Thank you for responding to these serious issues.

Sincerely,

CURT WELDON,
Member of Congress.

WHAT WILL HAPPEN TO HEALTH CARE REFORM?

The SPEAKER pro tempore (Mr. TAYLOR of North Carolina). Under a previous order of the House, the gentleman from Washington [Mr. MCDERMOTT] is recognized for 60 minutes.

Mr. MCDERMOTT. Mr. Speaker, 3 years ago President Clinton announced that he wanted to provide Americans with health insurance that can never be taken away. The congressional leadership has publicly bragged, in both bodies, that they killed health care reform. My concern tonight is, what is their alternative? Now, we have in the Senate presently, the other body, a bill languishing, the Kennedy-Kassebaum bill, that gives minimal protection, and yet not even that bill can get out of the other body, so the question is, what is going to happen? It seems to me that the history of this issue needs to be reviewed.

As you may know, it was a mere 150 years ago that the first surgery was done under anesthesia at the Harvard School of Medicine. Perhaps that is a good place to begin this examination of where we have been in health care and where we are going.

Many in my generation retain a deeply etched image of a painting depicting a physician sitting beside the bed of a small child while the parents huddled pitifully in the background. The title of the painting is something like ''Waiting for the Crisis''.

Physicians 100 years ago could do very little beyond setting fractures, amputating, and administering a variety of empirically tested concoctions.

Physicians were among the most broadly educated in the society and, as such, they were highly respected and expected to participate fully in the civic life of the society.

Even earlier, one of the most prominent physicians in the American Colonies was Benjamin Rush; as a Member of the Continental Congress, Dr. Rush signed the Declaration of Independence.

Eventually, he was defeated for reelection, but he spent the remainder of his professional career improving the lot of prisoners and the mentally ill in Pennsylvania. That was the last time a psychiatrist served in the Congress before I arrived in 1989.

Maybe some of you see a moral therein.

Advances in the diagnosis and treatment of disease between 1846 and 1946 were painfully slow. Services were rendered to patients by individual physicians who were paid on a fee-for-service basis.

Health insurance was a rare commodity, and thousands of people simply did without the treatment that was available because they could not pay for it. Others paid what they could when they could.

There was no expectation of a societal response to the need for universal health coverage.

I am speaking only of the United States here because you must remember that, in 1883, Otto von Bismark instituted government-sponsored health care for German miners as a preemptive strike to halt the spread of socialism.

The 1930's were, of course, a time of great turmoil in this country and, during that period, President Franklin Roosevelt proposed a system of universal health coverage for all Americans.

He did so at the same time that he was proposing Social Security, and the political weight of the two programs proved too great.

So he decided to separate the two proposals and to wait until the next Congress to complete his health care proposal. Unfortunately, the Second World War interfered with his plan.

Meanwhile, in typical American fashion, the American people were beginning to develop their own responses to the lack of affordable care.

For example, the Kaiser construction company was building dams in rural Washington State. Mr. Kaiser recognized the need to make doctors and hospitals available to his employees who were working at dangerous jobs in isolated areas.

Thus were planted the seeds of prepaid health insurance.

And during the war, more and more employers, eager to maintain a healthy and reliable workforce, began to offer health coverage.

At the end of the war, a wage and price freeze was imposed on the American economy.

But smart and thoughtful labor leaders found a way around this constriction on wages by inventing a concept called a benefit package, which was primarily a health insurance program to pay for doctor visits and hospitalizations.

Nonunion companies suddenly realized that if they did not also provide a benefit package for their employees, they soon would have union organizers working the floors of their plants and offices. So, they, too, provided a benefit package.

Emerging around the same time as employment-based health insurance, the prepaid coverage seeds sown by Kaiser were sprouting among groups of citizens who believed that only collectively could the costs of health care be met and contained.

In Seattle, a group of teachers and a few doctors began Group Health Cooperative of Puget Sound.

Group health was considered worse-than-radical; it was socialism, and the healthcare establishment repudiated it totally.

