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SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

PANEL DISCUSSIONS ON

NATIONAL HEALTH INSURANCE

PREPARED STATEMENTS OF PANELISTS

ON THE SUBJECT OF

BROAD ASSESSMENT OF AMERICAN HEALTH STATUS AND THE AMERICAN HEALTH CARE DELIVERY AND FINANCING SYSTEMS

Including Press Releases Announcing Panel Discussions, and Releasing Additional Information on Panel Discussions, as well as Opening Statement of Chairman Dan Rostenkowski

JULY 10, 1975

Printed for the use of the Committee on Ways and Means

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C O N T E N T S

	Page
Subcommittee on Health Press Release No. 7 dated June 24, 1975, announcing panel discussions on National Health Insurance	1
Subcommittee on Health Press Release No. 8 dated July 1, 1975, releasing additional information on National Health Insurance Panels	2
Opening Remarks of Chairman Rostenkowski before Panel Hearings on July 10, 1975	7
Statement of E. L. Wynder, M.D., President, American Health Foundation	9
Statement of John G. Freymann, M.D., President, National Fund for Medical Education	23
Statement of Rashi Fein, Professor of the Economics of Medicine, Harvard University	32
Statement of Uwe Reinhardt, Professor of Economics, Princeton University	39

FOR THE PRESS
FOR IMMEDIATE RELEASE
TUESDAY, JUNE 24, 1975

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515

SUBCOMMITTEE CHAIRMAN DAN ROSTENKOWSKI (D., ILL.) SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, ANNOUNCES PANEL DISCUSSIONS ON NATIONAL HEALTH INSURANCE BEGINNING JULY 10, 1975

Subcommittee Chairman Dan Rostenkowski (D., Ill.) of the Subcommittee on Health of the Committee on Ways and Means announced today the second stage in the Subcommittee's consideration of national health insurance. This stage will involve small panel discussions on the broad issues in national health insurance. The Subcommittee will form these small panels from members of the Advisory Panel on National Health Insurance, which it established earlier this year (see: Press Release Nos. 2, 3, and 5).

The panel discussions will begin on July 10, 1975 at 10:00 a.m. and are also scheduled for July 11, 17, and 24. The sessions will be conducted in the Main Hearing Room of the Ways and Means Committee in the Longworth House Office Building.

It is expected that public hearings and additional panel discussions will be scheduled later in the year on the subject of national health insurance.

In addition, on July 31, the Subcommittee will meet to consider which aspects of medicare it will want to address in public hearings to be held after the August recess. Included in the discussion will be possible action on recent Department of Health, Education, and Welfare medicare regulations which were the subject of a public oversight hearing on June 12, 1975 (see: Press Release No. 6).

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FOR THE PRESS
FOR IMMEDIATE RELEASE
JULY 1, 1975

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D. C. 20515

SUBCOMMITTEE CHAIRMAN DAN ROSTENKOWSKI (D., ILL.) SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS RELEASES ADDITIONAL INFORMATION ON NATIONAL HEALTH INSURANCE PANEL DISCUSSIONS FOR JULY

Subcommittee Chairman Dan Rostenkowski (D., Ill.) of the Subcommittee on Health of the Committee on Ways and Means today released additional information about the panel discussions on national health insurance scheduled for July, first announced on June 24, 1975 (see: Press Release #7). It is expected that the Subcommittee will schedule public hearings on this subject in the late summer or early fall. The membership and structure of each panel discussion is attached.

PANEL ON NATIONAL HEALTH INSURANCE--JULY 10, 1975

(SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS)

Subject: Broad assessment of American health status and the American health care delivery and financing systems

Panelists:

1. E. L. Wynder, M.D., President, American Health Foundation.

2. John G. Freymann, M.D., President, National Fund for Medical Education.

3. Rashi Fein, Professor of the Economics of Medicine, Harvard University.

4. Uwe Reinhardt, Professor of Economics, Princeton University.

5. Kerr White, M.D., Professor of Health Care Organization, The Johns Hopkins University.

The panel will begin its presentation to the Subcommittee at 10:00 a.m. on July 10, 1975, in the Main Hearing Room of the Committee on Ways and Means in the Longworth Building at New Jersey and Independence Avenue, S.E.

(Over)

PANEL ON NATIONAL HEALTH INSURANCE--JULY 11, 1975

(SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS)

Subject: The role of Government in American health

Panelists:

1. Lewis H. Butler, Professor of Health Policy, University of California.

2. Pierre R. de Vise, Professor of Urban Science, University of Illinois at Chicago Circle.

3. Richard Heim, Executive Director, Health and Social Services Department, New Mexico.

4. Lowell Bellin, M.D., Commissioner of Health, New York City.

The panel will begin its presentation to the Subcommittee at 9:00 a.m. on July 11, 1975, in the Main Hearing Room of the Committee on Ways and Means in the Longworth House Office Building at New Jersey and Independence Avenue, S.E.

PANEL ON NATIONAL HEALTH INSURANCE--JULY 17, 1975

(SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS)

Subject: Private sector role in American health.

Panelists:

1. Herman M. Somers, Professor of Politics and Public Affairs, Woodrow Wilson School of Public and International Affairs.

2. Nathan J. Stark, President, University Health Center of Pittsburgh.

3. Robert G. England, M.D., Carlinville, Illinois.

4. Lawrence M. Cathles, Jr., Retired Senior Vice President, Aetna Life and Casualty.

5. John Larkin Thompson, President, Blue Shield of Massachusetts.

The panel will begin its presentation to the Subcommittee at 10:00 a.m. on July 17, 1975, in the Main Hearing Room of the Committee on Ways and Means in the Longworth House Office Building at New Jersey and Independence Avenue, S.E.

(Over)

55-309 O - 75 - 4

PANEL ON NATIONAL HEALTH INSURANCE--JULY 24, 1975

(SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS)

Subject: Problems and issues in health care organization, delivery and financing

Panelists:

1. Martin S. Feldstein, Professor of Economics, Harvard University.

2. Herbert E. Klarman, Professor of Economics, New York University.

3. Wilbur J. Cohen, Dean, School of Education, University of Michigan.

4. Charles A. Siegfried, Madison, New Jersey.

5. Avedis Donabedian, M.D., M.P.H., Professor of Medical Care Organization, University of Michigan.

The panel will begin its presentation to the Subcommittee at 10:00 a.m. on July 24, 1975, in the Main Hearing Room of the Committee on Ways and Means in the Longworth House Office Building at New Jersey and Independence Avenue, S.E.

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OPENING REMARKS OF CHAIRMAN ROSTENKOWSKI

PANEL HEARINGS ON NATIONAL HEALTH INSURANCE

July 10, 1975

Today the Subcommittee on Health begins active consideration of issues in national health insurance. Instead of beginning our consideration by receiving testimony on specific proposals from interested organizations and individuals, we thought it would be useful to begin by exploring, with a series of expert panels, the broad outlines of health care in the United States and some of the major issues we will need to address as we frame a national health insurance bill. Later, probably in early fall, we will likely hold public hearings at which all interested parties can express their views.

At the beginning of this year the Subcommittee invited individuals and organizations to submit written statements on the subject of national health insurance. This permitted the updating of testimony presented during the extensive hearings on national health insurance the Committee on Ways and Means completed a year ago, and also offered a fresh opportunity for the expression of views by those who had not previously testified. These statements will soon be available in the form of a printed record thus furnishing the Subcommittee the full benefit of the information and views presented before we begin consideration of specific national health insurance proposals.

The panels of experts who will be sharing their knowledge of the American health care system with us during this month were selected, like the larger Advisory Panel of which they are a part, not to represent the viewpoint of any organized group but rather to let us benefit from the fruits of their own individual studies and experiences in health care and health care financing. There will be ample opportunity later for the expression of official positions by organizations and individuals. Our objective for the moment is simply to learn and try to understand, so that the decisions we make later will be soundly based.

We begin our broad review of this subject with an exploration of American health status, our health care delivery system or systems, and how we finance the $100 billion or so being spent for personal health care. Tomorrow we will take a broad look at the role of Government at all levels in American health. On July 17 we will examine the private sector role. And on July 24, we will take up problems and issues in health care organization, delivery, and financing.

