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NATIONAL HEALTH INSURANCE

A Pragmatic Perspective

By Harry Schwartz

With a Foreword by
Dr. Michael DeBakey

National Center For Policy Analysis

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Preface

One hundred years ago there was free and unrestricted competition in virtually every area of the market for medical care in the United States. Public policy toward health care differed little from public policy toward the production of most other goods and services.

Over the last one hundred years, however, things have radically changed. By the end of the 19th century, most states had adopted strict licensing laws governing both entry into the medical profession and the conditions under which medicine could be practiced. In the early part of the 20th century, proprietary medical schools were abolished, and the "business" of medical education was replaced by non-profit medical schools whose objectives were to pursue certain social policies, rather than to maximize profit. By the 1940s, the health insurance industry in this country had ceased to resemble the market for other types of insurance, and under government regulation, had become an industry largely dominated by non-profit institutions. Throughout the 20th century, the "business" of providing hospital services also underwent radical reform. As a result of both state and federal government policies, proprietary hospitals, which dominated the market in the early years, accounted for only 7 percent of all hospital admissions by 1970.

During the 1960s and 1970s, public policies toward health care fostered even more important changes in the structure of the medical marketplace. The advent of Medicare and Medicaid caused government spending to rise from 25 percent to over 40 percent of all spending on medical care. These programs, in turn, paved the way for health systems agencies, PSROs, federally subsidized HMOs, certificate-of-need requirements, and the Medical Device Amendments, which placed one of the fastest growing parts of the health care industry — biomedical technology — under the control of the FDA.

Our health care system, then, has become increasingly shaped, not by competition in the free market, but rather by government regulations and controls. Since spending on health care now constitutes over 10 percent of our gross national product, it is essential that we understand how these regulations and controls affect both the quality and cost of that care.

The Center for Health Policy Studies was established at the University of Dallas in 1980. Its purpose is to provide a rigorous economic analysis of public policies toward health care in this and in other countries, and to make the results of this analysis available to the general public. To this end, we have now begun a series of monographs on the most important of these policies. We are indebted to the National Center for Policy Analysis for its willingness to be the publisher of the series. We would also like to thank Hoffmann-La Roche Inc. for its assistance in making this monograph possible.

It is appropriate that the first monograph in this series should deal with a major public policy which has not been adopted in our country, but which has been adopted by virtually every other developed country — national health insurance.

In this monograph, Dr. Harry Schwartz analyzes the most important arguments which have been advanced in favor of national health insurance, and finds that these arguments lack validity. He also surveys the experiences of other countries which have adopted national health insurance and finds that these health care systems are generally inferior to our own.

In the decade of the 1980s, the issue of national health insurance threatens to be a recurring specter on the national political scene. Dr. Schwartz's analysis is "must reading" for all who seek to understand what is at stake in this important debate.

John C. Goodman
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Center for Health Policy Studies
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Foreword

The concept of national health insurance is based on the assumption that it is the best and most efficient mechanism for providing equal access to health care for all the people. The experience of other countries that have adopted it, however, has shown that this objective has not been attained. Neither equal access to medical care for all their citizens nor control of rising medical costs has been achieved by these countries. Moreover, the quality of medical care, at least for most patients, has suffered. This decline in quality is exemplified by certain benefits of modern medical technology that are denied certain segments of the society and by the long periods that patients must wait before receiving some methods of treatment. In these respects, the quality of medical treatment in general is better in our country than in those countries that have had long experience with national health insurance.

That is not to say that our health care system is perfect. There is no question that a certain proportion of our citizens do not receive adequate medical care because of their inability to pay for it. In proportion to the total population, their numbers are relatively small. Nonetheless, they represent a need that must be addressed. This need does not, however, constitute the basis for abandoning our present system of medical care and imposing in its place national health insurance.

In this monograph, Dr. Schwartz has presented an analysis of various factors that impinge upon this subject, including medical care costs and statistical data from this country, as well as those countries with long experience with national health insurance. It is a valuable contribution in presenting factual information on the continuing controversy and debate over an important national issue.

Michael E. DeBakey, M.D.
Houston, Texas
July 1982

Chapter 1:
Introduction

Superficially, it would seem that proposals for National Health Insurance (NHI) in the United States have landed in the dustbin of history, and the issue is no more. Certainly the Reagan Administration has made no secret of its opposition to NHI, and the current emphasis is on reducing government involvement in, and spending on, health care. The Reagan Administration will be replaced by other administrations, however, and the pendulum could then swing back in favor of NHI. *That there is a political base for such a reversal is beyond doubt.*

At the White House Conference on Aging in late 1981, for example, Representative Claude Pepper, and the political forces he speaks for, made no secret of their desire for comprehensive NHI built on the "traditional" model. Also in 1981, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, appointed by former President Carter, spent much time considering the issue of equity in the availability and distribution of health care. This consideration at least implied the possibility of some future government action allegedly seeking to increase equity in this area, perhaps through instituting NHI. The minutes of the Commission's November 1981 meeting reveal that it discussed the possibility of improving equity in health care by "reallocating" resources from "non-beneficial care,"desired by some patients, to "beneficial care" needed by others. Clearly NHI could be one mechanism for such "reallocation."

* * *

The Concept of NHI — a comprehensive system of government health insurance for all Americans — involves much more than merely financing health care. It raises the question of how the provision of medical care, and the production of all the goods and services required for such care, should be organized and directed. Inevitably, any discussion of NHI contributes to the continuing national dialogue over the relationship of the individual to the state, and the extent of state power. Since annual national health expenditures in this country now comprise about 10 percent of the Gross National Product, nationalization of the United States medical system would, if implemented, have profound consequences for all sectors of American society.

In the U.S., the discussion of the relationship between government and the health of citizens dates from the yellow fever epidemic of 1793. That epidemic led to a 1796 law requiring federal officials to supervise state enforcement of quarantine laws. The justification was that epidemics ignore state lines and are, therefore, a species of interstate commerce, a

view that Chief Justice John Marshall and a Supreme Court majority soon declared unconstitutional.[1]

Others might date the debate's beginning to the mid-19th century when the national mental health bill was sponsored by Dorothea Dix. It passed Congress, but was vetoed by President Franklin Pierce, who argued that the government had no right to intervene in its citizens' health problems.[2]

Even the narrowest definition must concede, however, that the NHI debate in the United States began at least in the first two decades of the 20th century, when health insurance developments in Western Europe attracted the attention and approval of American reformers. These reformers began to think about how to replicate, in the United States, the models used by Bismarck and his European followers. By 1906 the American Association for Labor Legislation (AALL) was established, and by 1912, appointed a group of experts to draw up what became "Nine Standards for Compulsory Health Insurance."[3]

The "Nine Standards . . ." proposal, prepared 70 years ago, was the first formal prescription for an American NHI plan. The plan was designed by a politically influential group that hoped the prescription would become a reality. The group enunciated certain principles which still resonate in the national debate:

- They looked forward to a system in which membership would be compulsory for all workers with incomes below a certain level, while remaining optional for all others.
- The funds needed were to come "from the worker, the employer, and the public."
- Standard No. 7 declared that "benefits to members are to include medical care, hospitalization, nursing care and medical supplies."
- Standard No. 9 asserted that "prevention is to be emphasized so that compulsory health insurance will lead to a health conservation campaign similar to the safety campaign resulting from the passage of Workmen's Compensation."[4]

By 1916, the AALL drafted a model bill which it hoped state legislatures would enact. Its intent was to make compulsory health insurance a reality. In this effort the AALL had the full support of the American Medical Association, whose "Committee on Social Insurance" worked closely with

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1. Tyrus G. Fain, ed., "National Health Insurance," *Public Documents Series* (R.R. Bowker Company, New York and London, 1977), p. 27.

2. Monte M. Poen, *Harry S. Truman Versus the Medical Lobby* (University of Missouri Press, Columbia and London, 1979), p. 9.

