human needs. This advocacy, in its appropriate form, should be a normal part of the life of congregations, presbyteries, synods, the General Assembly, and its agencies.

Substantiation: Major problems including the right to health care, access to the health care system, adequate and appropriate care within the system, the equitable distribution of health care resources and services, the balance of human and technical values, the education and placement of health personnel, the financing of health care, and the responsibility of government in assuring that needs are met are a continuing concern.

The 183rd General Assembly in its "Health Policy" statement entitled "Toward a National Public Policy for the Organization and Delivery of Services" set policy guidelines with regard to health care services which continue to need implementation.

The General Assembly and its agencies, synods, presbyteries, and congregations need to identify these problems as they appear in their own context of responsibilities and develop strategies in conjunction with other church bodies and public and private agencies to deal with them. International, national, regional, state, and local strategies are required so that this advocacy be effective and pursued

even when it encounters opposition in society or within the church itself.

Conclusion: THE CHURCH IN ALL ITS STRUCTURES SHOULD CONTINUE AND INCREASE ITS ROLE AS ADVOCATE IN HEALTH MATTERS WITH A CONCERN FOR EQUITY, JUSTICE, AND THE PRESERVATION OF HUMAN VALUES.

3. Human value concerns in health.

Proposition: In the rapidly changing scene of medical knowledge, technology and their application in health services, human values need to be asserted constantly. Knowledge is not necessarily applied humanely and new information continually raises problems affecting human rights and dignity.

Substantiation: The development of new knowledge through research and the application of this knowledge is constantly opening up new areas which are of great importance to the health and well-being of people and communities. With each advance new human problems arise which need an equal degree of interest, vigilance, understanding, and action as is applied to the development of those advances.

The problems of genetic manipulation and genetic counseling are immediate. Complex problems related to the use and misuse of drugs for behavior control are now constantly present. The prolongation of life by artificial means is regularly reported. Questions related to abortion, euthanasia, and the control of human experimentation are in the arena of public debate. Life and death decisions with regard to the abnormal newborn, accident victims totally disabled, and persons afflicted with gross senility have to be made daily by health personnel. Problems of allocation of health resources so as to reach the poor and neglected are matters of recurrent concern.

In all of these types of matters the church and church people need to be informed and involved both for their own ability to respond as they may personally be affected and so that the influence of Christian concern may be brought to bear on social policy.

Conclusion: THE CHURCH NEEDS TO CONTINUE AND ADVANCE ITS INVOLVEMENT WHERE HUMAN VALUE QUESTIONS EXIST AND ARISE.

4. The ecumenical approach in health ministry.

Proposition: The involvement of the church in health and wholeness in the changing world is too large and complex a task to be

undertaken by one denomination. Moreover, this task calls for the continued engagement in study, consultation, planning, and action of the churches in as broad collaborations as possible including ecumenical, governmental, and intergovernmental agencies.

Substantiation: The United Presbyterian Church has been strongly involved in the support of the Christian Medical Commission of the World Council of Churches since its beginning. This broad ecumenical base has been a most suitable context for the development of new understandings, plannings and strategies in the health field. National and regional bodies are now functioning ecumenically in the development of health programs. New types of health service have been begun, especially in the area of basic health services, as demonstration models which have informed and guided both church and government planning. A similar broad ecumenical context has proved to be most valuable in work with health professional education in this country through the United Ministries in Higher Education's Society for Health and Human Values and in other health care projects that are regional or local in scope. A significant aspect of all these ecumenical endeavors in health care has been the inclusion of representatives of health planners and policy makers having local, national and world involvement. This has resulted in an exchange of ideas and development of programs that have been mutually beneficial. It is also recognized that while there has been considerable exchange of ideas there is a great need for much more extensive cooperation between church bodies in health concerns.

Conclusion: THE CHURCH SHOULD CONTINUE AND INCREASE ITS ECUMENICAL APPROACH IN HEALTH MINISTRY AND ALSO CONTINUE CONSULTATIONS WITH HEALTH ORGANIZATIONS IN THE PUBLIC SECTOR FROM THE COMMUNITY TO THE WORLD LEVEL.

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Mr. THOMPSON. Our appearance here today is based on the concern of religious organizations for the wholeness of persons as children of God, and therefore about their physical and mental health. By being here, we believe we are responding to God's command to care for, and to act on behalf of all his children.

When you and the other members of this subcommittee prepare legislation on national health care, we believe that the essential and basic principle which should underlie all your decisions should be this one:

All persons within the United States of America are entitled to adequate health care and the Federal Government should guarantee that entitlement as the only agency which can act for all the people.

Senator KENNEDY. Reverend, that is exactly our premise. That is exactly what I am committed to, and the overwhelming majority of the American people I believe are committed to this.

I just wonder why we have such difficulty in getting the citizens of this Nation to be able to express that in a way which legislators can understand so that we can achieve that goal.

Mr. THOMPSON. Senator, we certainly applaud your own personal initiative in bringing this matter to the stage that it has now reached. And we applaud your continuing initiatives in bringing it before the Congress, and we assure you of our support in making certain that those whom we represent will be informed and will respond in a political way in contacting their own Representatives and Senators.

Senator KENNEDY. Do you think the religious groups could help in an active way? I mean, do they understand that this is a moral issue as well as a public policy question? I separate those but, obviously, they are together in this sense.

Could you maybe expand on that point?

Mr. THOMPSON. I am certain that it is possible.

I must begin in responding to your question by saying that you address me a moment ago as Reverend. I am not an ordained clergyman. I am a lawyer who happens to work for the United Presbyterian Church. As such, I am an administrator within the bureaucracy of the church, if you will.

I work with a number of clergymen and members of the clergy who are women, and I can assure you that within the circles in which I move, the moral aspects of this issue are not only understood, but taught.

Our remarks today will deal exclusively with national policy on personal health care services. We recognize that you, in particular, are familiar with the abundance of evidence that the Nation is in a large and steadily worsening health care crisis. We shall not repeat that evidence except to accent our belief that congressional action is long overdue. This is especially true with respect to the most frequently mentioned part of that crisis—rapidly rising health care costs and the growing struggle of thousands to pay for them. The question as to whether or not the Nation can afford a comprehensive health care policy is no longer valid. Our national experience has long since answered it. A mass of data signifies we can no longer afford not to develop and implement such a policy.

In singling out rising costs for special mention, we underscore the utter futility of dealing with that problem in isolation. It can be successfully dealt with only in conjunction with other components of the health care crisis:

(1) Inadequate, maldistributed resources for delivering health care services.

(2) A poorly organized and grossly inefficient system for delivery of health care services which results in unequal access to health care.

(3) Inadequate controls with appropriate accountability to Government and consumers to assure quality of health care.

In evaluating legislation designed to deal with national policy on personal health care we, therefore, support features which enhance a coordinated, comprehensive approach. We reject those which focus on only one aspect of the health care crisis. An example of the latter is so-called catastrophic national health insurance. It addresses only one aspect—financing.

Mr. Chairman, we appreciate the opportunity to offer comment on the outline of a new national health insurance program prepared by the Committee for National Health Insurance in collaboration with your office.

As an outline of broad, general principles we find much to commend in it. For example: We like the commitment to universal coverage.

We like the commitment to comprehensive benefits.

We like the commitment to immediate cost containment and to the budgeting of costs in advance.

We like the emphasis on preventive medicine and the encouragement of alternative delivery systems such as health maintenance organizations.

We like the assurance of full public accountability and the insistence of consumer participation in the development and administration of the proposed plan.

With regard to certain other principles which we believe to be important, we find the language of the outlined statement to be vague or equivocal. For example, it does not contain language which makes it certain that the program will be mandatory for all residents.

The statement seems to us to lack sufficiencly explicit language about the absence of any means test. And the statement gives, in our opinion, insufficient attention to the important issue of quality controls.

On all of the issues we have mentioned so far in this testimony, there are some implications in the language of the statement that final legislative language will provide the specifics which are lacking in the present statement. We recognize the limitations of an outline of principles as compared with a final bill. There are, however, some fundamental principles contained in the statement with which we take issue or have serious questions. These are:

(1) The role for private insurance companies: We regret the role assigned to the private insurance companies in the statement of principles. Providing a significant role for the insurance companies diminishes the extent to which the Federal Government can be held accountable for guaranteeing high-quality health care for all. It will

enormously complicate the administrative machinery and costs. We hope you will reconsider that decision very carefully. We believe that some congressional leaders are prepared to wage an aggressive campaign for grassroots support for a bill which assigns a much larger administrative responsibility to the Federal Government. We are convinced that such a campaign would receive support from labor, religious organizations, senior citizens, and many other groups.

(2) Restraints on Federal budget: We also regret the decision to finance the new program in such a way as to keep Federal budget expenditures at a minimum. The political advantages are obvious. But the program advantages are dubious. It may result in greater total national expenditures for health than under public financing. We realize the complexities of this issue both politically and economically. All we ask now is careful restudy of this issue. We believe again that grassroots support can be generated for the public financing route.

(3) Public financing option: Even if the final bill provides a significant role for private insurance companies, and even if a major part of the financing is retained in the private sector of the economy, we believe that the public financing option should be available to any individual or employee group. Perhaps the basic approach should be through public financing, with a voluntary choice being available for those who prefer to deal with the private insurance companies.

Such an approach would have the advantage of establishing and testing a governmental mechanism which could take over in the event that private insurance companies either refuse to do the job or perform it inadequately. At the very least, it would test the capability of the Federal Government to perform the task and afford opportunity to develop and improve its capacity to do so.

In summary and conclusion:

(1) We believe that the broad general principles contained in the statement are a good start on a new bill. We regret that they have been modified to provide a significant role for private insurance companies and to keep the burden on the Federal budget at a minimum. We urge that these decisions be reexamined.

(2) We believe that a bill based on this statement can and must provide many reassuring details particularly with regard to nonuse of the means test, deductibles, and coinsurance.

(3) We therefore would welcome an opportunity to comment on the bill ultimately drafted and based on the proposal now under consideration. Such comment would be based upon the principle adopted by governing bodies.

We thank you for the opportunity of appearing before your subcommittee today. Rabbi Sternberger will make some supplementary comments. After his comments and Msgr. Lally's testimony, we shall be happy to respond to your questions.

Rabbi STERNBERGER. The Union of American Hebrew Congregations represents 700 or more Reform Jewish Churches. I am glad to say that we, too, have passed some very, very forthright resolutions at our annual convention in 1972, a copy of which will be submitted to the committee which, essentially, includes all the points we made in the testimony.

Senator KENNEDY. Very well. It will be made a part of the record.

[The following was received for the record:]

The Bible commands us "Thou shalt not murder." The Talmud teaches us that "he who takes one life it is as though he has destroyed the universe and he who saves one life it is as though he has saved the universe."

The UAHC supports legislation to implement the recommendation of the National Commission on the Causes and Prevention of Violence to eliminate the manufacture, importation, transportation, advertising, sale, transfer and possession of handguns except for limited instances such as the military, police, security guards and licensed and regulated pistol clubs.

Recognizing the similarity of problems in Canada, we furthermore call for implementation of the above recommendations where they are applicable in that country.

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HEALTH CARE AND HEALTH INSURANCE

Judaism teaches us that where there is a way to alleviate suffering, not to do so is to deny our responsibility to humankind. The question, "Am I my brother's keeper?" has always been answered affirmatively by Jewish tradition. In modern society, which places a very high value on good health as a necessity for full participation in the benefits of our secular culture, the financial costs of medical care have risen to a level which effectively bars large numbers of people from relief of suffering. With this in mind, the UAHC supports the proposal that:

1. In the United States there should be made available national comprehensive prepaid single benefit standard health insurance with no deductible, to cover prevention, treatment and rehabilitation in all fields of health care.

2. This insurance should be made available to all on an equitable basis according to their ability to pay.

3. Standards of health care service should be established and be continually reviewed by a board on which consumers are represented. Standards of licensure and professional competence should be continually reviewed by professional boards.

4. Both private and government efforts should be made to enlarge the supply of health personnel and to make more effective use of all professional and paraprofessional resources.

5. The rights of persons to choose among doctors should be assured. Equally, the rights of doctors to practice according to their judgment must also be assured, provided they meet appropriate standards of competence and responsibility.

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WORLD HUNGER

WHEREAS millions of people throughout the world continue to face starvation due to population increases, dwindling food reserves, land, water, energy and fertilizer shortages and inequitable distribution of God's resources; and

WHEREAS the Jewish people, when confronting these tragic situations, have felt God's commanding presence and taught, "Share your bread with the hungry" (Isaiah 58.7); and

Rabbi STERNBERGER. I am happy to state that the UAHC was one of the founding members of the Coalition on National Health back in 1970 and 1971.

I don't want to indulge in oneupmanship of Mr. Fraser, but I would like to point out although he said there was national health insurance back in Germany in the Bismarck regime, we had it back in the ghetto.

When the Jews were living in a semiautonomous state, the only time, except for Israel in modern times, when they were oppressed and weighted down under man's injustice to his fellow man, we did not lose sight of the biblical injunction that health is a God-given right. So in the ghetto, in the Middle Ages in Europe, Western Europe and Middle Europe, we had health care that was available to everybody. In probably the poorest community at that time, health was a right for everyone and I am very proud to point that out.

Senator KENNEDY. Thank you very much.

Rabbi STERNBERGER. I would also like to inject one personal note. I could have been sitting here yesterday. In my short lifetime, my family has been devastated by two illnesses—financially devastated. When I was a student in the seminary, my father suffered three coronaries in a row which totally wiped out my family's finances, so that I had to support my parents from that point on until this very day.

Just 5 years ago, my mother was devastated by a stroke and I have to say that I am still paying off two bank loans that almost totally wiped me out financially, so this is not just a theological, biblical or religious commitment. It is a very personal experience for me.

Senator KENNEDY. I think, Rabbi, your experiences are probably shared by most families in one form or another.

Rabbi STERNBERGER. Yes.

Senator KENNEDY. I wish to welcome Reverend Lally. He has had a long association with my family in Massachusetts for many years, back to my grandfather, and father. He was a very distinguished editor of "Pilot." He has a great sense of public consciousness and public responsibility.

We are glad to welcome you.

Monsignor LALLY. Thank you.

Mr. Chairman and members of the subcommittee, I am Rev. Msgr. Francis J. Lally, secretary of the Department of Social Development and World Peace of the United States Catholic Conference; the national level action agency of the American Bishops. I join my coreligionists today in expressing gratitude for the opportunity to speak to the question of national health insurance before us.

At the outset, let me say that we are very pleased to see a project set in motion by the Senate Subcommittee on Health which is aimed at fundamental reforms in the manner in which this country addresses health and health care. We feel this action is long overdue. It is unfortunate that hearings and discussions on national health insurance would have to await the final days of the 95th Congress. Surely the deplorable health statistics of the present day as well as the astounding inflationary economics of the present system would have dictated a greater sense of urgency and priority on this domestic issue.

The labor leadership and others appearing before this subcommittee have documented the severity and intensity of our national health

problem. Before the close of this series of hearings, the membership of this subcommittee will no doubt document the injustice of our present "nonsystem" of providing for or ignoring the health needs of our citizens. It is a national scandal to see that over 10 million American families today cannot obtain any health insurance coverage whatsoever.

As a priest and as a pastor, I can tell you from very personal experience that economic anxieties of fathers and mothers in providing for the health necessities of their children, their aged parents and themselves, in a time of staggering costs for health protection, are taxing the basic strengths of American families.

It is out of a deep moral concern, then, that I appear before you today to reinforce the direction taken by you, Senator Kennedy, in introducing the proposed National Health Insurance Act of 1979.

We at the U.S. Catholic Conference have had a brief opportunity to review the proposed legislation and its basic thrust in the areas, for example, of universal coverage, cost containment, prospective reimbursement and public financing. While we do not profess any particular competency to judge the technical effects of such proposals, in general, we feel that most provisions conform to basic principles on national health insurance outlined by the U.S. Catholic Conference on several occasions during the past 5 years.

I won't mention these principles here now, but I would like to insert an earlier and more extensive statement made on the subject.

Senator KENNEDY. Very well.

[The prepared statement of the U.S. Catholic Conference, Catholic Hospital Association, and National Conference of Catholic Churches before the Committee on Ways and Means, U.S. House of Representatives, follows:]

PREPARED STATEMENT OF UNITED STATES CATHOLIC CONFERENCE, CATHOLIC HOSPITAL ASSOCIATION AND NATIONAL CONFERENCE OF CATHOLIC CHARITIES ON NATIONAL HEALTH INSURANCE

"I have come that men may have life and may have it more abundantly."
(John 10:10)

Over the years, the United States, as a relatively young nation, has had to develop a national philosophy of living largely by itself and through its own efforts. The weaving of a peculiarly American philosophy, like that of a rich fabric, has been slow and difficult, filled with starts and stops, but characterized by continuing progress and growing awareness of the importance of relationship among its varied elements. Examples of a developing U.S. social philosophy abound, and the U.S. Congress and this Committee in particular have often been the molders and the interpreters of our understanding of ourselves as we grow and mature as a nation.

Among the elements within an evolving national philosophy is our attitude as a people toward health and health care. Few would deny today that every citizen in this country has the right of access to adequate health care, although such a statement at one time was sharply questioned and disputed. Few would deny today that the United States of America possesses an enormous national resource with some of the finest health care institutions and personnel in the world, although at one time we were far behind in the quality of health care and research enjoyed by other nations; and few would deny today the commitment of the Congress and the federal government to continue and improve upon the dedication to excellence in the provision of health care to our citizens.

The current hearings conducted by this Committee are an example of this commitment. That the Congress recognizes the critical need to update the health care delivery system and make decent comprehensive health care available to all, is in itself a courageous and important step forward in the development of

a national social and moral philosophy. And the translation of principle to concrete and beneficial programs further illustrates this commitment.

As representatives of the Catholic Church's concern for adequate health care in America, our basic approach to the issue of national health insurance is rooted in the fundamental tenet that every person has the right to life, to bodily integrity and the means which are necessary and suitable for the development of life. The right to life clearly implies the right to health care; indeed, the two are philosophically and practically inseparable. The right of persons to health care further implies that such health care will be available, and that the route of access to necessary and comprehensive care will not be strewn with impediments.

In spite of the enormous dimension of the national commitment to health, we recognize the inadequacies of the health system. There exist presently widespread disparities throughout the country in the availability of treatment, facilities and personnel. And in a significant number of rural areas, inner cities, ghettos and barrios, there are few medical facilities and, in some cases, no physicians or nurses, contributing to haphazard and generally poor standards of health for millions of people. Health care costs have risen to the point where many will not or cannot seek necessary treatment because of severe or ruinous financial demands.

Such factors are partly responsible for the fact that—despite an estimated health outlay of 90 to 100 billion dollars in fiscal 1975, and a geometric growth in sophisticated medical technology, research and knowledge—in several areas, the United States ranks poorly among developed nations in the application of those advances via the health delivery system. For example, in 1950, the United States ranked fifth in infant mortality rate. Today, the United States ranks fourteenth in infant mortality, behind Canada, Switzerland, Hong Kong, Western Samoa and Fiji. In life expectancy, the United States ranks twelfth for women and twenty-seventh in life expectancy for males behind Spain, Greece and five Communist nations in Eastern Europe.

With such facts and statistics in mind, we strongly endorse the prospect of a national health care insurance program. We believe it is only through a well-planned national approach that the United States can begin to strike a balance between the actual delivery of health care to all persons living within our borders and our undisputed excellence in the areas of health research and technology. We believe that there can be no further delay in recognizing the moral necessity of developing a national health care insurance program within which all participate. The question, in other words, is not whether we should have a national program; it is how such a program should be developed and implemented.

Our testimony today reflects the principles we would wish to see included in any national health care program which will finally emerge, and seeks to address specifically those elements within several of the pending bills which we likewise feel should be included in the legislation. No one bill, in our view, provides a total and practical solution to the inadequacies in the present health care system, nor does any one bill speak adequately of the preservation of the better aspects of our present delivery system.

For almost 200 years, the Catholic Church in one area or another has been involved in the maintenance and delivery of health care. Presently, over 700 Catholic hospitals provide health care and related services to millions of Americans each year—Catholic and non-Catholic alike. The Catholic hospital system, with its current capacity of 158,000 beds, represents approximately 30 percent of the acute care voluntary beds in the United States. The Catholic community, through its dioceses and network of hospitals, clinics, medical and nursing schools, educational and other health care institutions, is planning expansion and new construction costing over $2 billion, 200 million. The complex health system sponsored by the Catholic community—which is a vital part of the overall American health system—treats some 25 million patients annually and, in related systems, maintains homes for 35,000 dependent children and almost 50,000 aged persons. Our Church engages in health care services in response to the needs of people. Our country's recognition and encouragement of a pluralistic system of health care delivery have complemented our continuing interest in service, as has the concept of individual and institutional integrity which recognizes the fundamental right of free adherence to ethical and/or religious beliefs. We submit that the voluntary Catholic system has made a

historic and substantial contribution to the overall system and provides high quality and sensitive alternatives to other equally qualitative modes of health care. Indeed, because of its history and tradition within the health care field, the Church bears witness to the importance and validity of the pluralistic, voluntary nature of health care delivery in the United States. The Church, through its commitment to Christian values, exists primarily to serve, particularly to serve the poor, the aging and sick among all peoples. Because of that tradition, we will continue to stay in the health care delivery system and seek to expand our services.

Indeed, the commitment to a Catholic expression of health care delivery, we believe, is analogous to and compatible with the growing country-wide commitment to a national health care program as expressed in the Congress. We see no necessary conflict between the advent of a national health insurance program and the continued role of the Church in health affairs.

The Church's commitment to the health care field is reflected in the understanding that its people are both providers and consumers of health care. Indeed, we are testifying today, in effect representing millions of consumers as well as speaking for 1,200 Catholic institutions providing health care. Within this understanding of the Church as a community of consumers and providers in terms of health care, we view the coming of national health insurance as a means to enhance the voluntary system of health care.

Consonant with our conviction to build on the strengths of the existing health delivery system, we offer the following legislative suggestions, recognizing that in some respects we are departing from other major provider groups.

COVERAGE

We believe that by attaching resrictions on who may be covered under a national health insurance program, or by attempting to define eligibility, many thousands and possibly millions of persons will either never be covered or will lose protection for a variety of economic reasons, including, in some cases, nonenrollment in the social security system. Distinctions among people, classes of people, or places of national origin are, in terms of the right to health care, an affront to the dignity of man. Therefore, coverage should be universal, including all U.S. citizens, resident aliens and aliens admitted for employment. Any other approach would compromise too severely a truly national approach.

In keeping with our Church's particular concern for those who are deprived of the abundance of life, we recogize that, as in so many areas, it is the poor and the aging who suffer most from the deficiencies of the current system of health care.

Escape from poverty is enormously difficult at best, but the possibility of breaking free is greatly complicated and often rendered impossible by the constant presence of potential debilitating ill health. While there are obvious differences among poor urban and rural communities in respect to health care, they share in a common fate—they receive less than adequate health care. Lack of subscription—individual or group—to health coverage policies, high costs, poorly equipped and understaffed clinics (where such exist at all), greater susceptibility to disease or accident, higher unemployment or underemployment—all contribute to sharply lower standards of health among the poor. Thus the endemic hopelessness of the ghetto—urban or rural—is maintained, welfare costs constantly escalate, and the price paid for erosion of the human spirit continues to climb. We support, therefore, the "folding-in" of Medicaid within a national program.

BENEFITS

We believe that the legislative enactment of a mandated package of benefits should include the following: preventive services, all physician services and all inpatient, outpatient and medical services. This is intended to include coverage for all catastrophic illnesses, all prescription drugs, post-hospital extended care, nursing home care, medical home health services, rehabilitation services, care for the developmentally disabled, dental care including orthodontia, therapeutic devices, prosthetic devices including hearing aids and eyeglasses, health-oriented social services, mental health services and necessary medical transportation.

We believe that a preventive approach to mental health care should especially be encouraged, including the developing of community-based mental health serv-

ices. Automatic cut-off limits on mental health services, such as a 30-day limit, should be discouraged in favor of an emphasis on quality control and peer review. Services provided by other certified mental professionals—in addition to psychiatrists—should be included in any final legislation.

The daily tragedies ranging from serious automobile, industrial and home accidents to the spreading incidence of severe long-term coronary disease, cancers and other crippling illnesses are incalculably compounded by the financial blows which too often accompany them. In a nation marked by its generosity and abundance in so many spheres, there is no longer any justification—medical, moral or monetary—for the prospect of severe financial difficulty or ruin being visited upon any individual or family as the direct or indirect result of serious injury or sickness. Elimination of a system which permits treatment and recovery only through great personal loss would top many an American's list of redressed grievances.

We would endorse the principles and concern which led to the inclusion of catastrophic coverage first in the Long-Ribicoff bill and retained and liberalized somewhat in the Kennedy-Mills measure. Liberal universal catastrophic coverage is only meaningful in the context of a total national health insurance program and, therefore, should not be enacted separately. The benefit package we have endorsed and our recommendation which follows—folding in Medicaid and Medicare and endorsing a long term care provision—would give us the catastrophic coverage we need in an overall, total program.

HEALTH EDUCATION

Our conviction about the right of all to health care prompts us to speak within the context of preventive health care for an equally strong programs of health education. Indeed, without such a program, even a liberally funded approach to preventive medicine could result only in marginal success. In spite of our country's vast and diverse commitment to education in general, there is no similar commitment to national and widespread health education, a condition symptomatic of the deficiencies within our present health care delivery system. We view national health insurance as an important vehicle for emphasizing health education through education and information programs. These programs should complement and stimulate health education programs in the school systems and community institutions. Health education on this large scale would be primarily preventive in tone, covering illnesses and ailments which people can take steps to prevent themselves, without unnecessary medical and institutional involvement. We maintain that a carefully developed program of national health insurance, accompanied by solid health maintenance education will result in the long run in substantially decreased medical services and institutional costs. We believe that such a program is crucial for the heatlh of the country, and see a national health insurance system as the most logical context within which to proceed.

PREVENTIVE MEDICINE

We believe there should be substantially more emphasis on preventive medicine and services than is reflected in most of the pending bills. We recognize that there may be present financial limitations in respect to immediate creation of a far-ranging effort to institutionalize, in effect, the practice of preventive medicine. Legislation should include authorities for the development of preventive health services and strong encouragement for the conversion of our present inclination to treatment of episodic illnesses to an approach which places more emphasis on comprehensive prevention of sickness.

The Congress, in its wisdom, took an important step in this direction last year through passage of the Health Maintenance Organization Act of 1973. We would like to see more funds allocated under national health insurance for the development of HMO's and for other methods which favor a preventive approach to health care. A national system of health care which places increasing emphasis on person-oriented preventive treatment should ultimately succeed in reducing the per capita cost of health care. Emphasis on preventive treatment—as well as health education—should reduce the high number of unnecessary hospitalizations. Physical check-ups, routine eye and dental examinations, chest X-rays, etc., should become commonplace features of coverage, as well as full screening tests for severe ailments such as diabetes, cancer or high blood pressure. As representatives of the Church, our concern relates to keeping persons and families

physically, mentally and spiritually healthy. We can think of no better general approach to this end than a well-planned, accessible preventive system of health care.

LONG-TERM CARE

Recognition of the needs of the old and poor really may be viewed as the forerunner of the general need for national health insurance. The need for health care increases as one grows older, both in terms of treatment and the use of medicine. Aging persons are naturally prone to a greater variety of illnesses and the necessity of ongoing health care is far more likely to become a permanent condition of life, rather than episodic. Yet this greater need for health care among the aged occurs most often when their financial resources are dwindling, or fixed as on a pension, and is poignantly illustrated in the nursing home situation in this country.

The needs of our elderly citizens and others for long-term care have never been satisfactorily met. The separation of levels and types of care has been a particular problem in the maintenance of the health and well-being of the elderly whose needs are often so great.

In line with our recommendation of universal coverage and no premium payment, we feel that Medicare should be folded into a single overall health insurance program and only phased out as new legislation is implemented. We would specifically recommend the inclusion in any bill of the concept of long-term care as envisioned in Title II of the Kennedy-Mills bill (H.R. 13870, S. 3286). For the first time, the range of care possibilities envisioned by this title seems aimed realistically at the range of need experienced, and offers the possibility of tailoring care to insure the maximum maintenance in as normal a community setting as possible. The establishment of entitlement to a multiplicity and full range of services not necessarily related to hospitals is excellent.

We do have some specific concerns which should be built into the eventual long-term care title.

As with our earlier recommendation on health insurance as a whole, coverage should be universal. The long-term care title should be mandatory in the states. It should not involve the payment of a premium. The mandated consumer participation in the proposed title is excellent. The "consumer's" freedom of choice should be preserved. We would also urge recognition of the provision of services for the elderly within the context of the religious-cultural traditions.

The long-term care title should provide for medical social work, dental care and routine preventive services and other ancillary services needed by the aged.

We feel that the title should be worded to prohibit a provider from becoming the community long-term care center. And, in the field of long-term care, there should be specific incentives for non-profit providers of service.

Title XIX of the Social Security Act, medicaid, would be repealed. But since 70 percent of the money for long-term care presently comes through Title XIX, we would urge that this part of Title XIX be phased out only as the new long-term provisions are actually phased in. In addition, we feel federal standards for long-term care facilities should be clearly mandated in the legislation.

The present practice of separating levels of care for fiscal purposes frequently results in moving elderly patients arbitrarily, resulting in great disorientation and often destroying the will to live. It also results in arbitrary definitions of what is one level of care, and what is another. We would urge the provision of a uniform system of monitoring which is humane and does not freeze in levels of care which require moving patients to less expensive facilities providing less service for fiscal reasons alone. There should be prospective reimbursement to providers on a cost-related basis for actual care rendered rather than reimbursement on the levels of care.

FINANCING

Three years ago our three organizations testified on behalf of using the principle of social insurance in financing any national health insurance program. Now we wish to make that more concrete. In order to distribute most equitably the cost of health care on as wide a base as possible, we believe health insurance should be financed by a mix of tax on employer payrolls, a tax on the self-employed and general federal revenues. No tax should be assessed on income received from public assistance, supplemental security income, social security or unemployment and workmen's compensation. This approach would help greatly

to ensure that nobody suffers from lack of coverage. And the method should eliminate the demeaning means test relative to health care. Any means test is injurious to a person's dignity, is almost impossible to administer fairly or efficiently, and accomplishes little.

A major difference between the various bills before this Committee is in the financing mechanisms. The Administration's Employer Health Insurance Plan (H.R. 12684 and S. 2970) is voluntary, which we think is unsound public policy because it may encourage employers to provide some more immediate employee benefit while discouraging employee participation in a more costly health insurance plan. It has some additional untoward side effects. The estimated premium for a family (three-fourths of which would be paid by the employer) is $600. The estimate per single individual is $240. The possibility of additional payroll expense could serve to promote the hiring of single and/or temporary employees. Even if this did not develop into a trend, another possible detrimental feature is the regressive aspect of the fixed premiums. Lower income persons, paying a family premium do so in proportionately larger amounts in relation to their income.

Other bills have similar regressive effects, or create separate tiers of care for the poor and non-poor, or operate on the experience-rating system of limited groups and do not share the cost of national health insurance over a sufficiently wide base. And some bills would not pool the purchasing power in a manner which can have a salutary effect in improving the delivery system.