I believe that the Subcommittee will agree with me that we should plan for additional sessions like the ones already scheduled with selected members of the Subcommittee's Advisory Panel as we narrow our attention to more specific issues. I say this because one thing that has become clear to me in the months since I assumed Chairmanship of this Subcommittee is that the American health care system is extraordinarily complex. You cannot change any part of it without affecting other parts--perhaps in ways not able to be anticipated. We need to learn a great deal about the American system of health care, and we must approach the task of framing national health insurance legislation with a great deal of sensitivity and even humility.

I have been looking forward to beginning these panel sessions. We have a fine group of expert witnesses who have agreed to meet with us and I want to have every member participate in these sessions to the fullest.

We hope to proceed somewhat informally today, using a format that will promote understanding and the exchange of views. The panel members have been asked to make a brief opening statement, so as to leave adequate time for questioning and discussion among both panel and Subcommittee members.

* * * *

HEALTH GOALS FOR THE UNITED STATES

Ernst L. Wynder, M.D.
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New York, New York 10019

INTRODUCTION

It would seem from the history of medicine, as indeed from history in general, that while Man has obviously enhanced his knowledge, he has not enlarged his wisdom. Forty-Five Hundred years have passed since Huang Ti declared in China, "Hence the sages did not treat those who were already ill; they instructed those who were not yet ill...To administer medicines to diseases which have already developed and to suppress revolts which have already developed is comparable to the behavior of those persons who begin to dig a well after they have become thristy, and of those who begin to cast weapons after they have already engaged in battle." Several decades ago William James Mayo was quoted as saying, "The aim of medicine is to prevent disease and prolong life. The ideal of medicine is to eliminate the need of a physician." We would concur that this is still the basic goal of medicine, as indeed is well reflected in an old Greek motto that has become the basic saying of our Foundation -- that it should be the function of medicine to help people die young as late in life as possible.

THE ISSUE:

This being the case, we should ask how our current medical care delivery system is addressing itself to this issue, where the primary problems in achieving these goals lie, and how a program of National Health Insurance could contribute towards its attainment. With a decreasing birthrate, we are faced over the next few decades with the predictability of fewer wage-earners to support the disabled and ailing part of our population. We must pay increasing attention to keep as many of our wage-earners as healthy as possible and reduce the need for unnecessary and increasingly expensive hospitalization among our older individuals.

If we fail in this, our nation will be required to undertake a major shift of priorities in the national economy; one that would see an ever increasing percentage of the gross national product tied up in health care delivery services. This would be a task of unprecedented dimensions, and one that might well be impossible within the present productive framework of our nation, particularly in view of other formidable competing priorities.

The consideration of a national health insurance system is politically natural in the increasingly mutualistic atmosphere of our democracy. A health insurance system immediately brings to mind hospitalization needs and the coverage of disease costs, but if we are not to make of this system an economic monster, I urge you to consider how disease, life, and money saving measures can be built into such a system.

That is why I shall stress in my remarks areas involving preventive medicine. I would like to caution, however, that as has been experienced by National Health Insurance systems in other countries, and indeed from our own experience with Medicaid and Medicare -- a cost-effective health insurance system requires, in order not to be economically overburdened, a disciplined population and a disciplined health care profession in order that its obvious advantages are not destroyed by an over zealous use of its opportunities.

It seems appropriate that, in discussing the health needs of the United States, one begins by enumerating the major causes of death and disability in our country,

the opportunities for preventing or curing these conditions and the problems we face in combating these major foes of premature death and disability. It so happens that four conditions: heart disease, cancer, stroke, and accidents, make up 70% of all deaths among Americans, while heart disease, arthritis and rheumatism, impairment of back, hips and lower extremities, mental and nervous disorders and hypertension represent 40% of the reasons for disability among our population. Therefore, it is in these areas that we need to concentrate if we are to make a significant impact on disease rates in the country.

The major factors contributing to death from heart disease, cancer and stroke in the United States have been well established by epidemiological and laboratory studies. Factors for which the incidence is most consistent include-for cardiovascular disease--overnutrition (especially with regard to fat and cholesterol intake), hypertension, excessive cigarette smoking and physical inactivity; for cancer--

excessive tobacco usage, nutritional deficiencies and excesses, and certain occupational exposures; and for highway accidents, alcoholism and drug abuse, poor highway and automobile designs.

Thus, in a society where infectious diseases have been largely overcome through sanitary measures, immunization, and antibiotics, the major causes for today's death toll are chronic diseases. This death toll is largely due to unhealthy lifestyles, unhealthy working environments and disease-inducing products. If we are to prevent these diseases, we need to concentrate on their causes.

Problems of Disease Prevention

It may be asked why, if etiological factors of certain diseases have been established, there hasn't been more progress in the prevention of these diseases. Among the reasons for this failure are man's apparent apathy towards anything preventive--whether with regard to energy conservation, highway safety programs, or health. We tend to live for the present, believing that the future will take care of itself. We also seem to suffer

from an illusion of immortality, apparently related to our inability to face death. The problem is further compounded because doctors are trained mainly in therapeutic medicine; and because reimbursement for medical care is nearly totally geared towards therapy. Given these facts, adding that preventive advice given to patients is not as dramatic in public or private terms as combating symptomatic diseases, it is little wonder that many of today's physicians do not stand in the vanguard for the cause of prevention.

The hospital system is another part of the problem. Our hospitals deal primarily with cure, not prevention. Since reimbursement is aimed mainly at in-patient, rather than ambulatory care, and since hospitals are reimbursed for therapeutic rather than preventive care, it is not surprising that the latter is being neglected.

These attitudes are reflected in current practices of the health insurance industry which, again, concentrates largely on reimbursement for therapy for specific disease symptoms and not on prevention. It is unrealistic

to expect that the medical and allied professions, in an economic climate such as ours, will behave any differently than any other segment of society. As long as our society provides economic incentives primarily for therapeutic care, it will be therapeutic care which receives the most attention.

Yet, we know from medical history that the world's major diseases did not succumb to therapy alone; instead the only time they were ever eradicated was when effective preventive measures were applied. This lesson from history also applies to chronic noncommunicable diseases such as cardiovascular disease, cancer and chronic pulmonary disease--diseases which have a long latent period, which by and large are not likely to be cured in their later stages, but which are often preventable.

RECOMMENDED MEASURES

The following attemps to crystalize the major steps which can ~~also~~ lower costs and contribute to a better health care program than the one we presently have.

1. First of all we, as a nation, must resolve that health care ranks as one of our country's major goals. To accomplish this goal requires the cooperative efforts of various segments of society. It is obvious that the medical profession cannot, by itself, determine which type of a health system would be best for the country. Industry, labor, economists, health insurance experts, Congress, and the public at large need to coordinate their expertise with that of the health professionals in order to arrive at a health care delivery system which is best suited to the needs of the United States.

2. In order to improve the health care delivery system, both medically and economically, several measures should be included in whatever type of national health insurance system is contemplated.

The system must accentuate financial incentives for ambulatory care. Existing hospitals should be reorganized so that they can provide, in addition to therapeutic care, efficient ambulatory care for their communities. Appropriate incentives should also be given to physicians to provide PREVENTIVE care. Included in this care should also be: immunizations, maternal and child care, pre and postnatal care, general health education and motivation, as well as therapeutic care. The ambulatory care unit thus includes both preventive (primary and secondary) and therapeutic programs. The preventive care programs should be of the short and long-range type and should modify their services in line with the specific needs of various population groups. The ambulatory preventive care program should be extended into the schools where meaningful health programs are currently almost nonexistent. Effective preventive medicine--as is the case with education in general--has its greatest impact on the young.

3. Ambulatory care delivery programs can, to a large extent be carried out by allied health professionals, nurses, medical corpsmen, health educators, behaviorial psychologists and sociologists who, under the overall supervision of physicians, in many instances can undertake effective therapeutic programs and significantly help in modifying the lifestyles of our people and in detecting early disease.