3. Daniel S. Hirshfield, *The Lost Reform* (Harvard University Press, Cambridge, 1970), pp. 10-14.

4. *Ibid.*, p. 171.

the reformers. But the American Federation of Labor (AFL), under Samuel Gompers, vigorously opposed compulsory health insurance. Gompers himself asked publicly, "Is it wise to open up opportunities for government agents to interfere lawfully with the privacy of the lives of wage earners?" The AFL Executive Council unanimously opposed compulsory health insurance in a 1916 vote, and soon Gompers and his associates joined with business representatives to forge "an alliance between the unions and their employers to fight their common foe — the social workers."[5]

In view of their later histories, the spectacle of the AMA supporting a version of NHI while the AFL opposed it seems incongruous. By 1920, the AMA had reversed itself and opposed NHI, an attitude it would adhere to until the 1970s. The Great Depression and the passage of time served to change the AFL's position, so that by 1935 it backed NHI, a position the union movement continues to maintain.

Composed primarily of physicians in fee-for-service practice, and others working alone or in small groups, the American Medical Association values above all the independence of its members. It has seen correctly that the greater the involvement of government in paying for medical care, the more likely are government regulations and restrictions governing doctors and their work — a process that might ultimately mean that physicians become simply the hired employees of the state, no different from soldiers or public school teachers. The AFL and later the AFL-CIO, has been favorable since the 1930s — and especially since the passage of the pro-union National Labor Relations Act — to many extensions of government power, believing that the unions were politically strong enough to exert much control over the use of that power. Additionally, since 1945, union leaders have been acutely aware of the large costs for medical insurance in most union contracts. No doubt it has occurred to more than a few union leaders that if NHI became a reality, and the money now paid by employers for private health insurance went directly into the workers' pockets, those union leaders who could claim credit for such a development would reap important political benefits.

It is beyond the scope of this work to describe in detail the ongoing struggle over NHI since World War I. However, it is pertinent to note that the hopes of NHI advocates for Congressional approval were very bright in the administrations of Franklin D. Roosevelt and Harry S. Truman, but both times those hopes were frustrated. Roosevelt might have asked Congress for compulsory health insurance along with his request for old age pensions and unemployment insurance, but he thought that inclusion of NHI might prevent the passage of the entire package. After the Social Security Act became law, the threatening international situation which culminated in World War II, deflected the nation's priorities and energies

5. Poen, *op cit.*, pp. 11-12.

away from compulsory health insurance. In the Truman Administration, the President gave repeated verbal support for NHI, but factors influencing Congress dictated that priority should be given to programs for building new hospitals, for expanding the National Institutes of Health, and for supporting the rapidly growing programs of basic and applied medical research.

During these years, Senator Robert F. Wagner emerged as the leading Congressional advocate of NHI. He introduced the Wagner National Insurance Bill in 1939 and, in later years, the successive Wagner-Murray-Dingell Bills toward the same end. The AMA, supported by other conservative groups, vigorously and skillfully fought NHI. It repeatedly spent large sums raised from its membership for anti-NHI advertising and lobbying. The coalition fighting for NHI enlisted the support of Northern and Western Democratic politicians, many labor leaders, some important businessmen, the heads of major foundations, and that minority of physicians which was willing to oppose the AMA publicly.

But while the debate and the political struggle over NHI raged from World War I to World War II and then into the 1950s and early 1960s, the scientific, medical, social, economic and political background of the controversy changed profoundly.

Medical progress — from antibiotics and steroids to open heart surgery, kidney dialysis, and beyond — made medical care much more effective and therefore more valuable. From the perspective of 1980, some might argue that physicians knew so little a half century ago, that it is hard to understand why people attached value to medical care before 1930. But attach value to it they did.

Meanwhile, the pressures on the American Medical Association and the American Hospital Association brought by the NHI conflict caused these groups to try to provide private alternatives to NHI. These pressures played a great role in the formation and rapid expansion of Blue Cross, a hospital association-sponsored system of private insurance for hospital care, and Blue Shield, an AMA-sponsored system of private insurance for surgical and certain other physician fees.

As Blue Cross and Blue Shield spread among millions of American workers after World War II, private insurance companies — Aetna, Metropolitan, Prudential, Connecticut General, etc. — also entered the market, selling their own policies which offered protection against the costs of illness.

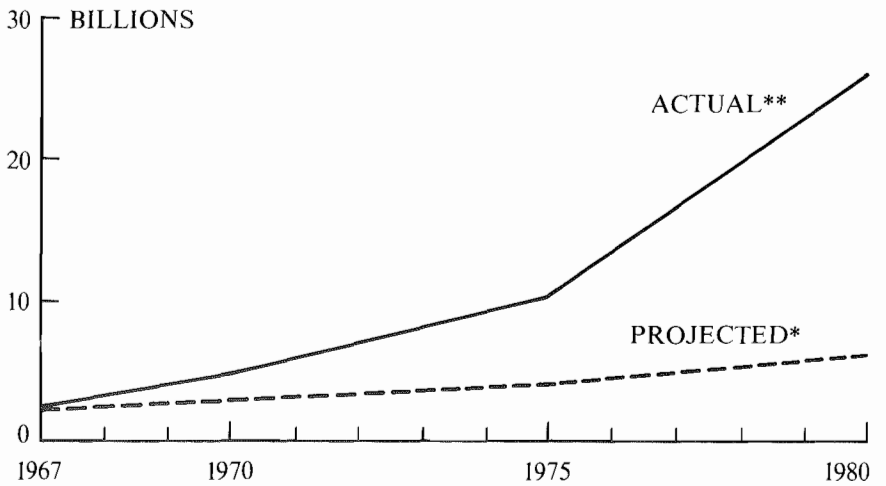
While the fight for NHI raged furiously and fruitlessly, ever larger numbers of working Americans received substantial insurance coverage at their jobs for their medical costs. The major change could not help but produce an impact on the more general debate over national health insurance. The growth of private insurance inevitably raised the question of why the government did not focus primarily on those without private insurance.

The battle over NHI reached a climax in the first half of the 1960s, with the advocates led first by President Kennedy and then by President Johnson. Legislation providing for what we now term as Medicare (medical insurance for the aged) and Medicaid (medical insurance for the poor) was passed in 1965. President Johnson dramatically emphasized the importance of the event by travelling to Independence, Missouri, and signing the bill before former President Truman, thus paying tribute to Truman's early efforts on behalf of NHI. The programs actually went into effect in mid-1966.[6]

Figure 1

Hospital Costs

1965 Projected vs. Actual Federal Expenditures on Medicare



*Calendar year basis
**Fiscal year basis

Note: Sources for figure are the publications cited in Footnote 7 plus *Health Care Financing Review*, September 1981, p. 42.

6. For a concise history of the last stages of the struggle over what were to become Medicare and Medicaid, Cf. Carleton B. Chapman and John M. Talmadge, "Historical and Political Background of Federal Health Care Legislation," *Law and Contemporary Problems*, 35(2):343-45, Spring 1970.

Many observers thought that the Medicare and Medicaid measures would quickly be broadened to cover the entire population, and be transformed into a system of universal, comprehensive national health insurance. Those expectations proved false. True, Medicare was extended to cover victims of kidney disease and the totally disabled. *But the great majority of the American people are not now covered by government health insurance.* This basic fact is the background for the debate which has raged over NHI since 1965. Despite the endorsement of NHI at different times by leading figures of both the Democratic and Republican parties — Presidents Carter, Nixon and Ford and particularly Senator Edward Kennedy — NHI has not been adopted as the law of the land.

Both proponents and opponents of NHI agree that one reason national health insurance is such an elusive goal is because Washington initially failed to understand how very expensive Medicare and Medicaid would be in practice. "Once burned, twice shy" — Congress consistently refuses to act on NHI, afraid of enacting a financial time bomb even greater than Medicare and Medicaid.

Indicative of the gap between early estimates of Medicare cost and actual cost is Figure 1 (on page 15), which compares 1965 estimates of government hospital payments under Medicare with the actual amounts paid during the first years of Medicare's operation.[7]

7. Harry Schwartz, *The Case for American Medicine* (David McKay, New York, 1972), pp. 129-30. U.S. Bureau of the Census, "Statistical Abstract of the United States 1979" (Washington, D.C.), p. 330.

Chapter 2:
The Case for National Health Insurance

In this chapter we will examine the key arguments offered for NHI — in the sense of a universal and comprehensive governmental arrangement — by its proponents. We will then compare those arguments with the available facts and try to reach conclusions about the extent to which the arguments are true.