We endorse the establishment of a national trust fund within the Social Security Administration to handle the collection and disbursement of funds—in terms of purchasing and reimbursing services. The contributions of employers and the self-employed, which would be collected on a national basis, should be earmarked specifically for the national health insurance program and should not be a part of the general federal budget. Amounts of monies involved should be strictly on the public record. Such an approach, accompanied by broad federal guideilnes, would illustrate the truly national character of the program. Under these federal guidelines, we see private insurance companies as fiscal intermediaries, suppliers of supplementary insurance and developers and managers of health maintenance organizations on a reasonable cost basis.

COINSURANCE AND DEDUCTIBLES

We have noted, of course, the differences among the pending bills on the issue of co-insurance and deductibles. We would say, on both subjects, that they have no place in a national health insurance program, and we would urge the Committee to eliminate all deductibles and co-insurance within a national plan. It is alleged that the presence of deductibles and co-insurance militates against overutilization of the health care system, in respect both to use of physician services and provider care. We contend that this is theory at best, with no firm body of supportive evidence. On the contrary, most utilization is determined by physicians in the provider system. We would also submit that the pricing policy in our current system inhibits and limits access to health care on the part of untold numbers of persons who need care. Furthermore, if deductibles and co-insurance were totally eliminated from the national plan, we believe that any initial overuse which might result will be more than offset by judicious use of peer review and an important emphasis on preventive health care and health maintenance education. We also believe that inclusion of the deductible and co-insurance systems and figures in any one of the pending plans will prove onerously difficult and expensive to administer. Dropping them altogether, we feel, would ultimately result in significant savings for the system, and end once and for all the financial and personal inequities associated with the practice.

ADMINISTRATION, STATE AND LOCAL ROLES, DELIVERY OF SERVICES

A national health insurance program would be unwise and excessively costly unless coupled with steady and substantial improvements in health care delivery. So we believe the financial leverage of that health insurance program ought to be used to secure substantial improvements in the delivery system. Secondly, while professional judgments and the responsibility of physicians for diagnosis and treatment must be assured, subject to peer review, national standards for health care services should be mandated for both individual and institutional providers of health care services.

So, while endorsing the fiscal role of the federal government, we feel equally strongly that the rate-setting, regulation, and certificate-of-need systems must be separate from mandated involvement of the federal government. The state governments must be in a position to assure the availability, the access, quality, and viability of the needed health services. We see strong state involvement in regulatory activities, rate-setting and health planning as the core of a national health insurance system in which the cost control rests with the federal government and the voluntary, pluralistic approach to health care options and delivery are enhanced by greater participation on the part of the states.

We feel the most logical way to proceed is through establishment of state health commissions, as proposed in H.R. 1, with the authority to regulate providers and the responsibility to assure that quality health care is available and accessible to all residents. State health commissions should be constituted independent of state control after having been duly created by the states in accordance with mandated federal guidance.

Each state health commission, in other words, would be the principal agency responsible for regulatory and related functions. In order to reduce any potential conflict within a commission, we would make two suggestions. First, there should be adequate local provider and consumer participation in the planning, rate review and certificates-of-need functions. Such local participation would preclude arbitrary and capricious decisions made at the state level. Secondly, there should be two equally responsible divisions within each state health commission—a rate review division and a planning/certificate-of-need division. Hopefully, this would eliminate competition relative to discussion and action on operating funds (rate review) and capital funds (planning/certificate-of-need).

We recommend that the local government (town, city, county) be the facilitator of coordinated planning among providers with strong consumer involvement. Regional and local comprehensive planning groups should be continued and fostered as the conveners of local providers and consumers with the responsibilities to promote needed services and to advise the state health commission on certificates-of-need and rates.

In order to assist the states in these endeavors, we recommend the establishment of broad federal standards, possibly accompanied by a federal contingency plan to impose regulatory, rate setting and certificate-of-need granting on a state or groups of states which are unable or unwilling to develop the means to implement the national health insurance program.

We recognize that professional and institutional providers must meet high standards of quality, efficiency and effectiveness. We likewise contend that national standards must be consonant with reasonable geographic and regional standards. Again, therefore, we would like to emphasize our belief that the respective roles of the federal and state governments be integrated under a truly national health care insurance program. We would call for federal specification of a broad set of benefits for all persons and the provisions of incentives for state and local agencies.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The basic intent of P.L. 92-603, relating to Professional Standards Review Organizations, is to provide peer medical review of the quantity and quality of medical services rendered, particularly in respect to the aged and the poor. Overutilization was a principal object of concern when the legislation was being considered, as reflected in the Senate Finance Committee's report that: "in view of the per diem costs of hospital and nursing facility care, and the costs of medical and surgical procedures, the economic impact of . . . overutilization becomes extremely significant."

Because utilization review, as such, was found not to prevent such overutilization, "regional norms of diagnosis," to be applied by area Professional Standards Review Organizations, were aimed at alleviating costly overutilization and, therefore, improving the quality of care. Our organizations support these basic objectives. But, because Professional Standards Review Oragnizations are just beginning to be placed into operation and because there is not yet sufficient empirical evidence to support the conclusion that they will successfully perform their functions, it is strongly recommended that their development and operation be accompanied by a formal and ongoing evaluation program.

Specifically, we would make the following recommendations. First, we think there must be statutory protection against possible intrusion into patient record confidentiality by Professional Standards Review Organizations' non-medical personnel. Secondly, we believe that, under Professional Standards Review Organizations' procedures, physicians should be subject to liability for disapproved medical services. Thirdly, there should be relief or appeal procedures in the law which recognize that some of the "norms of diagnosis" to be followed by Professional Standards Review Organizations may be unreasonable, arbitrary or unmanageable, for example, medical school standards in some settings. Fourth, Professional Standards Review Organizations' deliberations should not be subject to public scrutiny because of adverse effects on physician review procedures. If professional Standards Review Organizations' minutes were subject to public disclosure, physicians may be hesitant to review objectively a peer's medical procedures. And finally, attention must be paid to the problem of possible administrative delays in hospital reimbursement under Professional Standards Review Organizations' procedures.

THE ROLE OF THE CONSUMER IN NATIONAL HEALTH INSURANCE

The responsibility for maintaining good health and for high standards of health is shared by those who need or receive services as well as those who provide the care. The relative paucity of health care providers in poor or minority communities is clear testimony to an over-emphasis on provider determination of services and locations. We believe that any integrated system of health care delivery and any national health insurance plan must provide for substantial and equitable participation by consumers in determination of policy and review. Such participation should be both mandated and encouraged. The bills before the Committee vary widely on this subject, according the issue differing levels of importance. We would urge that the subject receive priority attention.

Mr. Ullman's measure (H.R. 1) establishes the principle of consumer participation in local delivery mechanisms. We agree that institutional and group providers should have equitable consumer representation on their boards. H.R. 22 and S. 3, sponsored by Mrs. Griffiths, Mr. Corman and Senator Kennedy, provide for consumer participation in an advisory capacity as regards determination of policy and the administration of the program. We believe that consumers should justly be involved in any local, state or regional planning agencies and in federal and state agencies charged with designing and implementing the elements of a national program.

In the latter respect, we urge a National Health Service Advisory Council be established to relate to the National Trust Fund and State Health Services Advisory Councils be established to relate to the State Health Commissions. Advisory councils should be in a position to contribute both to the development of fiscal policy and to standards-setting procedures. Half the membership of these councils should be composed of consumers of health care services and half of providers. We also favor the provision that these advisory councils have included among their responsibilities the review of any proposed regulations or regulation changes prior to publication in the Federal Register. Experience with the Medicare-Medicaid Amendments of 1972 and other legislation, in corresponding with the Department of Health, Education and Welfare on the matter of social services, shows how implementing regulations can be subject to numerous and often conflicting interpretations.

Regarding our support of the Title II long-term care provisions of H.R. 13870, the Kennedy-Mills bill, we favor the definition of consumer participation in the governing boards of the community long-term care centers, and we urge a consumer role in state long-term care agencies as well.

Earlier we said consumer participation should be both mandated and encouraged. We note that it is easier to mandate participation than it is to encourage meaningful involvement. Consumers, especially the poor, minorities and the aged, will need special education and assistance to participate strongly and meaningfully. Indeed, we feel that attention should be given to providing consumer representatives professional, technical or other staff back-up, responsible to them, so that they do not participate at a disadvantage in relation to providers who substantially control the language and know the complexities of the system.

We believe that consumer initiatives in respect to bringing health services into a community must actively be encouraged. Accordingly, we feel that the legislation should provide clearly for federal override of any state regulations or

legislation which curtails or discourages consumer initiatives in relation to federal health funds and programs. Without such protection, consumer participation will vary widely and significantly among the states, to the detriment of a national health insurance program. We urge also appropriate procedures for appeals.

Finally, we suggest that a definition of the word "consumer" be provided in the legislation which will exclude providers and government officials (who are also consumers) from the terms of the definition, and will specifically include equitable representation for the poor, minorities and the elderly.

FAMILY PLANNING

In light of our commitment to a positive national health insurance program, we must also state our convictions as regards family planning services within potential legislation. The proposed emphasis on preventive health care and on mandating a broad set of benefits should not, in our view, include family planning services—particularly sterilization and abortion procedures—as parts of those benefits. We unequivocally oppose their inclusion in any legislation.

For the purpose of today's testimony, we will especially address the subject of abortion as one of the family planning services which might be covered under the terms of national health insurance. We strongly oppose any program that includes abortion as a method of family planning. The Congress has prohibited funding abortion as a method of family planning, and this prohibition must be extended to national health insurance. We cannot over-emphasize our belief, as stated in the papal encyclical of Pope John XXIII, "Peace on Earth," that "any human society, if it is to be well-ordered and productive, must lay down as a foundation this principle, namely, that every human being is a person, that is, his nature is endowed with intelligence and free will. By virtue of this, he has rights and duties of his own, flowing directly and simultaneously from his very nature. These rights are therefore universal, inviolable and inalienable."

Further in that encyclical letter, Pope John affirms that "every man has the right to life, to bodily integrity, and to the means which are necessary and suitable for the proper development of life."

We firmly maintain that the practice of abortion is absolutely violative of the right to life and its development. Health care must include protection of the child in utero. We submit that the right to privacy, as defined in the Supreme Court decision of January, 1973, cannot take precedence over the immutable right to life itself. We believe that the preponderance of scientific evidence clearly shows that the fetus is a living, individual human being whose pre-natal development is but the first phase of the long and continuous process of human development that begins at conception and terminates at death. We hold that, regardless of the circumstances of origin, human life is valuable from conception to death because God is the ultimate Creator of each human being, and because human life is valuable in and of itself simply because of its own inherent sanctity. We also feel that someone must speak forcefully on this subject within the context of potential national health legislation because we strongly believe that the right to life is a basic principle of all health care services. Moreover, if the taking of human life through abortive procedures is sanctioned federally, equally destructive practices—such as euthanasia and sterilization, particularly of the mentally retarded—will become commonplace in the future, as evidenced by incidents that have been carried out in federally funded programs in the past. Moreover, public opinion surveys continually show that the majority of Americans oppose abortion on request.

As representatives of the Church, we must assert that whenever a conflict arises between the law of God and any human law, we are bound to follow God's law. With respect to religious beliefs, conscientious convictions, moral directives and ethical codes, we strongly urge the Committee to include adequate protection for individuals and institutions within national health insurance legislation. Congress has already taken cognizance of the need for conscientious protection by incorporating relevant provisions in the Health Programs Extension Act of 1973, Public Law 93-45. In addition, many states have adopted, or are in the process of adopting, protective legislation.

In summary, we believe that participation by persons and institutions in any system of national health insurance must not be contingent upon nor result in the violation of deeply held beliefs by persons of many faiths. Catholic people

and Catholic health care institutions could not participate in any plan which would require the violation of such beliefs, most emphatically in the areas of abortion services.

CONCLUSION

We would urge the enactment of a total health care insurance program now, though we recognize the program itself will have to be phased in over a period of time. The phasing aspect will allow the program to mature—particularly in terms of administration and experience—and will allow for an orderly transition to the full package of benefits which, understandably, will require time to achieve.

This concludes the testimony, Mr. Chairman, of our three organizations. We would like to emphaize once again that by appearing today, we are confirming the commitment of the Catholic Church and the thousands of priests, sisters, lay persons and health personnel associated with the Catholic expression of health care in the United States. They and we are vitally interested in the proposed legislation, and we and our staffs stand ready at any time to assist the Committee and its staff in the formulation and clarification of a national health insurance program. You and the Committee are to be commended for the comprehensive hearings you have held and for your understanding of the need for this legislation. Thank you very much for the opportunity to discuss our concerns and wishes with you.

Msgr. LALLY. Continuing with my own statement, as my colleagues have noted, we, too, believe that some refinement or amendment is in order to clearly rule out any form of means test in a national health insurance program. Without such a commitment, it is probable that we will continue to see a two-class system of health care, one for the wealthy and one for the poor.

Beyond these concerns, however, which have been adequately and thoughtfully noted, I would wish to bring to your attention an area of particular concern to those of us in the Catholic community. We are compelled to state our conviction regarding certain services under a proposed national program for health. We are opposed to provisions for contraceptive devices and sterilization for contraceptive purposes. We are opposed to the inclusion of abortion services as "benefits" in any national health insurance plan. It is our contention that human life is inviolate at every stage of its being. Belief in this principle motivates us to urge this subcommittee in the most serious and certain terms to reject any effort to provide for abortion services through the means of national health insurance coverage.

There is one further point which we feel compelled to stress at this time as well. For almost 200 years in this country, the Catholic Church, in one form or another, has been involved in the maintenance and delivery of health care. We engage in health care services in response to the needs of people and as a witness to the love of Christ. The church, through its commitment to Christian values, exists primarily to serve, particularly to serve the poor, the aging, and the sick among all peoples. Because of that tradition, we will continue to stay in the health care delivery system and we will seek also to expand our services. We see no necessary conflict between the advent of a national health insurance program and the continued role of the church in health affairs. In this connection, we are pleased to see that the proposed program builds upon the strengths of the voluntary sector. We would underscore the value of a pluralistic approach to health care and ask that this value play a significant role in the subcommittee's thinking as it refines its plans on this measure.

In closing, let me say that we are heartened by the action taken by this subcommittee today. Comprehensive health reform is, in reality, a national commitment toward alleviating the extensive sickness and suffering which many American families are forced to endure because they do not have access to our system of care today.

As you, Senator Kennedy, noted many times, nowhere are the inequities of our society more obvious than in the sickness of those many millions of our citizens who must endure illness in life because they cannot afford health care. We know that the more affluent few in our society can buy the world's best and most expensive medical care. We heard about that this morning.

But, in the United States today, millions of our citizens are sick and they are sick only because we have a multibillion dollar enterprise that cannot serve their basic needs. Their sickness is scandalous because we could attack it so easily had we the national will to do so.

Thank you very much.

Senator KENNEDY. Thank you very much, Monsignor.

Do you think the church is willing to play a role in mobilizing the public support for the uphill struggle?

Msgr. LALLY. I think that all the churches are very seriously interested in the moral question you mentioned earlier.

We are coming kind of late on the scene with the understanding that health is a basic human right, and it has to be demanded from Government and from the society, and the church should be a principal agent in this matter.

Senator KENNEDY. Mr. Thompson, there is just one brief response that I would like to make to the questions that you raised in your testimony.

I think I have indicated that those points of the general principles I will give you every assurance that legislation henceforth will be universal, will have the comprehensive benefits.

I believe in the importance of hospices. We will have the cost containment which you mentioned, and the strength on preventive medicine and consumer involvement.

There is a strong commitment in the involvement in the shaping of health planning programs that will be mandatory for all residents. And we are committed toward not having that needs test. We want the kinds of quality controls which we believed in for a long time. We had a Quality Control Commission on the first HMO bill that was dropped. The opposition of organized medicine is to try to evaluate inputs and outputs and make that available to the public, to permit that kind of discretion.

So these are all elements that we are strongly committed to. Downpayment on preventive aspects will be passed in the Senate this year. I want to give you reassurances in those areas.

The rule for the private companies and restraints on the budgets, as you know, we are really out of a direct request of a meeting with the President to try to develop an approach which would meet the objectives of S. 3 in terms of its impact on the consumer, but also to try at least to respond, to some extent, to the President's perception of the concerns of some role for the private sector and also for the line budget items. I quite clearly believe that is the fairest and most progressive way to raise the resources.

But the realities of this situation, whether we are going to be able to impact the American citizens with the benefits of S. 3.

I am more flexible about how we are going to get there. Although I have my own views, if it were let up to me as to how I would proceed, I do not think there can be any adjustment of the points that you have raised in terms of its universality and containment aspects, and your excellent statement on catastrophic insurance is a partial step. But I want to give you the full and complete assurance, as far as I am concerned, that those objectives will be incorporated in any legislation.

I do think in these other areas about the role of the private companies and the questions beyond budgeting are matters that we are going to have to come to grips with, and they are troublesome to me. They are troublesome to me in terms of fashioning any legislation that I would support. But I do feel that we can, and must, deal with the realities, and this policy issue is the climate and atmosphere in which we find ourselves.

If we waited another 20 to 30 years, there are going to be millions of people who are sick and ill who are going to fail to be provided for. I am against a halfway meaningless measure, but I am strongly committed to challenging thoughtful men and thoughtful women in all aspects of the health area to try to work with us and see if we cannot achieve those fundamental principles which I think all of you have stated very eloquently as a basic fundamental human right that finds its significance in the Judeo-Christian ethic.

One aspect on a point that you mentioned concerned the developing of a public financing option on this, and we can examine it. We will look into this. The concern I have is that we may perpetuate a two-class system. There seemed in our examination of it that there was a greater value of bringing those with a higher kind of risk together to insure that there was at least one standard. If it were to fall in one place where we just had those and are not covered in a public finance system, we may have to perpetuate a dual kind of system of health care which, I think, in too many instances, exists in our society.

We heard some statements on it from Bill Hutton and other witnesses as to what happens to our elderly people. Yesterday we had a very eloquent statement from an elderly lady.

So I think we are in harmony in terms of both objectives and fundamental kinds of principles. I think even with our own group there is a difference perhaps in terms of too many kinds of aspects. But clearly we are on the path together and the broader areas of common agreement. I think, are so overwhelming that by working closely together and fashioning this legislation, I think we can respond to the moral issues which all of you have testified are so fundamentally involved in this area of public policy.

We are going to need very strong help and support.

We are going to need the pointing out of the moral aspects of this issue. I believe in it myself, but it is important that people understand.

My own sense, after 16 years of the Congress, is that we are a very lethargic institution. We are constantly subverted by private interests, special interest groups.

I think the role of special interest groups in our society, and as it is being reflected in the Congress is growing.

I think the extraordinary power of campaign contributions, the skill with which specialized groups are able now to bring influence and pressure on Members of Congress is as high in intensity as I have ever seen it in my 16 years in the Congress and in the Senate, and the ways in which this Congress and this country have been moved in recent times in the most important ways, which are awakening the conscience of the Nation in the area of basic civil rights and the great movements in the period of the 1960's which included the ending of the war in Southeast Asia, were basically grassroots movements. It was when the moral issue was raised.

If this really came from the grassroots part of the country, it would help enormously. There are a few of us who have tried to raise this issue and to focus on it, but it basically has to be raised as a moral issue. There are no groups which have testified here today that I think can bear a greater responsibility in assuring that the American people understand it, and there is perhaps no more important group in awakening the conscience of the citizens of this Nation about their duty to see that this Nation addresses it in a serious and responsible way. That is what we want to do.

I welcome the opportunity to work closely with your groups and trying to see that we fulfill our responsibilities to people who occupy this great Nation.

Mr. THOMPSON. Senator, I can assure you, I can pledge to you the cooperation of the groups we represent in the further discussion of this issue.

I can assure you that we share your concern about the ultimate goal, and I can inform you, if you are not aware of the fact, that the religious community has established a network throughout the Nation known as the Impact Network in which 17,000 of our fellow citizens have been enlisted which will be at the disposal for support of the very principle that you have enunciated.

Senator KENNEDY. Thank you very much.

We will recess until Friday at 9 o'clock.

[Whereupon, at 12:12 p.m., the subcommittee recessed, to reconvene at 9 a.m., Friday, October 13, 1978.]

NATIONAL HEALTH INSURANCE, 1978

FRIDAY, OCTOBER 13, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH,
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 4232, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Javits, and Chafee.

Senator KENNEDY. We will come to order.

We welcome the Secretary of HEW here this morning. It is always a pleasure to have him before our Senate Health Committee. And we welcome Jim Mongan, the Deputy Assistant Secretary, who worked very closely with us on the health policy issue, and Dr. Karen Davis, Deputy Assistant Secretary for Planning/Health.

Mr. Secretary, we want to congratulate you and the administration for achieving so much on cost containment. It may not be what the administration wanted fully, but I think there is a very clear indication that the American taxpayer is fed up with exploding health care costs.

The administration and the people in HEW have been of enormous help and assistance to those of us here on the Hill. Hopefully, in these final hours, we can have a positive response from the House of Representatives.

We're glad to have you and we look forward to your testimony. I have had a chance to go through it, but we would ask you to proceed in whichever way you wish.

STATEMENT OF HON. JOSEPH A. CALIFANO, JR., SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DR. JAMES MONGAN, DEPUTY ASSISTANT SECRETARY FOR HEALTH/NATIONAL HEALTH INSURANCE, AND KAREN DAVIS, DEPUTY ASSISTANT SECRETARY FOR PLANNING/HEALTH

Mr. CALIFANO. Mr. Chairman, let me just express on behalf of myself and on behalf of the President our appreciation for your efforts in leading the cost containment fight here in the Senate, with Senator Nelson. It was your committee that reported out the administration's bill, and it was you and Senator Nelson who led the fight on the floor yesterday and the work before. So let's hope we can get the House of

Representatives to act on that legislation which will save the American people at least $30 billion over the next 5 years.

Mr. Chairman, why don't I submit the entire statement for the record, and I'll read portions of it, if I may.

Mr. Chairman, few ideas have been the subject of more national debate and less congressional attention than national health insurance, as you have indicated. Not only have Presidents since Truman sought passage of a national health insurance plan, but in the last decade a number of proposals have been introduced in the Congress, with some of the most important and thoughtful plans bearing your name—Kennedy-Griffith, Kennedy-Mills, Kennedy-Corman.

Yet only one of these bills, a catastrophic bill, has emerged from a full committee of the Senate. None has been reported out by a full committee of the House. And, of course, neither the Senate nor the House has approved a national health insurance proposal.

It is imperative, therefore, that we in the administration and you in the Congress, who are deeply concerned about the state of health care in the United States, work together to devise a strong piece of legislation, but a piece of legislation that, unlike past proposals in this area, can be enacted into law.

As we move from generalities to specifics in the months ahead, we all recognize that we will be dealing with a highly complex subject, with significant implications for our health care system, for the fiscal and budgetary policy of the Federal Government and for the state of our Nation's economy.

Health care in the United States is big business. In fact, the health care industry is our Nation's third largest, with expenditures of $183 billion, or 8.8 percent of the gross national product, in fiscal 1978.

Almost 6 million persons, 6 percent of the labor force, are employed in the health care industry.

Twelve point seven cents of every Federal tax dollar—nearly $60 billion in the fiscal 1978 Federal budget—is spent on health care costs, and States and localities spend an additional $25 billion annually.

In fiscal 1977 there were 37 million hospital admissions; 170 million Americans visited a physician at least once, with the average person making five visits annually; more than 1½ billion prescriptions were filled; and 5 billion laboratory tests were ordered.

In fiscal 1978 we estimate that medicare and medicaid alone will reimburse 120 million days of hospital care, and that there are 800,000 physician visits each day that medicare or medicaid will reimburse.

These figures alone reflect the complexity, and the potential difficulty, of making needed changes in an industry not subject to the normal economic forces of the free market.

Yet, both the administration and this subcommittee share a strong belief that it is imperative to make some basic changes in the health care industry. We share an understanding that our present health care system is fundamentally flawed.

First of all, millions of Americans lack coverage for basic health services and lack protection from catastrophic medical expenses.

At least 20 million Americans have no health insurance, and more than 18 million Americans have inadequate insurance; and about 85 million Americans, 40 percent of the population, have no insurance against very large medical bills.

Under the present health care system, these gaps in health coverage will not be closed.

Second, the costs of health care are out of control in this country, adding to inflation and threatening the stability of governmental budgets. Spending in the health care industry has been rising at an annual rate of 12 percent, with little improvement in the health of our citizens.

Thus, this year an American citizen will spend $112 for the very same health care that cost him or her $100 last year. These expenditures cannot be successfully contained under current health delivery and financing methods, which produce unnecessary hospitalization, overreliance on expensive technology, and inadequate preventive care.

Unless we can institute meaningful cost containment measures through hospital cost containment and restraints in a national health plan, national health care costs will rise to $322 billion by 1983, nearly 10 percent of the gross national product; Federal health care expenditures will rise to $90 billion by 1983, more than 13 cents of every Federal tax dollar under current projections for that year; and the cost of individual health care will rise steeply.

The average cost for a family of four will leap from $2,115 in 1978 to $3,590 in 1983, and the average cost for an elderly individual will soar from $2,014 to $3,417 during the same 5-year period.

Let there be no mistake, Mr. Chairman. These soaring costs will not be restrained by voluntary efforts. Let me give a striking example from the hospital industry to illustrate the point.

In 1976, the average rate of increase in hospital expenses was 15.4 percent over 1975. In figures recently developed by the hospital industry itself, we learn that in 1977 the rate of increases is 14.2 percent over 1976. But that change is the result of mandatory cost containment programs operating in nine States, where the average 1977 rate was 12 percent over 1976.

In the 41 States that had either voluntary cost containment programs or no program at all, the average rate of increase in hospital expenses was a whopping 15.8 percent in 1977 over 1976.

The voluntary effort to hold down hospital costs, which are 40 percent of health costs, is a sham, an imposter seeking to usurp the achievements of the mandatory State efforts. Strong constraints are essential to hold down inflation in the hospital industry.

Third, systematic reforms are needed to increase access to health services, to provide more appropriate types of services, and to eliminate the inefficiency and lack of competition in the health care industry.

Mr. Chairman, these are the fundamental problems that demand solution if our health care system is truly to serve the American people.

In the 20 months since the Carter administration assumed office, we have worked with you in developing a number of important initiatives to deal with these problems: Hospital cost containment, HMO reform, clinical laboratory legislation, and reauthorization of the health planning legislation to name a few.

But we have also been committed, as you have, to solution of these major flaws in our health care system by introduction and passage of a national health plan.

Last year I appointed an Advisory Committee on National Health Insurance, chaired by Under Secretary Hale Champion, and comprised of members and representatives from consumer groups, providers, labor, insurers, and other organizations with interests and with a vital stake in the national health insurance debate. We also sponsored a series of regional hearings, and at least one hearing was held in every State in the Union. And we developed four prototype plans for public discussion and criticism.

This first phase of our efforts culminated in the President's statement of principles, which was issued on July 29 of this year. In his July statement, the President directed me to develop a tentative plan which embodies these principles and which will serve as the basis for in-depth consultation with the Congress, with State and local officials, interest groups, and consumer representatives. I expect that we will make this tentative plan public later this year.

After intensive consultation, we will then prepare detailed recommendations for the President early in 1979, so that he can make decisions about the actual shape of the legislation he will submit to the Congress.

As I have repeatedly emphasized, this schedule for development of our national health plan will not and should not delay the introduction, passage, or implementation of a comprehensive, universal plan.

We have always hoped that Congress would act favorably on a national health plan in the 96th Congress, and that we could begin to phase in new benefits several years after passage of the bill.

Mr. Chairman, let me turn briefly to the substance of the President's principles for a national health plan. In summary, the first principle indicates that the plan should be universal and comprehensive, and should include protection against catastrophic costs;

The second and third indicate that quality care should be available to all, and the people should have freedom of choice in selection of providers;

The fourth indicates that the plan should include aggressive efforts to control inflation and should include strong cost controls and efforts to strengthen competition in the health sector;

The fifth sets out a goal—that additional expenditures should be offset to the extent possible by savings from greater efficiency in the health care system;

The sixth principle focuses on phasing, indicating that implementation will begin in 1983 and will proceed gradually. It states—and I quote:

> As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other government programs, in which expenditures far exceed initial projections, must not be repeated.

The seventh indicates that financing should come from a number of sources, including Government funds, employer and employee premiums, and some cost sharing by patients.

The eighth indicates that there should be a role for the private insurers, subject to appropriate Government regulations.

The ninth and tenth, that the program should seek to improve the health delivery system and assure consumer involvement.

The President is deeply concerned that the present health care system fails to serve millions of Americans. And, like you, Mr. Chairman, he is equally concerned about the intolerable inflation in the health care industry, inflation that has had corrosive economic effects with little accompanying improvement in health care for our citizens.

It is the need to address the critical problem of health cost inflation—which stems from fundamental failings in the health care system—as well as the need to provide adequate health insurance and health care services to millions of Americans which has led the President to call his proposal a national health plan, not just a national health insurance initiative.

As we moved forward to address these fundamental problems in the health care industry, we do so with the understanding that solutions to our health care problems are closely tied to two other major national priorities: The need to bring inflation in the economy as a whole under tight rein, and the need to spend the Federal dollar prudently.

The President underscored these points in his directive to me—and I quote:

> Before I submit legislation to the Congress, I want to be certain that the plan is consistent with our efforts to control inflation in the health care sector and the general economy. Before you send me final recommendations for a national health plan, you should analyze the issues of cost control and health system reform in greater depth. The American people would not accept, and I will not propose, any health care plan which is inflationary. A comprehensive national health plan will provide a critical opportunity to mount a national effort to bring the system under control.

Given the broad national concerns which must be taken into account by the President in the formulation of any particular policy, it is understandable—indeed, inevitable—that the President should ask his advisors to develop a proposal that protects the economic well-being, as well as the health of the American people.

Mr. Chairman, let me now turn briefly to the outline for a national health program that you announced on October 2, 1978.

Senator KENNEDY. Before you do, at this point in the testimony you make the very compelling case, and one which I agree with completely, about the costs being virtually out of control in our current system. And you have a number of pages on that particular point.

Then you also reach the conclusion which I would certainly subscribe to, that the only way you're going to be able to get an effective control on the costs is by the effective kinds of cost controls that come through in a national health plan.

But then you also say you're going to consider the phasing in of some aspects to depend upon some other kind of economic factors. There seems to be some inconsistency in that position. If you say the costs are going absolutely out of control, which I would agree with, and if you say the middle income, the elderly, the working people cannot afford it because it's going out of control and, therefore, would need health insurance, and then you say on the other hand "well, we're not really going to move ahead on health insurance until we're able to get a health care plan which isn't inflationary," it seems to me, at least, to be a non sequitur.

Mr. CALIFANO. Mr. Chairman, I believe the point we're trying to make is that our experience in putting government programs into ef-

fect in the health care industry—perhaps the two most notable being medicare and medicaid—in both programs you and I realize that if we could legislate ourselves, we would make some significant changes to get better control over costs.

We want to make certain that as a national health plan is put into place, it does, indeed, control the costs as we hope it will. When we recommend the legislation and when the Congress passes it; that if at various points it's ineffective in doing that, or if at various points when the benefits of that plan are due to go into effect there are other economic or budgetary considerations which indicate that the——

Senator KENNEDY. How can you make other economic considerations to determine whether the elderly people or the poor will be able to get it? Why have a contingency on their ability to receive the benefits of this program depend upon whether there's a strike or whether there's some kind of national disaster? You are going to have a continuation of the explosion of health care costs and you'll continue to have the needs of the elderly and the needy.