Because the doctors of group health rejected the concept of fee-for-service payment, they were denied membership in the Washington State Medical Association.

A lawsuit that eventually ended up before the State supreme court was necessary to force the association to admit group health practitioners.

At the same time, a similar group care program evolved in New York.

As it entered the post-war era, then, the United States was pursuing two major approaches to health care delivery and financing.

One system, financed by employers, offered no guarantee of continued coverage either during employment or certainly after leaving employment. Only union contracts in certain cases guaranteed coverage during employment.

Nonunion employees had no protection whatsoever.

The other system of delivery and financing was an adaptation of the cooperative movement that emphasized control by the recipients of the system's services.

Keep in mind that the insurance industry did not leap willingly into the mix and only reluctantly accepted the risk of insuring the health of individuals. They were hesitant, I expect, because they had no experience on which to base their rates.

It is against this historical backdrop of health care delivery and financing that we must view the medical developments of the postwar period. It was an era in which medical science and technology literally exploded. What is possible today was hardly conceivable to even the most imaginative scientist after the war.

Antibiotics revolutionized both infectious disease treatment and postoperative infections. Kidney dialysis laid the groundwork for transplant therapy. Noninvasive imagery such as CAT scans and MRI's made diagnosis more precise, and complicated surgeries more likely of success.

Bone marrow transplants and other cancer treatments made certain and speedy death from cancer less likely. Antipsychotic medications recast the treatment of the severest mental disorders.

When I walked into the ICU recently to visit my 90-year-old father, it struck me that nothing in that area of the hospital existed when I graduated from the University of Illinois Medical School in 1963. Only the human body remained essentially the same, except, of course, the hip and knee replacements and the cardiac bypass surgeries and the heart valves.

If you consider even briefly all of this rapid and turbulent change, you will appreciate the trepidation with which employers and the health insurance industry viewed the modern landscape of health care delivery and, especially, financing.

Health care delivery in this country has been conducted primarily by individual providers paid through a fee-for-service system.

As more treatment and procedures have been developed, the costs of care have risen exponentially.

Employers and insurers began to seek ways to provide coverage to employees while simultaneously controlling expenditures. Unfortunately, they sought cost controls in a system with no incentive whatsoever to limit expenditures. After all, the system suggested, if a treatment for a given condition is known, shouldn't everyone with the condition receive it?

To further complicate the mosaic which we call our health system—I would call it a nonsystem—in 1965, the Federal Government entered the scene to provide coverage to two groups not covered by the private sector because they are not employed.

The programs created to cover these two groups are Medicare and Medicaid.

They were designed to address the health needs of the elderly, the disabled, and poor women and children.

Neither the governmental nor the employer-based system had any agreed-upon definition of what constituted adequate care, or who should pay what portion of the bill for whom.

Thus, we have, in this country, a hopeless maze of health care delivery and payment schemes. The extent and quality of the health care you receive depends upon your age, where you live, for whom you work, the race or ethnic group to which you belong, and finally, your economic status.

The inconsistencies within our present system are truly mind-numbing, and the call for reform of both delivery and financing comes from all quarters.

As the cacophony of voices for reform began to rise, thoughtful minds examined other models of health care delivery and financing.

Because the cooperatives had been relatively successful in delivering good care at reasonable cost, they attracted the attention of those who, on the one hand, wanted to continue to provide health coverage to their employees but, on the other hand, worried increasingly about the costs of doing so.

Stories began to appear in the press, noting, for example, that the Chrysler Corp. was spending more on its payments to Blue Cross of Michigan than it was for the steel in its automobiles.

The cooperative model of health care delivery was very democratic; it gave a large role to its consumers both in defining the scope of benefits and in the selection of providers. The doctors were salaried and the organizations were run by executives responsible to a consumer board.

It was a functional structure, but one that did not correspond to the political views of most employers in this country.

Yet, another significant factor contributing to the present crisis in health care financing is the gradual globalizing of the economy.

The United States emerged from the war in 1945 as practically the only functioning, productive nation in the world.