The approach taken here is purely pragmatic. It does not assume — as some do — that full egalitarianism is what is desired in American society. Senator Kennedy, for example, declared a decade ago that "we must begin to move now to establish a comprehensive national health insurance program, capable of bringing the same amount of high quality health care to every man, woman and child in the United States."[8] It is not very far from this assertion to the Labor Party position in Britain which holds that, as regards medical care and the work of doctors, "all charges should be abolished" while "private practice was immoral and no one should have the right to buy health care."[9]

But such extreme egalitarianism seems foreign to American tradition. Moreover, if pressed, Senator Kennedy might concede that different people require different amounts of health care, depending on how ill they are.

The pragmatic case for a universal and comprehensive national health insurance system under government auspices in the United States is focused on three points.

One is the assertion that the health of the American people is unsatisfactory, particularly the health of the poor. As Senator Kennedy puts this indictment:[10]

> "In the United States today — the wealthiest nation in the history of man — millions of our citizens are sick. And they are sick because they are poor . . .
>
> "The difference in health care between the rich and the poor is measured by the stunted bodies, shortened lives and physical handicaps of those who live in poverty."

Seven years later the senator stated the same idea more prosaically, declaring: "The statistics reveal just how far behind we are in providing

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8. Cf. the senator's introduction to Daniel Schorr, *Don't Get Sick in America* (Aurora Publishers Limited, Nashville and London, 1970), p. 11.

9. Statement of Labor Party spokesman Stanley Orme, MP, in House of Commons debate January 23, 1980. Cf. *British Medical Journal*, February 2, 1980, p. 338.

10. Schorr, *op cit.*, p. 10.

quality health care, compared to other industrialized countries in the world. The latest statistics show that the United States ranks 12th in the world for infant mortality . . . Our nation ranks 10th in the world for the maternal mortality rate . . . The United States ranks 21st in the world for longevity in males . . . For females, the United States ranks 9th in the world . . . ."[11]

The second argument is that many Americans cannot afford to pay for health care. Here is Senator Kennedy's statement: "For these Americans who have no decent insurance, every illness can turn into a financial disaster. Since every penny comes out of an already limited income, they weigh every decision as to whether or not to seek a doctor — and sometimes they wait too long and suffer needless pain.

"There is no way to tell how many children grow up in America with needlessly twisted limbs, dulled minds, or other handicaps simply because fear of the cost kept his parents away from the doctor for too long. There is no way to tell how many Americans suffer needless pain and even early death simply because good health costs too much."

The senator added that what he calls the health care crisis is "evident in the 5,000 American communities that have no doctor, and to patients who wait in city hospital emergency rooms six or eight hours for help because they have no doctor or because they cannot reach him after hours."[12]

In recent years, a third argument for NHI has appeared. It is an apparent response to the widespread concern over the rapid rise in the nation's medical expenditures since Medicare and Medicaid became law. The argument holds that a properly constructed system of national health insurance can make medical care more widely and equitably accessible, while at the same time restraining the growth of future medical expenditures.

Are these arguments valid? First turn to the claim that the health of the American people is unsatisfactory, particularly when compared to the health of the citizens of other industrialized countries. The argument makes at least two debatable assumptions. First, that the medical system of a nation determines the health of that nation. And second, that numerical comparisons of mortality and morbidity rates among different nations are reflective of the relative merits of different nations' medical systems.

On the first point, Dr. Eric J. Cassell has written very pertinently:

> "Medical care — doctors, nurses, paraprofessionals . . . hospitals, clinics and so on — is about the care of the sick, not about health . . . . Most people know now that the health of a population is not primarily related to its medical care. Having many doctors and

11. Fain, *op cit.*, p. xiii.

12. *Ibid.*, p. 9.

hospitals does not necessarily make people healthy. A healthy population is more likely one in which people do not get sick in the first place, rather than get sick and then better."[13]

It is widely understood that the level of health of a population depends primarily upon factors other than medical care. These include the availability of nutritionally adequate food, pure water and safe milk; the mass abstention from such suicidal practices as heroin addiction and alcoholism, the general existence of a sanitary environment as well as adequate housing with needed heat during winter, and the creation of a general educational level that induces people to take care of their health by refraining from smoking, by getting exercise, and by avoiding obesity.

International comparisons are meaningful only when the nations compared are truly alike. In many of the international comparisons "proving" that the health of Americans is bad, all or most of the countries alleged to have better records in general mortality, infant mortality or longevity, are relatively tiny nations like Iceland, Sweden, Norway and Holland. These are countries with small populations, between a few hundred thousand and a few million persons. Moreover, these countries tend to be relatively homogeneous in both ethnic composition and standard of living. They are hardly comparable with a United States whose highly diverse population of well over 200 million is spread over most of a continent. Ironically, such comparisons usually fail to make comparisons between this country and the only other large industrialized country with a very diverse population spread over a huge area. That country is the Soviet Union. NHI proponents rarely compare Soviet health and mortality statistics with those of the United States, because although the Soviet Union has the equivalent of national health insurance, its infant mortality and longevity data are appreciably inferior to those of the United States, thus suggesting an embarrassing situation for supporters of socialized medicine.

Britain, which has now had NHI for over 30 years, provides substantial proof that the connection between national health insurance and a population's health is complex. In 1976, for example, infant mortality in different parts of that country varied from 11.2 deaths per thousand births in East Anglia, to 15.5 deaths per thousand births in Yorkshire. The highest regional figure was 40 percent higher than the lowest.[14]

Part of the substantial variation in Britain is explained by a recent article in a major British publication, "Why Don't They Want Our Health Services?" The article emphasizes that even when medical care is freely

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13. *Wall Street Journal*, March 3, 1980.

14. Office of Health Economics, "Compendium of Health Statistics," 3rd edition, 1979 (London), p. 16 "Mortality."

available, it may not be used by those who need it most. The author stresses that it is "preventive services" which are under-utilized, "antenatal or child health clinics, or vaccination, or cervical smears; and often evidence of rejection is coupled with evidence of correlation with low social class and with increased levels of illness or death among those who reject these services."[15]

These considerations suggest that the discussion of health in the United States, at least so far as NHI is concerned, needs to take an account of trends in mortality and morbidity *in this country.* In mid-1979 an official report from the Department of Health, Education, and Welfare began with the words: "The health of the American people has never been better." This publication, "The Surgeon General's Report on Health Promotion and Disease Prevention," presented evidence which was summarized in the *New York Times* as follows:[16]

> The report "goes on to point out that this country's death rate has been cut in half since 1900, that 1977 saw a record low in infant mortality, that between 1960 and 1975 the difference in death rates between white and nonwhite babies had been cut in half, that deaths due to heart disease in this country fell by almost a quarter between 1968 and 1977, and that a baby born here now can expect to live 73 years as against only 47 years for a baby born in 1900."

These gains are illustrated by the change in United States infant mortality since 1965, as shown in Figure 2.[17] In only 16 years, the United States infant mortality rate was cut by more than half.

A similar improvement is shown by available data on death rates for the entire population. United States statisticians age-standardize their data; that is, they take the crude death rate for each year and calculate what it would be if the population of this country in, say, 1979 or 1977, had the same age distribution as in 1940. The reason for the adjustment, of course, is the fact that all people must die and the older a population is, the higher the death rate will be simply because of that fact. To assure comparability over time, therefore, the age distributions of different years are made the same. Figure 3 demonstrates the pattern that emerges for 1950-1980.[18] Thus between 1950 and 1980, the age-adjusted death rate for the United States declined by almost one-third.

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15. Alex Scott-Samuel, "Why Don't They Want Our Health Services?" *Lancet*, 1980; i:412-13.

16. *New York Times*, September 11, 1979.

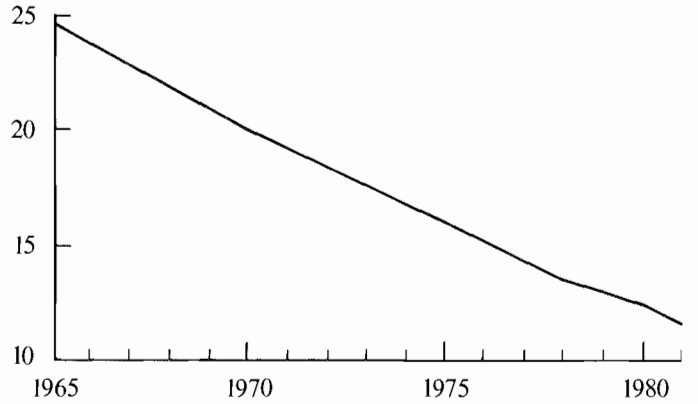
17. Data from "Annual Summary of Births, Deaths, Marriages, and Divorces for the United States, 1980," and *Monthly Vital Statistics Report*, March 18, 1982.