4. A national health insurance program should not only provide effective ambulatory and preventive care programs but should also provide incentives for the public and the health care delivery system to see to it that such health services are effectively utilized.

5. Recognizing that individuals will always represent the weakest link in preventive procedures, in addition to providing meaningful incentives to utilize cost-effective preventive services, emphasis should be placed on "managerial" preventive measures. These include further development of less harmful smoking products (a measure especially recommended for a society which is likely to continue to condone smoking as socially acceptable) and the modification

of American food products towards developing a "prudent" diet, one low in fat and cholesterol and thus more commensurate with today's reduced caloric expenditures, as well as a diet that leads to proper growth of our poor and under-priviledged. Managerial preventive medicine also includes reducing workers' exposure to harmful elements through legislation and making certain that no new harmful components are introduced into the environment. It also includes the enforcement of speed limits which, in addition to saving lives, would also help in the conservation of energy. Existing laws with respect to drunken driving and automobile and highway safety should be vigorously enforced.

6. It is suggested that all preventive programs as currently conducted by various branches of HEW and other governmental agencies, be coordinated and supervised by an Office of Disease Prevention to be headed by a Deputy Assistant Secretary reporting directly to the Assistant Secretary.

Finally, I would like to bring the following recommendations to your immediate consideration, that

7. In any authorization for national health insurance-- even in the initial development stage-- specific allocation equal to one tenth of one percent of the dollar authorization be directed toward preventive medicine, research and evaluation of existing systems;

8. That the Chairman with the advise of the Committee direct the Secretary of HEW to appoint a task force on Preventive Medicine for the purposes of examining, on an across-the-board basis, the extent that preventive medicine is presently being practiced for the purpose of determining specific feasibility as to what is accomplishable through preventive medicine.

9. That the Chairman with the consent of the Committee direct the Secretary of HEW to report within 90 days on the extent of the taxpayer-supported research in the area of evaluating the cost benefit of preventive medicine; and

10. That the Chairman direct every witness to address themselves to the specific question of how the financial cost of disease care can be reduced through preventive medicine.

In summary, we have emphasized the roles which ambulatory care, preventive care, allied health professionals can, and should, play in a national health insurance program. It should be emphasized that all such programs should be continuously scrutinized for their cost-effectiveness and cost benefits.

Preventive medicine, if properly advanced, can make a major impact -- both medically and economically -- on the high rate of disease in this country. It requires a full time-coordinated effort for its goals and aspirations to be fulfilled. We have also set forth the obstacles -- scientific, economic and human -- which face the proponents of preventive medicine. To overcome these obstacles requires the understanding and the support of the people and, consequently, the Congress. Congress, through its legislative powers and particularly through its influence on a National Health Insurance program, has the opportunity to make ours a healthier society, one with the lowest infant mortality and highest longevity, and one where our motto of..."dying young in life, as late as possible" will be fulfilled. With the scientific evidence

55-309 O - 75 - 3

available today, with the cooperation of the medical and allied health professionals, and with the determinaion of the American people along with legislative stimulus from the Congress, we can make the realization of this motto come true in our lifetime.

Statement of John G. Freymann, M.D. delivered at first panel session

on national health insurance

Mr. Chairman: I am John Gordon Freymann, a physician, a member of the Family Practice faculty of the University of Connecticut medical school, and president of the National Fund for Medical Education.

Henry Ford said that history is bunk. I will not argue the point, but history is the only way I know to understand the complex and seemingly irrational organization of the American health care system. My assignment is to take the Subcommittee through a brief history to show how our system got to be the way it is. To do this, I will trace three chains of causation which, woven together, have produced what we have today. These three chains are: 1) The organization of health facilities, with particular reference to short-term hospitals; 2) The education of the health professions, with particular reference to physicians; and 3) The financing of health services.

I. Organization of Health Facilities

Pennsylvania Hospital in Philadelphia was the first voluntary (i.e., private, non-profit) hospital in the nation. Opened in 1750, it was a faithful copy of the hospitals of London. These institutions had evolved a peculiar, tri-partite organization over the centuries. The board of Trustees, which owned the corporation, was a mechanism for governance that replaced the Church after Henry VIII abolished the monastaries in 1536. The hospital administration was employed by the Trustees, but the medical staff was an independent cadre of private practitioners. They were not employees because the original hospitals were hospices for the poor. Centuries passed

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before they became places exclusively for the sick where an attending staff of doctors was needed. Hospitals eventually employed some doctors, but they were apprentice physicians or surgeons.

This medieval model, brought to the Colonies from the Mother Country, is still followed throughout the United States. All of our voluntary hospitals, secular and religious, have this same basic organization. So do most city and country hospitals, although here the Trustees may be elected or appointed officials. The administrative staffs are employed by the Trustees, as are the apprentice doctors whom we now call residents. In the last 25 years many hospitals have hired full-time, salaried doctors to head major departments such as surgery and internal medicine. But the vast majority of doctors working in these hospitals are practitioners who receive the privilege of using the facilities from the Trustees and are paid directly for their services by their patients or by third-party payers.

In spite of their long history, hospitals played a minor role in the American health care system until the 20th century. In 1873 there were only 178 non-governmental hospitals; by 1909 there were 4359. Even then, however, hospitals were still primarily places for the poor. Anyone who could afford it was cared for -- even operated on -- at home. By the 1920's surgery had moved into hospitals, but 44% of American babies were still delivered at home in 1940. Internists were even slower than the obstetricians. Not until the discovery of a panoply of "wonder drugs" and invention of a variety of highly technical diagnostic and treatment techniques did departments of internal medicine become the

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key components of every hospital they are today.

The magnitude of the change in hospitals -- from havens for the poor to social necessity for all -- is reflected in the following figures. Between 1936 and 1973, the number of hospital admissions per thousand population rose from 61 to 145. One American in ten is now admitted to a short-stay hospital at least once every year.

The place of in-patient hospital facilities in the American health care system is important to this Committee because half of all national health expenditures occur in this milieu. However, I have another, perhaps more important reason for emphasizing hospitals. They have become the nuclei for medical practice in many (if not most) communities.

Use of hospital ambulatory facilities for diagnosis and treatment has risen far more rapidly than inpatient admissions. Ambulatory visits now exceed admissions by 5 to 1. But since nearly 90% of all doctor-patient encounters still occur in doctors' offices, isn't this where the action really is? Yes, if one looks at volume instead of expenditure, the action <u>is</u> in doctor's offices. However, the gravitational pull of hospitals is having a pronounced affect on where these offices are located. Across the nation doctors' offices are clustering more and more around hospitals. Thus, although direct fiscal links between hospitals and doctors are infrequent, in a <u>functional</u> sense each hospital has become (or is rapidly becoming) a community health center.

This close association among doctors and hospitals is peculiar to the United States and Canada. In every other major nation, doctors are rigidly divided into an elite cadre of hospital-based

specialists, who are usually salaried, and a larger group of less specialized or primary physicians who care for ambulatory patients and are denied access to hospitals. In contrast, the American doctor without hospital privileges is an exception. In fact, the discovery that several thousand doctors in New York City had no hospital association was viewed as scandalous.

I come to the end of this first chain of causation in the evolution of our health care system with this point: the machinery for delivering personal health services to the American people may be divided roughly into 6000-plus clusters. Each of these consists of a relatively autonomous hospital and a constellation of doctors, most of whom are in private practice. It is a symbiotic relationship. The doctors are dependent on the hospital's diagnostic, treatment, domiciliary and (to a growing extent) educational facilities. The hospitals depend on the doctors to refer the patients who are the source of 95% of hospital revenues.

How did this symbiosis develop? Why don't we have the neat pyramid of health services that other nations such as Britain have: a broad base of primary physicians, a network of secondary hospitals, and a few tertiary hospitals at the apex? For the answer we must look to the other chains of causation.

II. Education of Physicians

After a promising start in the 18th century at Pennsylvania and Columbia, medical education in the United States went into a long century of decline. Over 400 schools -- most of them

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diploma mills -- bloomed and whithered during the 19th century. Doctoring fell to such a low estate that it was said medicine was the career for those who were too lazy to farm, too stupid for the law, and too immoral for the pulpit.