So why do you contingent your program on factors that have absolutely no kind of relationship to these other kinds of disasters? By your own testimony, you indicate the health care costs are going to continue to escalate dramatically.

What rhyme or reason or what logic is there behind that?

Mr. CALIFANO. Mr. Chairman, if on the benefits side of any national health plan package. for example, there are major costs for the Federal Government or for the American taxpayer scheduled to go into place, it is our view that the President should have an opportunity at various points in the plan to make judgments as to other considerations.

Let me give you an example. If benefits costing $5 billion were due to go into effect in a certain year, and at the same time we had a massive amount of unemployment, it may be that the President and the Congress, in their wisdom, would decide that only part of those benefits should go into effect and some of the funds should be directed at a jobs program to employ the unemployed.

The objective that we seek I think is the same. I think both of us believe that health care is a right, but that there are other rights of similar importance in this country: Every individual that wants to work has a right to a job; every individual has a right to as much education as he or she can take, and to develop their talents.

The problem is to——

Senator KENNEDY. If the right is conditioned on whether OPEC raises the cost of energy, if the right is conditioned on whether we're going to have some kind of strike in this country, if the right is conditioned on some other factor in terms of inflation of health care costs continuing, then its a meaningless right. Then it is no right.

That, effectively, is what you're saying. You're saying that if these other kinds of conditions come in, then we're for universal, comprehensive factors. But if we run into factors in which health has no impact, or effectively has nothing to do with health care, then it's going to be a conditional right.

If you make it conditional, then you're saying to the elderly and needy that if all these other conditions are OK, you're going to get

those benefits, or perhaps you'll get those benefits. But you're conditioning a right on factors which are not related to the health issue. If it's a conditional right, then I don't think it is a right.

Mr. CALIFANO. Mr. Chairman, I don't consider it a conditional right and I would not put it the way you have put it. I would go back to what I——

Senator KENNEDY. Well, are you going to have one bill or multiple bills on health insurance?

Mr. CALIFANO. That's another issue, and that issue has not yet been resolved. As I indicated the President, in the announcement of his principles, indicate a strong preference to have one piece of legislation. But whether we will or not is something we have not yet resolved.

Senator KENNEDY. This goes into the differences with the administration. I think that one bill is absolutely fundamental. If you're going to say the elderly and the needy people are going to have to come back to Congress time and time and time again, to insist on and demand these rights, in a series of different types of actions, then again I feel you're failing on the fundamental question of getting a universal and comprehensive program.

You're just saying you're going to phase this in and take it piece by piece. The elderly can't keep coming back here, and the working people can't keep coming back to the Congress, but the American Medical Association can and the American Hospital Association can, and the special interests can, and they'll be out to torpedo each phase of this, which they have opposed right from the very beginning.

I think if you basically make the decision about multiple bills, you're stacking the deck against the people who need this health insurance.

The other point is that while all of that is happening, you're getting the continued explosions of health care costs. Those are going to continue unless, as you point out, you're able to get an effective kind of cost control.

Mr. CALIFANO. Mr. Chairman, I think we both share the same objective. What I think is everyone—you, President Truman, President Kennedy, President Johnson—has tried to pass a national health plan. For 30 years this country has tried to pass it. We have had two major steps forward, medicare and medicaid, which passed in 1965.

Now, to make a "right" real, to put some flesh on the bones of any right, we have got to have legislation that we can get through the Congress. I think our best judgment at this point is that our strong preference is for one piece of legislation to do this. But if we thought that submitting more than one piece of legislation would have a better opportunity of making this right real for the Nation's elderly or the poor or the working people of this country, we would make that judgment and submit more than one piece of legislation.

Senator KENNEDY. Well, let me ask you about that.

Who is your constituency? The ones that are going to be the most affected or impacted do not support that particular program. You're saying, possibly you can develop the kind of political support around the country to support your type of program, and yet we have heard from the elderly people, we have heard from representatives of working people, we have heard from the ministers and the leaders of the

various church groups, and we are going to hear from those that represent and speak for the minority groups and others, who deplore this kind of slicing of this particular program, because they have been around the Congress long enough to know the power of these various special interests.

They're absolutely right. After 16 years in the Senate, they're absolutely right about that. They feel the only way they can get the support is by at least assuring the burden is going to be on those who want to take those rights away from them after the Congress acts, rather than coming down here every 2 or 3 years and trying to get one more piece of the pie.

I don't know who your constituency is.

Mr. CALIFANO. Mr. Chairman, on that point I would say that we need a broader constituency than the constituency that has traditionally supported national health insurance.

As well intentioned and as dedicated and as extraordinarily able and energetic as that constituency has been, it has not been able to obtain passage out of any committee of the Congress, much less out of any House of the Congress, much less out of both Houses of the Congress, of a national health plan, I would hope that we would be able to put together a broader constituency. I am sure that's your objective, as it is mine, so that we can get the kind of backing that is necessary to get the bill out of committee—and it may be more than one committee, as you know, in each House—out of each House, through a conference, and on the law books of this country.

Senator CHAFEE. Could I ask a question, Mr. Chairman?

Senator KENNEDY. Let me just finish this thought, and then we'll come back to you.

I think you're starting off at the outset without an effective opportunity to achieve the program. These constituencies are not aboard and are opposed to this type of approach. I don't see how you can get to where you're going. I think you need those kind of constituencies, and you need a good deal more. You have to be able to convince the American people of the fact, that you are not going to get a handle on costs unless you're going to have effective budgeting and cost containment. You're just not going to do it. You have got to tie that in with a benefit package, and that's what the national health program has to include.

It seems to me, unless you're going to have those items together, and have the constituency in support of it, and across the country, and build on that basis, and then effectively you're going to have a piecemeal approach with noneffective kinds of cost controls. You're going to insure that the Congress is going to take the easiest aspect, the easiest road out.

The people that are in the greatest need for the kinds of programs that this is designed to impact are going to be left without the coverage.

Senator CHAFEE. Isn't the problem really one of money, Mr. Secretary? There are all kinds of constituencies that come before the Congress. There's a constituency for mental retardation, there's a constituency for education, a constituency for defense, and to say each person has a right, sure, they've got a right. They've got a right to a decent

house and a right to education and a right that their children be healthy.

The problem is, there is not a sufficient belief in the Congress or reflected through the people that the Government should step in and pay for the total coverage that is espoused here.

Isn't that basically the problem we've got?

Mr. CALIFANO. Senator, let me answer that from two vantage points: In the broadest sense, the President is obviously concerned about inflation and costs; he is obiously concerned about the relationship of any massive program dealing with the third largest industry and its relationship to unemployment, to education, to the economy generally, to the right of every worker in this country to have a wage that is not eroded and corroded by inflation.

But in terms of cost, in the health industry itself, this Nation cannot afford not to have a national health plan. First of all, there is so much leakage and waste in the current system; there are 130,000 excess hospital beds, costing between $20,000 to $25,000 per year to maintain, not determined by HEW bureaucrats but by local health systems agencies.

On the west coast of the United States the average length of stay in a hospital is 6.4 days. In New York State it's 9.9 days. That alone costs the people of New York State and this country $819 million a year in unnecessary hospitalization.

There's too much surgery in this country that is utterly unnecessary. Insurance companies that have gone to second opinion plans have reduced surgery by 30 percent.

There is a tremendous amount of waste at all kinds of points in this system. We believe there is ample room in this system to substantially cover the costs of providing broader national health coverage. Without it——

Senator CHAFEE. Are you suggesting, with second opinion on surgery and so forth—and I believe in a second opinion on surgery and the different points you brought out here—but, are you suggesting we can get the coverage that is suggested in the program that Senator Kennedy has proposed, that we can get that without an increase in Federal outlays?

Mr. CALIFANO. I am suggesting we can get a national health plan and substantially, if not entirely, cover costs by putting the right kinds of incentives, competition, and cost controls into this system.

The numbers are substantial. We are approaching $3 billion a year in excess hospital bed costs. If the whole country could be brought to the 6.4 day length of stay that is the standard on the west coast for hospital stay, we would save something approaching $2 billion. The hospital cost containment bill alone will save, over the next 5 years, $35 billion.

And if this is accompanied—and I think it would be a part of Senator Kennedy's plan as it would be a part of the President's plan—by a substantial preventive program, there would be tremendous savings. For example——

Senator CHAFEE. That's a point I would like to get to. Regarding the prevention program, it doesn't seem to me the administration—I know you're beset with all kinds of problems—but it seems to me the

administration has not shown all the interest they might in a disease prevention program. I know that medical care is much more urgent, but in the long run it's the prevention of illness that is going to keep people out of hospitals.

Mr. CALIFANO. Senator, I think our childhood immunization program illustrates some of our efforts in preventive programs. When I realized that our children had fallen to dangerously low levels of immunization, I set a standard for more than 90 percent of the children in this country to be immunized. The investment this country has made of $100 million in 15 years on measles vaccination has resulted in savings of $1.2 billion.

I have tried to mount an antismoking campaign——

Senator CHAFEE. I'm a little confused on the differences between you and the President on the smoking issue. Maybe we're getting ahead of ourselves here.

Senator KENNEDY. Maybe we are.

Senator CHAFEE. I know where you stand. I'm not clear where he stands.

Senator KENNEDY. Mr. Secretary in the height of an OPEC embargo, in the height of a nationwide strike, in the height of all of these calamities, you are still going to have an explosion of health care costs that are going to destroy this country or bankrupt it.

Now, that happens to be the fact of the matter. And for you to condition both the program which is effectively going to get a handle on the costs and deal with benefits on these extraneous factors I think misses the ball.

I think, for the reasons you have outlined in your testimony, all of the explosions in health care costs which are going to strap the working people, the elderly and middle-income people, are going to continue during all the conditions that you say may be the circumstances by which we will avoid national health insurance. I just don't think your position is defensible.

Mr. CALIFANO. Mr. Chairman, as I said before, I think the President, sitting where he's sitting, has got to consider the state of the budget. He has got to consider the success of some of the cost containment measures; he has got to consider the state of the economy, whether it's inflation or unemployment. There are other things he has got to consider.

His objective, my objective, like yours, is to make this right a real right——

Senator KENNEDY. In response to Senator Chafee, and you gave the right answer on that as far as I'm concerned——

Mr. CALIFANO. Thank you, sir. [Laughter.]

Senator KENNEDY. But if you say the ability to spend less is with the health insurance program because you're going to have effective cost containment on that, then how can you say you're going to hold back implementing the program if you have other factors that aren't related to health at all—like an OPEC strike, or deficit rates of inflation.

You say with effective cost controls in implementing the program, you're going to spend less, which I believe, because you're going to have prospective budgeting. Then why make the implementation of

that contingent on factors that have no relationship to the health question?

Mr. CALIFANO. Mr. Chairman, let's just take what seems to currently be in vogue up here on the Hill today, something on its face that might appear to have no relation, which is the Senate's Kemp-Roth proposal which the House yesterday instructed its conference committee to take. If that kind of program went into place, putting those kinds of restraints on Federal programs for providing services to people, it will have a staggering and devastating impact on most discretionary programs in the Federal Government.

If the national health plan were going into phase step by step, somebody has to make some judgments, some responsible judgments, about where you trim back. I think it would be foolhardy to have a plan that went into effect and, in effect, says every other priority—whether it's housing for poor people, whether it's jobs for poor people, whether it's transportation for old people, whether it's security and safety for old people—goes by the wayside because as the next phase is ready to go into place, the Congress comes along with a proposal as preposterous in terms—and unfair in terms of its impact on the people and services that people need in this country—as the whole Kemp-Roth idea is.

And yet, we may be on the verge of something like that and subjecting all the social programs in this country to that kind of a whimsical tax relief proposal.

Senator KENNEDY. Well, what we might do in Kemp-Roth and what we might do on some other program in the future is not reason or justification, I would hope, for what the position of the administration is.

Now, you either believe you're going to get an effective kind of cost controls with respect to budgeting, and the justification and reason for that continues, I think, no matter what happens in terms of the economy. We have got to bring the costs under control, which is what I hope you believe in, and you have testified to that, and then to get the costs under control you're going to have to implement this program. And waiting to see and conditioning it on a variety of other factors, about whether something might happen, I think it will mean a failure to get effective cost controls and I think it fails to meet the human aspects of it in terms of human need.

Please continue with your testimony.

Mr. CALIFANO. After reading the outline of your plan and your accompanying statement, Mr. Chairman, it is clear to me that we share a common definition of many of the problems that a national health plan should address.

It is also clear that we share a number of vital goals. For example, assuring that all citizens receive comprehensive benefits, protecting them against the toll exacted by catastrophic medical expenses, developing strong and workable cost control mechanisms, making needed improvements in our health care delivery system, and providing quality health care to all Americans.

While there is obviously much common ground, we may well find in the course of further discussions that there are some differences.

For example, in contrast to the President's request that we explore phasing options, your outline seems to indicate that the vast bulk of

the coverage and benefits would come into effect all at once, 2 years after enactment of legislation. The President——

Senator KENNEDY. We're flexible on that, Mr. Secretary.

Why don't you continue.

Mr. CALIFANO. In addition, the heavy reliance in the outline on "earnings based premiums" as the major financing mechanism and insurance consortia as the major administrative mechanism may constitute areas on which we hold different views.

We, of course, look forward to learning more details of your proposal, details not discussed in the outline, that relate to the President's belief that the actual provisions of a national health plan should be consistent with the imperative national needs of restraining Federal spending and controlling inflation, our number one domestic problem.

In particular, we will be interested in such issues as the nature of the employer based premium, including possible subsidies of the employers' share; the details of the benefit package; the extent, if any, that patients will pay for part of their medical costs; respective Federal and State roles; the role of insurance companies; and the specifics of proposed cost control mechanisms.

As written, the outline does not present enough information for us to assess what the plan would ultimately cost, both in terms of additional Federal expenditures, and in terms of additional health costs in the economy as a whole.

Indeed, it is difficult to tell whether the plan will add $30.8 billion to the Federal budget in fiscal year 1983, as the outline indicates. For example, we will need to know such things as the amount of savings we can realistically expect from cost control provisions; the extent of ultilization changes in the absence of patient cost-sharing provisions; the exact definitions of income and family size used to determine those citizens eligible for Federal subsidies; and the cost of the Federal subsidy to employers, especially if there is no patient cost sharing.

We all want the costs of a national health plan to be tolerable, but the American people obviously must know specifics before they can reach that conclusion.

Nevertheless, Mr. Chairman, I hope and believe we can work out any differences that may emerge as both the administration and this subcommittee develop more precise specifications.

Senator KENNEDY. I would hope so, too.

Mr. CALIFANO. We are hopeful that with a comprehensive yet prudent plan we will be able to build a coalition in the Congress. A coalition with enough breadth to pass the legislation, a coalition with enough staying power to complete the task, which has been too long neglected, of assuring comprehensive health insurance protection for all Americans.

Mr. Chairman, I would just close by noting how important it is for us to work together, because using just yesterday as an example of how well we were able to work together in order to get such a significant piece of cost-containment legislation through the Senate.

Thank you.

Senator KENNEDY. Thank you.

Senator JAVITS. Thank you very much, gentlemen. I appreciate being permitted to examine the witness.

Mr. Secretary, one of the statements which you made which I particularly like is the designation of national health insurance as a national health plan.

I think national health insurance promises too much and too little at the same time. One, it promises a complete sharing of the costs, which, in fact, will not occur because Government will have to make large contributions for the unemployed, working poor and other classes of people. As you indicated, this will have a significant impact on the Federal budget.

Second, national health insurance promises a bargain between the customer and insurance company, and this may not be a realistic expectation.

There are two major issues I would like to question you about, if I may. One relates to the phasing issue. One school of thought proposes the phasing in of services and benefits, another proposes the phasing in of population groups. We have heretofore proceeded on the basis of phasing in population groups—for example the aged and the poor under medicare and medicaid.

What is your feeling regarding these two approaches to phasing?

I, for example, have been advocating the phasing in of children and pregnant mothers, which, of course, represents another population group.

Mr. CALIFANO. Senator, I think, over the long haul of any phasing plan, it would probably involve both phasing in benefits and phasing in population groups.

For example, if you take the legislation to which I think you're alluding and, which you have supported strongly, namely CHAP legislation, that legislation would expand eligibility for children and pregnant women and also expand the benefits available to assessed children. So I think it would likely be some combination, as the CHAP bill is.

Senator JAVITS. I would go with that.

I personally believe the population group approach is the more promising, because of the danger of overpromising on the services approach, which I think comes out in your colloquy with Senator Kennedy. You can only do so much with what you have, and if you try to do more, the whole thing will break down. That is one of the great dangers of national health care, as much as I am deeply for it, as I have been for 30 years.

Now, the other question I would like to ask you is about the voluntary effort. The legislation the Senate passed last night relating to hospital cost containment is conditioned on voluntary effort; that is, if the voluntary effort doesn't measure up, then a mandatory cost-containment program is triggered.

Now, you say on page 7 of your statement:

> The voluntary effort to hold down hospital costs—which are 40 percent of health costs—is a sham, an imposter seeking to usurp the achievements of the mandatory State efforts.

Now, in view of the legislation passed last night, do you feel we're just wasting our time with the voluntary effort, and that we simply have to understand we have to go right to mandatory and that there's no other way?

Mr. CALIFANO. Senator, my point about voluntary effort goes, you will note, to the 41 States that have no mandatory program to back up what would voluntarily be done. In the 41 States which just have a purely voluntary effort, in effect, in which the hospitals say "we will hold down costs," their costs are up 15.8 percent, 1977 over 1976. and a slightly higher rate of increase in 1976 over 1975.

The legislation the Congress passed last night has mandatory "teeth" behind the voluntary effort. If the hospitals don't make it, then a mandatory program goes into place. I think that kind of a program can work, Senator, and I applaud you, Senator Kennedy, and others for passing that program yesterday.

Senator JAVITS. Thank you so much.

I note with great pride that New York, which installed its cost control program in 1969, has a 6.2-percent record as against this 15-percent average that you mentioned for the 41 States in 1977, the latest year in which we have figures. Would you agree that's quite a record?

Mr. CALIFANO. Yes, sir, it is.

In the last 2 years, Governor Carey has taken the hospital and health cost containment program and worked it as effectively and aggressively more so than any other State in the Union.

Senator JAVITS. Please forgive me when I say in 1969 it wasn't Carey; it was Rockefeller. [Laughter.]

Now, the other point I would like to make with you is the difficulty of getting anything through the Congress, about which my staff tells me you spoke.

I have introduced a bill which I would like to mention because I think it's important, which would establish a single joint committee of the House and Senate, composed of representatives of those committees which would normally have a hand in health legislation which would have exclusive jurisdiction over all bills and resolutions relating to the formulation of a national health plan.

What do you think about it?

Mr. CALIFANO. I think, particularly with Senator Kennedy as the chairman, and you as ranking minority member, we would do everything we could to get such a committee in place.

Senator, I think anything that can be done to reduce the number of committees that health legislation has to go through would be enormously helpful.

For example, in the House, the Speaker put together a single committee on the welfare proposal this year. That was able to handle legislation that otherwise would have gone to three committees. So we would like to see as much consolidation as is possible in terms of congressional committee consideration.

Senator JAVITS. The other thing I would like to mention to you is the point you make at page 16, your statement with respect to Senator Kennedy's point about "earnings-based premiums" as the major financing mechanism and insurance consortia as the major administrative mechanism.

I might recall that back in 1960, when our very dear friend and tragically lost President, Jack Kennedy, was in the Senate, Clinton Anderson and I introduced a national health plan which was based on "earnings-based premiums."

By the way, I agree with Senator Kennedy thoroughly, regarding the administrative mechanism—we should make use of insurance companies and other existing entities which have experience in this business.

I believe the concept of "earnings-based premiums" deserves careful consideration, even though your initial judgment is skeptical. I hope the administration will review the idea carefully.

Mr. CALIFANO. We will, sir.

Senator JAVITS. Lastly, Mr. Secretary, I was asked a challenging question at a press conference the other day, and I would like to ask your views on the same question.

I was asked, "Senator, if you had to choose between welfare reform and a national health plan, which would you give priority?"

I'll give you my answer. You don't have to answer if you don't want to. I said I would have to go for the welfare plan first, because it would provide immediate fiscal relief to our municipalities. Welfare reform could be implemented promptly. Our national health plan, as we all know, will take some time to work out. What are your feelings?

Mr. CALIFANO. Well, Senator, my own judgment is that we can do both and we should do both. In many ways they are both intertwined, particularly the medicaid portion of our present health plan.

One of the things that will have to be worked out in any ultimate welfare reform will be what to do about medicaid eligibility and reimbursement. So I guess my answer would be that we should try and do both at the same time.

Senator JAVITS. I join you in that.

Thank you, Mr. Chairman.

Senator CHAFEE. Mr. Secretary, first I would note my State is the next lowest. [Laughter.] Also, I think you're a little harsh when you say, "The voluntary effort to hold down hospital costs * * * is a sham, an imposter."

I think those who have worked terribly hard in my State will take exception to that remark. It has produced rather drastic improvements and I think it can do more. I don't know how New York ever got down to 6.2 percent, but that presents a challenging goal. Rhode Island is second, lower than Massachusetts, also, I note. [Laughter.]

Mr. CALIFANO. Senator, your State, of course, has a mandatory program, as you well know.

Senator CHAFEE. Well, it's really not mandatory. If voluntarily negotiated, it's perpective reimbursement. We don't have to go into all that. But it's not the toughest of controls by a long shot. Any hospital can drop out, they just won't get paid by Blue Cross. But that's voluntary. [Laughter.] It's not in the State law.

What I would like to emphasize because you're about to wind up your testimony, is the importance of preventive medicine. It is all well and good to support immunization, which you have done, and I think that's grand. But the facts of the matter are—and I don't think they're contradicted—that we only spend between 2 and 3 percent of our total Federal health budget on preventive medicine——

Mr. CALIFANO. We spend $48 billion, and we spend about $2 billion, 4 percent——

Senator CHAFEE. All right. And we have passed legislation in here to increase support to local public health departments, and I'm all for that. But somehow the problem is that Americans just don't keep themselves healthy. The results of a health promotion program which encourages exercise and nutrition are very dramatic, as you well know. I mean they're absolutely dumbfounding.

I think if the Department should put greater efforts into promotion of other good health habits, just as you have done with smoking—and I hope that has had some national results—such as proper diet and exercise and so forth. I would just like to leave that thought with you.

I know you are beset from all sides, with people telling you to do this and that, but this is an area that I think will produce the most startling results.

Mr. CALIFANO. We do plan later this year, Senator, to produce the first Surgeon General's report on prevention, so we will be pushing hard in that direction.

As I'm sure you're aware, Senator Kennedy has introduced a four title piece of legislation in the area of prevention and we would hope that part of the national health plan would provide assistance as well.

I would also note that it is surprisingly difficult to get relatively small amounts of money for health education in the HEW budget from the Appropriations Committee, although the payoff is tremendous, I agree with you.

Senator CHAFEE. Yes; but I'm not sure the administration comes forward with programs that public health——

Mr. CALIFANO. We have always gotten less than we have asked for in the last 3 years for health education.

Senator CHAFEE. You're getting less than you're asking for now——

Senator KENNEDY. Sometimes you get more.

Mr. CALIFANO. Yes.

Senator CHAFEE. I would like to join in the tribute to Senator Kennedy's efforts in this area. He has been a one-man show, sometimes narrow, but never in doubt. [Laughter.]

Senator JAVITS. I would just attach a word with what has been said. First, I thoroughly agree with Senator Chafee about preventive care. You can be assured, Mr. Secretary, we will make that a major component of any national health plan.

I also want to add to his litany the subject of industrial illnesses. This is one of the real "sleepers" in our country.

We have a doctor in New York, Dr. Selikoff at Mount Sinai, who specializes in the study of industrial illnesses. I hope very much, too, Mr. Secretary, that you will bear this problem in mind and work with the Secretary of Labor on that particular problem.

Mr. CALIFANO. We will, Senator. I think what we have done with asbestos is unprecedented in terms of that kind of alert to workers. We are moving into the occupational health area.

Senator KENNEDY. Mr. Secretary, on this point of prevention, this has been a matter of enormous importance to Senator Chafee. He has pressed this committee and has been instrumental in the fashioning of our legislation on health prevention, which has passed the Senate. It's now going to conference.

But one of the key elements is the reimbursement mechanism. Under the current system, we do not provide reimbursement for prevention. This is a key element that we're going to have to adjust that particular structure. I think the only way that can be done is in the context of a health insurance system, because otherwise we find virtually the prohibition or nonreimbursement on such things as nutrition counseling, any kind of counseling by a family physician.

The other kinds of stress that is placed on it, it just doesn't exist. Our financing mechanism puts a heavy stress on sickness rather than on disease prevention, and until we come to grips with that factor, I think we can do useful things. I am strongly in support of the efforts you have made with smoking and these other factors in the States. But I think that will have to be an essential aspect of the program.

Mr. CALIFANO. On that, Mr. Chairman, we're in total agreement.

Senator KENNEDY. Thank you very much.

[The prepared statement of Secretary Califano follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT OF

SECRETARY JOSEPH A. CALIFANO, JR.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

SENATE COMMITTEE ON HUMAN RESOURCES

Friday, October 13, 1978

Mr. Chairman and members of the Subcommittee on Health:

I am delighted to appear before this distinguished Subcommittee to discuss a matter of great importance to the American people, to President Carter and to you, Mr. Chairman -- a National Health Plan that will ensure universal, comprehensive coverage while controlling rampaging health care costs.

The Administration has worked closely with this Subcommittee on vital health care issues in the last 20 months, and we are most appreciative of the leadership you have demonstrated on important legislation like Hospital Cost Containment.

We look forward to an equally constructive relationship as the Congress moves forward in the next session to consider carefully National Health Insurance. Indeed, the 96th Congress has the opportunity to be remembered in history as the Health Care Congress -- has the chance to enact a seminal piece of legislation that has eluded Presidents and Congressional leaders for three decades.

For, as you pointed out when you opened these hearings, Mr. Chairman, few ideas have been the subject of more national debate and less Congressional attention than National Health Insurance. Not only have Presidents since Harry Truman sought passage of a National Health Insurance Plan, but in the last decade a number of proposals have been introduced in the Congress -- with some of the most important and thoughtful plans bearing your name, Mr. Chairman.

Yet only one of these bills has emerged from a full Committee of the Senate. None has been reported out by a full Committee of the House. And, of course, neither the Senate nor the House has approved a National Health Insurance proposal.

It is imperative, therefore, that we in the Administration and you in the Congress who are deeply concerned about the state of health care in the United States work together to devise a strong piece of legislation -- but a piece of legislation that, unlike past proposals in this area, can be enacted into law.

As we move from generalities to specifics in the months ahead, Mr. Chairman, we all recognize that we will be dealing

with a highly complex subject -- with significant implications for our health care system, for the fiscal and budgetary policy of the Federal government and for the state of our nation's economy.

Health care in the United States is not just men and women dressed in white coats carrying little black bags ministering to the infirm. It is also, as this Subcommittee knows well, big business.

- In fact, the health care industry is our nation's third largest -- with expenditures of $183 billion, or 8.8 percent of the Gross National Product, in Fiscal 1978.

- 5.8 million persons -- about 6 percent of the labor force -- are employed in the health care industry.

- More than 12 and a half cents of every Federal tax dollar -- nearly $60 billion in the Fiscal 1978 Federal budget -- is spent on health care costs, and States and localities spend an additional $25 billion annually.

- In Fiscal 1977, there were 37 million hospital admissions; 170 million Americans visited a physician at least once (with the average person making 5 visits annually); more than a billion and a half prescriptions were filled; and 5 billion laboratory tests were ordered.

- In Fiscal 1978, we estimate that Medicare and Medicaid will reimburse for 120 million days of hospital care, and there are 800,000 physician visits a day that Medicare or Medicaid will reimburse.

These figures alone reflect the complexity -- and the potential difficulty -- of making needed changes in an industry that is not subject to the normal economic forces of the free market.

Yet, both the Administration and the members of this Subcommittee share a strong belief that it is imperative to make some basic changes in the health care industry. For we share an understanding that our present health care system is fundamentally flawed.

First, millions of Americans lack coverage for basic health services and lack protection from catastrophic medical expenses.

- At least 20 million Americans have no health insurance, and, of these, about 13 million have incomes above the poverty line.

- More than 18 million Americans have inadequate insurance that fails to cover basic hospital bills, doctors' services or medical tests, and, of these, 13 million have incomes above the poverty line.

- About 85 million Americans (40 percent of the population) have no insurance against very large medical bills.

Under the present health care system, these gaps in health coverage will not be closed.

Second, the costs of health care are out of control, adding to inflation and threatening the stability of governmental budgets. Spending in the health care industry has been rising at an annual rate of 12 percent with little improvement

in the health of our citizens. Thus, this year we will spend $112 for the same health care that cost us $100 the year before. These expenditures cannot be successfully contained under current health delivery and financing methods, which produce unnecessary hospitalization, over-reliance on expensive technology and inadequate preventive care. Unless we can institute meaningful cost containment measures through hospital cost containment and meaningful restraints in a National Health Plan.

- National health care costs will rise to $322 billion by 1983 -- nearly 10 percent of GNP.

- Federal health care expenditures will rise to nearly $90 billion by 1983 -- more than 13 cents of every Federal tax dollar under current projections for that year.

- The cost of individual health care will rise steeply. The average cost for a family of four will leap from $2115 in 1978 to $3590 in 1983, and the average cost for an elderly individual will soar from $2014 to $3417 during the same period.

Let there be no mistake, Mr. Chairman: these soaring costs will not be restrained by voluntary efforts. Let me

illustrate the point. In 1976, the average rate of increase in hospital expenses was 15.4 percent over 1975. In figures recently developed by the industry itself, we learn that, in 1977, the rate of increase is 14.2 percent over 1976. But that change is the result of mandatory cost containment programs operating in 9 states, where the average 1977 rate was 12 percent.*/ In the 41 states that either had voluntary cost containment programs or no program at all, the average rate of increase in hospital expenses was a whopping 15.8 percent in 1977.

The voluntary effort to hold down hospital costs -- which are 40 percent of health costs -- is a sham, an imposter seeking to usurp the achievements of the mandatory state efforts. Only strong constraints will work in holding down inflation in the health care industry.

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*/ The nine States are:

(Year Mandatory Program Begun)	1975 (Annual Rate of Increase in Hospital Costs Over Prior Year)	1977
• Colorado (1977)	22.9 percent	15.1 percent
• Connecticut (1974)	16.8 percent	11.4 percent
• Maryland (1973)	19.8 percent	11.8 percent
• Massachusetts (1976)	17.7 percent	13.7 percent
• New Jersey (1971)	18.3 percent	11.8 percent
• New York (1969)	19.9 percent	6.2 percent
• Rhode Island (1971)	20.5 percent	11.1 percent
• Washington (1973)	21.7 percent	15.2 percent
• Wisconsin (1975)	16.6 percent	12.4 percent

Third, systematic reforms are needed to increase access to health services, to provide more appropriate types of services and to eliminate the inefficiency and lack of competition in the health care industry. For example,

- Health services are poorly distributed within our nation -- we estimate that almost 51 million citizens live in medically underserved areas.

- Private health insurance contracts often do not cover preventive and ambulatory services -- those services which are among the most beneficial and the most cost effective.