18. *Health United States 1979* (United States Department of Health, Education, and Welfare, Public Health Service, Hyattsville, Maryland, 1980), p. 104, DHEW Publication No. (PHS) 80-1232. Also "Annual Summary of Births, Deaths, Marriages, and Divorces: United States, 1980," *op cit.*, p. 5.

Figure 2

Infant Mortality in the U.S.A., 1965-1981

(deaths per 1000 live births)

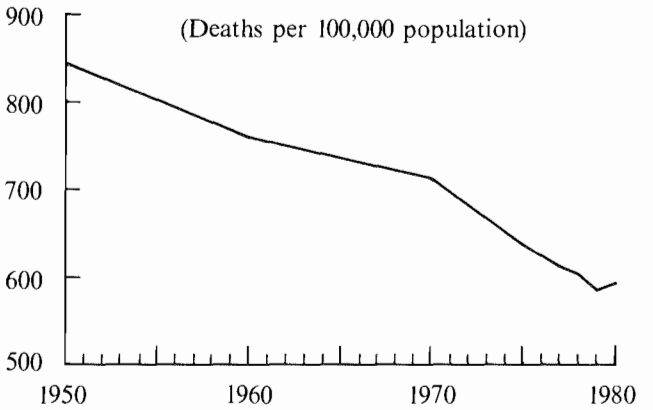


Source: "Annual Summary of Births, Deaths, Marriages, and Divorees for the United States, 1980," and *Monthly Vital Statistics Report*, March 18, 1982.

Figure 3

Mortality Rates for the U.S.A., 1950-1980

(age adjusted)



Source: *Health United States 1979* (United States Department of Health, Education, and Welfare, Public Health Service, Hyattsville, Maryland, 1980), p. 104, DHEW Publication No. (PHS) 80-1232. Also "Annual Summary of Births, Deaths, Marriages, and Divorces for the United States, 1980," *op. cit.*, p. 5.

It is possible to cite additional statistics, but the point seems clear enough: As the United States government concedes, with the usual statistical criteria, the health of the American people is the best in its history. Substantial progress in lowering the death and sickness rates in the United States has been realized in the years since World War II even though this country has not had national health insurance.

On the basis of this record, it can be assumed that further substantial progress in this area will be registered in the years ahead, even if NHI continues to be a subject for debate rather than an actual reality. Thus, the burden of proof is on the supporters of NHI. They must demonstrate that adoption of NHI would significantly increase the health progress of the United States, but the past record shows that this progress is likely to improve without NHI.

The second argument for NHI, i.e., the claim that large numbers of Americans cannot afford to pay for health care, is the kernel of the whole case for National Health Insurance, which presumably removes the individual's economic barriers to health care.

This argument cannot be assessed without some prior discussion of existing financial arrangements for medical care in the United States:

- Persons 65 years and older are entitled to Medicare and supplementary medical insurance that together pay for large amounts of hospital and physician care after a small deductible has first been paid by the patient.
- Medicaid exists to help millions of poor Americans, and particularly special categories of the poor such as families with dependent children and persons who are blind.
- There is a third government program, CHAMPUS, which pays for medical care for dependents of the members of the armed forces. And of course Soldiers, Sailors, Marines, and Air Force personnel get their medical care from physicians and hospitals attached to the various armed services. Additional millions of Americans are entitled to receive medical services from the Veterans Administration.
- In the private sector, large numbers of insurance companies provide protection against medical costs for millions of persons, insurance often paid for by employers.

Given this pluralistic and diverse collection of systems of health insurance, it is difficult to calculate how many people have insurance protection for medical costs and the degree to which these people are adequately protected.

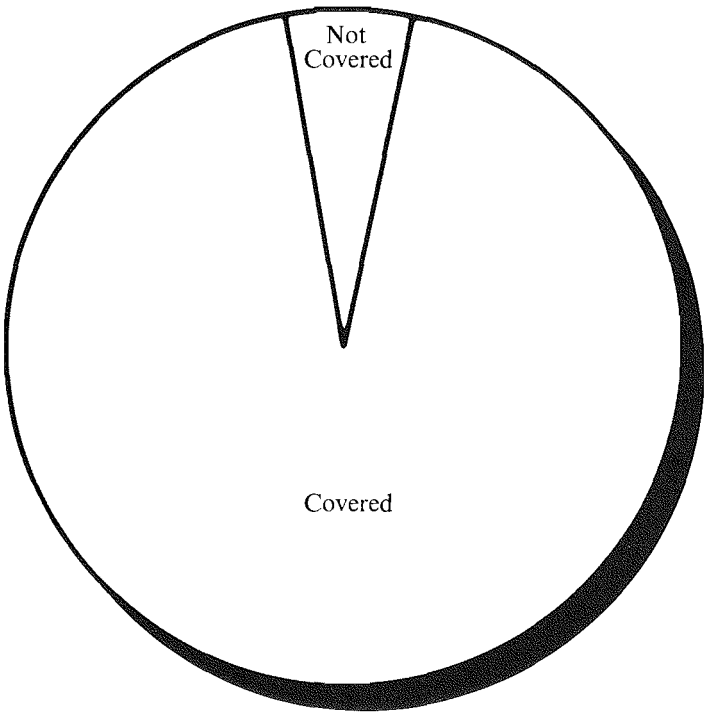
One of the most comprehensive efforts at such calculation appears to have been made in an earlier study authored by Stephen G. Sudovar, Jr.

and Kathleen Sullivan. The conclusions of their study, applicable to the United States of the mid-1970s, are illustrated in Figure 4.[19]

This figure indicates that in the mid-1970s, over 94 percent of the American people had some coverage against the costs of medical care while less than 6 percent had no such protection.

Figure 4

Population Covered By Private or Public Health Insurance



19. Stephen G. Sudovar, Jr. and Kathleen Sullivan, "National Health Insurance Issues: The Unprotected Population" (Roche Laboratories, Nutley, N.J., 1977), p. 2.

Of those found to have some health insurance protection, more than 75 percent — 150,500,000 — were covered by private insurance policies. The rest were protected by some government plan including 22,000,000 persons with Medicare; 15,500,000 with Medicaid; 7,600,000 with coverage from the armed forces programs; 1,700,000 with Veterans Administration protection; and 1,000,000 entitled to aid from other government programs such as Workmen's Compensation, etc.

The less than 6 percent of the American population without any health care insurance was defined in the study as follows: "This population, though not poor enough to qualify for public assistance or old enough to qualify for Medicare, is found to be uninsurable by virtue of health status, or unable to afford private insurance coverage. For the most part, the unprotected are unemployed, marginally employed, self-employed or in poor health. Over 50 percent of the unprotected earn less than $10,000 in family income annually."[20] These findings are generally supported by the subsequent study by the Congressional Budget Office, which found that 11 to 18 million people, or 5 to 8 percent, have no third-party coverage.

How adequate is this health expense coverage? To answer this question, Mr. Sudovar and another collaborator employed a novel technique. They convened a panel of specialists and asked them to define a standard of adequate protection against medical expenses. The panel[21] included individuals of different ideological persuasions and expertise, and finally produced the following definition:

> **"Benefits:**
> "An adequate benefit package must include protection against the expense of the following services: Inpatient hospital care, physician services, laboratory and x-ray services, prenatal care, inpatient psychiatric care, outpatient services, nursing home care.
>
> **"Protection:**
> "At least 80 percent of the expense of covered services must be borne by a third-party entity, with the exception that patient cost-sharing for inpatient psychiatric care must be required in excess of 20 percent of expenses.
>
> "At least $250,000 of catastrophic expense protection must be provided by the third-party entity and the sum total of patient cost-sharing must not exceed 10 to 30 percent of income."[22]

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20. *Ibid.*, p. 3.

21. The panel consisted of Stuart H. Altman, Alain C. Enthoven, Anthony R. Kovner, Daniel W. Pettengill, Uwe E. Reinhardt, and William R. Roy.

22. Stephen G. Sudovar and Patrice Hirsch Feinstein, "National Health Insurance Issues: The Adequacy of Coverage" (Roche Laboratories, Nutley, N.J., 1979), p. 11.