Opening of Johns Hopkins Hospital (1889) and Johns Hopkins Medical School (1893) marked the birth of a new era. Hopkins took all that was best in English and French medical education, which was based on clinical experience in hospitals, and combined it with all that was best in German medical education, which was based on research-oriented universities. The result was unique -- a medical school in which students were taught by clinician—scientists in a hospital. John Shaw Billings, the unsung genius who conceived Hopkins, never intended it to replace other medical schools, which he saw continuing to produce practitioners. To him, Hopkins was a unique school for future teachers and researchers.

A Kentucky schoolmaster named Abraham Flexner changed all that. His Report on the state of medical education in the United States was published in 1910 with the powerful backing of the AMA and the Carnegie Foundation. Hopkins was the only school which completely met Flexner's standards because he wrote the report under the influence of members of the Hopkins faculty who believed medicine was emerging as an exact science on par with physics and chemistry. Like Moses descending from Sinai, Flexner presented the Hopkins curriculum to the other schools. Those that did not accept it eventually closed their doors, and for the next sixty years American medical students marched in lockstep through a curriculum which had been exemplary in 1910.

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The other part of Flexner's credo was that this curriculum should be taught by full-time professors who were not distracted by practice. This took longer to achieve. There was not enough money to pay full-time faculty in most schools until the Congress poured federal funds into research from 1945 to 1965. This permitted the many schools that had been unable to achieve Flexner's dream of a full-time faculty to finally consummate it.

Unfortunately, by the time the last school fell into line the Flexnerian era was over -- a victim of its own success. Almost all the infectious diseases that blighted the nation in 1900 had been conquered by 1954. In that year the death rate suddenly stopped falling and we entered a new era. Now the chief banes of the nation's health are emotional, environmental and genetic in origin. But the pattern first cut at Hopkins had been set. Scientific medicine was too complex for a single mind to encompass, so doctors divided into two dozen specialties. Scientific medicine, taught on hospital wards full of patients with florid diseases, beguiled students into specialty practice, and general practice whithered and almost died. Scientific medical practice required modern hospital facilities, and two generations of superbly trained specialists brought this message to communities across the land which were eager to provide them with everything they needed.

Thus we can see how the first two chains of causation intertwined to produce the system we have today. Hospitals flourished and became centers of medical care because scientific practitioners

7.

post-Flexnerian
needed them, but/doctors became what they were largely because they were taught in hospitals where the main thrust was care of and research on acute diseases. The third chain, financing of health services, simply bound the first two more tightly together.

III. Financing Health Services

I will spend the least time on this topic because most of it is well known to the Committee.

Health insurance had flitted across the national stage since the early 1900's, but the Great Depression gave it a major role. The earliest plans covered hospital expenses for surgery, and, some years later, surgeons' fees. Over the years, benefits have been extended to cover most hospital expenses (although many still skimp on psychiatric coverage) and most doctors' fees for services rendered in the hospital. Only recently have benefits been available for ambulatory care -- and these are still far from comprehensive. Medicare and Medicaid perpetuated this undue emphasis on hospitalization. The reason is simple. Discrete services for acute conditions rendered in 6000 hospitals are far easier to monitor than comprehensive care rendered in 100,000 offices and clinics. But in their eagerness to control costs the accountants put the finishing touches on the system that had been developing for 200 years. Third-party payers dangled incentives to hospitalization before patients, doctors and hospital administrators that were impossible to resist. To do otherwise meant the patient paid out of pocket, the doctor had less certain fees, and the administrator staffed empty beds.

8.

Conclusion

The vast enterprise which some find so confusing that they call it a health care "non-system" evolved through a chance coming together of 18th century organizations, 19th century science and education, and 20th century finance. But evolution has not stopped. It is still going on as the nation experiments with new methods of delivering care, with new educational techniques, and new financing schemes. We have not come to a dead end Far from it.

The problems we face today resulted from the <u>successes</u> of our health care system, not its failures, and if it can continue its evolution I am confident that we can lick the problems of the present and prepare for those this nation will face in the 21st century. The three chains of causation have not come to an end. Knowing the directions they have taken in the past and the effects these changes have had, we should be able to extrapolate each chain into the future. With a knowledge of history, we can substitute a degree of rationality for mere happenstance as we move ahead.

Flexibility, innovation, evolution -- these are the keys to success. But let me close with this caveat. Every other nation that has adopted national health insurance has frozen its health care system at that particular moment in its development. No other nation has been able to use national health insurance as "a lever to move the earth." On the contrary, national health insurance has made change slower and more difficult. I respectfully suggest that this Committee should resist the temptation to think that one piece of

9.

legislation can revolutionize health care.

Americans are always tempted to tear down the old and rebuild from scratch, but the history of previous legislation to effect social changes shows that it is impossible to tear down social systems which have taken centuries to evolve. This is even more true when the hospitals of our health care system represent a $40 billion capital investment, a $50 billion annual budget and employ nearly 3 million poeple. Like it or not, we must build on what we have, not on airy flights of fancy.

The challenge to this Committee, as I see it, is to construct an insurance system that will remove all financial barriers to health care but will not raise barriers to the continuing evolution of our health care system.

Mr. Chairman, thank you for this opportunity to present my views. I wish the Committee good fortune in the task ahead.

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Mr. Chairman and members of the Subcommittee. I very much appreciate the invitation to participate in this panel discussion and am pleased to be able to do so.

National health insurance remains one of the most important, unresolved domestic issues that this Congress faces. In part the postponement of debate on a universal and comprehensive national health insurance program reflects the fact that other high priority matters have commanded the attention of the Legislative and Executive branches and of the American public. In part it reflects the complexity of the issues that surround the medical care sector and its financing. It is, therefore, most encouraging that you have decided to move forward with these sessions. All of us who are concerned with the inequities, inadequacies and costs of existing programs and who are convinced that action is required if all the American public is to receive its full money's worth for the over $100 billion spent in the health sector look forward to your deliberations.

In the interests of allowing a maximum opportunity for questions and answers, my prepared remarks are very brief. I have outlined a few major points that may help provide a framework for discussion of the goals and mechanisms of a national health insurance program.

1. The economics of the medical care sector is unlike that of other sectors. We are led astray if we apply the tools of conventional economic analysis: assumptions concerning the goal of profit maximization, assumptions concerning competition, consumer sovereignty, and so forth.

2.

The medical care system has developed patterns of behavior and of decision making, patterns of resource allocation and funding that set health care services apart from other economic activities. All economic sectors have their own special characteristics, but the health sector is more "special" than others. Perhaps the most critical element of difference is that the key decision maker in the medical care drama is the producer (physician); not the consumer (patient). To focus on patient decisions is to misdirect our attention. Patients do not enter or leave a hospital, do not buy drugs, order tests, or elect surgery except as physicians decide for them that they shall consume these goods or services. While only 21 percent of the $90 billion spent for personal health care is accounted for by physicians' services, the physician "controls" the level of expenditure for other major parts of the health care sector (e.g., the $41 billion for hospital care). It is the physician who, in large measure, decides what and how much care shall be consumed. Financing programs that are designed to affect consumer behavior (say, via cost-sharing mechanisms) miss the essential point: it is producer behavior that is at issue. It is the physician, not the patient, who is making the critical and costly consumption decisions.

2. It is a fallacy to imagine that physicians make decisions solely on the basis of "scientific" considerations. Many variables--including economic relationships--affect choices. Medical care services can be produced in different ways, utilizing various combinations of resources.

3.

The choices--which services, where offered, for whom--are not determined by medical science alone. They are affected by payment mechanisms, economic incentives and penalties, reimbursement formulae--by the nuts and bolts of insurance contracts, government regulations, etc. If public or insurance dollars are available to pay for certain services (e.g., hospital care) rather than for others (e.g., preventive care), the system will emphasize the former. Physicians and institutions respond to the availability of various resources and to the existing patterns of financial coverage. There is no "neutral" financing program. The issue of the range and scope of benefits, thus, becomes more than an issue of financial protection. It lies at the heart of the resource allocation problem. It affects the direction and costs of the system.