- In many areas of this nation, citizens do not have the option of choosing efficient health maintenance organizations or other alternative systems of health care delivery.

Mr. Chairman, these are the fundamental problems that demand solution if our health care system is truly to serve the American people.

In the 20 months since the Carter Administration assumed office, we have worked with you in developing a number of important initiatives to deal with these problems: hospital cost containment, HMO reform, and reauthorization of the health planning legislation to name a few.

But we have also been committed -- as you have -- to solution of these major flaws in our health care system by introduction and passage of a National Health Plan.

Last year, I appointed an Advisory Committee on National Health Insurance, chaired by Hale Champion, HEW's Under Secretary and comprised of representatives from consumer groups, providers, labor, insurers and other organizations and interests with a vital stake in the national health insurance debate. We also sponsored a series of regional hearings -- and at least one hearing was held in every State in the Union. And we developed four prototype plans for public discussion and criticism.

This first phase of our efforts culminated in the President's statement of principles, which was issued on July 29, 1978. In his July statement, the President directed me to develop a tentative plan this year which embodies

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these principles and which will serve as the basis for in-depth consultation with the Congress, State and local officials, interest groups and consumer representatives. I expect that we will make this tentative plan public later this year.

After intensive consultation, we will then prepare detailed recommendations for the President early in 1979 so that he can make decisions about the actual shape of the legislation the Administration will submit to the Congress.

As I have repeatedly emphasized, this schedule for development of our National Health Plan will not delay introduction, passage or implementation of a comprehensive, universal plan. It was never likely that the Congress would take any formal action on National Health Insurance this year, in part because its agenda was so crowded with other important domestic initiatives proposed by President Carter.

We have always hoped that Congress would act favorably on a National Health Plan in the 96th Congress and that we could begin to phase in new benefits several years after passage of the bill.

Mr. Chairman, let me turn now to the substance of the President's principles for a National Health Plan. (A copy of the President's July statement is attached.) In summary:

- The first principle indicates that the plan should be universal and comprehensive and should include protection against catastrophic costs;

- The second and third indicate that quality care should be available to all and that people should have freedom of choice in selection of providers;

- The fourth indicates that the plan should include aggressive efforts to control inflation and should include strong cost controls and efforts to strengthen competition in the health sector;

- The fifth sets out a goal -- that additional expenditures should be offset to the extent possible by savings from greater efficiency in the health care system;

- The sixth principle focuses on phasing -- indicating that implementation will begin in 1983 and will proceed gradually. It states: "As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other government programs, in which expenditures far exceed initial projections, must not be repeated."

- The seventh indicates that financing should come from a number of sources including government funds, employer and employee premiums and some cost sharing by patients.

- The eighth indicates that there should be a role for the private insurers, subject to appropriate government regulations.

- The ninth and tenth indicate that the program should seek to improve the health delivery system and assure consumer involvement.

Mr. Chairman, the President is deeply concerned that the present health care system fails to serve millions of Americans. And, like you, he is equally concerned about the intolerable inflation in the health care industry -- inflation that has had corrosive economic effects with little accompanying improvement in health care for our citizens.

It is the need to address the critical problem of health cost inflation -- which stems from fundamental failings in the health care system -- as well as the need to provide adequate health insurance and health care services to millions of Americans which has led the President to call his proposal a National Health Plan, not just a National Health Insurance initiative.

As we move forward to address these fundamental problems in the health care industry, we do so with the understanding that solutions to our health care problems are closely tied to two other major national priorities: the need to bring inflation in the economy as a whole under tight rein and the need to spend the Federal dollar prudently.

The President underscored these points in his directive to me:

"Before I submit legislation to the Congress, I want to be certain that the plan is consistent with our efforts to control inflation in the health care sector and the general economy. Before you send me final recommendations for a National Health Plan, you should analyze the issues of cost control and health system reform in greater depth. The American people would not accept, and I will not propose, any health care plan which is inflationary... A comprehensive national health plan will provide a critical opportunity to mount a national effort to bring the system under control."

Given the broad national concerns which must be taken into account by the President in the formulation of any particular policy, it is understandable -- indeed inevitable -- that the President should ask his advisors to develop a proposal that protects the economic well-being, as well as the health of the American people. It is for that reason that the President has insisted that we develop for his consideration different methods of phasing in various stages of a universal, comprehensive plan in a manner consistent with sound budget policy and with the need to control inflation.

Mr. Chairman, let me now turn briefly to the outline for a national health program that you announced on October 2, 1978. As we move forward with the development of our tentative plan, we will review that outline with great care. Our response on the various pieces of the outline will, in the main, be reflected in the provisions of our tentative plan made public later this year.

After reading that outline and your accompanying statement, it is clear that we share a common definition of many of the problems that a National Health Plan should address.

It is also clear that we share a number of vital goals -- for example, assuring that all citizens receive comprehensive benefits, protecting them against the toll exacted by catastrophic medical expenses, developing strong and workable cost control mechanisms, making needed improvements in our health care delivery system, and providing quality health care to all Americans.

While there is obviously much common ground, we may well find in the course of further discussions that there are also some important differences.

For example, in contrast to the President's request that we explore phasing options, your October 2nd outline seems to indicate that the vast bulk of the coverage and benefits would come into effect all at once, two years after enactment of legislation. The President believes that a program this complex -- affecting the nation's third largest industry which employs 6 percent of the entire work force and having profound implications for Federal, state, and local budgets -- must be phased in with singular care and sensitivity to the economy, governmental budgets and the Administrative complexity of the health care system.

In addition, the heavy reliance in the outline on "earnings based premiums" as the major financing mechanism and insurance consortia as the major administrative mechanism may also constitute areas on which we hold different views.

We, of course, look forward to learning more details of your proposal -- details not discussed in the outline -- that relate to the President's belief that the actual provisions of a National Health Plan should be consistent with the imperative national needs of restraining Federal spending and controlling inflation, our number one domestic problem.

In particular, we will be interested in such issues as: the nature of the employer based premium (including possible Federal subsidies of the employers' share); the details of the benefit package; the extent, if any, that patients will pay for part of their medical costs; respective Federal and state roles; the role of the insurance companies, and the specifics of proposed cost control mechanisms.

As written, the outline does not provide enough information for us to assess what the plan would ultimately cost -- both in terms of additional Federal expenditures and in terms of additional health costs in the economy as a whole. Indeed, it is difficult to tell whether the plan will add $30.8 billion to the Federal budget in FY 1983, as the outline indicates. For example, we will need to know such things as: the amount of savings we can realistically expect from cost control provisions; the extent of utilization changes in the absence of patient cost-sharing provisions; the exact definitions of income and family size used to determine those citizens eligible for Federal subsidies; and the cost of the Federal subsidy to employers, especially if there is no patient cost-sharing. We all want the costs of a national health plan to be "tolerable," but the American people obviously must know specifics before they can reach that conclusion.

Nonetheless, I hope we can work out any differences that may emerge as both the Administration and this Subcommittee develop more precise specifications.

We are hopeful that with a comprehensive yet prudent plan we will be able to build a coalition in the Congress. A coalition with enough breadth to pass legislation; a coalition with enough staying power to complete the task -- which has been too long neglected -- of assuring comprehensive health insurance protection for all Americans.

Thank you.

THE WHITE HOUSE

WASHINGTON

July 29, 1978

Presidential Directive/DPS-3

TO: The Secretary of Health Education and Welfare

SUBJECT: National Health Plan

I have consistently expressed my support for the goal of a universal, comprehensive national health plan to contain skyrocketing health costs and to provide all Americans with coverage for basic health services and with protection from catastrophic expenses.

Such a plan would be the cornerstone of a broader national health policy designed to improve the health of Americans by reducing environmental and occupational hazards and encouraging health enhancing personal behavior, as well as by improving the effectiveness of our medical care system.

The current health care system has significant defects which must be remedied:

- The health care system is highly inflationary. Spending in the health care industry -- the nation's third largest industry -- has been rising at an annual rate of 12%, with little improvement in the health of Americans. These expenditures cannot be successfully contained under current health delivery and financing methods, which produce unnecessary hospitalization, over-reliance on expensive technology and inadequate preventive care.

- At least 20 million Americans have no health insurance.

- Another 65 million Americans face potential bankruptcy because they lack insurance protecting them against catastrophic medical expenses.

- Health resources are unevenly distributed across the country, resulting in significant gaps in vital medical services for many residents of rural and inner city areas.

In pursuing the goal of a comprehensive national health plan, I also wish to draw on the strengths of the American health care system:

- American health care professionals and hospitals are among the finest in the world and deliver dedicated, high quality medical care.

- A growing number of Americans have private health insurance. American business increasingly is paying for health coverage for its employees.

- Various government programs have provided an opportunity for millions of elderly, poor and geographically isolated Americans to obtain quality health care.

In past months you and other members of my Administration have been exploring the most effective means of fulfilling my commitment to a comprehensive national health plan. You have considered a broad range of options. However, before I submit legislation to the Congress, I want to be certain that the plan is consistent with our efforts to control inflation in the health care sector and the general economy. Before you send me final recommendations for a national health plan, you should analyze the issues of cost control and health system reform in greater depth. The American people would not accept, and I will not propose, any health care plan which is inflationary.

At the same time, the American people must recognize that if we fail to act, health expenditures will continue to soar. In 1977, health expenditures were $162 billion; they are expected to reach $320 billion by 1983. A comprehensive national health plan will provide a critical opportunity to mount a national effort to bring the system under control.

I am directing you to address these concerns as you proceed to develop in greater detail a national health plan for the American people. The plan must improve the health care system, and combat inflation by controlling spiralling health care costs. To achieve these objectives, the plan, when fully implemented, should conform to the following principles.

1. The plan should assure that all Americans have comprehensive health care coverage, including protection against catastrophic medical expenses.

2. The plan should make quality health care available to all Americans. It should seek to eliminate those aspects of the current health system that often cause the poor to receive substandard care.

3. The plan should assure that all Americans have freedom of choice in the selection of physicians, hospitals, and health delivery systems.

4. The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending. The plan should include aggressive cost containment measures and should also strengthen competitive forces in the health care sector.

5. The plan should be designed so that additional public and private expenditures for improved health benefits and coverage will be substantially offset by savings from greater efficiency in the health care system.

6. The plan will involve no additional federal spending until FY 1983, because of tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other government programs, in which expenditures far exceeded initial projections, must not be repeated.

7. The plan should be financed through multiple sources, including government funding and contributions from employers and employees. Careful consideration should be given to the other demands on government budgets, the existing tax burdens on the American people, and the ability of many consumers to share a moderate portion of the cost of their care.

8. The plan should include a significant role for the private insurance industry, with appropriate government regulation.

9. The plan should provide resources and develop payment methods to promote such major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services, attracting personnel to underserved rural and urban areas, and encouraging the use of prepaid health plans.

10. The plan should assure consumer representation throughout its operation.

I am directing you to develop a tentative plan as soon as possible which embodies these principles and which will serve as the basis for in-depth consultation with the Congress, State and local officials, interest groups, and consumer representatives. You should then provide me with detailed recommendations so that I can make final decisions on the legislation I will submit to the Congress next year. To respond fully to my economic and budgetary concerns, you should develop alternative methods for phased implementation of the plan.

Jimmy Carter

Senator KENNEDY. Our next witness in Veron E. Jordan, president of the National Urban League, and Sylvester Davis, chairman of the National Board Health Committee, NAACP.

Mr. Jordan, we're glad to have you here, and we welcome you as a distinguished and articulate spokesman for a very important organization, and we welcome you as a friend, a long time friend. And, Dr. Davis, we're delighted to have you here. It's good to see you.

You may proceed on your own.

STATEMENT OF VERNON E. JORDAN, JR., PRESIDENT, NATIONAL URBAN LEAGUE, INC., ACCOMPANIED BY DR. SYLVESTER S. DAVIS, CHAIRMAN, NATIONAL BOARD HEALTH COMMITTEE, NAACP; MAUDINE COOPER, DEPUTY DIRECTOR, WASHINGTON BUREAU; AND LIONAL BROWN, VICE PRESIDENT OF PROGRAMS AND GOVERNMENT AFFAIRS, NATIONAL URBAN LEAGUE, INC.

Mr. JORDAN. Thank you, Mr. Chairman, and Senator Javits and Senator Chafee. I thank you for this opportunity to be here.

In addition to Dr. Davis of the NAACP, to my left is Miss Maudine Cooper, who is the deputy director of our Washington bureau, and Mr. Lional Brown, vice president of programs and government affairs, of the National Urban League.

Senator, I want to join your colleagues and express my appreciation for your leadership in this area, and we have come to say that we hope you won't get weary and that you will continue to lead.

The issue of a national health plan is one with which the National Urban League has been struggling for quite some time now. We feel very strongly that it is the only hope for most poor people, and particularly the minority poor, in their struggle to enjoy a healthy life.

Wide gaps exist between the health status of whites and nonwhites, despite recent progress in narrowing this gap. Nonwhites still experience 50 percent more bed disability days, a 70 percent higher infant mortality rate, and a life expectancy 6 years shorter than that of whites.

Nonwhites are more likely to suffer from a number of specific conditions often treatable by modest but often unavailable health care.

Equally important is the need of health care designed for early detection and prevention—both often unavailable to this Nation's poor and minority populations.

The result, therefore, is to be anticipated. Approximately 50 percent of black American men do not live to be 65. Death by stroke is 61 percent higher for black males than whites; diabetes twice as high, and sclorosis 87 percent higher.

One could conclude from these figures, Mr. Chairman, that the Surgeon General should issue a warning that "Being black can be dangerous to your health".

As bad as these statistics are, they represent a——

Senator KENNEDY. These are staggering statistics, and I think they show where the valley is in terms of health care in our society.

We had a spokesman for organized medicine who said, sitting in that very chair 2 days ago, who said "we have the best." He sat right

there and said it. Obviously, he wasn't referring to the human need and human tragedy that you describe, And it's the case, in many urban areas, in rural areas.

Mr. JORDAN. It's clear, Mr. Chairman, that this is an area where the "trickle down" theory is operable.

As bad as these statistics are, they represent a significant improvement. Medicaid and medicare are the primary vehicles for financing health care to the poor. The glaring defects in these programs are well known to us all. Yet our relative short experience with medicaid and medicare give us some insight into the great strides that could be made if this country did, in fact, have a unified and comprehensive national program for quality health.

Since the enactment of medicaid-medicare nearly 15 years ago, there has been a marked shift in the utilization of physician services by the poor. By 1974 poor people were reported to be using physician services at a somewhat higher rate than the rest of the population. There has been a long drop in the proportion of persons who have not seen a physician within a 2-year period.

In other words, with all of its flaws, medicaid and medicare have contributed to the improved health status of poor and minority citizens. And still, there are some 8 million persons below the poverty line who are not even covered by medicaid and medicare. These are largely the working poor, the near poor, who simply do not have financial resources to afford needed health care.

Not only is a unified and comprehensive national health insurance program good for minority and poor people; it is good, we believe, for the overwhelming majority of Americans. The need for quality comprehensive health care transcends race, sex, economic status, and region. Illness, Mr. Chairman, is no respecter of persons.

We heard this in 1970, when Fortune magazine editorialized that:

> American medicine, the pride of the Nation for many years, stands now on the brink of chaos.
>
> To be sure, our medical practitioners have their great moments of drama and triumph. But much of the U.S. medical care, particularly the everyday business of preventing and treating routine illnesses, is inferior in quality, wastefully dispensed, and inequitably financed. Medical manpower and facilities are so maldistributed that large segments of the population, especially the urban poor and those in rural areas, get virtually no care at all, even though their illnesses are most numerous and, in a medical sense, often easy to cure.

We have heard it in every reputable public opinion survey since 1943, all attesting that the public regards health care as a right and favors national health insurance as the vehicle for fulfillment of that right. In August 1977, a New York Times-CBS poll showed that by 60 to 33 percent—7 percent had no opinion—Americans favored a national health program.

We are beginning to hear it now from no less formidable forces than the proposition 13 tax revolters who, in North Dakota, rallied 13,000 persons to sign a petition to place medical cost control on the ballot in November. And from Gov. Jerry Brown of California, who warned the health care industry that if it continues to ignore "outrageous" runaway costs, the people will clamp on controls themselves, like they did with property taxes under proposition 13.

Mr. Chairman, this strongly suggests to me that the public is growing sick and tired of waiting for national leadership on this issue and have already begun another revolt.

The National Urban League has worked long and hard with Government agencies and health consumer advocacy groups to obtain a national health insurance program for all Americans. One year go, Ms. Maudine Cooper to my left gave testimony before Mr. Califano outlining our thoughts on this subject.

At that time the Urban League endorsed the National Health Security Act of 1977, popularly known as the Kennedy-Corman bill. The league's support for that bill was based on the fact that it contained the following basic principles: Universal and mandatory coverage, comprehensive benefits, and equal access.

In the intervening period, we have been full participants in the debates and the efforts to get a workable bill before the U.S. Congress.

It seemed as though progress was being made. However, it now appears that political compromise has overtaken the recognized needs of the American people. The administration's principles for a national health plan dilute essential elements too much. It does not require much imagination to foresee the imposition of distortion and the ultimate death of a program scheduled to be slowly phased in over a period of time, with each phase requiring new legislation, and with each phase newly dependent on current economic and political climate.

Senator KENNEDY. So you oppose the triggered process?

Mr. JORDAN. Yes.

Senator KENNEDY. Why do you oppose it?

Mr. JORDAN. We think it ought to be comprehensive from the beginning, and the phasing in, depending upon the temperature of the two Houses here, is not enough. We think it ought to go to the whole kit and caboodle.

Senator KENNEDY. And we're reminded that many of those who supported the medicare program thought that was going to be the beginning of the phasing in of health insurance. If we go back to those statements of those who supported it on the floor of the U.S. Senate we hear that it will only be a little while and we'll get another part.

Now we find out that under the medicare program there is less payment for elderly health care costs than there was prior to the passage of that program. This is a part of the problem.

Mr. JORDAN. The new proposal for the National Health Insurance Act of 1979 seems to offer much encouragement. First I am encouraged because it contains those basic principles for quality health care enumerated earlier.

I am encouraged further because the proposal reflects the experiences gaind from past efforts at trying to get S. 3, the National Health Security Act, passed. It has built-in cost control features, the most significant of which requires submission of budgets and/or fee schedules by both the hospital, the physician, and the health professionals.

This is a step that neither the administration nor the health services industry has been willing to take, but one the public is more and more demanding. And, while I thoroughly understand the concern some people may have with the role of the insurance industry, I believe its

participation under ongoing Federal regulation represents a wise and satisfactory provision.

Many Americans, as already noted in the first day of these hearings, have been devastated by catastrophic hospital costs. Many, who had high expectations based upon this administration's early commitment to national health insurance as a national priority, have been sorely disappointed.

It has now become apparent, gentlemen, that things simply have gotten out of hand. I know it, you know it, the American public knows it. The proposal for the National Health Insurance Act of 1979 is most timely and most sensibly provides us with a practical handle on this situation. It is a plan for all Americans, and I am happy to have the opportunity to express my support this morning.

Mr. Chairman, that concludes my formal testimony, but I beg your indulgence to make just one personal statement, and that is, since 1965, my wife has had multiple selerosis, which is a crippling, deteriorating disease of the nervous system. And while during that 13- or 14-year period I have been fortunate to have a decent job with a decent wage and have been able to support her in a manner to which she has become accustomed.

I worry, on the other hand, about some half-million Americans suffering from multiple sclerosis, who make $10,000, $7,000 or less, or $15,000 a year, who are my age, my wife's age, and my daughter's college age, and I worry about how they can, given the devastating effect of that disease on a person, and it's rippling effect on other members of the family, and its economic effect, I worry about how, in fact, families in America with that particular disease or others that last for a long time, how they, in fact, make it.

So I plead not for myself, but I make a plea for those thousands upon thousands of Americans in this country who have no way out and have no possibility of dealing with that, and I happen to think that national health insurance, that a comprehensive, unified plan for the delivery of quality health care, is absolutely essential for those who have not, as well as for those who have.

Thank you, Mr. Chairman.

Senator KENNEDY. Thank you. It's a very fine statement and a very touching one.

Dr. Davis?

Dr. DAVIS. Senator Kennedy, I speak today representing the NAACP membership and its friends and supporters throughout this Nation. For the past 1½ years I have served as chairman of its National Board Committee on Health.

The NAACP, recognizing the importance of health as a human right, has authorized the development of a Department of Health Affairs to be headquartered in its national offices in New York City. This characterizes the NAACP's commitment and concern in the matter of health as it applies to all our citizens with special emphasis on the needs of minorities, the poor, and the underserved.

This area of national involvement includes the input and expertise of leading educators, health providers, and administrators in the minority community.

You are no doubt acquainted with the contributions of Howard University——

Senator KENNEDY. Doctor, we have just been notified a cloture vote is set for 12 noon, so we're going to have to complete our morning by 12 noon. So if it's possible, we will include your full statement in the record, and if you would just summarize it. We regret there has been a time problem.

Would you care to summarize your testimony?

Dr. DAVIS. Just briefly, the NAACP would like to recommend the following principles to be included in any basic national health insurance program—and we certainly agree with Mr. Jordan's presentation with regard to statistical need.

The program should be available to all citizens regardless of ability to pay; it should be universal; it should include preventive care; it should involve freedom of choice and quality assurance. It ought to involve full minority participation in all areas of planning, establishing regulations, implementation and monitoring. It obviously should be federally regulated. There should be provisions for adequate manpower development with full minority participation.

There ought to be a complete program of public education for health; there should be full adherence to civil rights laws including minorities at all levels of policy and administration; financing should be a combination, as we see it, of private and public funding, and all unemployed should be fully insured by Federal sources.

Provision of care should be by all forms of quality-care sources, be they private, public, organized or institutional.

The NAACP congratulates Senator Edward M. Kennedy for his energetic approach to the matter of national health insurance. The association endorses the principles included in his proposed program. The NAACP eagerly awaits the opportunity to participate at a meaningful level in the development and structuring of such a program in a manner which would best serve the interest of all American citizens. It serves notice, therefore, of its intention to join hands with all those who worked honestly toward the goal of developing and maintaining and improving level of health for all Americans regardless of race, creed or economic status.

Thank you, Mr. Chairman.

Senator KENNEDY. Thank you, Doctor.

We will include your statement in its entirety in the record.

Mr. Jordan, as vice chairman of our Committee on National Health Insurance, and Dr. Davis, I just have one question: How do you think we can vocalize people in support of this concept? Do you think there is the support out there for this to be able to overcome the power and the influence of the special interest groups that are strongly opposed to it? Can we do that job?

Dr. DAVIS. I think the NAACP recognizes in particular the importance of health. We have had for years a stated position and a functioning health committee, and they do have a wide representation and constituency throughout this country.

Basically, the NAACP has supported the full implementation of total citizenship, and one has to be healthy in order to enjoy it. We think we have a mechanism whereby the communication of this kind of information can be disseminated rather easily.

Senator KENNEDY. You're a doctor in private practice?

Dr. DAVIS. Yes, sir.

Mr. JORDAN. Mr. Chairman, I do believe there is a constituency out there, a constituency beyond that which Dr. Davis and I represent, simply because the issue of health in America I believe is a people issue, and I believe it transcends, as I said in my statement, race, economic status. We're all affected by it and it clearly is in no respect to persons.

I think we have to get the facts to the people, and I believe the people will be responsive.

Senator KENNEDY. Very good. I have no further questions.

Senator JAVITS. I would like to ask one, if I may.

Gentlemen, I think we all must acknowledge that this program is going to be very expensive and that everyone to the extent possible, will have to share in paying the bill.

I weep with you on what I consider a tragic sentence, Mr. Jordan, in your statement, that nonwhites still experience 50 percent more bed disability days, a 70 percent higher infant mortality rate, and a life expectancy 6 years shorter than that of whites.

If you translate that into unemployment, Blacks have double the unemployment of whites, and translate that into per capita income, generally speaking, 40 percent less per capita income than whites, it's a very tragic litany. No one understands it better than I and Senator Kennedy.

But I would like to ask you this question: Will you, in working with your constituents, make it clear that when you have a national health plan there has got to be some way of paying for it, and that a part of their dignity will be in their contribution. I think that is a very important point, knowing the constituency to which you are referring. I think there's a certain dignity in their advocacy which will come and lend strength and weight by the fact they will realize they, too, like everybody else, are going to be paying participants.

I would just address that to you because I think in that way you may be able to engender a sense of militancy broadly throughout the community you represent and it could be very helpful in getting action.

Mr. JORDAN. These organizations have historically been involved in two things, involved with black people, in both the rights, rewards and responsibilities of their society. Therefore, we understand our responsibilities; we always have. And if you get cloture over there on Humphrey-Hawkins, we might be better able to do our part. [Laughter.]

Senator JAVITS. Thank you.

Senator KENNEDY. Thank you very much.

[The prepared statement of Dr. Davis follows:]

MR. CHAIRMAN:

I RISE TO REPRESENT THE N.A.A.C.P. MEMBERSHIP AND ITS FRIENDS AND SUPPORTERS THROUGHOUT THIS NATION. FOR THE PAST YEAR AND A HALF, I HAVE SERVED AS CHAIRMAN OF ITS NATIONAL BOARD COMMITTEE ON HEALTH. THE N.A.A.C.P., RECOGNIZING THE IMPORTANCE OF HEALTH AS A HUMAN RIGHT, HAS AUTHORIZED THE DEVELOPMENT OF A DEPARTMENT OF HEALTH AFFAIRS TO BE HEADQUARTERED IN ITS NATIONAL OFFICES IN NEW YORK CITY. THIS CHARACTERIZES THE N.A.A.C.P.'S COMMITTMENT AND CONCERN IN THE MATTER OF HEALTH AS IT APPLIES TO ALL OUR CITIZENS WITH SPECIAL EMPHASIS ON THE NEEDS OF MINORITIES, THE POOR AND THE UNDERSERVED. THIS AREA OF NATIONAL INVOLVEMENT INCLUDES THE INPUT AND EXPERTISE OF LEADING EDUCATORS, HEALTH PROVIDERS AND ADMINISTRATORS IN THE MINORITY COMMUNITY. YOU ARE NO DOUBT ACQUAINTED WITH THE CONTRIBUTIONS OF HOWARD UNIVERSITY, MEHARRY MEDICAL COLLEGE, THE DREW POST-GRADUATE SCHOOL OF MEDICINE AND THE NEW MEDICAL COLLEGE AT MOREHOUSE IN ATLANTA, GEORGIA. EACH OF THESE INSTITUTIONS IS DEDICATED TO CONCERNS SIMILAR TO THE N.A.A.C.P.'S POSITION IN SUPPORT OF MINORITY HEALTH ASSURANCE AND THEY ARE COMMITTED TO PROVIDING EXPERTISE IN THE DEVELOPMENT OF ANY MODALITY WHEREBY THE HEALTH PROVISION FOR MINORITIES IS BETTER SERVED.

DR. W. MONTAGUE COBB, PROFESSOR EMERITUS AT HOWARD UNIVERSITY, AND LONG RECOGNIZED AS AN OUTSTANDING PROPONENT OF QUALITY HEALTH CARE FOR ALL AMERICANS IS KNOWN TO YOU, HAVING TESTIFIED MANY TIMES HERE ON THE HILL ON HEALTH MATTERS. THERE ARE NUMEROUS OTHERS RECOGNIZED AS EXPERTS IN THEIR FIELDS INCLUDING DR. WILLIE S. WILLIAMS, ASSOCIATE DEAN FOR STUDENTS AT CASE WESTERN RESERVE UNIVERSITY. DR. JOHN ARODONDO OF MEHARRY MEDICAL COLLEGE DEPARTMENT OF FAMILY PRACTICE, DR. MARION MANN, DEAN OF THE COLLEGE OF MEDICINE AT HOWARD UNIVERSITY, DR. LEON SULLIVAN, PRESIDENT OF MOREHOUSE MEDICAL COLLEGE, AND DR. JESSE B. BARBER, CURRENT PRESIDENT OF THE NATIONAL MEDICAL ASSOCIATION. I LIST THESE NAMES ONLY TO ESTABLISH THE FACT THAT THE N.A.A.C.P. IS IN

THE POSITION TO OFFER CONSIDERABLE EXPERTISE IN THE MATTER OF DEVELOPING, IMPLEMENTING, AND MONITORING A QUALITY NATIONAL HEALTH PROGRAM. THERE WILL BE MANY AREAS OF QUESTION WITH REGARD TO TECHNIQUE BUT THERE WILL NEVER BE ANY DOUBT AS TO OUR DEDICATION TO DEVELOPING AN AFFORDABLE SYSTEM WHICH PROVIDES QUALITY CARE TO ALL WHO NEED ITS BENEFITS.

MINORITY CITIZENS OF THIS NATION CANNOT TOLERATE DELAY IN THE DEVELOPMENT OF A NATIONAL HEALTH INSURANCE PROGRAM. I SPEAK FOR A GROUP OF PEOPLE WHO HAVE FIVE TIMES AS MUCH TUBERCULOSIS AND THREE TIMES AS MUCH HYPERTENSION. THIS GROUP DIES TWICE AS OFTEN FROM DIABETES AND ITS MEMBERS ARE FOUR TIMES AS LIKELY TO HAVE CHRONIC KIDNEY DISEASE. MATERNAL MORTALITY IS AT LEAST THREE TIMES AS HIGH. MINORITIES HAVE 33% MORE DISABILITY DAYS AND THOSE OVER 65 HAVE 225% MORE DISABILITY DAYS. NEONATAL DEATHS IN THE MINORITY COMMUNITY ARE STILL TWICE THAT IN THE WHITE POPULATION. THE MINORITY POPULATION BELOW AGE SIXTY-FIVE HAS ONLY ONE-HALF THE HEALTH INSURANCE PROVISIONS AVAILABLE TO A SIMILAR GROUP IN THE MAJORITY COMMUNITY.

URBAN AND RURAL MINORITIES IN FACING THESE TERRIBLE HEALTH SITUATIONS FIND SEVERE SHORTAGES OF HEALTH SERVICES EITHER BECAUSE OF LOCATION AND DISTANCE OR BECAUSE OF INADEQUATE MANPOWER TO MEET THEIR HEALTH NEEDS. THE PRIMARY SOURCE OF HEALTH CARE IN THE MINORITY COMMUNITY HAS BEEN THE BLACK PHYSICIAN BUT THE NUMBERS ARE SO SLIM AND THE DISTRIBUTION IS SO ERRATIC THAT OFTIMES CARE SIMPLY IS NOT AVAILABLE. THE CURRENT METHODS OF GOVERNMENT AND INSTITUTIONALLY SPONSORED HEALTH CARE (LOCAL, STATE, AND FEDERAL) HAVE MANY TIMES FORCED MINORITY PHYSICIANS OUT OF CENTRAL URBAN AREAS FOR A VARIETY OF REASONS. SOME OF THESE REASONS INCLUDE LACK OF SENSITIVITY TO THE NEEDS AND MORES OF THE COMMUNITY INVOLVED AND THE FAILURE TO INCORPORATE MINORITIES IN ALL LEVELS OF THE HEALTH CARE UNITS. IT SEEMS ESSENTIAL THAT IN THE AREA OF ACTUAL DELIVERY OF SERVICES SPECIAL ATTENTION BE GIVEN TO INNOVATIVE TECHNIQUES INCLUDING MINORITY OWNED AND OPERATED I.P.A.'S, P.A.'S, AND H.M.O.'S. A PORTION OF THE SPECIAL

CONSIDERATION OUGHT TO INCLUDE GENEROUS SUPPORT OF THE RISK FACTOR AS IT APPLIES TO HMO'S SERVING MINORITY AND POOR COMMUNITIES.