Using this definition, the researchers studied the adequacy of protection available to the 202,317,000 Americans with some private or governmental health insurance in 1977. The findings are summarized in Table 1.[23]

Table 1

% of Americans with Health Insurance Coverage by Type

	Net Number Adequately Protected	Percent of Protected Population	Percent of Total Population
Acute Care Services:			
Inpatient Hospital Care	184,849,000	91.3	85.3
Inpatient Psychiatric Care	184,539,000	91.2	85.1
Inpatient Laboratory and X-Ray Services	194,109,000	95.9	89.5
Maternity Care	122,201,000	67.5*	62.9*
Inpatient Physician Visits	107,590,000	53.1	49.6
Physician Office and Home Visits	87,198,000	43.0	40.2
Long-term Care Services:			
Nursing Home Care	96,138,000	47.5	44.3
Catastrophic Protection:			
Greater than or Equal to $250,000 or Unlimited Catastrophic Protection	124,927,000	61.7	57.6
Maximum Out-of-Pocket Limit	63,886,000	31.5	29.4

*Represents percent under age 65.

Source: Stephen G. Sudovar and Patrice Hirsch Feinstein, "National Health Insurance Issues: The Adequacy of Coverage," (Roche Laboratories, Nutley, New Jersey, 1979), p. 11.

23. *Ibid.*, p. 26.

Subsequent to the above studies, the National Medical Care Expenditure Survey examined the question of health insurance on the basis of data for 1977-78. In broad terms, the results are very similar to those cited above, though they are presented somewhat differently, with more emphasis on the dynamics of the situation and the changes that occur during a year. According to this study, at any single time in the period covered, there were 212,000,000 Americans, of whom 187,000,000 to 190,000,000 had health insurance; while 22,000,000 to 25,000,000 did not. But behind this shifting statistical reality, the study found the population divided into three groups. One group, about 178,000,000 persons, consisted of those who are insured throughout the year. A second group, about 16,000,000 persons, consisted of those who have health insurance during some periods of the year, but not at others, the changes presumably related to shifts in Medicaid, Medicare, and employment status. Finally, the study found about 18,000,000 persons who did not have health insurance at any time of the year.

Interestingly, many of those who have health insurance only part of the time tend to seek medical aid frequently when they are covered. In general, those least likely to have health insurance are residents of the South and West, inhabitants of rural areas or small towns, poor blacks or Hispanics, and young adults aged 19 to 24. The latter group, of course, tends to be relatively healthy and many of its members presumably feel no need for health insurance. Summaries of this study appeared in *Hospitals*, December 1, 1981, p. 28, and *American Medical News*, November 20-27, 1981.

One conclusion emerges clearly from the data presented earlier. Spontaneously, under the influences of the free marketplace, most Americans already enjoy the benefits of widespread health insurance coverage. Most Americans are substantially protected against the high costs of hospital care and also have some form of catastrophic insurance that provides $250,000 or more to cover costs of a single illness. The available protection is not complete — a maximum out-of-pocket medical expense limit is available to less than 30 percent of all Americans. But, the traditional claim by NHI supporters that vast millions of Americans cannot afford any health care has little basis in fact. Ironically, the poor who are covered by Medicaid often have the best and most complete protection against medical expenses; Medicaid has no upper limit on coverage for basic services, nursing home care and the like. Thus, it is not surprising that in the 1970s, family income turned out to be roughly inversely correlated with the provision of medical services, i.e., the poor tended to get more health services than those with higher incomes.

The official HHS data on the frequency of physician visits by income class in 1972 and 1977 is seen in Figure 5.[24]

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24. Data are from *Health United States 1979*, *op. cit.*, p. 132.

Figure 5

Family Use of Health Care Services (Physician Visits) by Income Groups

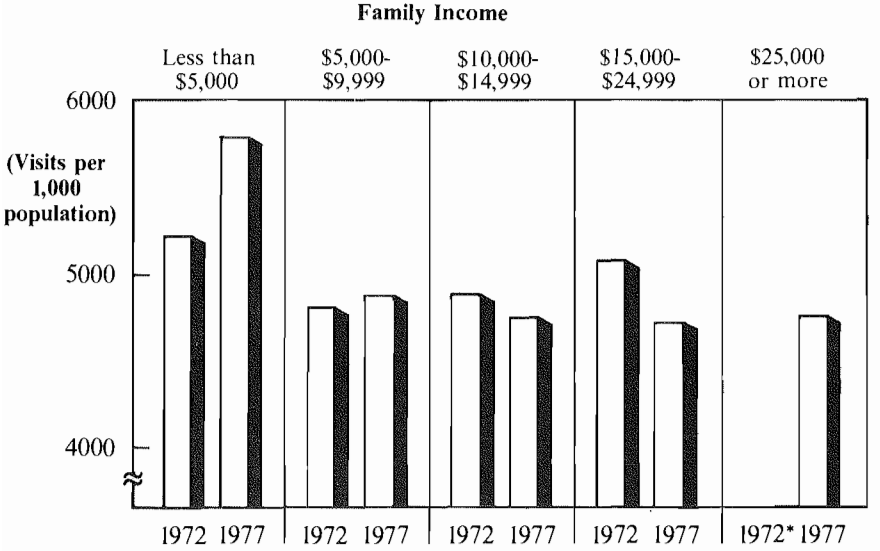

*Figure does not meet standards of reliability or precision

Source: *Health United States 1979, op. cit.*, p. 132.

A similar pattern emerges if we study the number of hospital stays (technically, hospital discharges) and the number of hospital days, and their variation by family income, in 1972 and 1977, as seen on Table 2[25] (on page 28).

These data show that in a system where the great majority of people have no financial barriers to hospital use, poor people will generally use the hospital more than upper income groups. Poor people tend to be sicker than more affluent people and, in addition, sickness is an important force reducing individuals and families to poverty income levels. But even so, the magnitude of the differences is impressive. In both 1972 and 1977 the poorest group of Americans tended to spend roughly twice as many days in a hospital per capita as the most affluent. We noted in the data presented earlier that the number of Americans having insurance coverage for

25. Data from *Ibid.*, p. 145.

outpatient physician visits was only about half as large as the number having hospital insurance. Nevertheless, the data on physician visits show that, on the average, poor Americans see physicians more often than Americans with higher incomes.

These data expose the usual rhetoric — that numerous Americans are denied health care — as a gross distortion of reality. Why such rhetoric persists even now, 15 years after the passage of Medicare and Medicaid, is hard to understand except as an example of the durability of false

Table 2

Proportionate Use of Hospital Facilities by Income Groups, 1972 & 1977 (per 1000 population)

Family Income	Hospital Discharges		Hospital Days	
	1972	1977	1972	1977
Less than $5,000	142.5	158.3	1,444.2	1,541.0
$5,000-$9,999	129.2	139.8	1,191.3	1,164.3
$10,000-$14,999	119.5	124.0	1,092.3	1,051.8
$15,000-$24,999	114.1	117.4	967.6	912.1
$25,000 or more	98.4	93.4	745.6	678.8

Source: *Health United States 1979, op. cit.*, p. 145.

stereotypes. Nevertheless, the fact that poor Americans get more medical care on the average than higher-income Americans does not deny that there may be — in fact, probably are — some cases of poor individuals or families who do not receive needed medical care. These cases, when unearthed and exploited by the media or politicians, rouse understandable public sympathy and strengthen the old stereotypes.

Another factor that must be taken into account is that the poor see a doctor more often in hospital emergency rooms or outpatient clinics. Some of these facilities have a very impersonal atmosphere and their personnel do not always show the respect for a patient's dignity that one expects when visiting a conventional physician in his private office. But the other side of the coin is the fact that the staffs of hospital emergency rooms in inner city neighborhoods tend to be expert — from long and repeated

experience — in caring for the needs of victims of the violence which is endemic in many inner city areas. A patient wounded by a bullet or a knife slash is much more likely to be cared for properly in, say, the emergency room of New York's Harlem Hospital or Chicago's Cook County Hospital, than if that patient went to a suburban family physician or internist who may never see a bullet or a knife wound for an entire year.

The indictment that the existing medical system denies care to large numbers of the poor is exaggerated. However, improvement does need to be made in this area. But, it is an improvement that can be realized through modest changes in the present arrangement. It does not require the drastic transformation of a medical system that serves most Americans well.