3. Historical developments have emphasized insurance protection for hospital expenses. This is fully understandable: these are the high price-tag items, and both patients and hospitals needed the financial protection. Nevertheless, it is a fundamental error to believe that all that hospital insurance did was: (1) to offer financial protection and (2) to permit some persons who required hospitalization to enter the marketplace and obtain these services. We also "force-fed" the hospital sector. We have paid, are paying and will continue to pay a high price as a result of our emphasis on hospital care. We must avoid the error of believing that the care we finance in the future and the way we finance it will not help shape system response. What you will give priority to in defining a national health insurance program

will determine the priorities of the system itself. That, for example, is the reason that many observers believe that that which is sometimes termed catastrophic health insurance would be just that: catastrophic.

4. Just as covering some services but not others has not been neutral to the "uncovered" elements of medical care, so the presence of third-party payment for some persons has not been neutral to those without it. Many Americans have no private insurance or coverage through public programs. Those without coverage tend to be the economically vulnerable: e.g., persons with marginal or irregular employment or with low incomes. These individuals face a medical care system whose behavior is influenced by the fact that others have insurance. It is not only that producers prefer to serve those for whom payment is guaranteed. It is also the case that those without protection enter a system whose price levels, standards and orientation have responded to the presence of insurance. Those without protection become doubly disadvantaged.

5. Insurance coverage meets many needs. For the producer of services it means a guarantee of payment. To patients and potential patients it means the sharing of financial risk and the opportunity to budget. The former point (risk sharing) is self-evident. The latter point, however, has a special, dynamic consequence. Because of the desire for budgeting, consumers will attempt to insure themselves against extremely high deductibles. Thus, the attempt to erect significant cost barriers in order to bring economic "discipline" to decision making

will fail as those who have the economic resources to purchase insurance to cover the deductible will do so. In turn, we would reenter the world of inequity--the world in which some have and others lack protection, the world in which some utilize preventive care services since "they are already paid for" while others postpone care hoping to avoid the dollar expenditure.

6. The historical development of third-party payment mechanisms has not stressed the achievement of equity or the translation of the concept of access to medical care into operational reality. While, today, there seems to be significant agreement that the utilization of medical care services should not depend on an individual's income, there is still disagreement on specifics and on mechanisms to assure this right: shall a program be universal, shall it cover all services, shall it provide first-dollar coverage? In considering alternative operational answers to these questions, we must remember to assess the administrative costs associated with "refinements." The less comprehensive the range of covered services, the less complete the dollar protection, the less universal the program, the greater the burden of administrative costs. Nor do such mechanisms reduce total costs. We are already spending over $100 billion in the health field. The issue is how to share these costs--not whether we "can afford" national health insurance. If payment for care comes out of many sources--out of pocket as well as insurance--we do not lower the total costs of health care, but we do increase the total costs of administration. The goal of equity and of

6.

low administrative costs is best achieved by departing from the fragmented and categorical approaches of earlier days, approaches which have contributed to our present difficulties.

7. The financing and provision of medical care is "organized" in a highly fragmented manner: out-of-pocket direct payments, private insurance, social insurance (Medicare), public payment for costs of services (Medicaid), public provision of services (V.A.). Different patterns apply to various individuals who must be sorted into the "appropriate" program by a host of variables such as age, employment status, income, medical condition. This fragmented approach is superimposed on fragmentation in regard to which services are covered and to what degree. The system's energies and priorities cannot be redirected, given the existing complex patterns of finance. In a sense, the system is both inequitable and out of control, and present economic arrangements underwrite and validate the explosive situation. One key difficulty is that the medical care system does not face an effective budget constraint that would lead to a considered allocation of scarce resources on the basis of potential benefits and consumer preferences. The medical care system does not face the discipline imposed by competitive market forces or the discipline of planning. A program that provides for equitable access can be structured to provide for effective control of expenditures. Without such structure, we will continue to watch medical care costs escalate.

Each of these points and others could be elaborated upon. These limited remarks, therefore, do not represent a complete discussion of the issues involved in national health insurance. Nevertheless, in order for my colleagues on this panel to present their views, I must conclude my remarks. Let me briefly summarize the issues that I have mentioned:

1. The key to system performance and system orientation is the physician.

2. The physician is heavily influenced by existing financing arrangements and their characteristics.

3. These arrangements have stressed payment for hospital services and have worked to the detriment of other modalities of care.

4. They have also worked to the detriment of those who do not have third-party protection.

5. The fragmented nature of third-party payment systems has reenforced inequity, inhibited system reform and prevented effective cost control.

The complex nature of the health care economy has made action on national health insurance difficult. It has also made it necessary. None of us underestimates the problems that you face. We are equally certain that you do not underestimate the problems that the public faces.

PANEL ON NATIONAL HEALTH INSURANCE

SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

JULY 10, 1975

Prepared Statement of U.E. Reinhardt, Associate Professor of Economics and Public Affairs, Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, N.J.

Mr. Chairman:

It is a privilege and a pleasure to join with you, the members of your Committee, and this panel in a discussion of issues surrounding the introduction of national health insurance in the United States. By its very nature, such a system will alter the financial flows accompanying the delivery of health services and thereby the economic incentives and constraints confronting the consumers and the providers of health services. One need not be a card-carrying economist to appreciate the fact that these financial factors tend to influence the performance of the health-care system significantly. The designers of the nation's future health insurance system therefore have the opportunity to do much good -- or to do much harm.

You and your Committee are to be commended for your decicion to precede legislative action on this issue with a series of relatively unstructured roundtable discussions. I trust that my colleagues on the panel join me in the hope that we, as perennial students of the health system, may be able to provide you with useful perspectives on the American health-care system. I am certain that, as a faculty member in a school of

public affairs, I shall benefit personally from participating in your deliberations.

A number of distinct objectives could be posed for a national health insurance system, namely:

Objective 1: The system is to be designed as a bona fide insurance scheme introduced to protect individuals from catastrophic financial losses associated with illness.

Objective 2: The system is to be designed as a redistributive mechanism that channels purchasing power for health services from middle and upper income families to lower income families and, in so doing, redistributes available or projected health services in like manner.

Objective 3: The system is to be designed as a set of financial and administrative levers through which the public sector can reshape the organization of health-care production and delivery.

These objectives may be posed singly or jointly. The point to note is that, even if all three objectives were proposed side by side, different commentators would give them different relative weights individually. Implicit in each particular weighting of the objectives would be a particular set of views of what is right and what is wrong with the current health-care delivery and health insurance systems. Such views are, unfortunately, rather subjective. The collection of experts invited to discourse with you on this topic is therefore likely to leave you with a sense of unresolved controversy.

OBJECTIVE 1 AND ITS UNDERLYING ASSUMPTIONS ABOUT THE U.S. HEALTH SYSTEM

Those who stress objective 1, perhaps to the exclusion of the other

two, appear to assume either that the current health delivery system is not in need of a reorganization or, if it is, that such a reorganization cannot or should not be effected through a health insurance system. By posing the objective, however, one does assert that the current health insurance system in this country -- the mosaic of private and public insurance schemes -- has failed large segments of society. Why else, one may ask, would the nation need to introduce a publicly sponsored, bona fide health insurance system in the first place?

Failure of the existing health insurance system to serve society well can be traced to at least two prime causes. First, one would expect that many low-income families would find it impossible to finance the premiums for adequate health insurance coverage, even if these premiums were actuarially fair (that is, were on average as high as the average outlay insurance companies would have to make for such families). This aspect of the problem cannot fairly be laid to the doorstep of the nation's insurance industry. It is a problem that has its root cause in the nation's overall income distribution. The proper remedy clearly lies in altering that income distribution, either through a negative-income tax scheme, or at least through public subsidies toward the health insurance premiums of low-income families.