THESE FACTS NO DOUBT ARE WELL KNOWN TO YOU SINCE THEY HAVE HAD WIDE DISSEMINATION IN VARIOUS JOURNALS AND PUBLICATIONS. I LIST ONLY A SMALL AMOUNT OF THIS INFORMATION IN ORDER TO DRAMATIZE AND TO CALL TO YOUR ATTENTION THE BASE FROM WHICH THE NAACP SPEAKS WHEN IT APPROACHES THE MATTER OF NATIONAL HEALTH INSURANCE.

THE INTEREST OF THE N.A.A.C.P. IN MATTERS OF HEALTH IS NOT NEW. IN FACT, THE N.A.A.C.P. FIRST PROPOSED A FORM OF NATIONAL HEALTH INSURANCE IN 1946. FROM THAT TIME ON THE N.A.A.C.P. HAS SUPPORTED THE CONCEPT OF FULL AND COMPREHENSIVE NATIONAL HEALTH INSURANCE FOR ALL CITIZENS IN THESE UNITED STATES.

NATIONAL HEALTH INSURANCE MUST MEET THE NEEDS OF ALL OUR CITIZENS. I AM SPEAKING VERY POINTEDLY TO THE N.A.A.C.P. CONCERN THAT ITS AVAILABILITY TO ALL BE GUARANTEED WITHOUT RESTRICTION IN ANY FORM. IT IS NOT REASONABLE THAT THE N.A.A.C.P. EXPRESS THIS CONCERN IN VIEW OF THE PAST HISTORY OF THIS NATION IN PROVIDING VARYING DEGREES OF ACCESS TO FULL AMERICAN CITIZENSHIP. NO NATION CAN CONTINUE TO AFFORD THE LUXURY OF BESTOWING UPON ONE SEGMENT OF ITS CITIZENRY TWICE THE EFFORT IN DOLLARS FOR THE MAINTENANCE OF AN ACCEPTABLE STANDARD OF HEALTH WHILE RELEGATING THE MINORITY SEGMENT TO SERVICE OF POOR QUALITY AND LIMITED AVAILABILITY.

BLACK PHYSICIANS NUMBER LESS THAN 2% OF ALL PHYSICIANS IN THIS COUNTRY. GREAT HOPE FOR IMPROVEMENT IN THIS AREA OF MANPOWER NEEDS DEVELOPED IN THE LATE 60'S AND EARLY 70'S. MUCH TO OUR CHAGRIN WE NOTE THAT NEW (BLACK) MEDICAL STUDENT NUMBERS ARE DECREASING BOTH NUMERICALLY AND PERCENTAGE WISE. ENROLLMENT AT FIRST YEAR LEVELS HAS DROPPED FROM 7.5% IN 1974 TO 6.7% IN 1978 IN SPITE OF AN INCREASE OF MEDICAL SCHOOL FIRST YEAR PLACES FROM 8,000 IN 1968 TO 14,000 IN 1978.

MEDICAID PROGRAMS SCATTERED THROUGHOUT THE STATES HAVE SERVED AN INCREASING NUMBER OF THE POOR INCLUDING MINORITIES. HOWEVER THE PROGRAMS HAVE BEEN IMPLEMENTED UNFAIRLY. IT IS WELL_DOCUMENTED THAT SEVENTY-FIVE PERCENT MORE DOLLARS HAVE BEEN EXPENDED PER WHITE RECIPIENT WHEN COMPARED TO MINORITY RECIPIENTS. A SIMILAR DISCREPANCY EXISTS IN THE MEDICARE PROGRAM. HERE THE FIGURES SHOW 60% MORE FOR PHYSICIANS SERVICES AND 20% MORE FOR INPATIENT CARE FOR WHITES WHEN COMPARED TO NONWHITES. AS ONE REPORT DESCRIBES IT: "THE POOR AND MINORITIES WERE AT A TWOFOLD DISPARITY HEALTHWISE: THEY WERE IN POORER HEALTH AND THEY HAD LESS SPENT ON THEM FOR HEALTH SERVICES".

THE FACTS LISTED ABOVE ARE NOT INTENDED TO SHOCK OR DEPRESS THIS PANEL. I REFER TO THIS MATERIAL TO SUBSTANTIATE THE SINCERE AND UNSWERVING INTEREST OF THE N.A.A.C.P. IN A UNIVERSAL HEALTH PLAN WHICH INCLUDES AN AWARENESS THAT NO MATTER WHAT FORM IT TAKES THE N.A.A.C.P. MUST INSIST UPON FAIR AND EQUITABLE IMPLEMENTATION. TO THAT END WE WOULD LIKE TO RECOMMEND THE FOLLOWING PRINCIPLES TO BE INCLUDED IN ANY BASIC NATIONAL HEALTH INSURANCE PROGRAM.

1. AVAILABLE TO ALL REGARDLESS OF ABILITY TO PAY
2. UNIVERSAL-ONE LEVEL OF BENEFIT TO EVERY CITIZEN (INCLUDING ALL FORMS OF MEDICAL AND DENTAL CARE)
3. PREVENTIVE CARE
4. FREEDOM OF CHOICE
5. QUALITY ASSURANCE
6. FULL MINORITY PARTICIPATION IN PLANNING, ESTABLISHING REGULATIONS, IMPLEMENTATION AND MONITORING.
7. FEDERALLY REGULATED
8. PROVISIONS FOR ADEQUATE MANPOWER DEVELOPMENT WITH FULL MINORITY PARTICIPATION
9. COMPLETE PROGRAM OF PUBLIC EDUCATION FOR HEALTH
10. FULL ADHERENCE TO CIVIL RIGHTS LAWS INCLUDING MINORITIES AT ALL LEVELS OF POLICY AND ADMINISTRATION.
11. FINANCING SHOULD BE A COMBINATION OF PRIVATE AND PUBLIC FUNDING. ALL UNEMPLOYED SHOULD BE FULLY INSURED BY FEDERAL SOURCES
12. PROVISION OF CARE BY ALL FORMS OF QUALITY-CARE SOURCES BE THEY PRIVATE, PUBLIC, ORGANIZED OR INSTITUTIONAL

I WISH TO THANK THE COMMITTEE FOR GRANTING ME THE OPPORTUNITY TO PRESENT THIS COMMENTARY. THE N.A.A.C.P. STANDS READY TO LEND ITS SUPPORT TO THE PROCESS OF DEVELOPING A VIABLE AND EFFECTIVE PROGRAM FOR ALL THE CITIZENS IN THESE UNITED STATES.

RESPECTFULLY SUBMITTED,

SYLVESTER S. DAVIS, M.D.
CHAIRMAN, NATIONAL BOARD HEALTH COMMITTEE
NAACP

Senator KENNEDY. The next panel is Victor Lutnicki, the executive ivce president, Health Insurance Association of America, and Mr. Henry DiPrete, associate vice president, John Hancock Mutual Life Insurance Co. They represent the Health Insurance Association of America.

It's nice to see you.

STATEMENT OF VICTOR A. LUTNICKI, EXECUTIVE VICE PRESIDENT, JOHN HANCOCK MUTUAL LIFE INSURANCE CO., ACCOMPANIED BY HENRY A. DiPRETE, ASSOCIATE VICE PRESIDENT; AND JAMES BARRETT, MUTUAL BENEFIT OF OMAHA

Mr. LUTNICKI. Thank you, Mr. Chairman.

Anticipating that you would have a problem in scheduling, we have kept our statement very short. This is Mr. DiPrete, and I have with me Mr. James Barrett of Mutual of Omaha.

As you have announced, we appear here today on behalf of the Health Insurance Association of America, representing 318 health insurance companies who cover a very significant proportion of the working population both through group insurance and individual insurance.

Let me state at the very beginning, as forcefully as I can, exactly where our Health Insurance Association stands today on the issue of health care for the American people.

We want quality health care services at affordable cost to be available to every American. We acknowledge that this condition does not exist today. We and our member insurance companies want to be a part of bringing it about.

The chairman's opening statement and the testimony received on the first day of this hearing put clearly into focus the two principle goals to be addressed by national health insurance legislation:

One, the need to contain rising health care costs, and two, the need to guarantee to all Americans, regardless of health status or ability to pay, access to comprehensive health insurance, which we note is to be underwritten in part by private insurers, or by prepayment plans.

No American should live in fear of medical misfortune that will bring financial tragedy for themselves or their dependents.

Now, from our point of view, the coming debate will not be over objectives, better health care for all Americans, and providing protection for those not now protected. It will be over how we can best achieve those objectives. And this is not a new position for us.

We have said it in our sustained support of the National Health Care Act, introduced by Senator McIntyre and Congressman Burleson into five Congresses.

We have said it in our industry's support for the legislation already enacted in Connecticut which guarantees to all residents the availability of comprehensive health insurance at a reasonable price, regardless of the condition of one's health.

And we support Federal legislation which would, in effect, require the establishment of such a system in all the States.

Nor is the goal of cost containment new to our industry. We have worked hard to get prospective hospital budget review enacted in

States such as Massachusetts, Maryland, and Connecticut. We are working hard to make those programs effective.

Over the last 5 years, we have worked closely with your committee for the enactment and perfection of Federal legislation designed to make our health care system more cost effective. We have supported the Health Planning Act legislation to encourage the development of HMO's, and more recently, but unfortunately less successfully, Federal hospital cost containment legislation.

Your position is to be commended for recognizing that containment of medicare-medicaid costs will produce a shift, but little if any reduction, in the cost of health care to the country.

Now, Mr. Chairman, the twin goals of cost containment and universal protection will be difficult to achieve. It will take the best efforts and total commitment of all of us—legislators, insurers, doctors, hospitals, patients, employers, and Americans everywhere—but it can be done.

The new proposal unveiled at this hearing makes significant progress toward resolving some of the basic differences that have separated participants in the debate on national health insurance. It appears to recognize that the desired goals can be achieved only if constructive use is made of the full resources of the private sectors. Differences remain, but we believe that with the prevailing attitude these can be resolved. We are anxious to assist and participate in this effort.

In short, we applaud this development, recognizing that we have in front of us only the bare outlines of a plan. This will have to be developed into legislation, which we will examine most carefully, and with a positive and supportive attitude.

We are committed to giving this committee our best effort, our best suggestions, and constructive assistance toward developing practical legislation that will solve the problems that are before us.

That completes our short statement, Mr. Chairman.

Senator KENNEDY. Thank you very much. I think it's a very constructive and very positive statement. We appreciate the support of your association on the cost containment program, and on the planning legislation. I think your support and help on the floor of the Senate made a great deal of difference. We very much appreciate it.

I think you have challenged us to draw on your association to achieve, as you point out on the top of page 3, the twin goals of cost containment and universal protection to which we're very strongly committed. We know you've got a lot of expertise and a lot of know-how, and we want to draw on that from your association.

Mr. LUTNICKI. We appreciate it.

Senator KENNEDY. I think this is a very constructive and positive contribution in the first phase of our hearings, and we are going to accept the offer for help and draw upon you and your association for assistance.

Thank you.

Senator Javits?

Senator JAVITS. I feel exactly the same way.

I am pleased to see this new attitude on the part of insurance companies regarding your willingness to participate in the implementation of a national health plan. Insurance companies have not always taken this position.

I would like to join Senator Kennedy in saying how deeply pleased I am that you have made this presentation, and how constructive it has been. I think you have at least boosted by 50 percent the chances of a national health plan in the next 2 years.

I would ask the chairman and you, whether you are prepared to also take some continuing role in the development of the legislation, so that at all stages any of us who are involved may feel free to consult with you and gain the benefit of your expertise?

Mr. LUTNICKI. Senator Javits, we would respond to that by saying we will provide you with any assistance. We have individuals, such as Mr. DiPrete here and Mr. Barrett, men who are very familiar with this problem. They have worked in it as people out in the field. They are working on the State level and planning councils. They are working with the staff of various congressional committees. They are working with the Department of HEW. They are available to you, and without prejudice, will give you what we think are the right answers to any questions you ask.

Senator JAVITS. Thank you very much.

Senator KENNEDY. Thank you. It's nice to see you.

We have a final panel of Tony Dechant, who is president of the National Farmers Union; Jay Dobkin, president of the Physicians National House Staff Association; Dr. Mauksch of Vanderbilt, who represents the American Nurses Association; and Miss Carol Burris, president of the Women's Lobby, Inc.

STATEMENT OF TONY T. DECHANT, PRESIDENT, NATIONAL FARMERS UNION

Mr. DECHANT. Mr. Chairman, I would like to introduce my associate, Mrs. Ruth Kobell, who is here with me.

For the record, I am Tony T. Dechant, president of the National Farmers Union, an organization of 275,000 farm families spread across the agricultural areas of the Nation.

The health of American farm families is important to the Nation because they produce an abundant and stable food supply which is so vital to the nutrition and health of our population.

Let me say at the outset, Mr. Chairman, that we appreciate your continuing commitment, as expressed in the new proposal before the subcommittee, to finding ways to meet the health care needs of the people.

In all frankness, we are appalled at the attitude of the top advisers in the Carter White House who say we must put off what needs to be done in the field of health care because it would be costly and inflationary.

Senator KENNEDY. So you don't believe in the trigger concept?

Mr. DECHANT. No; I do not. What we're doing now is not working. We do not concur that, desirable as it may be, a national health care program must only be phased in bit-by-bit over a period of 5 to 10 years.

If we accept such a course, by the time the initial parts of the new program are operative in 1985, total national health care outlays, public and private, will exceed $350 billion a year—double the current

cost—without any appreciable improvement in quantity and quality of services.

Clearly, doing nothing about health care will be the most costly course of all for the American people. This conclusion is generally supported by studies already reported by the Congressional Budget Office and HEW itself.

To update available material, we urge that the staff of this subcommittee be directed to prepare and report projections of the total cost of health services under this legislation and under a continuation of the existing system.

This would be very helpful to us, Mr. Chairman, in terms of programs considering health legislation that we have underway in the field, to have cost projections.

We have every confidence that realistic projections will show that a national health plan, along the line of this proposal, will, when fully implemented, provide dramatically better health care at less comparative cost than the present ineffective system, continued in the years ahead.

The new bill would be of particular benefit to rural America, which has one-third of the Nation's population but only 12 percent of the doctors and 18 percent of the nurses.

The doctor-patient ratio is 1 to 2,400, compared to 1 to 500 in the urban areas.

We have 138 counties, with a combined population of a half million, without any doctor.

Ten thousand of the doctors serving rural America are over age 55, and presumably will be retiring in the next 10 years; but the number of doctors choosing to serve in rural areas is well below the rate needed for replacement.

Rural residents have less adequate health insurance and their payments for health care take a larger share of family income, about 10 percent as compared with an 8-percent share for urban residents.

We have occupational hazards in agriculture, from accidental injury and from exposure to pesticides, chemicals and wearing physical exertion. Rural residents have a higher incidence of chronic illnesses, including digestive, respiratory and circulatory health problems. We have 22 percent more ulcers, 26 percent more frequent hypertension, and 29 percent more strokes than city residents. Infant deaths are nearly triple the national rate.

I assume from reading the preliminary plan that involvement in the program——

Senator KENNEDY. These are important, Mr. Dechant, when we have heard a spokesman for organized medicine talking about the best. We do have the best for people able to afford it in this society.

The statistics Mr. Jordan gave earlier about health conditions among many in our society, and now you are pointing out what the situation is for rural America. It's a real challenge to be sure people aren't going to be left out of the system. That's what I get from your message here today, about the challenge or rural America.

I just want to give you every assurance that in the bill I support we will address those needs. It's good to get your testimony in this area and your spelling it out. We want to give you every assurance that we will certainly work closely with you.

Mr. DECHANT. Thank you, Mr. Chairman. I have never questioned our expertise or our knowhow. My concern is the delivery to the people who need it.

I am glad that the program that you have in the proposals stage will be mandated for all citizens. We have just got to make sure that there is no way for people to be dropped from eligibility or otherwise fall between the cracks.

Farm families have widely fluctuating gross and net income levels from one year to the next. And they have no way to pass on, through sale of the food and fiber they produce, the inflation in production and living costs. I hope the perfecting legislative language will deal with this problem as it relates to the level of premium payment for health care coverage by farmers and other self-employed citizens.

In conclusion, let me say that few things are more devastating to an individual's hope of living up to his full potentiality than the gnawing insecurity of health problems and the economic inability to cope with them.

We recognize, of course, that many rural doctors, nurses and other health workers are making a dedicated and valiant effort, working uncounted hours to serve their communities. However, they, like ourselves, have little capacity to improve the present situation without the major changes encompassed in the legislation which you are now considering.

Again, we therefore commend you for this initiative and commend the subcommittee for its work, and emphasize its importance to farmers and rural residents.

Thank you, Mr. Chairman.

Senator KENNEDY. Thank you very much.

[The following information was subsequently received for the record:]

National
Farmers Union

October 20, 1978

Honorable Edward M. Kennedy
Chairman
Subcommittee on Health
Senate Human Resources Committee
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

Last week Tony Dechant, President of National Farmers Union, wrote you concerning his views on the North Dakota initiative to control health delivery costs. As he pointed out, the time pressure constraints of the hearing schedule precluded his enlarging on this subject when he appeared before you.

I hope it will be possible to include his letter and the accompanying article from the North Dakota Union Farmer as a part of the hearing record.

Thank you for your help in this matter.

Sincerely,

Ruth E. Kobell

Ruth E. Kobell
Legislative Assistant

REK:gp

Suite 600, 1012 14th Street, N.W., Washington, D.C. 20005 — Phone (202) 628-9774

North Dakota Union Farmer

October 5, 1978

NDFU supporting health measure

November positions announced

JAMESTOWN — "North Dakota has the opportunity in the November general election to achieve a national leadership role in promoting consumer concerns about health care delivery and its costs," North Dakota Farmers Union President Stanley Moore said Sept. 29, in publicly announcing the farm organization's support for a health initiative to be voted on in November.

The NDFU board of directors at a special board meeting on Sept. 25 adopted an organizational position urging a "yes" vote on the health initiative, as well as on three proposed constitutional amendments.

The NDFU board reaffirmed the farm group's opposition to initiated measures on revenue sharing and income tax rate revision, while supporting an initiative dealing with return of interest revenue to a dedicated fund.

In the public announcement on support of the health measure, Moore said, "The urgent need for controlling health care costs and providing for an improved health care delivery system has not been met by indirect or voluntary approaches by the health care industry and the federal government."

He explained that while the state Farmers Union has traditionally supported a comprehensive national program towards these goals, "it is time, too, for states to take the initiative and develop interim programs to fill the national vacuum. A demonstration of concern over health costs from individual states should help prompt appropriate action on the national level."

The NDFU president indicated that while the health costs control system proposed by the initiated measure may not necessarily provide an immediate reduction in health care costs, it has the "potential for providing a system by which future increases in health care costs might be more effectively controlled." Moore emphasized that the important aspect of the initiated measure is that it would "through the public hearing process for the first time give consumers of health care a voice in determining the rates established for health services."

Moore said the measure would provide "greater consumer input into the decision-making process of the State Health Council." In addition, the state's voters would be provided another opportunity at a future election to vote on an alternative plan to improve and extend health insurance coverage, "he observed.

Moore acknowledged that the initiated measure does not provide a "total answer" to the state's health care needs, but said, "it can be a significant beginning step, especially at a time when health delivery and its costs are again developing into national issues." He said the referendum will become a "barometer of public attitude as to the need to contain spiralling health costs." He added that the initiated measure "would provide a beginning framework for the State Legislature and the Congress to more effectively deal with the health concerns of consumers."

He reported that the organization's board of directors feels that a yes vote in support of the measure would give "rural and urban consumers in the state a platform to begin discussions of health care issues that affect every single North Dakota family."

The health initiative was sponsored by a 19-member committee which included a number of well-known Farmers Union local and county leaders and was headed by State Insurance Commissioner Byron Knutson.

The measure would give authority to the state health officer to establish the maximum charges to be allowed for any health service in the state. The maximum rates would be established through a public hearing process under the state's Administrative Agency Practices Act.

NDFU supports health initiated measure

The state health officer would be required by the measure to develop rules and regulations for the rate-making process. It would permit maximum charges for a specific health service to vary in the state because of geographic, economic or other justified reasons.

The measure also reduces the number of members on the State Health Council from 11 to nine members. Three of the council's members would be providers of health services (compared to eight members under the present structure), with the other six members representing consumers. The council members would be appointed by the governor.

The measure also provides that the State Health Officer must be an "elector" (resident) of the state and must be at least 25 years old. It would not require that the health officer be a physician. The health officer's salary would be set by the governor, but could not exceed the governor's salary.

The health initiative would require the state insurance commissioner after an investigation of the "present state of health care" in North Dakota to "develop a plan to improve and extend insurance coverage in the state at a rate that shall not be excessive." The insurance commissioner would then be required to propose the plan at the next general election for approval or disapproval of the state's voters.

The NDFU board of directors adopted an organizational position in opposition to the initiated measure on income tax rates. NDFU President Stanley Moore explained that while "there is no question that the state's income tax needs to be updated," the farm organization believes that the measure would not provide "equitable tax reform." He pointed out the measure is "far different from the income tax revision supported by NDFU at the last legislative session."

Moore said, "The failure of the last legislative session to provide income tax reform should not become an excuse to approve an unacceptable tax revision." He reminded the organization's members that if the measure is approved, a future legislative session would have "great difficulty in readjusting the rate schedule because of the two-thirds legislative majority required to amend initiated measures."

The NDFU president said, "Considering the inflation rate and the two-thirds legislative majority required to amend initiated measures, the measure is not in the best long-term interest of the state's citizens."

The measure, initiated by a committee headed by Bismarck businessman Robert McCarney, would make the following changes in individual and corporate income taxes, with the current rates in parentheses:

INDIVIDUAL INCOME TAX RATES:

Below $2,000 at 1% (below $1,000 at 1%)
$2,000 to $3,000 at 2% ($1,000 to $3,000 at 2%)
$3,000 to $6,000 at 3% ($3,000 to $5,000 at 3%)
$6,000 - $13,000 at 4% ($5,000 - $8,000 at 4%)
$13,000 - $25,000 at 5% ($8,000 to $8,000 at 7½%)
Above $30,000 at 7½% (above $8,000 at 10%)

CORPORATION INCOME TAX RATES:

Tax rates of income between $5 and $100,000 would not be changed.
$11,000 to $25,000 at 6% ([illegible])
$25,000 and above [illegible]

The farm organization's board reaffirmed NDFU's opposition to the initiated measure on revenue sharing. The NDFU Board of Governors had taken an organizational position against the measure at its meeting earlier this year.

The revenue-sharing proposal sponsored by the North Dakota League of Cities would allot five percent of the total revenue from the state income and sales taxes to counties, cities, city park districts and townships. The revenue sharing formula would divide the five percent with half of the money being allocated on the basis of population and the other half being allocated on the basis of the real estate tax levy in the county.

Cities would receive the revenue sharing funds on both their share of a county's population and their share of property tax levies. A park district within a city would share the city's portion of the revenue sharing funds based on their respective mill levies.

Townships would receive 10 percent of the allocations made to the county in proportion to the population of each township to the population in all of the county's townships. In the state's 1977 fiscal year, a total of over $8.5 million would have been allocated under the proposed revenue sharing measure.

The NDFU Board of Governors, in urging a "no" vote on the measure, said the proposed revenue sharing would provide the greatest benefits to the heavily populated areas of the state, while shortchanging rural areas and townships.

NDFU President Moore reminded the farm organization's members that historically the organization has believed that initiated and referred measures concerning state revenues and taxation cannot be effectively reviewed through the ballot, because such measures do not necessarily consider the impact on the state's budget and budgeting process. They could create a serious financial imbalance for the state, he said.

On the basis that interest received on money in a dedicated fund should be returned to that fund rather than the state's general fund, the NDFU board of directors gave its support to an initiated measure sponsored by the United Sportsmen.

The measure would return the interest income received on funds of the State Game and Fish Department to that agency's fund. Under the measure, the Legislature would still determine the use of the interest income through the appropriation process. The State Game and Fish Department has announced that if the measure is approved, it would recommend that the Legislature appropriate the interest income for a special Game and Fish--farmer rancher habitat program.

The program would provide cost-sharing money for ASCS wildlife practices programs and other wildlife tree plantings, nesting cover, deer proof hay yards, and other such measures carried out on private land by the landowners.

The three constitutional amendments proposed by the last legislative session were endorsed by the NDFU Board of Directors as part of the farm organization's support for modernizing the state's constitution.

The first amendment on the November ballot would require that all records of governmental bodies (including any groups or agencies receiving state funds) be open for public inspection, unless otherwise provided by law. The NDFU board feels the amendment would "reinforce the public's right to know", and yet maintain the privacy of certain records as in the case of the current law which prevents the disclosure of the names of juvenile offenders,

The second constitutional amendment on the ballot would update the state's constitutional provisions on voting age and residency requirements to conform to court decisions and the U.S. Constitution. The amendment would reduce the voting age to 18 and allow the Legislature to establish residency requirements.

The third proposed amendment would revise the provisions concerning the initiative referendum and recall.

NDFU President Moore said that while the amendment would result in a higher number of signatures for initiated, referred, and constitutional measures, based on the current state population, the farm group "felt that the increases would not be burdensome nor would they be any real roadblock to citizens who wish to circulate petitions on an issue."

He said the measure would better "reflect the state's population as it changes." The seven-year limit on the, two-thirds legislative majority requirement to change initiated and referred measures, he said, would simplify legislative procedures and still prevent the Legislature from making "any hasty decisions" on such measures.

Senator KENNEDY. Senator Javits?
Senator JAVITS. Thank you. We appreciate the testimony very much. I have no questions.
Senator KENNEDY. All right.
Dr. Dobkin, you may continue.

STATEMENT OF JAY F. DOBKIN, M.D., PRESIDENT, PHYSICIANS NATIONAL HOUSE STAFF ASSOCIATION

Dr. DOBKIN. Senator Kennedy, Senator Javits, our association of 12,000 intern and resident doctors across the country supports a strong comprehensive national health program. We think the time to enact it is now.

Senator KENNEDY. Why do 12,000 young physicians support this while the AMA is vigorously opposed to it?

You represent the young doctors who have finished medical school, who are well trained, and who are looking to the future. Why does your group in the health profession give strong support to this?

Dr. DOBKIN. I guess the most charitable explanation is that medicine has changed a lot in the last 20 or 30 years certainly.

Certainly a lot of the technical aspects have changed and we are sure that the economic aspects have changed. Almost every resident deals with the paradoxes and shortcomings of the current organized system. We see people who go without care or are treated inappropriately or not at all.

Basically, out of that kind of frustration, we feel a change ought to be made.

Senator KENNEDY. The older doctors ought to see that, too. They must come across the same kind of inadequacies and failures the young doctors do, and yet organized medicine does not support this.

We must separate, obviously, the individual doctors, a number of whom support this proposal. The real spokesmen for the organized aspect have taken a strong exception to this approach. They must see the same kinds of things that you see. Why are they so reluctant to try to move with us while you are trying to assure that we meet this?

Dr. DOBKIN. There may be one important factor. The whole training process in the medical care system in this country is oriented so that people like us are acquainted with the worst aspects of it.

Senator KENNEDY. What do you mean by that?

Dr. DOBKIN. Most of the training of both medical students and interns and residents goes on in large public teaching hospitals where patients who have been turned away by the private system wind up, the people who have exhausted their insurance and people who run out of their assets in the private system come in.

In addition, people who are fresh out of medical school are less insulated from the concerns that present themselves. Also there is a very heavy propaganda phenomena, an enormous amount of verbiage and material, scare material and scare tactics about socialized medicine and taxation and the various evils of——

Senator KENNEDY. Rationing?

Dr. DOBKIN. Rationing. Most doctors are not in a position to very well analyze this concept, and they are influenced by it.

Senator KENNEDY. What about the argument of rationing? We have heard that story. You refer to it a little further down in your testimony. What about rationing?

Dr. DOBKIN. The plain truth is almost anybody going through medical training experiences knows that there is already rationing. It is perhaps irrational rationing. This seems to be based on the fragmentation of the marketplace, so a patient who needs an outpatient workup, X-rays and whatever gets put in a hospital which is more expensive and so forth because their insurance does not cover outpatient care.

A good example of that is the renal dialysis program.

When I started medical school, the big ethical debates were whether those people should be allowed to go on dialysis or not. In the last 10 years, it has been changed. The problem was not a lack of technology. It was a lack of money until the decision was made to pay for it. Now if your kidneys fail, you are lucky because you are covered. If your heart or liver fails, you are not so lucky and you may wind up not getting the care you need.

Senator KENNEDY. Please continue with your testimony.

Dr. DOBKIN. The experience of most young doctors working in large urban hospitals, and clinics confronts them daily with paradoxes in our health area. High technology has advanced rapidly while service delivery and administration have not. We see neglect of basic prevention and treatment alongside sophisticated expensive care of rare conditions. The current slogan applied to everything is cost-control. Yet, we see many vital areas which call for more, not less support.

Even the most resolute defenders of the status quo now grant that some reforms are needed: The AMA urges restraint on fees and more preventive care; the hospital associations promote "voluntary" reforms. But such piecemeal strategies as these or even targeted programs for catastrophic illnesses or certain disease categories are inadequate. In fact, the fragmented approach to health care has produced many of the problems we now face. We need, above all, a comprehensive national health policy, and a comprehensive program to implement it. The fragmented access to care frustrates patients and the fragmented payment system buries providers under mountains of forms. For all sides, especially at a time of scrutiny of the cost and efficiency of our programs, it is highly significant to note that whereas Canada's comprehensive system has an administrative cost of 2 or 3 percent, we spend about 6 times as much on administering our health care. Clearly, we pay for our current disorganization with more money and less health care.

The opponents of a comprehensive national health program will raise many doubts—can we afford it medically, politically or economically? The real question is can we afford not to act? One key worry is will such a program lead to rationing of care? It is easy to see that our current system is already rationing care, often rationing away the most needed or effective care first. Our public hospitals are an important example. Chronically, underfinanced and overburdened with the sickest and poorest patients, these city and county hospitals are being decimated by the forces of inflation, governmental retrenchment and economic warfare in the hospital industry. Pathetically, the first serv-

ice to be sacrificed is likely to be the emergency room or outpatient clinic on which the whole community, not just the indigent depend.

Young doctors are acutely aware that medicine and medical care are changing rapidly. While our diagnostic and therapeutic abilities have advanced greatly, our delivery capability is, in many ways, a relic of the days of bodily humors, cupping, and leeches. A broadly constructed national health program must be enacted to provide universal and comprehensive coverage, set priorities, control costs, and guarantee access to all. We must avoid both total inaction or the piecemeal fragmented approach. We cannot afford to do less either from a medical or economic perspective.

Thank you.

Senator KENNEDY. Can you comment on your concerns about the piecemeal approach, Doctor? Why do you have reservations about that type of approach?

Dr. DOBKIN. We have seen especially in the last few years, because of the disorganization of the system, that there is a great tendency toward bending rules and priorities. The entrenched interests are very capable of twisting the entire situation around, for example, increasing hospitalization and increasing unnecessary surgery to fill beds to meet minimum rates of occupancy.