But the World Bank, the International Monetary Fund, the Marshall plan, and countless other economic initiatives restored economic stability and prosperity to many countries.

As these nations regained strength, they became America's vigorous competitors. By 1980, the United States had lost its dominance of many spheres within the economic universe.

A widely held view insisted that production of competitively priced goods and services required curtailment of health care costs.

Plans fully paid by employers began to disappear. Deductibles, co-pays, and restrictions on the scope of services became commonplace as employers tried to control the costs of the health care benefits they offered.

Where labor and management once had squabbled only rarely over the costs of employee health benefits, they now saw these costs gradually becoming a source of ongoing friction and escalating conflict.

Today, reduction of existing health benefits is the single most common cause of strikes by American workers.

As the quest for cost control became more urgent employers began to scrutinize the activities of insurance companies.

In a booming economy, insurance companies took employers' premium payments, paid employees' claims, and paid dividends to stockholders.

They gave relatively little attention to cost control, in part because employers were not pressing for it, and in part because the insurers could simply overcome losses with the next year's inevitable rate hike.

But when the economy tightened, this traditional casual dismissal of cost controls no longer worked.

Multistate companies became exasperated with varying State legislative mandates and the inquiring eyes of State insurance commissioners; many began to opt for the self-insurance alternatives offered by ERISA legislation.

Small and medium-sized employers became increasingly agitated as their health care costs spiralled and their profit margins shrank.

They began to do one of two things: As they were not required by law to provide health insurance to their employees, some simply dropped coverage; and others began to complain to their insurers.

Employer-based health insurance peaked in 1980; it has been declining steadily since.

All of these factors led to the shrinking coverage that now leaves 40 million Americans without any health insurance whatsoever. A majority of these people belong to families in which at least one person works full-time.

As employers continued to drop the health insurance policies that covered their workers, insurers understandably sought ways to satisfy the cost and coverage concerns of their departing policy holders.

Eventually they seized upon a system of cost-controlled health care delivery known as the health maintenance organization, or HMO.

Let me take a moment here to define what I mean by HMO: A health maintenance organization is a healthcare delivery system in which every subscriber pays a fixed monthly fee that is used by a fixed group of salaried healthcare providers, mostly physicians, to provide a guaranteed package of benefits to the subscribers.

Although HMO's had existed in this country since the 1940's, they tended to be small cooperatives, not-for-profit entities controlled by the consumers they served. HMO's offered managed care, that is, a predetermined range of medical services for a predetermined charge. Of course, they were considered suspect by the traditional medical establishment.

Now back to our narrative: Insurance companies gradually recognized the lucrative potential of HMO's adapted to the for-profit free market.

So they devised a new type of HMO to deliver health care to policyholders and profits to stockholders. To do so, they scuttled the old cooperative approach of consumer control and doctors' participation in the program's structure.

In its place, they constructed a system of managed care designed primarily to yield generous profits.

Accountants took the place of physicians and consumers, and managed care has come to mean a tightly controlled arrangement in which profitability determines the availability of care.

This decision of the insurance industry to fashion a scheme of coverage and payment that excluded involvement of both consumers and providers set us on our present course.

Insurers have created a system designed to maximize industry profits by incorporating financial incentives that discourage providers from giving appropriate-but-expensive patient care.

For-profit managed care has proved so lucrative that it now is offered by companies created to do nothing else.

Ironically, we have yet to see any demonstrable evidence that managed care actually produces the cost savings it promises.

What is clear, however, is that managed care as practiced by the insurance industry is simply an arrangement to redistribute health care dollars from the delivery of care to administrative functions. In California and Florida, for example, the papers are full of stories about managed care companies denying care to their enrollees or using as much as 30 percent of their premiums for overhead or profit. Clearly, these plans are designed to enroll only the healthy—and inexpensive, while leaving the sick to taxpayer-funded programs.

Now the Congress is trying desperately to revise both Medicare and Medicaid to enable private insurers to cover the healthy enrollees of these programs but to relegate the seriously

sick and needy to the residual State and Federal programs.