The case of NHI was first advanced on the premise that many Americans face insuperable financial obstacles to receiving medical care. NHI was envisaged as a means of providing all Americans with all the health care they need. Original considerations of costs played little role in the arguments of the NHI proponents. This situation has changed dramatically since 1965 when Medicare and Medicaid were enacted. Now the entire NHI debate is permeated by cost-conscious considerations. The reason, of course, is the rapid rise of United States health expenditures since 1965, a rise summarized by the data seen in Table 3.[26]

Table 3

Rising Expenditures on Health Care by Sector, 1965 & 1980

Year	Total Health Expenditures	Gov't Health Expenditures (Billions of Dollars)	Private Health Expenditures
1965	41.7	10.8	30.9
1980	247.2	104.2	143.0

Source: *Health Care Financing Review*, September 1981, pp. 18 and 19.

26. *Health Care Financing Review*, September 1981, pp. 18 and 19.

The bare figures show that vast changes have occurred. Not only have total health expenditures increased almost sixfold, but government spending has jumped about 10 times, and even private health expenditures have almost quintupled. Government, which provided only about one-quarter of all health dollars in 1965, now puts up more than 40 percent of the total. Because this vast inflation was not foreseen by the backers of Medicare and Medicaid, its materialization — and the hard accompanying responsibility of voting taxes to pay these huge sums — imparted a new sobriety to serious NHI discussions. The question occurred spontaneously in many minds: *If Medicare and Medicaid could help produce such explosive increases in health spending, wouldn't any system of comprehensive and universal national health insurance have even more inflationary impact?*

President Carter campaigned as a supporter of NHI in 1976. When he entered the White House, his first health priority was passage of a hospital cost-containment bill, as an indispensable prerequisite for actual NHI legislation. Despite repeated efforts by the president and his supporters, passage of the bill failed in the first three years of his administration. As a second concern regarding the cost of NHI, the president announced that he would seek comprehensive and universal national health insurance through a series of bills that would phase in NHI over a period of years. The first of this series, unveiled in 1979, emphasized above all the establishment of catastrophic health insurance, a measure that all observers had agreed earlier would be the least costly increment to existing medical cost protection for Americans.[27]

The disillusionment this produced in many Carter supporters was voiced by Dr. Peter G. Bourne, then special assistant to the president for health issues. "Though there is still strong public support for a national health program," Dr. Bourne wrote, "the American people have made it clear that they want a cut in federal spending and that their top priority is not to solve major social problems but to keep personal disposable income as high as possible.[28]

A somewhat similar sentiment was voiced half a year later by one of Senator Kennedy's chief lieutenants in the Congressional battle over NHI, Representative James C. Corman. Perhaps the strongest force hindering adoption of NHI, Mr. Corman told an interviewer, ". . . is a general reluctance by the American people to do more through public action than they already are doing." He continued, "You know, I often think that if we didn't already have a public education system, we would find it very difficult to get one now."[29]

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27. *National Health Insurance Report*, 9(13): June 15, 1979. (This is a special issue on the Carter Administration's Phase I NHI plan.)

28. *Medical World News*, February 19, 1979, p. 111.

29. *Hospitals*, August 1, 1979, p. 88.

Senator Kennedy, however, voices no such disillusionment. Instead, he argued when he introduced his latest version of a comprehensive and universal NHI bill — the "Health Care for All Americans" bill — that NHI is desirable precisely because it provides a mechanism for controlling and containing medical care costs. Here is how he put the matter when addressing the Senate:[30]

> "Every American family knows what it means to live within a budget. It is time the American health care system learned to live within a budget. The proposal I am making public today imposes such a budget. No other program to guarantee comprehensive benefits to all Americans will cost less than this proposal. In fact, once cost containment takes effect, the nation will pay less for health care than if the current non-system is left unchecked.
>
> "I see national health insurance as the last, best chance of bringing the health system under control. It is more than a financing method. It is a system that will allow the nation to budget its health care expenses prospectively and then live within it; it is a system that will provide incentives for alternative, less costly delivery models — such as HMOs — it is a system which will enable, through progressive reimbursement policies, an emphasis on prevention of disease, of increasing individual responsibility for maintaining health; it is a system in which one can improve the quality of care."

The passage of the Kennedy bill would have an enormous impact upon the United States medical care system. But, would it guarantee cost control as the senator claims? Certainly the example of other government agencies gives little reason for this great confidence. Each year Congress votes supplementary appropriations for agencies and activities whose original budgets prove inadequate. Why would a health system organized as Senator Kennedy desires be any less likely to get supplementary appropriations than the Army or Navy, food stamps, subsidy programs for farmers, or any of the other million and one government activities financed out of the budget? Is it credible than an area of the United States which exhausts its prospective budget would let the sick go unattended and hospitals close just because the money ran out? Is it likely that the provider forces in American medicine — whose power was demonstrated in the recurrent defeats of the Carter hospital cost-containment bill — would be silent while Senator Kennedy and his allies imposed their doctrines upon our vast medical care system?

But Senator Kennedy's discussion has one great merit. It focuses attention on the question of how much is enough in medical care.

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30. *Congressional Record-Senate*, October 2, 1978, p. S16814.

Historically, NHI has been associated with the idea of more and better health care for all — not with the idea of limits set in advance as Mr. Kennedy now proposes.

The point is that the demand for medical care that is seen as "free" by the patient receiving it is potentially unlimited. The amount of resources that can be marshalled to help one patient, when cost is declared no object, is truly astonishing. Some years ago the great Soviet physicist, Lev Landau, was in an automobile crash and suffered extensive brain and other damage. The Soviet Union allocated dozens of doctors and dozens of nurses to take charge of his care for many months. Specialists were brought in from abroad to assay the problem and suggest solutions that might not have occurred to Soviet doctors. When *New York Times* columnist James Reston had an attack of appendicitis while visiting China a decade or so ago, a dozen of China's best physicians devoted themselves for several days to his case — presumably to make sure that this famous foreigner did not die while he was a guest of the Chinese People's Republic. When President Henry Boumedienne of Algeria underwent his terminal illness in the late 1970s, more than 100 physicians from all over the world were brought in to help care for him and try to secure his recovery. In 1980, during Marshal Tito's last illness, a full-time group of eight leading Yugoslav doctors served him alone, while consultants were brought in from the United States and the Soviet Union to give their opinions as to what should be done.

Senator Kennedy and his advisors have demonstrated that they understand that in the field of psychiatry, NHI could face endless claims. In his Senate speech January 11, 1977, introducing the "Health Security Act," he gave this cautious statement of psychiatric benefits in his comprehensive NHI scheme: "Psychiatric service would be provided to outpatients if given for active treatment of emotional or mental disorders, and if provided by comprehensive mental health organizations. Otherwise there would be a limit of 20 consultations by a psychiatrist during a benefit period." Twenty-one months later, speaking to the Senate on October 2, 1978, to outline his latest NHI plan, Senator Kennedy was even more vague on this point, contenting himself with the statement that "Specified mental health benefits will be included." Apparently, those advising this legislator are well aware that the demand for "free psychiatric care" alone might well bankrupt any NHI scheme which tried to deliver it.

Medical progress continues to raise the cost of medical care. But, it enables physicians and hospitals to provide more care for the ill than ever before. The cost of kidney dialysis and kidney transplants, already borne by Medicare, is more than a billion dollars annually. The cost of coronary bypass operations, which prevent the pain of angina, is estimated at a billion dollars or more annually, and all the people who might want such an operation are not yet covered by insurance that pays for it. One can only guess at the demand for heart transplants when medical scientists are able

to lick the problem of rejection which now makes a cadaver transplant in a human being such a dangerous medical adventure. The mind quails at the thought of the future demand when scientists develop a usable artificial heart that will substitute for a natural heart. Who would want to die of heart disease or a heart attack if he could live longer by having an artificial heart implanted?

We return to the basic theorem of medical economics, and certainly of NHI planning. The demand for medical care which costs the recipient nothing is potentially unlimited. In any system of NHI, that demand must be checked by a more or less explicit system of rationing. Area medical care budgets, as Senator Kennedy recommends, are one form of geographic rationing, but, they wouldn't determine to whom local authorities should deny medical care in the effort to keep within a predetermined budget. The health care system would become completely politicized with different groups of patients battling for pieces of the limited "pie" of "free" medical care. Imagine the Gray Panthers attempting to advance the demands of the elderly against mothers of new babies, parents of retarded or psychotic children, the relatives of cancer patients wanting every possible therapeutic modality to be used for their loved ones, etc., etc. It is not a pretty picture.