I think the piecemeal system we have now is responsible for most of the problems we are talking about. It is fragmented by disease categories, by economic status, and by geographic location.

Senator KENNEDY. You're concerned about what dealing with just a section of it or part of it will mean that rather than really any segment of it. We just would be dealing with the fundamental problems, is that what you are suggesting?

Dr. DOBKIN. One of the things that the prviders complain about—hospitals and individual physicians—is the enormous duplication of forms and bills. That is the clearest example of what happens when you have such a fragmented system.

In the Canadian system, the payment is very streamlined and simplified. Instead of spending 10 percent of the enormous national health budget on paper and bureaucracy, I would like to see it spend on health care.

Senator KENNEDY. Health insurance would mean less paperwork rather than more?

Dr. DOBKIN. I think so. It would be well received by both sides.

Senator KENNEDY. Thank you.

STATEMENT OF INGEBORG MAUKSCH, Ph. D., PROFESSOR AND FAMILY NURSE CLINICIAN, VANDERBILT UNIVERSITY SCHOOL OF NURSING

Dr. MAUKSCH. Thank you. I am Ingeborg Mauksch, professor and family nurse clinician at Vanderbilt University School of Nursing. I was a member of Secretary Califano's Advisory Committee on National Health Insurance which completed its report last February. Recently, I was appointed to the Committee for National Health Insurance. I appear here today representing the American Nurses' Association.

Being of very benevolent disposition, Senator Kennedy, I assume that the women were put last on the program because that indicates that you left the best for the last. [Laughter.]

Senator Kennedy, we really appreciate very much your proposal for a national health plan. We believe that it is very meaningful and the American Nurses' Association has supported national health insurance legislation for a long time. Basically we are particularly pleased with your criticism of the economic component of the President's principles, and I appreciate very much your dialog with the Secretary about that this morning.

I wrote a letter to Vice President Mondale several months ago. I did not receive an answer.

Senator KENNEDY. Why do the nurses support health insurance and organized medicine opposes it?

We hear that the young doctors support it, the interns support it, and the residents support it, and the nurses do.

Tell us why you support it.

Dr. MAUKSCH. I think it is very important for you to understand, Senator Kennedy, that we in nursing, while we work together and plan to continue to work together closely, have very many basic differences. Probably the basic differences concerns our consumer orientation. We believe organized medicine is self-oriented. It is provider oriented. One of the reasons that we support your plan is that it has many characteristics of consumer orientation. Nurses are not going into their profession for money. They go into it because they like to do things for people.

Senator KENNEDY. You are right. We shou ıave put you on first. [Laughter.]

Dr. MAUKSCH. Thank you very much.

Senator KENNEDY. Perhaps you would elaborate just a little bit on that point.

Dr. MAUKSCH. I would like to go back.

If we look into the history of nursing, it is now about 110 years old professionally. I am a graduate of one of the first schools in the country which is in your State, Massachusetts, Massachusetts General Hospital.

From then on, I was always socialized, Senator Kennedy, that we must do always for love and the physician's approach to money-making is not professional and is not acceptable to us.

I think that was overdoing the point somewhat. [Laughter.]

Nevertheless, I do believe that nurses have never embraced the materialistic component of health care. We have been traditionally and totally committed principally to the need of the consumer. Our official stance has demonstrated this. We supported medicare and medicaid. We were the only national organization that supported social security legislation in the 1930's before I even came to this country, so we have really been with it all the time, and we are very much with it today.

Senator KENNEDY. I would just like to make a point here. I think it is very interesting that a group that is the closest to the patient and sees the system from perhaps the patient's point in so many different respects, has given such strong support and endorsement to health

legislation. It reassures us for those trying to strengthen the quality aspect as well as the financial aspect. I think that is significant.

Very well. Please proceed.

Dr. MAUKSCH. I would like to very quickly say that we are particularly pleased with the emphasis in your plan of the home health care component, of the payment of drugs for the elderly. Many of my patients are not able to pay for their drugs, even though they are benefiting from other medicare provisions. We are very pleased that there will be relief for the States with regard to medicare and with respect to medicaid, and we are pleased that mental health is included.

Essentially, we endorse all of your provisions and are very, very supportive of your endeavors.

What we are disappointed in are the omissions. We view the national health plan as a two-thrust issue. One very definitely is a plan of financing. That has been discussed quite extensively today.

But the other one which has not been discussed extensively is that if we support a plan that does not have change, we are not really doing the job. We are asking you to consider seriously all the components of the plan that will deal with reform of the current system or nonsystem.

No health insurance plan can be successful without changes in the present health care delivery. Current reimbursement policies on medicare and most health insurance plans limit access to health services and contribute to high health care costs. It focuses on acute care with little emphasis on prevention and health education. And I am very glad that this was pointed out by the previous speakers. Yet, it also forces you to use expensive hospitals which could be prevented.

One proper response to skyrocketing health care costs should be a shifting away from the use of expensive inpatient facilities and toward the imaginative use of less expensive ambulatory services which are often more appropriate delivery mechanisms in the first place.

Now, we believe that the Kennedy plan, as outlined, does make one very serious omission. There is no reference to nursing services as a covered benefit. After all, this is hard for me to believe because nursing care is an integral part—in fact, it is the backbone of health care in our society. Nurses comprise the largest, most diverse, and most talented group of health and illness care providers.

Second, the practice of requiring physicians' signoff in order for nurses to be reimbursed has severely limited the access of consumers to health care.

This was recognized to a degree in the recently enacted (rural health clinics which made services of nurses in rural clinics reimbursable without requiring direct physician supervision.

We urge that attention be given to insurer's programs so that they clearly state covered health services and allow the consumer to choose and have access to services of nurses.

Nurse providers, whether they are self-employed or employed by institutions or agencies, can authorize appropriate nursing services. Insurance programs should not require the payment of a fee to a physician for signing a claims form for reimbursement of services which are provided by nurses with nursing authority.

Furthermore, we would like to suggest two basic shifts. One, I believe, is just in its infancy and that is the shift from illness care concentration to preventive medicine, health maintenance, and health education.

And when I talk about health maintenance, I also think the attainment of a better level of health because many people think they are healthy but they really could have a much better health status.

We are concerned that there is no grievance and/or appeals procedure in the present plan.

Last summer, when I traveled with Mr. Califano, I was extremely impressed from talking to rural workers in the south of Texas and with medicaid people all over the country who constantly said all these bad things happen to us, but how can we complain? There is no way to make known how bad our care is, how long we wait.

I think that is important.

I will conclude my statement in the interest of time, Mr. Chairman, by saying that the American Nurses' Association hopes that we will be included in the drafting of the legislation, that you will call on us because we are right here to help. We believe in this, and we thank you very much for doing it.

Senator KENNEDY. Thank you.

It is an excellent statement and you certainly will be included. We will value your suggestions about the nursing component. Of course, they are included in the areas providing services. However, I know you have some additional suggestions and we will welcome the opportunity to hear from you.

We also have in the legislation a grievance procedure which you mentioned as being very important, and also an advocacy aspect, which is very important, so we will value your suggestions.

[The prepared statement of Dr. Mauksch follows:]

Testimony of

AMERICAN NURSES' ASSOCIATION

on

National Health Insurance Proposals

to

Subcommittee on Health

Senate Human Resources Committee

U.S. Senate

October 13, 1978

Mr. Chairman, I am Ingeborg Mauksch, professor and family nurse clinician at Vanderbilt University School of Nursing. I was a member of ~~the~~ See Cobb 1 HEW Advisory Committee on National Health Insurance which completed its report last February. Recently, I was appointed to the Committee for National Health Insurance. I appear here today representing the American Nurses' Association.

The American Nurses' Association has long supported the concept that the goal of public health policy should be to make adequate health care available to all. We were one of the early supporters of Medicare legislation and are on record as advocating the enactment of a comprehensive national health insurance program that will guarantee to all American people access to health care services of an acceptable quality.

In spite of comments to the contrary, the need for a comprehensive national health insurance program is apparent. By conservative estimates, at least 20 million Americans have no health insurance. Of those that do, an estimated 65 million lack adequate protection against the costs of long-term illness and other catastrophic expenses. The rapidly growing elderly population will intensify the demand for the full range of health services--from home care to institutional care. Perhaps a quarter of the total aged population requires some

type of care for chronic illness.

Approximately 25% of the poor and near poor are not covered by Medicare or Medicaid. The unemployed and newly employed often are without health insurance.

A recent story in the Washington Post illustrates the need for improved coverage. It relates the case of a 36 year old mechanic from Virginia who had sustained two broken legs, broken arm and fractured wrist in an accident in May '78. Because this accident was not job-related, he could not apply for workman's compensation. Because he had recently changed jobs, he was not covered by insurance. His Social Security application was denied since he was not expected to be disabled for a year. Presently he is receiving food stamps and $240 in general state relief payments. Meanwhile, he has accumulated more than $7,000 in medical bills, and they are still mounting.

The maldistribution of health care services has added to the nation's problem, although recent federal efforts in this area are beginning to show progress. Health services available to many rural and inner city residents are minimal or nonexistent. Efforts to implement the Rural Health Clinics Amendment have been frustrated by long standing barriers to access and the predominately illness and acute care focus of the health care system.

Lamoille Home Health Agency, Inc. is a volunteer, non-profit agency providing services to residents of a county with a population of 14,500 in rural Vermont. Adjacent to a small community hospital and within miles of two small nursing homes--one acute, one convalescent--this agency provides the only home health services within a 35 mile radius. An estimated 85-90% of the agency's clientele is elderly. Were it not

for supportive care given by the nurses directly in the home, these older people would reside in the nursing homes--not by choice, but by necessity. A small percentage of the agency's clientele, consists of the profoundly afflicted, that is, for example, persons who are paraplegic or quadriplegic. A daily home visit for care from an agency nurse provides that small but crucial link enabling such persons to stay in their own homes rather than institutions. In spite of the obvious need for the services provided by the agency, Lamoille is having increasing difficulties being reimbursed. This is true because the present reimbursement is based on who provides the services rather than on what services are needed by the patient.

In a paper presented recently before the American Academy of Nursing, Elaine McCarty, a Family Nurse Practitioner in rural Maine, noted that the "uninsured are relatively young, low income, poorly educated, and urban. This is the group that is less healthy, pays more in out-of-pocket expenses for health care, and has a higher number of hospitalizations."[1]

Other groups are discriminated against in various ways under present insurance plans.

Divorced women, for example, frequently must pay disproportionately high premiums for their own health insurance, as so many of these women must stay at home with young children or work part-time in one of many places that offer no fringe benefits to such employees.

The American Nurses' Association believes that a national health insurance program is essential in order to guarantee that all U.S. residents will have access to health care services. It should provide coverage for a full comprehensive health service for all U.S. residents.*

* Attached is ANA Resolution on National Health Insurance.

Accessibility of health care is, of course, a key element. Ease of access is determined by several factors. Most pertinent are physical access, including flexibility in the scheduling of times to accommodate the client and locations that the client can reach; and financial access permitted by the system. Insurance defines both physical and financial access to the provider. If reimbursement for services is limited to one group of health professionals, this obviously limits access by excluding other health professionals, such as nurses, who can and do provide services in a variety of settings--schools, neighborhood health centers, public health departments, and the home.

We believe that no plan can be successful that does not make substantial changes in the present system of health care delivery. This should include changes in present reimbursement policies and greatly improved utilization of registered nurses and other non-physician health personnel.

We are pleased to note that Senator Kennedy's national health insurance plan would provide comprehensive health services, including in-patient services, physician's services in and out of hospital, home health services, x-rays, lab tests and specified mental health benefits. We would urge that the plan also include coverage for the following additional services: 24 hour emergency care, rehabilitative care, full mental health benefits, dental care, nutrition services and supportive care (health teaching, counseling and health education, maintenance care). These services, for the most part, are not medical services, but are integral to the delivery of comprehensive preventative health care.

Additionally, the Kennedy plan, as outlined, makes no reference to nursing services as a covered benefit. Nursing care is a key element in the delivery of health care in all settings. We believe that any comprehensive

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national health insurance plan must recognize registered, professional nurses as providers and must include nursing services as a benefit, regardless of the setting for that service, i.e. home, clinic, hospital, school, nursing home, etc.

In most hospitals, nursing service is an income producing department. However, nursing service costs, as well as certain other service costs, have traditionally been lumped in the multi-purpose category of routine operating costs of institutions. This practice has prevented true cost accounting and is one factor hampering the development of a financially responsive health care system. We believe that separate identification not only would provide a more accurate financial picture but would enable the consumer to better evaluate nursing care. It would also serve to increase the nurse's sense of accountability to the patient, encouraging the nurse to see herself as a provider of nursing care for the patient rather than a provider of nursing service for the hospital.

It has been estimated that 70 to 80 percent of health services required in rural and urban clinics can be competently handled by nurses, yet in order to be reimbursed for such services the clinics have had to provide physician authorization.

We urge that attention be given to providing that insurance programs clearly spell out covered health care services and allow the consumer to choose and have access to services of nurses and other health care professionals. Nurse providers, whether they are self-employed or employees of an institution or agency, can authorize appropriate nursing services. Insurance programs should not require the payment of a fee to a physician for signing a claims form for reimbursement of services which are provided by nurses with nursing authority.

We recognize that there can be different approaches to reimbursement for nursing services depending upon the variety of settings or organizational arrangements (i.e. hospital, home care agency, independent group practice, HMOs, etc.).

An example of the need to make nursing services a covered benefit is provided by Dolores M. Alford, a Geriatric Nursing Consultant in a Women's Center in Dallas, Texas. Ms. Alford relates that "...a sixty year old woman complaining of insomnia, lack of energy, loss of appetite, and no will to go on consulted her physician. His medical treatment was: 1) Valium, 10 mg., three times a day (prescription was for 100 tablets); 2) instruction to get involved in an outside activity; and 3) to return in one month if she had no relief of her symptoms. The time spent in the physician's office was ten minutes. The cost of the visit was $30.00, plus $15.00 for the Valium.

"That same day, she came to me upon referral from our Women's Center and reiterated her same complaints. My nursing diagnosis was depression secondary to difficulty in coping with living in a single dwelling with faulty new appliances, and also from experiencing stress resulting from loss of her high rise apartment which was destroyed by fire. My nursing treatment was 1) supportive care by listening and touching and promoting relaxation over a cup of tea; 2) asking her why she felt depressed; 3) using community resources to help her solve her problem, i.e. got out the yellow pages of the telephone book and found the service centers handling her type of appliances; 4) teaching her how to interact with the repair persons, explaining why she presented the signs and symptoms she did; went over the action, side and adverse effects of Valium; 5) asking if there were any other health problems I

could assist her with; and 6) providing follow-up care by having her call me when the appliances were fixed and having her in for an office visit the following week for continuing supportive care. Total time was two hours (two one hour visits) at a total cost of $40.00.

This client did not take the Valium. Her appliances were fixed the next day. Her symptoms quickly disappeared."

Under Medicare, the physician services in this example would be reimbursable. The nursing services, which actually solved the problem, would not.

We strongly support the inclusion of home health services as outlined in the Kennedy plan. The primary need of most individuals requiring home care is for nursing services. Such services provided in the home can help to avoid crisis situations and serious breakdowns that lead to the need for expensive care in nursing homes and hospitals. Nurses are the appropriate professionals to plan and coordinate the home care plan, to supervise LPN's and nursing assistants and to teach the individual and his family to assume responsibility for health care. There is a critical financial need to move from the illness/cure orientation of the current health system to one that promotes and maintains health and health practices. Many people do not have access to health promotion aspects of care unless they have contact with public health or visiting nurses.

We applaud the Kennedy plan's emphasis on preventive care. Access to preventive care services can eliminate the need for later, more acute care, with tremendous savings in terms of human suffering as well as dollars.

Nursing has long advocated greater attention to public health education and patient teaching. Health education and counseling are integral to nursing care. For example, prenatal and newborn care, which is basic to prevention of illness and promotion of wellness, is routinely taught to mothers by professional nurses. Nursing's teaching is directed towards health maintenance, towards prevention of disease and its complications and towards promotion of early return to maximum functioning following illness.

The professional nurse is in a key position to promote the development of health education programs in industry, health maintenance organizations, hospitals, nursing homes, physicians' offices, out-patient clinics, home health agencies, public health departments, schools. We would urge that this present and potential contribution not be overlooked in the formulation of new health directions.

We commend the inclusion of mental health benefits in the Kennedy plan. In this area again, we find that current law limits not only the types of professionals providing care but also the settings in which such care is delivered. Consequently, services of qualified psychiatric-mental health nurses and other qualified mental health practitioners are severely restricted. The result is that mental health services are unavailable to many who need them.

We think that provisions comparable to those for physical illness should be made for psychiatric-mental health care, ending the present discriminatory treatment in public financing against people with mental disabilities.

We are concerned that there seems to be insufficient provision in the Kennedy plan for informing the public of the availability of covered

services. We suggest that the final bill provide some guidance with regard to informing the public of the benefits available and of the procedures to be used in securing them.

It is encouraging that the Kennedy plan incorporates existing mechanisms of peer review and health planning. These mechanisms should be developed into a more comprehensive system which will provide for active participation in the decision-making processes by nursing and other health professions.

The nursing profession is committed to the establishment of peer review systems whereby providers of nursing care services can be held accountable by consumers and third-party payors for the effective and appropriate utilization of nursing services of high quality.

The American Nurses' Association supports the concept of health care cost containment. The current system, with its overreliance on hospitals and its emphasis on acute care has proved enormously expensive. One proper response to skyrocketing health care costs should be a shifting away from the use of expensive, in-patient facilities and toward the imaginative use of less expensive ambulatory services which are very often more appropriate delivery mechanisms in the first place. We share Senator Kennedy's concern that savings not be made at the expense of wage increases for low paid, non-supervisory health care workers, who only now are beginning to achieve parity with comparable workers in other sectors. (Recent HEW figures show clearly that wage inflation in the health care sector is well below the inflation in other health care sector costs.)

In addition, we believe the following factors not evident in the Kennedy plan should be considered in designing a cost containment system:

1. Voluntary cost controls should precede any mandatory controls.

2. Hospitals should be classified according to size and geographic location.

3. Cost controls should be extended to the suppliers of the health care industry, i.e. manufacturers, utilities, vendors, and to all providers and insurance carriers.

We thank you for the opportunity to express our views on national health insurance in response to your proposal. Your commitment to improving the health care system of this country is a matter of record. We look forward to further opportunities to assist you in the development of this highly important piece of legislation.

Note

[1] McCarty, Elaine Edith, Primary Care By Nurses: Sphere of Responsibility and Accountability. American Academy of Nursing, paper presented at Annual meeting, September 26-28, 1978, page 10.

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AMERICAN NURSES' ASSOCIATION

RESOLUTION TO REAFFIRM THE 1974 ANA HOUSE OF DELEGATES

RESOLUTION ON NATIONAL HEALTH INSURANCE

WHEREAS The House of Delegates of the American Nurses' Association has repeatedly called for the enactment of a national health insurance program, and

WHEREAS The American Nurses' Association has for many years worked for a national program providing universal coverage for comprehensive health care services, and

WHEREAS The American Nurses' Association has for many years called for a national health insurance program that would guarantee to all people access to health care services of an acceptable quality as a basic human right, therefore be it

RESOLVED That the 1978 ANA House of Delegates reaffirm the Resolution on National Health Insurance adopted in 1974, and be it

RESOLVED That in order that urgent health care needs of people be met the association work for early congressional action to provide for a humane and rational system of health care services, and be it

RESOLVED That the national health policy of the United States of America should include an integrated system for delivery of health care services that recognizes nurses as essential providers of care, and the services of nurses as an essential benefit of the system, and be it further

RESOLVED That the national health policy of the country recognize the authority of nurses for nursing practice, and the delivery of nursing services.

Adopted by the 1978 House of Delegates

RESOLUTION
NATIONAL HEALTH INSURANCE

WHEREAS: health, a state of physical, social and mental well-being is a basic human right, and

WHEREAS: government at all levels must act to insure that health care services are provided for all citizens, and

WHEREAS: there is a need for integrated systems to deliver comprehensive health care services that are accessible and acceptable to all people without regard to age, sex, race, social or economic condition, and

WHEREAS: there is a need for a national program designed to correct serious inadequacies in present health care delivery systems, and

WHEREAS: nursing care is an essential component of health care; therefore, be it

RESOLVED: that the American Nurses' Association aggressively work for the enactment of legislation to establish a program of national health insurance benefits, and be it further

RESOLVED: that the national health insurance program guarantee coverage of all people for the full range of comprehensive health services, and be it further

RESOLVED: that the scope of benefits be clearly defined so that they can be understood by beneficiaries and providers alike, and be it further

RESOLVED: that the national health program clearly recognize the distinctions between health care and medical care; and that the plan provide options in utilization of health care services that are not necessarily dependent on the physician, and be it further

RESOLVED: that nursing care be a benefit of the national health program, and be it further

RESOLVED: that the data systems necessary for effective management of the national insurance program protect the rights and privacy of individuals, and be it further

RESOLVED: that the plan include provisions for peer review of services that will protect the right and the responsibility of each health care discipline to monitor the practice of its own practitioners, and be it further

RESOLVED: that there continue to be a system of individual licensure for the practice of nursing, and be it further

RESOLVED: that provision be made for consumer participation in periodic evaluation of the national health insurance program, and be it further

RESOLVED: that the national health insurance program be financed through payroll taxes or payment of premiums by the self-employed, and purchase of health insurance coverage for the poor and unemployed from general tax revenues, and be it further

RESOLVED: that ANA strongly urge the designation of nurses as health providers in all pending or proposed legislation on National Health Insurance.

Adopted by ANA House of Delegates
June 10, 1974

Senator KENNEDY. The one light means a vote. We will recess for 5 minutes, then I will come back and we will hear from Ms. Burris.

[Short recess.]

Senator KENNEDY. Come to order.

Ms. Carol Burris.

STATEMENT OF CAROL BURRIS, PRESIDENT, WOMEN'S LOBBY, INC., ACCOMPANIED BY CAROLYN BODE, DIRECTOR, HEALTH AND ABORTION PROJECTS

Ms. BURRIS. Thank you, Senator.

It is an honor to be here today. I want to congratulate you for all of the work you have done and for bringing women into the health care area.

The main thrust of our testimony is really that women are poorer than other people. Sex cuts deeper than race or economics or education or geographic area. That means women are less able to afford health insurance than any other group in our population.

What is important about that is that women are more than half of our population, and we are the primary consumers of health care, and men are the primary providers.

The problem of the economic status of the women is that we cannot buy insurance even when it is offered to us in a nondiscriminatory way. It is rarely offered to us in a nondiscriminatory way. Women pay half as much again as male employees without maternity benefits, and about twice as much as male employees with maternity benefits for spouses. Often the coverage given to wives of male employees is better than the coverage offered to female employees although they pay more.

The other problem with the level of insurance discrimination is the regulation by the States in each State where there is not a strong insurance commissioner, there is absolutely no provision for discrimination on the basis of sex and, in some States, not even on the basis of race. Only New York State and Massachusetts provide for discrimination on the basis of both sex and marital status. This means as late as 1976, the Metropolitan Life would not offer insurance coverage except at higher premiums to employers if they had over 11 percent female employees. The other problem is that coinsurance and deductibles are an undue burden on women. Their average income is about $5,000 a year according to the Department of Labor, but according to census figures, a little more than $3,000. The census figures show men earning more than $9,000. Single parent families—most of those are all headed by women—are the poorest of all.

So 3 million women, 8 million children and only 150,000 men are receiving aid to families with dependent children.

Sixty-five percent of all medicaid is used by women. The problems that we see in providing some of the maternity coverage also include the qustion of what drugs are provided in insurance coverage. Tranquilizers are almost always provided so that 72 percent of all tranquilizer prescriptions are made out to women. But contraceptives, both drugs and devices, are not provided. There is not only no emphasis in our current health program for prevention, and women die more often of preventable diseases, but also the kind of fertility prevention that

has made long gains in life span for both black and white women are just not provided under insurance care.

Full fertility coverage is really necessary for women because of the high maternal and infant mortality rates in this country. The infant mortality rates in this country are a scandal.

We have included a chart that shows the disproportionate rate for mothers in this country. When you look at the rate for blacks as well as for whites, what we provide for blacks in terms of prenatal care and consequently infant mortality is absolutely shocking. Because many poor minority teenagers use medicaid, there were 100,000 medicaid abortions which were done when it was legal for girls 15 and under. That is the only group in society that has an increase in their fertility. We will see a constant increase in infant and maternal mortality without medicaid abortions.

One of the problems with phasing programs in as far as women are concerned is that they can have well-baby care and subsequent care after pregnancy. They do not often even know they are pregnant or they do not acknowledge they are pregnant until later in the pregnancy period. So the earliest prenatal care, which is the most efficient, is just not available. We do not treat them until after they are pregnant. Obviously, as a woman's group, abortion is an important part of any fertility coverage to us.

The other problems that women have concern the level of care they need because they suffer from preventable diseases. We are two-thirds of all of the diabetics in the country. The women who die from treatable cancer, since breast cancer is the leading cause of death in American women, is 1 of every 13 women. The problems that we see in no preventive care is that there has been no decrease in mortality rate in the last 40 years.

One of the problems that just concerns all of us is that kind of cancer and cervical cancer occur 4 times as often among Puerto Rican women and twice as often among black women.

When we talk about care, I defy any Senator that we have talked to or anyone in the administration to look at those women whose lives can be saved and tell them that, unfortunately, we had to phase in the care and, unfortunately, they had to die this year but maybe next year we can do something more.

The other problem affecting primarily affluent women and those who are insured and have earlier prenatal care in the level of unnecessary surgery. There is simply no ovary that is good enough to stay and no testicle which is bad enough to take out. [Laughter.]

What we have is a problem in which doctors' wives, half of all doctors' wives, before they reach the age of 65, will have hysterectomies. The rate had quadrupled in the last 30 years.

The rate of cesarean sections since 1970 has increased by 20 percent. I am sorry, it has doubled in the last 5 years, and now they account for 25 percent of all deliveries.

The other thing, and these are 1974 figures which were the most recent ones we could find, is that Representative Moss' investigations committee found that unnecessary surgery cost in 1974, $3.92 billion. With the increase in health care, the increase in cost is now incredible.

When you look at women and surgery and second opinions, you discover an enormous amount of decrease in the level of hysterectomies—as much as a third or a half after second opinions.

In the Washington Post, Dr. Sanford Marcus, president of the Union of American Physicians and Dentists, argued that a second opinion drove a wedge in the trust between surgeons and their patients.

Some wedge. If women were to trust surgeons, they ought to trust cobras as well. The other problem, we have little or no control over the doctors who treat us to provide some level of cost control and also to provide some level of peer review for that level of unnecessary surgery.

The problems of newborn care are just outrageous and many of the deaths that we see in the figures are just going to increase because the number of premature babies and the problems that have occurred in the past is that insurance coverage did not pick up babies until sometime after birth, so they were never treated for preexisting conditions.

The problems now have been pretty much solved with State laws except in Senator Chafee's State.

We did a survey of the entire Congress about your plan and the comprehensive care, and we discovered that 7 Congress people and 11 Senators feel that newborns should not be covered since it is a choice that a mother makes to get pregnant and, therefore, should not be an expense to the taxpayer. We discovered that there is a fair amount of support for repeal of the McCarran-Ferguson Act so that we can regulate the insurance industry at the national level which would make it possible to regulate problems with respect to sex discrimination and race discrimination.

As you can see from the figures in the testimony, there is about an equal amount of support for abortion coverage as for comprehensive care. Although we did not get really good answers from the entire group, we got a good tally of about two-thirds of the House and Senate. We just wanted to thank you for the amount of concern and care which you have taken.

Women simply cannot afford a phase-in plan. They cannot afford anything but comprehensive care because their earnings are just so insignificant.

Senator KENNEDY. That is an excellent statement on the women's issues and health. I think what it points out is the enormous disparity which exists in terms of the protection of women in our health care system.

Why do you think that is so? First of all, I would like to ask you what I have asked others.

What you have spelled out here today would indicate to me that at least a large segment of the women's groups—women's population—feel that there is a tremendous gap in our current care system. You have given us the chapter and verse on it.

I wonder if you could make some sort of summary kind of comment on that? We have heard the statements that we have the best health care system, therefore we do not need to tinker with it.

What you have testified to today shows that there are some very, very important gaps that affect women.

Could you make just a brief summary comment on it?

Tell us why you think it has been so.

Ms. BURRIS. I think it is related to two factors. One is that we have always assumed that women were going to be supported by men. Now, more than 50 percent of the women in the country are on the paid labor force. It is 77 percent for those women who are single or divorced, and 57 percent for women who are married. As they joined the paid labor force, no one expected them to stay. They never got to the executive level. The insurance panel was totally composed of men. They never negotiated for the company for their coverage. The myth persists that maternity care is odd and different and really terribly expensive. No one faced the fact that as we controlled our fertility, we would live longer.

Now, we are two-thirds of all the people over 65 with an annual income of $2,219. As we got older and poorer, we have many good congressional liberals suggest to me the solution to both health and money problems of older women is that they remarry older men, and that is considered to be a solution for our health problems as well. All we have to do is find a nice white man who will earn a really decent salary and he will take care of us.

Senator KENNEDY. That is an answer to the health care problem? [Laughter.]

Ms. BURRIS. White men are so valuable on the hoof in terms of health care [Laughter.]

But to collect on social security you have to keep them until they die. [Laughter.]

Senator KENNEDY. If it were not so true, it would really be funny.

I have a few final comments. I know that you and your organization have been part of our effort in fashioning and shaping this program. You made a comment earlier. Maybe you will elaborate on that.

Why do you feel that just phasing it in is not going to meet the needs of women?

Ms. BURRIS. The main reason is that we just don't get the kind of heart attack, acute illness things that men do die of. Our income is so low that when we pay for our own health care, what happens is that we cannot get any preventive health care.

I have figures for pap smears for women with total family incomes of about $7,000. It is about 53 percent.

For women whose total family income is under $3,000, is it only about 23 percent of them who ever get pap smears. The thing is that you have a group of people with very low earnings capability who are suffering now from things that should have been prevented. You are leaving them to die if you phase it in.

And I really defy Senators who have talked to us, particularly about newborn care, to look at a family whose child has just died and tell them, "We are really sorry we don't have the money this year. We will phase it in because OPEC is on."

We camouflage all this with the figures without ever confronting the patients who suffer from it. The disparate effect on minorities and young women means that we have problems that will stay with us for 40 years even if we started tomorrow, and we are just simply not addressing it.

Senator KENNEDY. We will look forward to working with all of you as we flash the details. It is a very important panel, and I want to thank all of you for your contribution.

[The prepared statement of Ms. Burris and additional material supplied for the record follows:]

OCTOBER 13, 1978

STATEMENT OF CAROL BURRIS, PRESIDENT
WOMEN'S LOBBY, INC.

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
HUMAN RESOURCES COMMITTEE
U. S. SENATE

NATIONAL HEALTH INSURANCE

Mr. Chairman, Members of the Committee, I am Carol Burris, President of Women's Lobby, Inc. The Lobby is a national organization with affiliates in forty states. We work solely on legislation pertaining to women. It is a privilege to appear before you today. We would like to commend you, Mr. Chairman, for your courage in discussing the issue of comprehensive care. Your unflagging interest in one class of care is commendable.