A second source of inadequate health insurance coverage, however, can be more properly traced to the insurance industry itself. A useful exercise for this Committee might be to go through a typical health insurance policy of the sort now being marketed, to imagine a variety of

different illness scenarios, and to infer from the policy, without expert advice, precisely what the extent of coverage is for the various hypothesized illness episodes. One suspects that the Committee would find this an excruciating task, as does the typical American citizen. The health-insurance industry will undoubtedly argue that the many riders, exclusions and provisos embroidering its policies are designed to accommodate a desire for efficiency. It can be argued, however, that whatever efficiency is so purchased is likely to be purchased at an inordinate price.

First, there is the real possibility that many Americans ultimately purchase inappropriate insurance coverage on the basis of mistaken impressions. The fact that many Americans purchase first-dollar coverage at premiums quite out of proportion with the maximum loss exposure they actually face* is consistent with that hypothesis. One suspects that persons making these insurance acquisitions seek to protect themselves against much higher imagined risks, an impression that is likely to have been fostered by the complexity of their health-insurance policies.

An added price is paid for this complexity, namely, the uncertainty it creates in the mind of consumers. Standard economic theory and empirical research suggests that uncertainty usually creates disutility (unhappiness) among individuals. Indeed, to eliminate the uncertainty

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*I am referring here to the much cited instance in which faculty members at the University of Pennsylvania bought first-dollar coverage for very low maximum risk exposure -- an instance often cited to demonstrate a strain of irrationality even among the educated. My argument is, pure and simple, that ignorance rather than irrationality explains the incident.

surrounding health-insurance coverage some observers have advocated an insurance system without any co-payment whatsoever on the part of the consumer, fully recognizing that so generous a policy may induce some unwarranted increases in health-care consumption.

WHATEVER CONGRESS, AFTER ITS DELIBERATIONS, DECIDES TO LEGISLATE IN THE AREA OF HEALTH INSURANCE, IT IS TO BE HOPED THAT IT WILL PRESENT AMERICANS WITH HEALTH INSURANCE OPTIONS (POLICIES) THAT ARE READILY UNDERSTOOD BY THE AVERAGE PERSON, EVEN IF SUCH AN APPROACH INVOLVES SOME INEFFICIENCY AT THE MARGIN.

Those who view objective 1 as the prime goal of a national health insurance system generally favor a system of deductibles and coinsurance borne by the consumer of health services at the time of consumption. Advocacy of cost sharing rests on the supposition that the demand for many types of health services is "price elastic," that is, sensitive to the out-of-pocket expenses consumers pay at the point of consumption. By forcing consumers to participate directly in the cost of health services, one hopes to reduce what the insurance industry refers to as "moral hazard" and is interpreted to be "unwarranted consumption of insured services," with the accent on unwarranted.

This is not an occasion to launch at length into that controversial subject matter. (See, however, a paper entitled "On the Benefit Structure of National Health Insurance," left with the Committee's staff.) Several pertinent observations may nevertheless be offered.

First, the objectives being pursued with cost-sharing are not likely to be reached if only a narrow stratum of the population

(presumably lower-income families) are effectively exposed to cost sharing, while upper- and middle-income families, and particularly members of trade unions, have first-dollar coverage. To eliminate this possibility, Congress might toy with the idea of prohibiting first-dollar coverage altogether, although one doubts that such a stricture could be legislated over the objection of interested parties. An alternative would be to alter the tax laws so that all insurance premiums paid by a household (or paid by employers on behalf of the household) must come out of after-tax income. Interested parties (the insurance industry and labor unions) would be likely to object to such a change as well, but the measure might stand a chance of passage.

Second, a system of coinsurance and deductibles is likely to be worth its cost only if it can be relatively easily administered.

Third, as already mentioned, a system of coinsurance and deductibles is likely to generate considerable psychic costs of uncertainty unless that system is easily understood by consumers and the latter can easily infer the maximum risk to which they are exposed.

A few observations may be in order on the putative assertion that there is nothing serious amiss in the American health-care delivery system. As will be seen further on, the catalogue of frequently voiced complaints against the present system is long and varied. On closer examination, many of these complaints involve value judgments or differences in the interpretation of available evidence. This being so, some observers of the American health system have sought to reject the recurrent criticism of that system out of hand by insisting that ours is

"the finest health-care system in the world." (One must, of course, observe immediately that even the "finest health-care system in the world" may still be able to accommodate improvements, and that it is certainly within the domain of public policy to speed whatever improvements seem feasible.)

Many of the system's ardent defenders are the parties who have a vested stake in alleging a superior track record. Their statements ought therefore to be taken with the appropriate grains of salt, as everyone in this room surely knows. There may, however, be something to the point that Americans have been far too swift in humbling themselves before the rest of the world -- that other nations that have gone down many of the allegedly remedial avenues now being proposed in this country have failed to compile a health-status record even as good as ours. An interesting case in point is the health system of West Germany. (A paper describing that system has been left with the Committee's staff.) Residents of that nation have for many decades enjoyed virtually universal, comprehensive health-insurance coverage without any cost-sharing on the part of the insured. By and large, that nation's health-care delivery system is similar to ours, although hospital-based physicians are salaried and private physicians have no hospitalized patients. Remarkably, West Germany fares considerably worse on such widely used health status indicators as infant mortality rates and maternal death rates. (See the tables appended hereto.) Indeed, on the latter statistic the West German average is roughly equal to the shockingly high ratio reserved for the non-white community in this country.

The point of the preceding paragraph is not to assert that the West German health system has failed society or to imply that no improvements are feasible in our system. The point has simply been to raise the caveat that health services are not the only input into the production of a nation's health status, and that the introduction of health-insurance coverage in this country, a redistribution of access to health services, and even a drastic reorganization of the American health-care delivery system may or may not trigger marked improvements in those indicators of health status on which Americans have so long condemned themselves, or generate many of the benefits expected from these changes.

OBJECTIVE 2 AND ITS UNDERLYING ASSUMPTIONS

An alternative, single motive for the introduction of national health insurance might be simply to place into the hands of low-income families the financial wherewithal to purchase adequate health services and to redistribute the overall costs of illness in the nation from those afflicted with illness to those blessed by good health. A compulsory, universal and comprehensive health-insurance system with premiums that are unrelated to the risk represented by insured individuals would accomplish that objective. (A sufficiently generous income redistribution system, such as a negative income tax, might be designed to achieve that objective as well. The fear here might be that the poor would not necessarily spend these transfer payments on health services in the manner intended by policymakers.)

Strictly speaking, one could view this objective as the most important mandate for national health insurance and still adhere to the supposition that there is nothing inherently wrong with the organization of the nation's health-care delivery system as such. One could even believe that the nation's existing health insurance industry has a spotless record. (A private health insurance industry would, of course, naturally tend to categorize individuals by actuarial risk class and set premia accordingly.) With some necessary oversimplification, the Canadian and West German health-insurance systems can be said to have been erected on primarily these notions. These systems are not bona fide insurance systems, nor do they seek to intervene purposefully into the organization of health-care delivery.

Implicit in the proposition of objective 2 is the assumption that lack of ability to pay for health services serves as an important barrier to adequate health care. That assumption in turn implies that one holds the demand for many types of health services to be price-elastic (sensitive to the out-of-pocket expenses consumers pay at point of consumption). Adherents to objective 2 part ways with the pure-insurancce school (those favoring objective 1) on the policy implications they derive from the putative high price-elasticity. Adherents to the pure-insurance school see in high price-elasticity the rationale for co-insurance and deductibles. Adherents to objective 2 typically reject cost-sharing on the part of patients, presumably because they deem the consumption of truly unnecessary health services to be a trivial problem

and do not wish to see coinsurance deter consumers from using needed health services. Precisely what health services are "necessary" or "unnecessary" is, unfortunately, a question on which the experts invited to this Committee are unlikely to agree.

In connection with the issue of coinsurance it may be observed that some opponents to cost-sharing appear to rest their case on mutually inconsistent assumptions. Thus, on the one hand they reject cost sharing on the ground that financial barriers (however small) may deter some consumers from seeking needed health care. On the other hand, they suggest that the demand for health services is typically quite insensitive to out-of-pocket expenses in the first place, and that cost-sharing can at best yield only marginal savings in health-care utilization. It is difficult to reconcile these assumptions, unless one is willing to accept the argument that those very few services the demand for which is price-sensitive also tend to be much "needed" services. Since the question of coinsurance is likely to come up time and again before this Committee, members may wish to inquire from opponents of cost-sharing on what set of assumptions they rest their case.