A relatively new element in the national NHI debate has been the appearance of so-called "pro-competition" schemes. In general, these plans proceed on the assumption that Medicare, Medicaid — and by implication, National Health Insurance — are, or would be, terribly expensive, because they offer no incentive for economy either to the patient or to the providers of health care. To insure such incentives, these "pro-competition" plans seek to encourage competition among providers, and to give the public financial incentives to be interested in the cost of health care by offering financial advantages to those choosing the cheapest health insurance plan.

We can illustrate by reference to H.R. 7525 (96th Congress, 2nd Session), called the National Health Care Reform Act of 1980 and introduced by Representative Richard Gephardt and David Stockman. The core of this plan is the idea of requiring the formation of competitive groups offering health care. Organizers of these plans could vary from, say, Blue Cross or a commercial insurance company, to an individual doctor, layman, nurse, pharmacist, etc. In every locality all of these plans would be required to compete for subscribers in terms of the price and quality of the health care offered. The groups would be governed by a basic schedule of health care services required as a minimum offering. A typical worker at a company such as IBM, General Motors or Western Electric, etc., would be asked to choose between these rival options, with his employer paying the group each worker chooses to enroll in. But in making the choice, the worker knows that if he opts for a plan whose premium is less than the amount his employer is committed to paying on the average, then the difference between the employer's payment and the lower cost of a cheaper plan

chosen by the worker is turned over to that worker by his employer and is a tax-free payment. Other groups — the elderly, the self-employed, etc. — would have somewhat different, but similar, incentives for choosing the cheapest plan.

The sponsors of this plan believe, as they said in a press release dated June 9, 1980, that adoption of their scheme "would introduce financial incentives for health care insurers and providers to contain costs while improving quality, and would remove the methods of payment which now make meaningful cost containment impossible."

During 1981, the Reagan administration's efforts to keep soaring health costs in bounds focused on direct controls. These included an unsuccessful effort to put a formal cap on Medicaid costs, and also to lump a variety of categorical health programs and other related activities into block grants to the states. The efforts were far from successful. From the beginning of the Reagan administration, it was assumed that an effort would be made to work out a competition strategy inspired by, if not following exactly, the Enthoven proposals mentioned earlier. Various task forces were formed, and on December 15, 1981, the *Washington Post* reported that HHS Secretary Schweiker had submitted the following proposals to a Cabinet committee:

1. Limit an employer's health insurance deduction per employee to $150 per month for family coverage and $60 per month for single workers.
2. Give tax credits to employers who offer their workers a range of competing health plans with different schedules of benefits and different costs. The intention is to have health plans compete, since the worker would choose amongst them with the knowledge that there would be a ceiling to his employer's contribution.
3. Offer Medicare beneficiaries an option under which they would receive government vouchers equal to 95 percent of Medicare's average per capita cost. The vouchers could be used to buy private health insurance at least equal to current Medicare benefits plus some catastrophic benefits, with voucher recipients able to choose among alternative health plans according to how extensive a coverage they wanted. The more expensive the plan, of course, the more the Medicare patient would have to pay out of pocket for the difference between the value of the voucher and his new policy's cost.
4. Alternatively, Medicare patients might have to pay 10 percent of the cost of each hospital day after the first, a change from the existing system of full coverage for days 2 to 59. In return, the patient would be given a catastrophic insurance policy guaranteeing he would not have to pay more than $2,500 a year for medical care. Under Medicare at present, there is no catastrophic coverage beyond the periods of hospital days for which Medicare pays first full cost and then half cost before it runs out.

By the end of 1981, it was clear that Reagan's efforts to reduce soaring health care costs had made only marginal gains. The same was true of similar state measures focused mainly on tightening eligibility and other requirements for receiving Medicaid. These measures had only a marginal effect on reducing the number of persons covered by government-paid medical care. But there is no reason to believe that these changes had in any way caused a large decrease in the number of older Americans or poor Americans covered by Medicare and Medicaid. Meanwhile, the growing level of unemployment presumably deprived some significant number of jobless workers of the private health insurance they had enjoyed while working for private companies. This was particularly true of the large number discharged by the declining and loss-ridden American automobile industry.

Debate over the Enthoven competition proposals increased during 1981. It was widely pointed out that the Enthoven scheme raised serious dangers of adverse selection. Young, healthy workers would presumably opt for the lowest cost and least generous health plans. Older and sicker workers would presumably opt for plans offering more generous amounts of treatment and care. This, opponents argued, would tend to make the cost of health care insurance become even cheaper at the low end — since young people need little medical care — and even more expensive at the high end, since older and sicker people need much more. Addressing the American Hospital Association, Professor Enthoven recognized the force of these arguments in a speech in early September 1981. He suggested a solution could be found by narrowing the range of permitted variation between competing health care plans. His response was ironic, since it would obviously very much reduce the range of consumer choice; yet Enthoven called his scheme the "consumer choice health plan."

The second half of 1981 saw very considerable financial and legal difficulties begin to bedevil the Federal Employee Health Benefits Program (FEHBP). But Enthoven had often pointed to the FEHBP as the allegedly successful model and inspiration for his own plan. Hence, the FEHBP difficulties added to the growing skepticism about Enthoven's plan.

During the first half of 1982, the deep impasse into which the American political and economic system has fallen with respect to these issues became more evident than ever.

On the one hand, it was clear that government spending on Medicare and Medicaid had become extraordinarily burdensome. Yet Congress appeared incapable of showing the political will needed to make cuts, a failure of will similar to that exhibited with respect to the Social Security System where bankruptcy loomed as early as mid-1983. The Reagan administration, however, was apparently similarly torn by the conflict between what was economically desirable and what was politically desirable. Such key Reagan administration figures as Budget Director

David Stockman and Secretary of Health and Human Services Richard S. Schweiker, had proclaimed their fealty to the competition concept of curbing health care costs even before Mr. Reagan's election. But as the spring of 1982 gave way to summer, the Reagan administration had still found it impossible to introduce a pro-competition bill into Congress. Instead there were more and more reminders from administration spokesmen that it might yet resort to tighter regulation, i.e., go down the same path as the Carter administration.

In this situation of paralysis of political will, the central truth emerged clearer than ever before. The American people want many more benefits from Washington than they are willing to finance through taxes. In this situation, Congressmen looking toward the November 1982 election found it equally intolerable to support the reduction of Medicare benefits — or Social Security benefits — as to vote for higher taxes to pay for the benefits. In this depressing atmosphere, one could only be grateful that the United States had no system of comprehensive government NHI which would simply have made all the difficult existing dilemmas even more insoluble.

Chapter 3:
Varieties of NHI and their Lessons

The concept of national health insurance is a complex one in both theory and practice. At its simplest, NHI implies the existence of a mechanism that will help all or many citizens with some part of their medical costs. Merely to state the matter, as in the last sentence, immediately makes plain some of the variables that must be considered. What kind of mechanism shall be provided: governmental or private or some combination thereof? What citizens shall be helped: all, most citizens, only the old, only the poor, only those incurring medical costs above a certain threshold figure . . .? Which medical costs shall be covered: all, most, only hospital costs, only outpatient costs, some combination of inpatient and outpatient costs, only costs incurred for organic disorders, only costs of psychiatric illness, only catastrophic costs? How shall medical care be organized under NHI: based on solo practitioners and private hospitals, based only on so-called health maintenance organizations (HMOs), under a pluralistic system in which the patient can choose the source of his medical care, under a nationalized medical system delivering care through hired physicians and government-owned-and-operated hospitals? What do we mean by medical care? Shall we include the services of chiropractors, psychologists, nurse practitioners operating independently, denturists, dentists, optometrists, marriage counselors, naturopaths, rolfers, podiatrists, physical therapists, art and music therapists, faith healers, Indian medicine men, African witch doctors, physicians' assistants, pharmacists giving primary care, midwives, Christian Science readers?