Women are poorer than other people. Sex cuts deeper than race, education, geographical region, marital status, and age.[1] Women earn 56¢ for every dollar men earn. We are concentrated in sales, service and clerical jobs. The median income for women age 14 years or older was $3,576, while the median income for men 14 and over was $9,426.[2] Of course, we are then overrepresented in the poverty population: there are 3 million women, 8 million children and only 150,000 men receiving Aid to Families with Dependent Children. 65% of those receiving Medicaid benefits were women.[3]

It is a disgrace that the United States and South Africa are the only industrialized countries in the world without state provided comprehensive health care. There is little else in which we want to emulate South Africa. The health care we do have is inadequate and expensive. Doctors are concentrated in urban areas and generally serve the affluent. The poor, minority groups and the old, who are two-thirds women, lack access to quality medical care. We don't emphasize prevention or early diagnosis, we spend our health dollars curing disease.

No health care program should be considered by this Congress unless it addresses the specific needs of more than one-half of our population: women. Women are the predominent consumers of health care while men are the predominant providers. In 1972, women made 5.6 visits to the doctor for every 4.3 visits made by men.[4] If we include pediatric visits, the figure is even larger. Women consume 50% more prescription drugs than men. They are admitted to hospitals much more frequently than men. Although 70% of all hospital workers are female, the policy makers - doctors, medical school deans, hospital directors and trustees, as well as the drug and health executives are almost always men.

INSURANCE

In the name of profit, insurance companies exclude Americans who need the most care. Insurance marketing practices in selling health insurance create special problems for almost all women. Now 50.5% of all women 16 and older are in the paid labor force.[5] This is 43 million women. More than 70% are single, widowed, divorced, separated or have husbands whose annual income is less than $10,000.[6] Any loss of earnings,

any excessive health costs or any higher insurance premiums mean financial disaster for them.

Determining premiums by "experience rating" may seem to be an equitable approach in assigning employers premiums for probability of illness and accidents in the group, the rates in fact are calculated on the basis of sex and age composition of the group and its recent actuarial experience. Women, the elderly and the handicapped do use more health services. Maternity benefits account for most, but not all of the higher utilization rates. This means that businesses that hire women may be severely penalized because this "claim experience" causes higher premiums.

For example, the Metropolitan Life Insurance Company Manual in 1973 warned employers that hiring women might result in above average claim cost.

> "Some married women are willing to accept a loss of income periodically rather than face up to the hardships of working full time and caring for their homes and families." [7]

Metropolitan increased the premiums on group health policies, "... if the benefits on females represent 11% or more of total benefits." [8] (Emphasis added)

Do women create prohibitive costs in insurance? In 1974, the New York State Temporary Commission on Living Costs and the Economy found that full maternity coverage for female employees in a typical employee group would increase health insurance costs by less than 3%. Including the wives of male employees increased costs by less than 10%. After the 1976 Supreme Court decision in Gilbert v General Electric, New Jersey's Blue Cross and Blue Shield offered full maternity benefits regardless of marital status and the cost was pennies more. In fact, the Blues didn't increase their premiums. New York mandated full maternity benefits,

including delivery and abortion, in 1977. The March, 1978 figures for central New York Blue Cross - Blue Shield show a 30¢ differential.[9] The Senate has passed a bill to overturn the Gilbert decision. The House has passed a companion bill with an anti-abortion rider and the conferees have not agreed.

The system of exclusions or riders, where the industry refuses payment for any disease or disability which has affected the insured before the contract creates further problems for women. For example, two out of every three diabetics are women,[10] they may be allowed to purchase coverage, but no payments will be made for any medical treatment or hospitalization relating to diabetes. Payment for gynecological disorders is routinely exempted by many insurance policies while coverage for male problems like prostate surgery is usually provided at standard rates if there has been no treatment for two years. Breast reconstruction is only covered immediately after the surgery when it is not medically indicated. There is no corresponding time limit on prostate reconstruction or glass eye replacement.

Standard industry practice is to make maternity benefits optional, require higher premiums and deny them to working women when employers will not pay the extra fee. Only about one-third of women in this country giving birth to legitimate children in 1964-66 had insurance coverage for hospital care, delivery and prenatal visits; one-fourth had only partial coverage; the rest had no coverage at all.[11] When the extra premium is paid, the woman must be enrolled in most plans for ten months before she is entitled to any benefits. There are no exceptions - not for obviously

premature babies, not for complications of delivery and not for miscarriages. Should women stop having children until Mutual of Omaha notices?

The Pennsylvania Insurance Commissioner's Advisory Task Force Report on Women's Insurance Problems found discrimination in both nonprofit and commercial plans. Citing Pennsylvania Blue Shield Plan B, the report quotes the Plan as paying a flat doctor's fee of $90 for a normal delivery, a rate first established in 1958! Blue Shield's own figures show the average charge for a delivery in Philadelphia in 1970 was $243. The Plan covered only 37% of the obstetrician's bill. In comparison, Plan B paid $150 or 70% of the charge for an appendectomy and appendectomies are often unnecessary surgery.[12]

Female employees pay more for less coverage of maternity than the wives of male employees. Ms. Barbara Shack of the New York Civil Liberties Union, in her testimony before the Joint Economic Committee, described a plan that gave female employees maternity benefits of a flat rate of five days of hospital care and maximum cash benefits of $300 for surgery and medical benefits. The same plan gave wives of male employees up to ten days of hospital care and a maximum of $1000 in medical costs.[13] Husbands of female employees are routinely excluded from medical and surgical benefit plans unless they are retired or disabled. A 1975 study by the Iowa Commission on the Status of Women demonstrated that women paid 50% more than their male coworkers for an identical plan and they paid twice as much for a plan including maternity benefits.[14]

Inadequate maternity services are often accompanied by a lack of abortion coverage with no contraceptive and family planning services. When the services are covered, they are available only under family plans, excluding single women and dependent female children. Current estimates are that one-fourth of the total expenditures for fertility control services would be immediately offset by reduced claims for maternity care alone.[15] Congress must recognize women's fertility health needs. Full maternity care with family planning services, contraceptive drugs and devices and abortion care must be covered without fees, deductibles or coinsurance for all women whatever their marital status or income and without waiting periods.

These insurance practices give us little reason to maintain and protect an industry which denies millions of women basic health insurance. Currently the 1945 McCarran-Ferguson Act exempts the industry from all federal regulation but the Sherman Anti-Trust Act. Regulation is a patchwork in the fifty states with a few outlawing discrimination on the basis of race or age and one or two states, notably New York, outlawing discrimination on the basis of sex and marital status. Only strong federal regulation will bring these health policies into any level of equity for women. We urge this subcommittee to consider total repeal of the McCarran-Ferguson as the price of including current carriers in any plan for national health insurance.

DELIVERY OF SERVICES

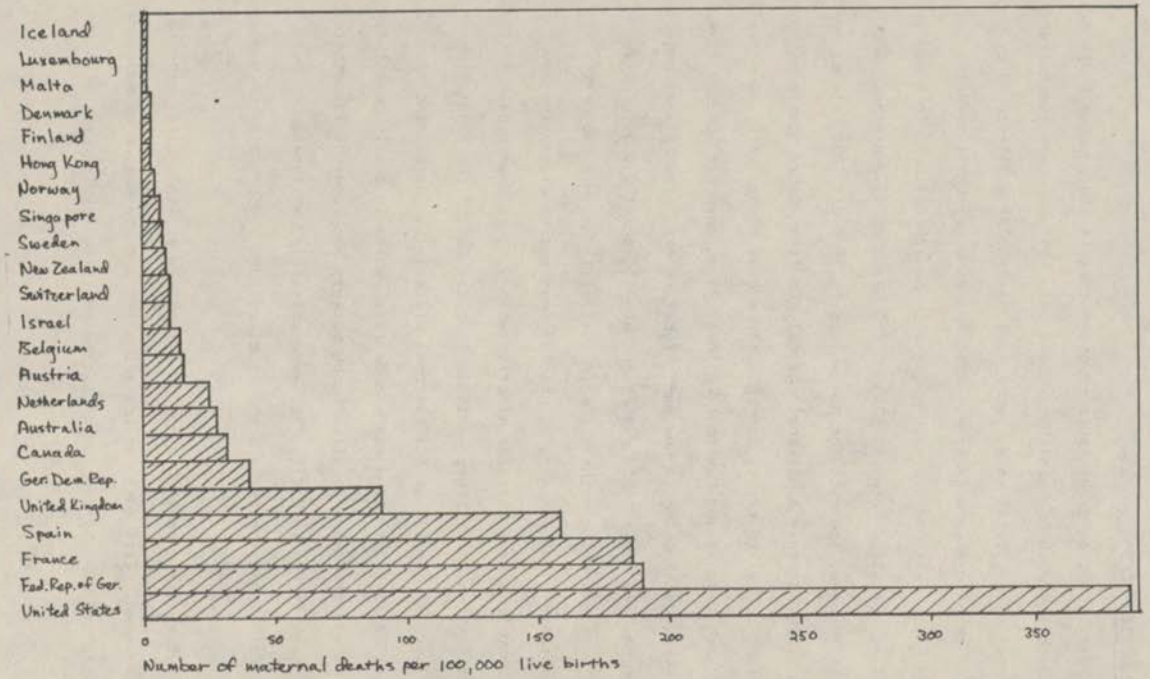
It is not only insurance coverage that is inadequate; there are serious problems with our health care delivery system. Only the current Kennedy plan offers total care. Women are particularly ill-served by well child care to an arbitrary age that leaves a gap until prenatal care is needed. Something is sinfully wrong with health delivery in a country whose infant mortality rate in 1974 was 16.7 per 1000 live births. And that's the average, the rate for non-whites is 26.8 per 1000, almost twice as high.[16] This is truly a national scandal. Fourteen other countries have lower infant mortality rates, but only three have higher maternal mortality rates, Ecuador, Japan and Mexico. We lose 376 mothers per 100,000 live births. What is shocking is how much higher we are. The Federal Republic of Germany has 190 per 100,000 and France has 185 per 100,000.[17] Five times as many non-white mothers die in childbirth as white mothers.[18] What more shameful evidence do we need of ineffective discriminatory prenatal and postnatal care for minority women. Rural women have little access to the health delivery system. They are 20% of the population but they account for 50% of all maternal deaths. (See Attachment 1).

One-third of the women who deliver babies in public hospitals receive no prenatal care at all. Among mothers who received inadequate prenatal care in New York City, 70% were classified as threatened by sociomedical risks; the mothers who received adequate prenatal care were only 40% at risk.[19]

Prenatal care should not be limited to physical care, especially for young women. Care must include education and prevention of malnutrition which increases susceptibility to gastroenteritis, respiratory infection,

Attachment 1

MATERNAL MORTALITY RATES - 1974-1975



Source: UN Demographic Yearbook 1976

and tuberculosis. Stunted growth in girls perpetuates a cycle of poor pregnancy outcome in the child bearing years with a resulting increase in premature births. Prematurely born infants require more medical attention in the first weeks of life and are vulnerable to lifelong damage.

DEDUCTIBLES AND COINSURANCE

Any preventive medicine with early diagnosis and screening is hampered by a program with coinsurance and deductibles for services. For women, with their disparate earning power, they are a total bar to using the service. Again, only the Kennedy plan provides decent care for women. Their inclusion in other plans makes them little more than catastrophic programs which will not reduce the out-of-pocket medical expenses for most families.

In 1977, the average American person spent $646 on health care. 46% of this money went for hospitalization, 23% for doctor's fees, and 8 % for drugs.[20] At the end of 1972, only 51% of the population under 65 had some insurance coverage for office and home medical visits, with 20% of the civilian population under 65 wholly unprotected.[21] Most of these are children and the poor. And women are most of the poor and the poorest children live in single parent families. 45% of all female headed households live below the poverty line. If you have the double jeopardy of being black and female, 50.1% of all those households live below the poverty line.[22] Less than six out of ten household workers, 98% of whom are women, are covered by private health insurance. Any family spending 15% or more of its income for medical care is likely to be rural, older and in a lower income bracket with a head of household who is not a full

time worker.[23] Twice as many women as men work part-time, 15.2 million to 8.3 million. The median income for women working part-time is $1,356 while the median for part-time men workers is $1,312. This is the only category of paid employment in which women outearn men.[24]

Coinsurance alone decreases the use of medical services in some studies. One from Stanford University was a prepaid group practice whose members were all Stanford employees. Originally the plan paid all outpatient and in patient charges. When it began a flat 25% coinsurance rate with no deductible to save costs, use of outpatient services fell almost 25%. No difference in the absolute change in use by income or race was detected, but there was a greater drop in utilization by dependent women. There was a large reduction in preventive services compared to other care for the lowest income group.[25]

Health Maintenance Organizations (HMO's) have shown effective and economical group practice that is prepaid with a focus on preventive medicine. Revenues are fixed in advance, so the HMO has incentives to have healthy patients out of the hospital. Hospital rates for prepaid group practice plans are half the rates of Blue Cross and indemnity insurers. In the Federal Employee Health Benefits Program, Blue Shield inpatient surgery rates are 121% higher than under prepaid group practice plan rates for federal employees.[26]

Only the Kennedy plan recognizes that adequate health care, given early avoids more expensive services later. Only this plan reflects the needs of women.

EARLY DIAGNOSIS AND SCREENING

Statistically, high income people are 3½ times more likely to

have a routine physical in the course of a year. Women from high income families are 4½ times more likely than those from low income families to visit an obstetrician-gynecologist.[27] How do low income women get Pap smears?

Among women aged 30-45, cancer is the leading cause of death.[28] And cancer involves the highest cost of treatment in the last year of life. Death and disability costs, according to a 1969 estimate, total $15 billion annually.[29] Prevention costs far less and the American Cancer Society studies show half of all cancers can be detected early enough to be cured.

Breast cancer leads in killing American women and there has been no reduction in the mortality rate in the last 39 years. One of every thirteen women will have breast cancer.[30] Only early diagnosis will help. In 1978, 90,000 women will have breast cancer and 33,800 of them will die. There will be 69,200 cases of genital cancer this year and 22,500 of those women will die. Cervical cancer incidence is second to breast cancer, but the mortality rate has declined 65% during the last 40 years because of the Pap test. Puerto Rican women have four times the cervical cancer rate of white women and black women have twice the rate of whites. We are condemning minority women to death because they don't have the money for $10 test. A recent study showed that 59% of women in families with incomes above $7,000 had had Pap tests, only 32% of those with incomes under $3,000 had had them. Only 53% of women over twenty have ever been tested.

Only preventive medicine and early treatment can stop this carnage. Only the Kennedy plan permits that immediately. It is a disservice to all those women who will die this year to tell them we can only phase in a plan to save their lives when economic conditions permit.

36-209 O - 79 - 21

Two of every three diabetics are women. It is a common illness, affecting 4,000,000 of us. The earlier it's detected, the easier it is to control. There are 1,600,000 Americans who are diabetic and don't know it.[31] Simple blood glucose tests can detect a proneness to diabetes and can detect it very early. When it goes untreated, it quickly leads to serious health problems. Diabetes is the second leading cause of blindness in this country.

One of every five women under age 20 has gonorrhea.[32] And recent studies show that women are five to ten times more suceptible than men to this venereal disease. Women have no regular screening as a routine part of gynecological care for V.D. so they go undetected. Untreated gonorrhea causes serious complications - one of the most common is infection of the fallopian tubes which causes scarring and sterility. The infection is passed on to the baby as it goes through the birth canal. The baby will be blinded unless successfully treated with penicillin.

DRUGS

Women use 50% more prescription drugs than men and constitute 71% of the users of anti-depressant drugs, and 72% of the users of minor tranquilizers.[33] These are big business for the drug industry. Ads in major medical journals portray women as frustrated, irritable, anxious, neurotic, guilty, indecisive, depressed and in need of their drugs. Many of these drugs have damaging physical side effects. For example, imipramine, sold under the brand name Tofranil and others, destroys the nerve cells of the budding limb structure in the fetus when taken in early pregnancy.[34]

Private plans have not dealt with this problem. In fact, 73% of all public and private insurance plans have drug coverage, so we can be

tranked to the eyeballs, but they routinely forbid oral contraceptives. We would support the provisions in the Kennedy-Corman bill which excludes anti-depressants and tranquilizers from covered drugs. We would also support language basing reimbursement on the lowest price assuming generic substitution.

UNNECESSARY SURGERY

Instead of preventive care and early diagnosis, our health care system victimizes women by surgery. We have twice as many surgeons as Great Britain per capita and we have twice as much surgery per capita. Our health care is based ondoctor's greed more than patient's need. We are twelve in life expectancy for women. Unless Medicaid and Medicare change greatly, the affluent and well insured are victims more than the poor.

Half of all doctor's wives will have hysterectomies by the age of 65 and half of those would be considered unnecessary by conventional medical criteria.[35] The U.S. has the highest hysterectomy rate of any industrialized nation.[36] In 1975 more hysterectomies were performed than tonsillectomies - 725,000 - an increase of 25% since 1970. This surgery has grown four times as fast as the population and studies show that 39% of those preformed are unnecessary. The hysterectomy rate is 31% higher in the South as in the Mid-West.[37] Since five of every 1000 discretionary operations are fatal, this is a real risk. We have not even discussed the replacement estrogen therapy after hysterectomy that increases breast cancer.

Caesarian sections have more than doubled in the last five years.[38] In some hospitals they are more than 20% of all deliveries. The earlier a woman goes for prenatal care and the more health insurance she has, the more likely it is that she will deliver by caesarian section.[39]

Simple surgery with removal of only the breast or part of the breast followed by radiation treatment is in several studies as effective as radical surgery which removes the entire breast and the surrounding lymph nodes, cutting away muscles of the chest and the arm. Although there are no definitive studies, women are never informed of this controversy by their doctors and thousands undergo radical surgery every year.

In 1975, Rep. John Moss as Chair of the House Oversight and Investigations subcommittee estimated after expert testimony that 17% of all operations in 1974 were unnecessary. That is 2.38 million procedures at a cost of $3.92 Billion![40]

Last month HEW opened a national campaign to urge second opinions before surgery by paying under Medicaid. In a test of the program among 1.5 million Medicare beneficiaries in New York and 350,000 in Detroit, there were 564 requests for second opinions. 268 got them and 6 requested a third opinion. In 79 cases the second opinion differed.[41] This is for an older, poorer population with little preventive care. The results are more dramatic with a more middle class population. A study by several Medical Schools in New York in a presurgical screening program for union health plans showed a quarter to a third of all hysterectomies unjustified with an additional 10% questionable. 43% of the D&C's and 21% of the breast surgery was considered unnecessary. This program saved the union health plans $500,000 in two years.[42] In the October 9, 1978

Washington Post, Dr. Sanford A. Marcus, President of the Union of American Physicians & Dentists in San Francisco argued that a second opinion "drove a wedge" in the trust between surgeons and their patients. Some wedge. Women need to trust surgeons like they need to trust cobras.

It is penny-wise and pound foolish to provide only care at the point of surgery. A comprehensive plan is the only answer to this problem.

CONTROLS

Peer Standards Review Organizations should provide some level of protection for incompetent and dishonest practitioners. But peer review is a whitewash at best. Even Medical World News reported that doctors have not done a good job of policing themselves. For example, Dr. Thomas Chalmers, Dean of Mount Sinai School of Medicine, told the American College of Physicians that doctors used the drug stilbesterol to prevent miscarriages for 20 years after studies showed it to be useless. Doctors only stopped prescribing it in 1971 after the FDA banned it when studies showed it to cause cancer in daughters of women who took it during pregnancy.

Only the Kennedy proposal provides any hope of review. We applaud your concern and urge that the final bill contain some measure of standards to prevent abuse by doctors.

Underuse of medical services by minorities and the elderly is often due to refusal by some doctors to treat them. In 1977-78 blacks were 6.0% and women were 23.7% of all medical school students. In 1977, only 9.2% of all doctors were black and less than 12% were women.[43] High school and college vocational counselors don't encourage women to become doctors. The "Bakke" decision is certainly not going to improve

this picture. Any national health program must qualify general hospitals as providers only if they agree not to discriminate in staff privileges on any grounds other than professional qualifications.

NEWBORN CARE

The first day of life, the newborn has a 10,000 times greater risk of dying than any other day. During the first seven days of life, the newborn is at greater risk than any other week. The only way to provide healthy babies is to provide early prenatal care. In 1976, there were 263.4 infant deaths per 100,000 live births due to congenital anomolies; 164.4/100,000 for other conditions including sudden infant death syndrome; 125.5/100,000 for unqualified immaturity; 119.7/100,00 for respiratory distress syndrome; 113.6/100,000 from nonspecific asphyxia; and 103.2/100,000 from hyaline membrane disease.[44]

Since 1976, all insurance policies, except in Rhode Island, must cover newborns for the first seven days. They are then entitled to regular coverage. Unfortunately, the problem is far from solved. Some parents have inadequate policies for long term illness or severe birth defects. Many insurance companies ignore the law and most insurance commissioners do not enforce this coverage.

No Senator or Congressperson would like to face a grieving parent, whose child lived only a day or two and explain the costs of preventive care. These numbers are so much easier to deal with on paper. But each figure is a dead child and only preventive care can stop this appalling carnage. The problem will only get worse without Medicaid coverage of abortions because 100,000 of the 1976 abortions went to women

who were fifteen and under. This is the highest risk group for mothers and children. Teenagers are also the only group in the society who have increased their fertility rate.

CONGRESSIONAL SURVEY

Although Women's Lobby has supported the Kennedy-Corman bills since 1972, there seemed to be little hope of passage. In 1973, we did a survey of the entire House and Senate on women and health and this summer and fall completed a survey around the question of comprehensive care. Your leadership, Mr. Chairman and a meeting with your staff led us to a series of meetings with U.A.W. President Fraser, with Secretary Califano and his staff and with Stuart Eizenstat in the White House. No one in the Administration has your vision of comprehensive care and we as women have such an enormous need for preventive medicine and so little money to buy it.

We visited every office and almost always talked with staff. We developed an information kit about women's need for comprehensive care and our specific health needs. Unfortunately, we failed to receive firm responses from a sizeable number of offices because health care is not taken seriously enough to be considered an important issue.

We wanted to measure support for four issues: a comprehensive plan; abortion coverage; preventive care for newborns; and the repeal of the McCarran-Ferguson Act. We found a shocking lack of support for full comprehensive coverage and little support for even newborn coverage. In the Senate there was more opposition to full coverage than support for it. While in the House there was 40% more support than opposition, even though opposition was strong. Eleven members of the Senate and seven of the House

oppose newborn coverage. In both Houses, support for repeal of McCarran-Ferguson was three times the opposition. Although abortion is not a winning issue in Congress, abortion coverage had roughly the same level of support in the House as comprehensive care, with the same level of opposition. In the Senate there was more support for abortion coverage than for comprehensive care and significantly less opposition to abortion coverage than to comprehensive care. These are the figures:

	Comprehensive Care:	Abortion:	Newborns:	McCarran-Ferguson:
House:				
For:	140	134	134	111
Against:	105	106	7	39
Senate:				
For:	26	28	28	15
Against:	28	20	11	5

We want to congratulate you again, Senator, for your vision and courage in supporting total care without a phase in. Because of their low wages, women suffer most from unemployment and from inflation. We need health care for ourselves and for our children. That health care must include prenatal and postnatal coverage and it must include abortion.

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FOOTNOTES

1. National Council on Women, Work and Welfare, Women, the Poorer Sex (Washington, May 1978).

2. US Department of Commerce, Bureau of the Census, Current Population Reports, Money Income and Poverty Status of Families and Persons in the US: 1976, Series P-60, No. 107.

3. Department of HEW, Social and Rehabilitation Service, Office of Information Systems, National Center for Social Statistics, October 1976 Publication No. (SRS) 77-03153.

4. Ways and Means Committee, National Health Insurance Resource Book (Washington, June 11, 1974), p.251.

5. US Department of Labor, Bureau of Labor Statistics, Employment and Earnings, June 1978.

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Women's Lobby, Inc.

201 MASSACHUSETTS AVE., N.E.
WASHINGTON, D.C. 20002
(202) 547-0044

Dear Senator,

The United States is the only Western industrialized nation without some form of national health insurance. What we have is a patchwork of public and private plans, resulting in inadequate health care at great and ever-increasing cost, leaving 18 million Americans with no health insurance at all.

Preventive care is actively discouraged by the catastrophic, hospital-based emphasis of most plans, and by a system of copayments and deductibles. Women suffer most from these biases. We die of preventable diseases: we are 2/3 of the diabetics in this country; over 90% of the women dying in their childbearing years die of preventable reproductive cancers; ranked at 20th, the US has one of the highest maternal/infant mortality rates. Women are poorer, earning 56¢ for every dollar men earn, working at sales and service jobs that have limited if any health care plans, and we cannot even pay that coinsurance, much less buy private plans with preventive care and maternity coverage to supplement our employee group plans.

In 1976 Americans spent $139.3 Billion on health care, nearly 9% of the GNP. Without some form of controls by 1981 that will rise to $252 Billion. We can no longer afford, in fiscal or human terms, to continue without some step towards a universal, comprehensive health care plan that answers the health needs of all Americans.

Sincerely,

Carolyn Bode

Carolyn Bode
Director, Health and Abortion Projects

WOMEN AND HEALTH CARE

Women have particular health care needs, mainly centering around our reproductive functions, that are ignored by standard health care plans. We need preventive care, we need two primary care doctors (a gynecologist and an internist) while men and health plans recognize only one, we need full reproductive care including coverage of pregnancy and its outcome. When health plans do extend coverage, it is at extra expense to the individual, and extra cost and negotiation by the employer. Any National Health Insurance plan must recognize and address the health needs of over half of all Americans: women.

Prevention

* The US has the highest maternal/infant mortality rate of any Western industrialized nation; sufficient prenatal care can lower that by one-third.

* Two-thirds of all diabetics are women.

* 94% of all women who die in their childbearing years die of reproductive cancers that are preventable.

Reproduction

* In 1975 women made 48% more physician visits than men and were admitted to hospitals 41% more often, but 13% of the physician visits and 36% of their hospital admissions were for gynecological or obstetrical services. Reproductive care accounts for a third of the sex differential in physician visits and nine-tenths of the hospital admissions.

* The median age for first time intercourse is 13.1 years for females, 12.9 for males. 10 year old children are having children. Well baby care will have to include family planning services.

Providers

* Women need two primary care doctors: a general practitioner or internist and a gynecologist, while men need only one. Most insurance plans allow only one general physician visit per year.

* Women meet many of their health care needs at family planning clinics, abortion clinics and women's health centers, served by nurse practitioners, nurse-midwives and physician extenders.

* Two-thirds of those using rural health centers which reach the underserved are women; two-thirds of those providing care in these centers are women.

WOMEN'S LOBBY FACT SHEET--NATIONAL HEALTH INSURANCE

INSURANCE COVERAGE

80% of the US population has some form of private or public health insurance. But:

... 18 million people have no insurance at all
... 1/5 of the people under 65 have no insurance
... 27% have no drug coverage
... 38% have no physician services coverage
... 66% have no preventive care coverage
... 83% have no dental coverage
... only 1/4 of the low income and poverty level children have hospitalization coverage

THE MEDICALLY UNDERSERVED

According to the World Health Organization the United States ranks 20th in infant mortality rates, 17th in life expectancy for men, and 10th in life expectancy for women, among Western industrialized nations.

... In 1976 133 counties in the US with a combined population of nearly half a million people were without a doctor.
... Nine states have fewer than 1 doctor per 1000 people.
... The doctor/patient ratio in rural areas is 1:2400; in urban areas 1:500. Doctors are concentrated in the affluent suburbs, leaving the inner city and rural areas underserved.
... One third of urban mothers receive no prenatal care.
... Nearly 1/2 of Black and Hispanic babies receive no well child check up their first two months of life.
... Only 40% of US children are fully immunized against rubella, measles, diphtheria, mumps and polio.
... The Black infant mortality rate is double that of the rest of the population: 26.8 per 1000 live births.
... Black women are 5 times more likely to die in childbirth.
... 20% of women are rural, but these women account for 50% of maternal deaths.
... The infant mortality rate in rural areas is double and triple the norm: 35-40/1000.

COSTS

In 1976 Americans spent $139.3 Billion for health care--8.9 of the GNP--or $638 per person. Of that:

... $39.9 Billion went to federal health programs
... $19 Billion to state health programs, Medicaid
... $80.5 Billion to Blue Cross/Blue Shield; for coinsurance, office visits, other items not covered in private policies
... $35 Billion in direct payments to private insurers

Over 40% of consumer health costs go to private insurance premiums which cover only 78% of hospital costs, less than 50% of physician care, and only 7% of other health needs.

Private insurer's retentions (what's left after paying out benefits) soared 28% in 1975 from $3.6 Billion to $4.6 Billion--twice the rate of increase in hospital and physician fees.

Health costs have been increasing at twice the rate of inflation; physician fees are increasing 40% faster than other items in the Consumer Price Index; hospital costs are rising 105% faster. By 1981 we will be paying $252 Billion in health care costs.

WOMEN AND HEALTH INSURANCE

The private insurance industry has a strong history of discrimination against women in benefits offered and price of coverage. Because the 1945 McCarran-Ferguson Act exempts the industry from federal regulation (except from Sherman Anti-Trust) regulation is done state by state, with great inequities and geographic discrimination. If National Health Insurance is to be administered through the private insurance industry we must have a strong intervention in McCarran-Ferguson to ensure that women will have full, equitable health coverage without extra cost.

Pregnancy related benefits
Many insurers do not cover or seriously limit maternity benefits.

--Blue Cross of New Jersey provides 7 hospital days for normal delivery, 9 for caesarian. The only other benefits with a day limit are alcoholism and mental disorders.

--In Michigan in 1975 commercial health insurance plans covered only 38-44% of maternity costs; in Pennsylvania in 1974 companies were using 1958 hospital rates to set these coverage limits.

--Often wives of male employees get better coverage than female employees.

--Even single women must enroll in the more expensive family plan to get pregnancy benefits; female minors, dependent daughters are routinely excluded from pregnancy coverage.

--A 1975 study by the Health Insurance Institute showed that 56.4% of all new health insurance group policies did not include maternity benefits.

--Most policies with maternity coverage won't cover claims occurring within the first 10 months; even miscarriages, abortions, ectopic pregnancies and other "unplanned" complications are rarely exempted from the waiting period.

Cost is the reason given for these limitations, but in New York the current cost of covering normal pregnancy and its termination by any means is only $44 per woman per year.

Hospital based emphasis
Health insurance coverage is acute care, hospital oriented, rather than geared to accomodate women's preventive care needs.

--Pap smears and breast exams are not covered despite their high predictive value and later cost saving.

--Contraceptive drugs and devices are rarely covered, though other drugs and devices are.

--Early prenatal and postpartum care can reduce infant mortality by one third, but are usually excluded. More than 1/3 of women delivering in public hospitals received no prenatal care.

--Hysterectomies and D and C's are usually covered; Congressional hearings have heard that 1/4 to 1/2 of these are unnecessary. Second opinions on surgery are not usually covered.

Gynecological exclusions

--Many insurers cover breast reconstruction only when done concurrently with breast removal; the same policies pay for testicle reconstruction or implantation of a glass eye at any time.

--It is common to find riders excluding all pre-existing gynecological disorders; the plans do not exclude pre-existing prostatic or other male disorders.

Newborns

It is common to exclude newborns for the first 15 to 30 days, and then refuse to cover genetic disorders because they are "pre-existing".