OBJECTIVE 3 AND ITS UNDERLYING ASSUMPTION

Those who would like to see the nation's health-insurance system evolve into an insurance-plus-redistributive scheme rather than a pure insurance scheme typically feel that merely granting the lower-income strata financial access to health services may not be sufficient if

health-care provider facilities fail to locate in the areas where such families concentrate (e.g., urban centers or the rural hinterland). Thus one finds demands for a redistribution of purchasing power commonly accompanied by demands for a reorganization of the health-care delivery system. These demands are based on the popular conception that our existing system is in a perennial state of crisis and certainly incapable of accommodating the additional demands likely to be placed upon it through the introduction of health insurance. While a mere expansion of the existing system along traditional lines might be an expedient solution, the shortcomings of the existing system are held to be sufficiently serious to rule out so simple a policy response. National health insurance is thus seen both as a source of potential problems on the delivery side and as a vehicle through which these problems can be solved.

As noted earlier, the catalogue of commonly stated grievances about the existing American health system is long and varied. However, with some simplification the misgivings that have at one time or another been voiced in this respect can be distilled into the following summary:

1. It is held that the existing provider system, composed as it is of several hundred thousand more or less independent decision-makers ("firms"), is really a "non-system" that lacks effective planning and coordination. This lack of coordination is said to have resulted in

   -- widespread duplication of costly facilities, equipment, and patient record systems, and hence unnecessarily high costs of health care;

   -- a maldistribution of medical resources, with a relative abundance of facilities in affluent urban areas

and a corresponding lack of facilities in the poorer urban or rural areas; and

-- lack of comprehensiveness and continuity of care.

2. It is held that current legal restrictions on medical practice, and in particular current licensure laws covering both medical and paramedical manpower, tend to

   -- discourage experimentation with the use of paramedical personnel (physician assistants, nurses, medical technicians) for tasks now requiring scarce and expensive physician time; and

   -- discourage entry of labor into the health-care sector since current licensure laws effectively rule out the prospect of upward mobility in the health-manpower hierarchy.

   While it is conceded that licensure laws do protect the consumer from unqualified personnel, it is felt that this benefit is not sufficient to offset their stifling effect on cost-reducing innovations in the organization of medical-care delivery.

3. It is suggested that the financial arrangements currently accompanying the delivery of health services, i.e., the emphasis on payment (fee or charge) -per-service, combined with the fact that the consumers are typically more fully issured for inpatient than for outpatient care tends to

   -- deter consumers not covered by third-party payment from seeking relatively inexpensive preventive care in the early stages of a medical condition, thus necessitating more expensive therapeutic care later on;

   -- encourage consumers (and their physicians) to substitute costly (but insured) hospital services for less costly (but uninsured) ambulatory care;

   -- bar some consumers (the lower-middle class) from access to needed care altogether; and

   -- encourage providers to overprescribe or oversupply health services to those consumers who can afford to purchase medical care.

4. With respect to the hospital sector in particular, it is held that the prevalent full-cost reimbursement formula,

combined with the fact that a hospital's prestige increases to some extent with the complexity of cases it can handle tends to encourage the acquisition of costly facilities and equipment that are not fully used.

In addition, it is sometimes argued that the pervasive control by the medical profession over almost all facets of the health-care delivery process -- e.g. the physician's voice in the management of hospitals -- has tended to make the health system more responsive to the intellectual interests of the profession than to the medical needs of consumers. This allegation is sometimes accompanied by the argument that, by virtue of their training, physicians are ill-equipped to manage properly so complex a system as the United States health-care sector and that a restructured delivery system should provide for expanded lay control over the allocation of medical resources.

It will have been noticed that the criticisms enumerated above tend to fall into two major categories: those concerned primarily with the quality of the health care received by the American people as a whole, and those concerned with the efficiency (or costs) with which that care is being produced. In other words, almost all proposals for a restructuring of the American health-care delivery system seek to accomplish improvements along either or both of these dimensions. As an economist I feel poorly equipped to address myself to the problem of quality. The following remarks will therefore be confined to questions related to the economic efficiency of the health-care delivery system.

In thinking about ways to reorganize the health-care delivery system it is convenient to divide that system somewhat arbitrarily

into two distinct (though much related) components, namely:

A. The technology of health-care production and delivery (by which is meant the organization of medical resources within health-care provider facilities, the distribution of available resources among facilities, and the geographic distribution of provider facilities); and

B. The financial flows accompanying the delivery of health services from providers to consumers.

Proposals for a reorganization of the technology of health-care production generally seek to bring about one or a combination of the following four changes:

1. The consolidation of small, independent provider facilities into larger units, with the aim of reaping potential economies of scale in health-care production.

2. The substitution of relatively more abundant and/or less costly productive factors for relatively scarcer and/or more costly inputs.

3. Increased division of labor and specialization of functions among some types of facilities (especially in the hospital sector) and the integration of specialized units into a coordinated, comprehensive, and efficient delivery system through either full-fledged regional planning or at least the more centralized control inherent in the HMO concept.

4. A significant redistribution of physician manpower among medical specialties (away from specialist services to primary care) and among geographic regions (away from the suburbs of metropolitan areas and toward low-income centers and rural areas.

In some societies, such changes could be attempted simply through regulatory edicts. At one time or another, proposals to resort to direct regulation of health-care providers have come forth in this country as well.

Once again, in a statement of this sort there is not room for an extended discussion of the merits and demerits of direct regulation of the health-care sector. (See, however, the Institute of Medicine's Controls on Health Care, 1975.) One is, however, not encouraged by the long-run performance of direct regulation in other areas of the nation's economic activities. The impact of public regulation on the nation's transportation industry certainly should give policymakers pause. It seems more in keeping with the American temperament to influence the provider system through manipulation of the financial flows accompanying the delivery of health services.

The financial flows accompanying the delivery of health services furnish an important nexus between a national health-insurance system and the nation's health-care delivery system. Since the insurance mechanism interposes a third party between the providers and the consumers of health services, that financial mechanism can clearly be so designed as to influence both parties -- in particular, to influence the manner in which the production of health services is organized. A rather bold attempt to use the insurance mechanism in this way was incorporated in an early version of the Kennedy-Griffith bill which would have provided for a massive shift away from the traditional fee-for-service reimbursement of physicians (and full-cost reimbursement of hospitals) towards prepayment to providers (HMO's) in return for a promise to deliver comprehensive care when and where needed. The theory was that health-care providers who operate under a prepayment formula have every

incentive to prescribe the most efficient bundle of health services capable of treating a given medical condition and to produce whatever services are prescribed in as efficient (least-cost) manner as possible. Whether a nationwide system of health-maintenance organizations would actually service these goals is as yet an open question inviting sustained empirical analysis. A priori it can be argued that if an HMO is permitted to package one year's costs into the next year's capitation premium, the incentive to minimize the cost of health maintenance may be considerably blunted. How acceptable the prepayment regime will ultimately be to the typical American physician and patient also remains an open empirical question.

Whatever the merits and demerits of the HMO concept will ultimately turn out to be, as a practical matter the designers of the nation's health insurance system ought probably to be prepared to work primarily with the traditional fee-for-service system. Such a system was incorporated into the Canadian health insurance program and it has also now been widely adopted in West Germany, after decades of experimentation with capitation payments.* There is every reason to believe that it will predominate in the United States for decades to come.

The question policymakers must resolve at the outset is whether the determination of the fee schedules to be used under national health

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*Actually, the reimbursement scheme adopted in West Germany resembles what would be known in the United States as a "medical foundation" with each foundation covering one entire state. In this connection, see the attached paper on the West German health system.

insurance are to be left to the good offices of physicians individually and collectively -- as is the case where physicians are reimbursed on the basis of "customary local fees" -- or whether these fee schedules are to be subject to strong public control. If the former approach is adopted, as might well be the case in the United States, policymakers willingly forego a potentially powerful lever through which the delivery system can be influenced. If the latter approach is used, policymakers ought to explore ways in which that fee schedule can be developed to serve society's interests.