This deliberate attempt to deplete the insurance pool of people who are unlikely to need expensive, protracted care simply is exacerbating cost escalation and reinforcing the image of Medicare and Medicaid as incompetent, wasteful, and ripe for overhaul.

By now, you may ask, quite rightly, ''What is the answer to this mess?''

The only sensible answer is a single-payor system to finance—not deliver—health care in the United States.

As I say this, I see the spines stiffen and the jaws tighten.

Let me assure you that I am proposing an American single payor system, not the 112-year-old German system, or the 50-year-old British or Canadian systems.

Throughout the world, each nation's single-payor health care system reflects historical factors present at the time of that system's creation.

So an American single-payor system must be developed in the current context.

If I asked each Member of Congress to define a single-payor system, I probably would receive 400 different responses.

So that we might have a reasonable meeting of the minds on this subject, let me propose that we use the following definition, which I have borrowed from Professor Tsaio at Harvard:

Any single payor system has these two characteristics:

(1) a defined set of benefits guaranteed to all citizens; and

(2) a global budget to pay for the health services provided.

Let me clarify here that the term ''global budget'' refers to the fixed total amount of money that will be spent for 1 year on a given set of benefits offered to the entire population.

Nothing in Dr. Tsaio's single-payor definition prevents the private practice of medicine or restricts application of a variety of treatments, provided that all Americans receive the same access to the treatments, and that it is paid for out of the global budget.

Mr. Speaker, how can we justify not having a system of universal health care available to all citizens in the wealthiest, most creative democracy on earth?

This brings us to the first decision we must make—and which we so far have avoided: Is affordable, high quality health care a right of all Americans, or is it a privilege subject to all the vagaries of the age, race, income, and residency differences in our society?

I categorically assert that, like fire and police protection, like common school education, and like myriad other services available to all Americans, such as highways and air traffic control, Americans should have universal access to health care insurance.

Every industrial society around the globe has found the ways and means to do this.

And, I might note parenthetically here that successful single payor systems have been developed by virtually all of our most vigorous trading partners. And I can assure you that none of these savvy competitors is contemplating replacement of its popular and cost-effective single-payor system with America's chaotic, wasteful approach to health care.

In no other civil society can a citizen be bankrupted by illness, accident, or injury.

If you are unemployed and, coincidentally, your house catches fire, we do not deny you the services of the fire department even though you cannot afford fire insurance.

Why, then, do we allow your economic future to be destroyed if you develop leukemia and do not have health insurance?

Is an automobile accident that leaves you with long-term disabilities and huge medical bills somehow less worthy of a societal response than a house fire?

My answer is an emphatic ''no.'' In all of these situations, random events strike individuals citizens with overwhelming force that can be counteracted only by the collective action of the society.

If we, as a society, cannot agree that health care must be addressed on an all-inclusive basis, we are accepting the present lottery-like nonsystem which truly personifies Darwin's description of ''survival of the fittest.''

If we can agree that health care financing can be addressed only on a national basis rather than the present stupefying panoply of programs, we then are prepared to begin the design of the American single-payor system.

I suggest we call it Unicare.

We have only two questions to resolve and our job will be finished: First, what benefits shall all Americans be eligible to receive from Unicare?; and second, how shall we pay for it?

Experience has taught me that defining the benefits is perhaps difficult, but it is infinitely easier than deciding how to pay for the program.

I contend that the benefit package must be very broad and very generous because anything else will build the inequities of our present system back into the new plan from the start.

Let me explain: If we establish a narrow range of benefits for all Americans, we immediately create a market for secondary insurance to cover all those treatments that some may need but that are not covered by Unicare.

Individual economic circumstances instantly come to the forefront as the varying capacity of people to purchase supplemental benefits insurance gradually divides us into those who have and those who do not.

This is the situation we have today.

Creating a limited guaranteed benefit package simply will perpetuate the present system in a different form.

So I propose that we begin right now the national debate on a comprehensive package including pharmaceuticals, long-term care, and mental health services.

I do not want to take any more time here arguing the content of the benefit package beyond the issue of comprehensiveness, but there are two corollary issues about actual delivery of the benefit package that merit attention.