Cost

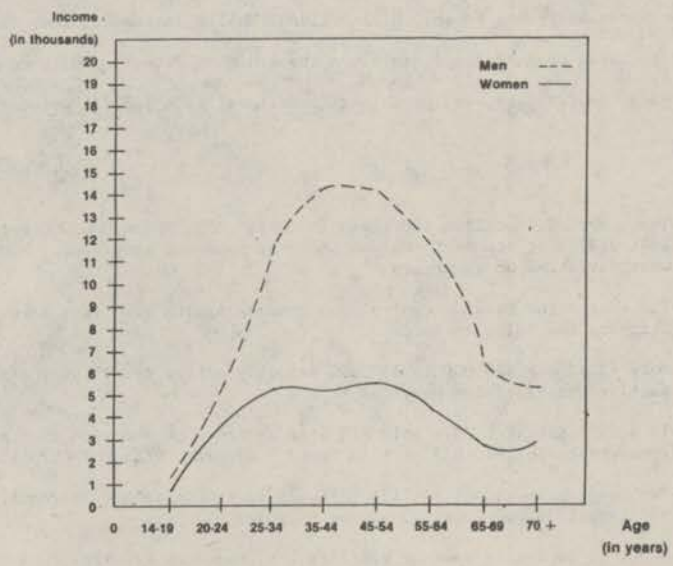
Women are poorer than other people, and the copayments and deductibles standard in any health insurance plan place an unfair burden on women.

--Women earn 56¢ for every $1 men earn; 14% of all women over 65 have no income whatsoever.

--Only 14% of the population are two parent families with only the father working outside the home. Yet employees payroll taxes are deducted for both workers to cover insurance, so the family pays twice. A family with four children pays no more than one with one child.

--An Iowa study showed female policy holders pay 50% more than males for identical coverage; they pay almost twice as much when maternity is included.

INCOME LEVEL BY SEX AND AGE



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WOMEN'S LOBBY FACT SHEET

ABORTION

On January 22, 1973 the Supreme Court recognized a women's right to decide whether or not to terminate a pregnancy. There have been several efforts to eliminate or severely restrict that right, particularly with poor women and young women. With National Health Insurance, that right may be taken from middle class women, by grouping abortion with cosmetic surgery, dental care, and psychiatric services, as a benefit not to be covered.

---There were 1.2 million abortions in 1976; 250,000 to 300,000 were Medicaid abortions performed on the very poor and very young; 300,000 were performed on teenagers.

---The Center for Disease Control has found abortion ten times safer than carrying the child to term.

---Only 7% of the 420,000 to 630,000 sexually active pre-15 year olds receive contraceptive services.

---In a 1976 Knight-Ridder poll 81% were in favor of abortion rights. Of Protestants polled, 82% were in favor; of Jews, 98%; of Catholics, 76%.

---Each year more than 1 million 15 to 19 year olds become pregnant; an additional 30,000 under 15 become pregnant.

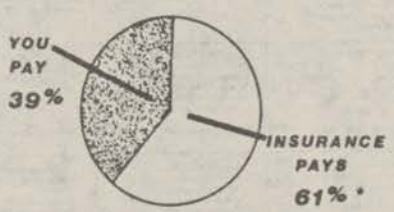
---7 out of 10 female teenage suicides are pregnancy related.

---An abortion costs $185, a live birth $600.

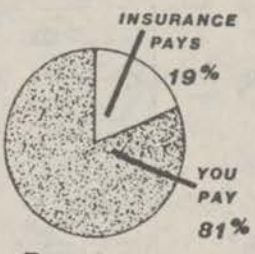
---Most women's maternity insurance plans cover abortion now.

---If abortion coverage were excluded from National Health Insurance, abortion costs would skyrocket, and the employer would have to negotiate for the extra coverage.

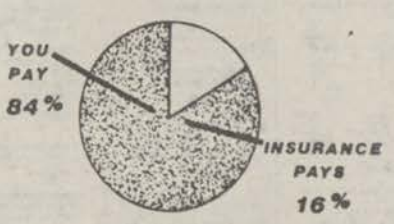
WHAT GOOD IS INSURANCE IF IT DOESN'T PAY THE BILLS?



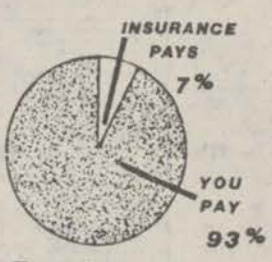
Physicians' Services



Dentists' Services



Drugs



Eyeglasses & Appliances

*...Most of this 61% is paid to Surgeons, Radiologists, Pathologists, Anesthesiologists and other hospital based physicians....

YOU pay for: Pediatricians
Obstetricians
Family Doctors
Ear-Nose-Throat Specialists
Eye Doctors
and others who maintain out-of-hospital offices.

WOMEN'S LOBBY FACT SHEET COMPARISONS
CURRENT ADMINISTRATION PLANS

Plan	Quasi Public Corporation	Publicly Guaranteed Plan	Target Plan	Consumer Choice Plan
Concept	Universal, comprehensive, one class coverage. Quasi Public Corporation oversees two insurance consortia, one of Blues, one of commercial insurers, offering approved minimum benefit package.	Universal, comprehensive, mandatory. Mixed public and private with minimum benefit standards and high risk reinsurance. Employers and individuals able to opt out of public for approved private plans.	Certain public assistance programs aimed at those currently left out of public and private financing	Voluntary, all private, market oriented. Individual plan encouraged over group plans. Consumer comparison shopping will force competitive pricing.
Eligibility	resident, open enrollment, individual basis*	resident, mandatory	Low income on Medicaid, aged on Medicare; any resident qualifies for catastrophic after expenses reach 25% of income; 18 and under get preventive care	resident, voluntary, open enrollment
	*family based coverage results in both spouses having to pay a payroll deduction; women and their children lose coverage upon divorce. (1/3 of marriages end in divorce)			
Financing	–private premium, 75% paid by employer; all by self-employed to cover general population –general federal revenue to cover plans for aged and poor	–employers–75% of premiums; possible tax credit for employers –general federal revenues for poor, aged, disabled –those opting out for private plans still pay 5% to high risk pool	–federal takeover of Medicaid administration and payments (Medicaid and Medicare replaced by Federal Insurance Plan for Aged and Poor) –federal grants for free children's preventive care (covers 18 and under so must have family planning) –tax incentives for programs meeting approved minimum benefits (excludes employer contributions and individual deductions)	–private premiums–employees plans –vouchers financed through income tax, possible special tax –personal health deductions and employer tax credit eliminated –tax credits–HMO users –vouchers–poor and aged, adjusted to actuarial data
Administration	–two consortia of insurers: (Blues and commercial) for high risk pool –private insurers, HMO's –Medicare retained, upgraded in benefits –federal regulation by Public Corporation	–private insurers, federally regulated –high risk pool amortized by regulation of private insurers	–private insurers –federal government assumes ultimate responsibility for catastrophic –federal standards for benefits, enrollment –federal takeover of Medicaid administration and payments	–private insurers, plans certified by federal government –federal government–vouchers and tax credits –[illegible] federal regulation of private insurers –Medicare retained, optional –Medicaid abolished
Phasing	–immediate coverage –if phased in will begin with a minimum benefit package: hospital and physician services with preventive care fully covered	5 year phase in: 1st year–aged and disabled 2nd year–Medicaid 3rd year–all cash assistance 4th year–basic high risk 5th year–employer contribution rises to 75%	–immediate	–immediate –could phase by increasing % federal government provides as vouchers/ tax credit –federal government picking up Medicaid, Medicare
Benefits	minimum benefit package: –preventive care –limited mental health –doctor services –outpatient services –hospitalization	minimum benefit package: –some preventive care for children –limited mental health –doctor services –outpatient services –hospitalization	–catastrophic for all (after 25% of income) –preventive, dental care, limited mental health for 18 and under –keep Medicaid –no exclusions for pre-existing conditions least coverage of plans	minimum benefit package: –catastrophic –open enrollment, i.e. all members of specific risk group pay same premium
Cost Sharing	–25¢ per dollar of income to a maximum of $1,500 out-of-pocket expenses per filing unit. –low income (at or below 1.5 times the Better Jobs and Income Guarantee–or 1.5G*) no cost sharing	–25¢ per dollar of income to a maximum of $1,500 out-of-pocket expenses –low income (at or below 1.5G) no cost sharing	–deductible of less of a) 25% income or b) difference between income and 1.5 G –100% covered beyond deductible –low income (at or below 1.5 G) no cost sharing	–all non-Medicare get tax credit of 60% of their actuarial cost (community rated) –low income (1.5 G or below) supplementary vouchers at 40% (brings up to 100%) –above 1.5 G voucher reduced 25¢ per dollar income until reaches zero
	*Better Jobs and Income Guarantee–e.g. $6,300 for family of 4 in 1978 dollars.			
Cost–new money	$25.5 Billion	$26 Billion	$15.5 Billion	21 Billion
Cost–Federal	$25 Billion	$34 Billion	$32.5 Billion	$72 Billion

Source: HEW Lead Agency Memo

Women, the Poorer Sex

A Report of the National Council on Women, Work and Welfare

May 1978

Editor: Nancy Cornblath Moshé

by Maureen Whalen

Two years ago, a group of women active in the fight to eradicate poverty began to discuss what they all instinctively knew — women are poorer than men. This conclusion was not based on careful examination of statistics or reading socio-economic studies, rather it was the outgrowth of knowledge gained first-hand. A knowledge founded on years of work with poor and low income individuals as well as on years of existing in the world as women.

During the discussions, everyone was asking the same question, "Why are women and children the majority of every poverty statistic compiled?" When answers to the question were sought, it was discovered that none existed. There was no organization that approached poverty as a women's issue. The National Council on Women, Work and Welfare (NCWWW) was formed to fill this void. We at the NCWWW investigate the relationship between economic deprivation and sex discrimination to answer the above question and many more. These answers can then provide a basis for innovative and realistic solutions to the problem of women and poverty.

The Poverty Population

- 25.9 million people live below the Federal poverty line.
- 15.0 million women and female children live below the Federal poverty line.
- 13.8% of all women and female children live below the Federal poverty line.
- 10.9 million men and male children live below the Federal poverty line.
- 10.7% of all males and male children live below the Federal poverty line.
- As of March 1976, 11.1 million children, 9.4 million women and 5.4 men lived below the Federal line.

In 1976, the poverty threshold for a family of four was $5,815, whereas the median income for all families was $14,958.

All poverty statistics are computed after cash transfer. (1975 data.)

In the nine months since the NCWWW opened its office in Washington, D.C., I have attended numerous meetings with public interest groups, Administration officials, Congressional staff members, and poor and low income women. Only the latter group clearly understands and willingly accepts our characterization of poverty as a women's issue, the rest demand proof.

Here is that proof. For 2 months, we at the NCWWW worked with census bureau reports, breaking the statistics down in ways rarely done before. The results are astounding. However, these figures only show that poverty is a women's issue, they do not answer the question of why women are poorer than men. That topic will be the subject of future reports. Our purpose here is to show that our characterization of poverty as a women's issue is not simply a gut level reaction, but a statement well founded in reality and easily documented.

Women, the Poorer Sex is a publication of the National Council on Women, Work, and Welfare, 201 Massachusetts Ave., N.E., Washington, D.C. 20002.

Income Levels

The following data was compiled from 1976 statistics and includes all income regardless of source received by men and women 14 years and older. More than half of these women have a yearly income of less than $4,000 while less than one-fourth of the men have similar incomes. The numbers reverse themselves when computing incomes of more than $10,000 yearly with 47.6% of the men and 12.4% of the women falling into this category. The median income for women aged 14 or older was $3,576. Men of the same age group had a median income of $9,426.

- 63,170,000 women age 14 years or older had an income.
- 72,775,000 men age 14 years or older had an income.
- 53.7% of all women age 14 years or older had an annual income under $4,000.
- 23.6% of all men age 14 years or older had an annual income under $4,000.
- 12.4% of all women age 14 years or older had an annual income over $10,000.
- 47.6% of all men age 14 years or older had an annual income over $10,000.
- The median income for women age 14 years or older was $3,576.
- The median income for men age 14 years or older was $9,426.

Income Level and Marital Status

The figures below were compiled from 1976 data, and break down income according to whether or not a spouse is present in the home. For women, the presences of a husband in the home makes little difference in terms of income level. While more women who are single, widowed, divorced or separated have an income, the levels of this income vary little from women who are living with their husbands. This is not true for men. Fifty percent of the 48 million men who live with their wives have an income greater than $12,000. This percentage falls to 18% when discussing the 22.3 million single, widowed, divorced or separated men.

- 78.0 million women are age 18 years or older.
- 70.3 million men are age 18 or older.
- 59.7 million or 77% of these women have an income.
- 68.6 million or 97% of these men have an income.
- 35.4 million or 59% of all women 18 or older with incomes have an income less than $5,000.
- 17.0 million or 24% of all men 18 or older with incomes have an income less than $5,000.
- 4.7 million or 7.8% of all women 18 or older with incomes have an income greater than $12,000.
- 28.2 million or 40% of all men 18 or older with incomes have an income greater than $12,000.
- The median income for women age 18 or older is $3,882.
- The median income for men age 18 or older is $10,051.

Married Individuals With Spouse Present In the Home

- 48.0 million women and men are married with the spouse present in the home.
- 31.4 million or 65% of these women have an income.
- 47.8 million or 99.5% of these men have an income.
- 18.4 million or 58% of these women have an income of less than $5,000.
- 6.9 million or 14.4% of these men have an income less than $5,000.
- 2.2 million or 7% of these women have an income greater than $12,000.
- 24.3 million or 50% of these men have an income greater than $12,000.
- The median income for women in this category is $3,845.
- The median income for men in this category is $12,151.

Income Level of Individuals Who are Single, Widowed, Divorced, or Separated

- 30.1 million women age 18 or older are either single, widowed, divorced or separated from their spouse.
- 22.3 million men age 18 or older are single, widowed, divorced or separated from their spouse.
- 28.2 million or 94% of these women have an income.
- 21.0 million or 94% of these men have an income.
- 16.9 million or 59% of these women have incomes less than $5,000.
- 10.2 million or 46% of these men have an income less than $5,000.

- 2.4 million or 8.5% of these women have an income greater than $12,000.
- 3.8 million or 18% of these men have an income greater than $12,000.
- It is impossible to compute the median income for women or men in this category.

Race, Sex and Income Level

The following data is based on 1976 figures. It breaks down income levels according to sex and race for individuals age 14 or older. The median income for black women in this category is $3,398, for white women it is $3,606. Black men have a median income of $5,983, while their white counterparts average income is $9,937. It is clear that sex cuts deeper than race when discussing who lives in poverty in this country.

Women

- There are 86.2 million women age 14 years or older.
- 63.2 million or 73% of these women have an income.
- There are 1.5 million non-white women 14 years or older.
- There is no data for income levels for this group.

White Women

- There are 75.2 million white women age 14 years or older.
- 55.0 million or 73% of these women have an income.
- 33.6 million or 61% of these women have an income less than $5,000.
- 4.2 million or 7.6% of these women have an income greater than $12,000.
- The median income for white women age 14 years or older is $3,606.

Black Women

- There are 9.5 million black women age 14 years or older.
- 7.2 million or 75% of these women have an income.
- 4.7 million or 65% of these women have an income less than $5,000.
- 424,000 or 5.9% of these women have an income greater than $12,000.
- The median income for black women age 14 years or older is $3,398.

Men

- There are 78.8 million men age 14 or older.
- 72.8 million or 92% of these men have an income.
- .9 million men age 14 years or older are non-white.
- There is no data on income levels of non-white males.

White Men

- 70.0 million men age 14 or older are white.
- 65.0 million or 92% of these men have an income.
- 17.6 million or 27% of these men have an income less than $5,000.
- 26.5 million or 40% of these men have an income greater than $12,000.
- The median income for white men age 14 years or older is $9,937.

Black Men

- 7.9 million men age 14 years or older are black.
- 6.7 million or 84% of these men have an income.
- 2.9 million or 43% of these men have an income less than $5,000.
- 1.3 million or 19% of these men have an income greater than $12,000.
- The median income for black males age 14 years or older is $5,983.

Who Uses Medicaid

- 17.6 million persons received medical benefits under the Medicaid program in FY 1974. (This figure is of the total reporting states for data on sex of recipients. By looking at requests for medical vendor payments, 22 million persons received medical treatment under Medicaid.)
- 6 million of these persons were male, or 34% of the total.
- 11.4 million women received medical benefits under the Medicaid program, or 65%.

(1974 data)

Source:

Dept. of HEW
Social and Rehabilitation Service
Office of Information Systems
National Center for Social Statistics
October 1976

Publication No. (SRS) 77-03153

Income Level by Sex and Age

The statistics given below are based on 1976 data and include all income regardless of source. This breakdown of income by age and sex shows explicitly that men at every age have significantly higher median incomes than women. The data also demonstrates that a woman's income level peaks at age 34 (at $5,372), whereas a man's income level peaks at age 44 (at $14,326).

Women

- 86.2 million are age 14 or older.
- 23.0 million or 27% of these women had no income.
- 63.2 million or 73% of all women age 14 or older had an income.
- The median income for all women age 14 or older was $3,576.

Ages 14-19:

- 12.4 million women are between the ages of 14 and 19.
- 6.7 million or 54% of these women had an income.
- 6.4 million or 95% of those with incomes had an income less than $5,000.
- 6,000 or .08% of these women with incomes had an income greater than $12,000.
- The median income for this age group was $897.

Ages 20-24:

- 9.8 million women are between the ages of 20 and 24.
- 8.1 million or 82% of these women had incomes.
- 4.9 million or 60% of these women with incomes had incomes less than $5,000.
- 163,000 or 2% of those with incomes had an income greater than $12,000.
- The median income for this age group was $3,839.

Ages 25-34:

- 16.4 million women are between the ages of 25 and 34.
- 14.9 million or 90% of these women had an income.
- 5.6 million or 37% of those women with incomes had an income less than $5,000.
- 1.2 million or 8% of these women with incbmes had an income greater than $12,000.
- The median income for this age group was $5,372.

Ages 35-44:

- 11.9 million women are between the ages of 35 and 44.
- 8.6 million or 72% of these women have an income.
- 4.2 million or 48% of these women with incomes have an income less than $5,000.
- 1.0 million or 8.4% of these women with incomes have an income greater than $12,000.
- The median income for this age group is $5,158.

Ages 45-54:

- 12.0 million women are between the ages of 45 and 54.
- 8.4 million or 70% of these women have an income.
- 3.4 million or 40% of these women with incomes have an income of less than $5,000.
- 1.1 million or 13% of these women with incomes have an income greater than $12,000.
- The median income for this age group is $5,331.

Ages 55-64:

- 10.6 million women are between the ages of 55 and 64.
- 7.7 million or 72% of these women have incomes.
- 4.4 million or 57% of these women with incomes have an income less than $5,000.
- 791,000 or 10.3% of these women with incomes have an income greater than $12,000.
- The median income for this age group is $4,054.

Ages 65-69:

- 4.6 million women are between the ages of 65 and 69.
- 4.2 million or 91% of these women have an income.
- 3.2 million or 76% of these women with incomes have an income less than $5,000.
- 190,000 or 4.5% of these women with incomes have an income greater than $12,000.
- The median income for this age group is $2,807.

Age 70 and over:

- 8.4 million women are age 70 and over.
- 7.6 million of these women have an income, 90%.

- 6.2 million or 81% of these women with incomes have an income of less than $5,000.
- 239,000 or 3.1% of these women with incomes have an income of $12,000 or more.
- The median income for this age group is $2,820.

Men

- 78.8 million men are age 14 or older.
- 6.0 million or 8% had no income.
- 72.8 million or 92% of all men age 14 or older had an income.
- The median income for all men age 14 or older is $9,426.

Ages 14-19:

- 12.4 million men are between the ages of 14 and 19.
- 7.4 million or 59% of these men had an income.
- 6.7 million or 90% of these men with incomes had an income less than $5,000.
- 46,000 men had income greater than $12,000 in this age group. The percentage is too small to compute.
- The median income for this age group is $1,032.

Ages 20-24:

- 9.4 million men are between the ages of 20 and 24.
- 9.0 million or 96% of these men had an income.
- 3.8 million or 42% of these men with incomes had an income less than $5,000.
- 974,000 or 10% of these men with incomes had an income greater than $12,000.
- The median income for this age group is $5,841.

Ages 25-34:

- 15.9 million men are between the ages of 25 and 34.
- 15.7 million or 98% of these men had incomes.
- 2.0 million or 12% of these men with incomes had an income of less than $5,000.
- 7.6 million or 48% of these men had an income greater than $12,000.
- The median income for this age group is $11,717.

Ages 35-44:

- 11.2 million men are between the ages of 35 and 44.
- 11.1 million or 99% of these men had an income.
- 1.1 million or 9.9% of these men with incomes had an income of $5,000 or less.
- 7.0 million or 63% of these men with incomes had an income greater than $12,000.
- The median income for this age group is $14,326.

Ages 45-54.

- 11.3 million men are between the ages of 45 and 54.
- 11.2 million or 99% of these men have an income.
- 1.3 million or 11% of these men with incomes have an income less than $5,000.
- 6.8 million or 60% of these men with incomes have an income greater than $12,000.
- The median income for men in this age group is $14,094.

Ages 55-64:

- 9.5 million men are between the ages of 55 and 64.
- 9.4 million or 99% of these men have an income.
- 1.8 million or 19% of these men with incomes have an income of less than $5,000.
- 4.5 million or 48% of these men with incomes have an income of $12,000 or more.
- The median income for this age group is $11,523.

Ages 65-69:

- 3.6 million men are between the ages of 65 and 69.
- 3.6 million or 100% of these men have an income.
- 1.4 million or 38% of these men with incomes have an income of less than $5,000.
- 699,000 or 19% of these men with incomes have an income greater than $12,000.
- The median income for this age group is $6,129.

Ages 70 and over:

- 5.5 million men are age 70 and over.
- 5.5 million or 100% of these men have an income.
- 2.9 million or 52% of these men with incomes have an income less than $5,000.
- 582,000 or 10% of these men have an income of $12,000 or more.
- The median income for this age group is $4,830.

Poverty Status by Sex and Race of Head of Household

The following data is from 1975 and looks at families living below the Federal poverty line in terms of the sex and race of the head of the household. The statistics show that five times as many female headed households live below the poverty line as male headed households. They also indicate that being female and heading a household is much more likely to result in living below the Federal poverty standard than being a male of any race. This again, supports the thesis that poverty is more an issue of sex than race.

- 48.8 million families have male headed households.
- 3.0 million or 6.2% of all male headed households live below the Federal poverty line.
- 7.5 million families have female heads of households.
- 2.4 million or 32.5% of the female headed households live below the Federal poverty line.
- 5.5% of all white male headed households live below the Federal poverty line.
- 25.9% of all white female headed households live below the Federal poverty line.
- 14.2% of all black male headed households live below the Federal poverty line.
- 50.1% of all black female headed households live below the Federal poverty line.
- 45% of all families living below the Federal poverty line are female headed households.

Poverty Status of Children

The statistics given below focus on the number of children who live below the Federal poverty line. They indicate that more than half of the children living in female headed households live in poverty, while this is true of less than 10% of the children who live in families headed by males. Both figures increase for black families, but there are still twice as many children living in poverty in white female headed households than in black male headed households.

- 10.9 million children live below the Federal poverty line; this is 16.8% of all children less than 18 years of age.
- 12.5% of all white children live below the Federal poverty line.
- 41.4% of all black children live below the Federal poverty line.
- 5.3 million children live in male headed households below the poverty line; this is 9.8% of all children living in male headed households.
- 5.6 million children live in female headed households below the poverty line, this is 52.7% of all children living in female headed households.
- 8.2% of all white children who live in male headed households live below the Federal poverty line.
- 22.1% of all black children who live in male headed households live below the Federal poverty line.
- 44.2% of all white children living in female headed households live below the Federal poverty line.
- 66.0% of all black children living in female headed households live below the Federal poverty line.

Income Level and Education

The following data is based on 1975 statistics and examines the correlation between education and income level. Many people attribute poverty and low incomes to lack of education. However, these figures clearly show that while more women have graduated from high school than men, more of these women end up living in poverty than do men with the same educational background.

Education Levels by Sex

- 85.0 million women are age 14 or over.
- 8.6 million or 10% have completed only the eighth grade.
- 31.9 million or 37.5% have graduated from high school only.
- 40.0% of all women are not high school graduates.
- 77.8 million men are age 14 or over.
- 7.9 million or 10% have completed only the eighth grade.
- 23.9 million or 30% of all males have graduated from high school only.
- 40.3% of all males are not high school graduates.

Educational Attainment of Persons Living Below the Poverty Line

- 10.7 million women age 14 and over live below the Federal poverty line.

- 1.7 million or 14% of these women have only completed the eighth grade.
- 2.5 million or 22% have graduated from high school, but have no higher education.
- 66.5% of all women age 14 and over living below the Federal poverty are not high school graduates.
- 6.6 million men age 14 and over live below the Federal poverty line.
- 1.0 million or 15% have completed the eighth grade.
- 1.1 million or 16% of these men have graduated from high school, but have not received any higher education.
- 69.2% of all men age 14 and over living below the Federal poverty line have not graduated from high school.

Poverty Population by Region

There are 25.9 million persons who live below the Federal poverty line. Fifty-seven percent or 14.8 million of these individuals live in the North and West. Forty-two percent or 11.1 million live in the South. The U.S. Census bureau defines the South as: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. The North/West includes all other states. The states considered the South by the Census Bureau account for one-third of all the states and one-third of the total U.S. population. However, the South has more than one-third of the number of persons living below the Federal poverty line.
(All figures are based on 1975 data.)

North/West:

- 10.4% of all persons living in the North/West live below the Federal poverty line.
- 9.0% of all white persons living in the North/West live below the Federal poverty line.
- 25.2% of all black persons living below the Federal poverty line live in the North/West.
- 5.7% of all persons living in male headed households in the North/West live below the Federal poverty line.
- 34.5% of all persons living in female headed households in the North/West live below the Federal poverty line.
- 5.3% of all white persons living in male headed households in the North/West live below the Federal poverty line.
- 9.3% of all black persons living in male headed households in the North/West live below the Federal poverty line.
- 30.0% of all white persons living in female headed households in the North/West live below the Federal poverty line.
- 49.1% of all black female households in the North/West live below the Federal poverty line.

South:

- 16.2% of all persons living in the South live below the Federal poverty line.
- 11.4% of all white persons living in the South live below the Federal poverty line.
- 36.6% of all black persons living in the South live below the Federal poverty line.
- 10.3% of all persons living in male headed households in the South live below the Federal poverty line.
- 42.9% of all persons living in female headed households in the South live below the Federal poverty line.
- 27.9% of all white persons living in female headed households in the South live below the Federal poverty line.
- 8.1% of all white persons living in male headed households in the South live below the Federal poverty line.
- 23.2% of all black persons living in male headed households in the South live below the Federal poverty line.
- 58.8% of all black persons living in female headed households in the South live below the Federal poverty line.

Statistical Characteristics of AFDC Recipients

The following statistics provide a profile of the individuals who receive Aid to Families with Dependent Children (AFDC). Eight million of those recipients are children, almost 3 million are women, about 150,000 are men.

- 3.4 million families receive cash assistance under the AFDC program.
- 8.1 million children are AFDC recipients.
- 236,407 families have two adult recipients; this is 6.9% of the total.
- 2.7 million or 78% of the total AFDC family unit recipients are single parent headed households.
- 106,312 or 3% of the total AFDC family unit recipients are single male headed households; 420,098 or 12% of the total have no adult recipient.

Age of mothers

- 79.3% of all mothers receiving AFDC are under 40 years of age.
- 51.4% of all mothers receiving AFDC are under 30 years of age.
- 30.3% of all mothers receiving AFDC are under 24 years of age.

Work experience of mothers

- 324,989 or 10.4% of all mothers in households receiving AFDC payments work full time.
- 178,895 or 5.7% of all mothers in households receiving AFDC payments work part-time.

Education

- 23.7% of all mothers in AFDC households have a high-school degree.
- 15.6% of all fathers in AFDC households have a high-school degree.
- 38.1% of all mothers receiving AFDC cash assistance have finished the eighth grade and some high-school.
- 30.4% of all fathers receiving AFDC cash assistance have finished the eighth grade and some high-school.

Age of children

- 51.5% of all children who are AFDC recipients are 8 years old or younger.
- 32.7% of all children who are AFDC recipients are between the ages of 8 and 14.
- 15% of all children who are AFDC recipients are over 14 years of age.

Number of children per AFDC household

- 37.9% of all AFDC households have one child.
- 26.0% of all AFDC households have two children.
- 16.1% of all AFDC households have three children.
- 20.0% of all AFDC households have four or more children.
- 82% of all the children receiving AFDC live in single parent households.
- 37.1% of these AFDC single parent families have one child.
- 26.3% of single parent AFDC families have two children.
- 16.6% of single parent families have three children.
- 19.9% of single parent families receiving AFDC payments have four or more children.

Source:

Aid to Families with Dependent Children
1975 Recipient Characteristics Study
Part 1. Demographic and Program Statistics

U.S. Dept. of HEW
Social Security Administration
Office of Research and Statistics
HEW Pub. No. (SSA) 77-11772

Our Sources

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Bureau of the Census
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1976 Data:

Current Population Reports
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May 24, 1978

Dr. Larry Horowitz
Subcommittee on Health
Senate Committee on Human Resources
4220 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Dr. Horowitz:

The interest of the labor movement in National Health Insurance is well known and our zeal in this part of the country is great. We would like to display that zeal by participating in the field hearings that Senator Edward Kennedy has said will be conducted.

We recommend that Denver be considered for a hearing site. Our central location and good transportation facilities make Denver an ideal location to hear a cross-section of views encompassing rural, suburban and urban health problems.

I would appreciate notification of dates and places of hearings in order to make arrangements for attendance. We look forward to working together on this vital need.

Sincerely,

William C. Himmelmann

William C. Himmelmann
President

WCH:jb
opeiu #5
afl-cio

Senator KENNEDY. We will stand in recess.

Let us reconvene and we will put this on the record.

Dr. Mauksch had an interesting comment and I would like to get it on the record.

It is the prerogative of the Chair to change his mind. [Laughter.]

This is just on the issue of phasing in.

Dr. MAUKSCH. I want to state why the American Nurses' Association does not favor phasing in. Not only are we in possession of statistics which show how many elderly people save their needs until they are eligible for medicare simply because they cannot afford to have those things taken care of, but by the time they are medicare eligible, these needs have increased, multiplied, and gotten much worse. And the care is infinitely more expensive.

Second, if we say that we are going to phase in a population of pregnant women and children, I have a very hard time to figure out how the determinations would be made.

Does it mean that when a woman is pregnant, she will be part of the plan, she will deliver the baby, and her economic status certainly has not changed. Suddenly, she is off when the care she may need, post partum care, may be infinitely more important.

Then a couple of years later, she becomes pregnant again, and so on she goes again. Think of the money and the book work if we put a person like this on and off the rolls of the national health insurance plan.

Please do not do phasing in of populations. Let us all be eligible.

Senator KENNEDY. Thank you.

Good. Excellent.

We will be in recess.

[Whereupon, at 12:07 p.m., the subcommittee adjourned, subject to the call of the Chair.]

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