Without dwelling at length on the potential role of fee schedules in a national health insurance system, it may be worth mentioning at least two concrete ways in which these schedules could be used to reshape the health-care delivery system.

First, under a national health insurance system it may be possible to introduce interregional differences in the absolute level of fees with the objective of encouraging a redistribution of medical manpower towards currently under-doctored areas. Relative to the customary local fees now paid under Part B of Medicare, the new fee schedules should enhance hourly physician remuneration in low-income urban centers and rural areas and depress it in areas traditionally preferred by physicians. Lest it be argued that such a policy would not be administratively

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*Besides, they would give health-care providers fairly free access to the public treasury.

**For a more extended discussion on this topic, see "Alternative Reimbursement Schemes for Non-Institutional Providers of Health Care," a paper left with the staff of the Committee.

feasible, it may be noted that medical fees in West Germany, for example, are calibrated toward precisely this objective. The degree of success attained under the West German system merits further investigation.

A second objective that might be pursued with officially administered fee schedules relates to the issue of health-manpower substitution. Current policies are to encourage the substitution of paramedical personnel (physician extenders and allied health manpower) for the time of physicians in the production of health services. Toward that objective, the public sector has subsidized the training of increased numbers of physician substitutes without, however, providing physicians with strong incentives to engage in the desired health-manpower substitution. Bluntly put, upward flexibility of medical fees has enabled even physicians who make wasteful use of their time to earn attractive incomes. Why such physicians would engage in more extensive task delegation is certainly not obvious.

Under a national health insurance system, attempts could be made to set the relative fees for particular medical services so as to provide physicians with strong financial incentives toward more extensive task delegation. More specifically, fees for services whose production could safely be delegated predominantly to lower skilled (and less expensive) manpower should be set in the fee schedule on the assumption that they are so delegated in every instance. Clearly, under such a schedule a physician who performed a delegatible service himself would effectively price out his own time at the imputed wages of a physician assistant. One suspects that, over time, such a fee schedule would

tend to encourage physicians towards greater efficiency in the use of their own time. It would clearly also serve to reduce the overall transfer of income that society at large has to make to the medical-care sector in return for the receipt of medical services. (For a more extended discussion on the potential role of fee schedules in a national health insurance system, see "Alternative Reimbursement Schemes for Non-Institutional Providers of Health Care," a paper left with the Committee's staff.)

CONCLUDING REMARKS

Since this is the first in a series of panel discussions on the issues surrounding national health insurance in this country, the objective of this statement has been to offer one potentially useful framework within which these issues can be discussed in orderly fashion. The objective has decidedly not been to furnish the Committee with a blueprint for an "optimal" national health insurance system. A plethora of such proposals already exists. At the very most, the author of this statement would be prepared to recommend a few quite general guidelines for the design of a health insurance system. These recommendations are:

1. WHATEVER THE PARTICULAR FORM OF NATIONAL HEALTH INSURANCE MAY BE, CONGRESS SHOULD OFFER THE AMERICAN PUBLIC AT LEAST ONE COMPREHENSIVE HEALTH INSURANCE POLICY WHOSE PROVISIONS ARE EASILY UNDERSTOOD BY THE AVERAGE AMERICAN AND WHOSE LANGUAGE REMOVES ANY UNCERTAINTY CONCERNING THE MAXIMUM FINANCIAL RISK TO WHICH THE INSURED IS EXPOSED. CONGRESS

MAY EITHER MANDATE THAT EACH PRIVATE INSURANCE COMPANY OFFER SUCH A POLICY, OR FACILITATE THE PUBLIC PROVISION OF SUCH POLICIES, PERHAPS IN COMPETITION WITH THE PRIVATE SECTOR. WHATEVER THE CASE MAY BE, A MINIMUM GOAL FOR NATIONAL HEALTH INSURANCE SHOULD SURELY BE TO FREE AMERICAN CITIZENS FROM UNNECESSARY ANXIETY.

2. IT IS IMPORTANT THAT, AT THE OUTSET, THE PUBLIC SECTOR (OR ITS INTERMEDIARIES) GAIN EFFECTIVE CONTROL OVER THE DETERMINATION OF THE FEE SCHEDULES ON WHICH NON-INSTITUTIONAL PROVIDERS OF HEALTH CARE ARE REIMBURSED UNDER NATIONAL HEALTH INSURANCE. FAILURE TO GAIN CONTROL OVER THESE FEE SCHEDULES WOULD MEAN FOREGOING ONE OF THE MORE IMPORTANT FISCAL LEVERS POLICYMAKERS CAN HAVE OVER THE ORGANIZATION OF HEALTH-CARE DELIVERY.

3. CONGRESS SHOULD SHY AWAY FROM ATTEMPTS TO COUPLE WITH NATIONAL HEALTH INSURANCE BOLD ATTEMPTS TO INTRODUCE <u>DIRECT REGULATORY CONTROL OVER THE HEALTH-CARE DELIVERY SYSTEM</u>. THIS RECOMMENDATION IS BASED NOT ONLY ON THE LACK OF A GOOD PERFORMANCE RECORD OF PUBLIC REGULATION ELSEWHERE. MORE IMPORTANT IS THE FACT THAT THE ULTIMATE IMPACT OF MANY OF THE ORGANIZATIONAL CHANGES NOW BEING PROPOSED IS ILL UNDERSTOOD AT THIS TIME. NO SOCIAL SCIENTIST WITH INTEGRITY COULD, FOR EXAMPLE, ASSERT AT THIS TIME THAT GROUP MEDICAL PRACTICE IS UNAMBIGUOUSLY SUPERIOR TO FEE-FOR-SERVICE REIMBURSEMENT, THAT SALARIED PHYSICIANS PRACTICE MEDICINE SUPERIOR TO THAT OF FEE-FOR-SERVICE PRACTITIONERS, OR THAT HEALTH-MANPOWER SUBSTITUTION WILL ULTIMATELY REDUCE THE COST OF HEALTH SERVICES IN THIS COUNTRY. UNTIL MORE IS KNOWN ABOUT THESE ISSUES, IT IS PROBLALY BEST TO DEFER DRASTIC CHANGES OF THIS SORT AND TO DESIGN THIS NATION'S FUTURE HEALTH INSURANCE SYSTEM PRIMARILY TOWARDS OBJECTIVES 1 AND 2 LISTED EARLIER.

4. IN DESIGNING A NATIONAL HEALTH INSURANCE PROGRAM, POLICY-MAKERS SHOULD SEARCH THE EXPERIENCES OF OTHER NATIONS FOR POTENTIAL LESSONS. IT IS SURPRISING, INDEED, THAT IN RECENT DEBATES OVER NATIONAL HEALTH INSURANCE THE HIGHLY RELEVANT EXPERIENCES OF CANADA, FRANCE AND WEST GERMANY ARE HARDLY EVER REFERENCED. THESE COUNTRIES NOW OPERATE NATIONAL HEALTH INSURANCE SYSTEMS NOT UNLIKE THOSE MOST COMPATIBLE WITH THE AMERICAN SETTING. FURTHERMORE THESE COUNTRIES HAVE IMPLEMENTED A GOOD MANY OF THE CHANGES NOW PROPOSED AS PANACEAS FOR THE SHORTCOMINGS OF THE AMERICAN SYSTEM. IN SOME INSTANCES THESE CHANGES HAVE YIELDED EXPECTED IMPROVEMENTS; IN OTHERS, THERE WERE UNEXPECTED AND OFTEN UNDESIRABLE SIDE EFFECTS. IN ADDITION TO THE HEALTH SERVICES RESEARCH NOW UNDERWAY ON ASPECTS OF THIS COUNTRY'S HEALTH SYSTEM, MUCH CAN PROBABLY BE LEARNED FROM CROSS-NATIONAL COMPARISONS.

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