Although our coinage proclaims ''e pluribus unum,'' we are, in fact, many different communities in this country.

So, I believe, in the maxim of the great progressive Senator of the 1930's, Robert LaFollette of Wisconsin, that State legislatures are ''the laboratories of democracy.''

I see great practicality in letting individual States decide how best to deliver the guaranteed benefit package.

HMO's may be the preferred delivery mechanism in some States, while, in others, a negotiated fee schedule for private practitioners might be the method of choice.

We can all agree, I am sure, that all wisdom in these matters does not reside in Washington, DC.

I also am convinced that to make a system work, its providers—primarily doctors—should be at some risk financially; at the same time, however, they must be allowed—encouraged—to participate in the design of that system.

Actuaries, accountants, and lawyers cannot be expected to recognize the elements of medical cost escalation and control that are evident to physicians eager to protect both their patients and themselves.

Failure to recognize this fundamental fact is the single most telling blunder of recent health reform efforts.

Exclusion of physicians' participation in the design of a health care system is a sure prescription for disaster. Evidence of this already is appearing in the press.

Time magazine's cover story in its December 23d issue details the ethical dilemma physicians confront when they try to practice responsible medicine in a system they had no part in designing.

Lest you think this is purely a theoretical challenge, consider that I recently attended grand rounds at Children's Hospital in Seattle.

For 2 hours, I discussed with a dedicated group of seasoned physicians and new practitioners the ethical questions inherent in trying to deliver appropriate care to children within the restrictions imposed by profit-driven managed care.

As more and more physicians attempt to practice good medicine within managed care schemes that do not allow them to do so, the very significant shortcomings of our present unworkable system will become only more glaring. Good medical care will become scarce, indeed.

Let me turn now to the second major decision that must be made about our Unicare Program for all Americans: how to finance it.

It is estimated that, in 1995, we in the United States consumed 950 billion dollars' worth of health care.

That is almost 50 percent per capita more than either Germany or Canada spent, and the health statistics of those countries are better than ours.

In case you share my difficulty in truly comprehending the purchasing capacity of such huge numbers, consider this: In 1994, the Congressional Budget Office estimated that, with a single-payor system in place by 1997, it would be possible to offer a very generous benefit package, including prescription medications, nursing home care, and home health care, and still be able to apply $100 billion to deficit reduction within 5 years.

But these are estimates of the costs involved in running a single-payor system in this country.

How shall we get the revenue to finance the system?

Right now, employers pay all or part of their employees' health care premiums, and employees pay some part of the premium, plus a Medicare tax to provide health care to senior citizens, plus general taxes to finance Medicaid for disabled persons and poor women and children.

Employers also pay taxes to cover injured workers' medical expenses, and all citizens contribute general tax moneys to finance medical care for veterans and for members of the military and their families. In addition, we all pay indirectly for medical coverage related to auto accidents.

Health care finance has become a specialty unto itself, and it is no wonder that people struggling to understand this mess are hopelessly confused.

Let me offer a simple, straightforward alternative: The ideal funding mechanism for the new Unicare plan would be a single, dedicated source of revenue that is stable and predictable. So I propose an employer payroll tax of 8.4 percent and an individual payroll deduction of 2.1 percent.

At these rates, about three-fourths of those Americans whose health coverage is connected to their employment actually would spend less on medical care than they do today, parceling out money to pay for all the different programs I mentioned a moment ago.

And, as most businesses presently spend more than 10 percent of payroll to meet their health care costs, they, too, would enjoy an actual reduction in spending.

Now, assuming that the Congressional Budget Office's estimates are correct—they usually are—you very reasonably might ask, ''Why has the single-payor idea not been adopted?''

How could the Congress reject a proposal that provides an affordable, generous health care benefit package and reserves control of health care treatment decisions to health care providers and their patients?

The apparent answer lies in the economic power of the medical-industrial complex to resist proposals that threaten to encroach on the $950 billion pie.

But, to be honest, the real obstacle to universal health care financed by a governmental mechanism is the American public's deep distrust of its Government's ability to operate a large—nondefense—program successfully.

This simmering sense of doubt and suspicion has been fanned to an explosive level by a decade-and-a-half of Presidential proclamations that ''Government is the problem,'' and that all challenges within our society can be overcome by ''getting the Government off the backs of American citizens.''

Only in such a climate could the insurance industry's $100 million advertising campaign so completely undermine President Clinton's valiant attempt to reform health care financing.

So—the options before you and the American people basically are two.

First, either invite the health insurance industry to maintain its control of healthcare finance at the expense of quality in care. Allow the industry to continue to ignore the valid criticisms leveled by providers and their patients at a system designed to benefit insurers and their stockholders.

Second, or change the system to one in which doctors accept some financial risk but regain significant satisfaction in the practice of medicine because they reclaim responsibility to make the treatment decisions they believe to be best for their patients.

Ewe Reinhardt, the James Madison professor of political economy at Princeton University, recently observed that ''The way things are going, all doctors may become serfs of insurance companies by the year 2000.''

That is a bleak prospect and one with which I do not disagree. But I also remain optimistic. Why?

Because I concur with the sentiments of Winston Churchill, who, when asked what to expect from the Americans, replied, ''You can always count on the Americans to do the right thing—but only after they have tried everything else.''

It is time to do the right thing. We have tried everything else, and we are in far worse condition today than we were when President Clinton began his historic reform effort just a few years ago.

Health care is a societal necessity that does not conform to free market pressures.

It is foolish and useless to expect our economic system to mirror the fundamental social precepts of the country.

Our present shambles of a health care system is intrinsically unfair. It is cruel, it is discriminatory, and it is appallingly wasteful.

These qualities have no place in a democracy. We simply must restructure our health care system to the single-payor framework. And we cannot wait any longer.

We already know that market reforms will not work in the health care financing arena.

They do not work because they can not. Market reforms are not driven by the considerations of fairness, compassion, and adequacy that must define our health care system if we wish to declare ourselves a decent and sensible society.

□ 1930

Mr. Speaker, I call upon you to bring the Kennedy-Kassebaum bill to the floor, so that we can at least start this debate. We can no longer wait and let this issue go on. It is one of the fundamental reasons why people are concerned about their economic security.

All across this country, we have people who are losing their health care coverage. One million people working a year lose their health care coverage, and that is simply not acceptable in a democracy with the wealth and the creativity we have. We must begin on this problem today.

SHORTCOMINGS OF CONVENTIONAL WASHINGTON WISDOM

The SPEAKER pro tempore (Mr. TAYLOR of North Carolina). Under the Speaker's announced policy of May 12, 1995, the gentleman from New York [Mr. OWENS] is recognized for 60 minutes as the designee of the minority leader.

Mr. OWENS. Mr. Speaker, we are returning to session after several weeks of being able to remain in our districts and intermingle with the people who voted to put us here, and that is a very good phenomenon. It is one that I am certain that every Member has benefited from greatly. I have certainly benefited from it.

I think it is very important to have the opportunity to allow the common sense of our constituents to irrigate the deliberative legislative process that takes place back here in Washington. Common sense is a shorthand expression for, I guess, wisdom of the people. It is the wisdom of the people that we absorb when we go back home, and the wisdom of the people is very much needed to counteract the Washington conventional wisdom, which is very much stuck in a rut.

The Washington conventional wisdom, and I speak of a bipartisan wisdom, there is a lot of agreement here on some things that represent conventional wisdom that certainly needs to be challenged by ordinary common sense. I think that we recently have experienced a phenomenon with respect to the Republican primaries that has certainly placed common sense on the radar screen. The rise of media star Pat Buchanan, a candidate for the Presidency, has certainly lifted certain basic issues into an area of high visibility.

On the radar screen you have a discussion of certain issues that Washington conventional wisdom has refused to recognize. Problems that just were not accepted as being problems are now being discussed. So the conventional wisdom has been shaken up, and that is good.