NHI has many dimensions. Some of these dimensions have been illustrated by the conflicting NHI bills which have been offered in Congress the past decade or more. Some sponsors, for example, have shown a preference for a system of NHI combining relatively comprehensive and universal benefits — though with important exclusions and limitations — with an all-government insurance and administrative mechanism engaged in centralized economic planning of American medicine. At another extreme, Senator Russell Long's name has been associated with a bill that primarily favors insurance for catastrophic illness. Representative Ronald Dellums and a number of leaders of the American Public Health Association have urged the full nationalization of American medicine so that physicians become hired hands and hospitals government property.

If we turn our eyes outside the United States and view the medical arrangements of other countries — many of which are usually classified as having NHI — we find a bewildering congeries of systems of medical care and insurance for it. In the Soviet Union, most medical care is provided "free" at time of receipt through a completely socialized system. But the Soviet Union really has two medical systems. One, for the great majority of citizens, emphasizes quantity over quality; the other, for the nation's

political, military and related elites, seeks to provide medical care at a respectable Western European level, even if that requires the importation of foreign physicians from the United States or elsewhere to give consultations or, in some cases, to operate on an influential Soviet leader.[31]

In West Germany, physicians practice fee-for-service medicine, while payment for the majority of the population is provided by one of several hundred "sickness funds," financed equally by employers and employees, and excluding only the self-employed and those who opt for completely private health care.[32]

In Italy, a new "free national health service" came into existence January 1, 1980. One account of the immediate consequences related: "Now Rome's hospitals are bursting at the seams. Nurses have been joining forces with patients to keep out new arrivals. Ambulances charge frantically across the city trying to find hospitals for their patients. At the hospitals of San Giovanni and San Camillo, beds jamming the corridors have been thrown out of the windows by angry nurses. Newspaper reports say patients have been pestered by mice, rats, bugs, and even ants, as the staff found themselves unable to cope with overcrowding."[33]

In Britain, the National Health Service (NHS) is now more than 30 years old. It is based on a system in which all inpatient and outpatient care by NHS personnel in NHS facilities is "free" at time of receipt, i.e., paid for primarily by taxation with insurance premiums making a small contribution. British physicians have been divided into what are, with few exceptions, two mutually exclusive groups: general practitioners (GPs), who give outpatient care and refer patients to specialists and hospitals, but do not treat their patients in hospitals; and consultants (specialists), who focus on hospital care and are aided by a small army of specialists in training, those corresponding very roughly to residents and fellows in United States hospitals. An unanticipated consequence of the NHS has been the following situation described by a British publication in January 1980:[34]

"If you live in the northwest of England and are admitted to a hospital, you will find that nearly every other doctor comes from overseas, most likely from Asia. The chances are much lower if you live in the west or southwest; in and around London they are roughly one in three . . . In England as a whole, nearly a third of hospital doctors qualified overseas, but only 14 percent of general practitioners."

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31. Cf. Vladimir Golyakhovsky, "Soviet Medicine from the Inside. Bribery as a Doctor's Way of Life," *Medical Economics*, February 18, 1980, pp. 220-234.

32. Jonathan Spivak, "Health Cost Controls in Germany," *Wall Street Journal*, December 19, 1979.

33. "Italy's Health Service Bedlam," *The Economist*, February 9, 1980, p. 46.

34. "Doctors, How's Your English?" *The Economist*, January 26, 1980, p. 26.

The point of this complaint is that many foreign-trained physicians are not as well-trained as British-born physicians, and often have problems communicating with their English patients.

NHI in Canada is based on two legislative acts — the Hospital Insurance and Diagnostic Services (HIDS) Act and the Medical Care Act (MCA), which were implemented on July 1, 1958, and July 1, 1968, respectively. There are differences in detail among the provinces, but for most purposes Canada can be regarded as having a national system of NHI with administration by provincial governments.

In Britain the division between GPs and consultants results in two different forms of payment: the GPs receive a fixed annual capitation fee for each person on their lists of regular patients; the consultants and their assistants are hired employees of the state, receiving salaries. British NHS hospitals are all state-owned. In Canada where doctors practice more or less as they do in the United States — i.e., the same doctor usually provides outpatient and hospital inpatient care— physicians are paid on a fee-for-service basis. The fee schedules are decided upon in each province by negotiations between doctors' organizations and the provinces — negotiations in which the provinces normally have the upper hand. Many hospitals in Canada are still nominally privately owned, but since they depend for almost all of their income on government payments based upon earlier province-approved budgets, they have little or no room for independent initiatives.

In this section we shall focus on the lessons the United States can learn from the experience of NHI implementation in Britain and Canada. To do so is not to imply that nothing can be learned from other countries, as well. But space and other resources available here permit detailed treatment of only these two countries. Moreover, even if only because of common language and geographical propinquity, United States medicine traditionally has close ties with the medical systems in Britain and Canada. Finally, we are able to take advantage here of two important studies by Professor Cotton M. Lindsay and his associates, of the Canadian[35] and British[36] experiences with NHI.

The Canadian experience was injected forcibly into the United States NHI debate by Senator Kennedy in the late 1970s. He held a series of hearings across the country, aimed at getting massive publicity through television, radio and newspapers.

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35. Cotton M. Lindsay with Steven Honda and Benjamin Zycher, "Canadian National Health Insurance: Lessons for the United States," (Roche Laboratories, Nutley, N.J., 1978), referred to hereafter as "Canada."

36. Cotton M. Lindsay with Bernard Feigenbaum, Steven Honda, Kenneth Tamor, Robert Williams, and a concluding essay by Arthur Seldon, "National Health Insurance: The British Experience," (Roche Laboratories, Nutley, N.J., 1980), referred to hereafter as "British."

At each hearing the Senator presented American families who were severely hit financially by the costs of particular illnesses or injuries. Simultaneously, he presented Canadian families with similar problems whose medical bills were paid by Canada's health insurance system.

The Senator insisted that these vivid contrasts proved the necessity of a national health insurance system for the United States, a system such as he advocates. Independent observers could not help but notice, however, that at most, his evidence showed the desirability of having catastrophic health insurance to help the tiny percentage of Americans who annually go through such financially disastrous experience. But Senator Kennedy frequently records his opposition to catastrophic insurance, while supporting his own proposals for a comprehensive version of NHI.

Professor Lindsay's analysis of the Canadian experience focuses on three issues:

- the short-run impact of NHI on access to medical care;
- the long-run effects of NHI on access to medical care;
- the budgetary consequences of NHI on alternative forms of social welfare expenditure and activity in Canada.

On the first question, citing earlier studies in particular areas, Professor Lindsay concludes that "these studies suggest . . . on the average, access to care in Canada was increased for lower income groups and reduced for upper income groups by the introduction of National Health Insurance. The evidence is far from conclusive, however, and must be treated with caution. Access is imperfectly measured by any of the statistics employed in these studies. Even [using] physician visits per year per capita fails to control for the quality of visits."[37]

In the short run, Professor Lindsay argues, NHI affects distribution of care. It substitutes rationing by waiting in queues, for rationing by market price. But in the long run, the distribution of medical care is ultimately decided by the geographical distribution of health care resources, particularly of physicians. Using an analysis based on economic theory, he argues that the long-run consequences of the controlled fee system used in Canada are the following:[38]

> "1. Greater variance will exist in the distribution of physicians across regions relative to pre-NHI conditions. Those areas previously endowed with a larger than proportionate share of physicians will attract even more. Those which were relatively undoctored will obtain proportionately fewer.
>
> "2. Increasing relative scarcity of physicians in unattractive areas coupled with the shift to zero pricing of medical services will confront

37. "Canada," p. 13.

38. *Ibid.*, p. 16.

practitioners there with incentives to lower the quality of care they provide. We predict that in these areas, office visits will become shorter, house calls will be more difficult to arrange, and other adverse effects will occur due to reduced resource commitments per patient.

"3. While queues should continue — indeed become worse — in the long run in the unattractive regions, the opposite conditions will prevail in the attractive regions. This scarcity of patients in the attractive regions should itself produce several disquieting results. Physicians will be employed fewer hours per week in these areas, and they will be treating increasingly trivial complaints."

The reasoning behind these conclusions can be summarized as follows: Physicians choose their location by considering both the income they can earn in a particular place and the environmental advantages there — such things as the quality of the schools, the availability of entertainment and of people with like cultural levels, the safety of the neighborhood, etc. In attractive areas, physicians are willing to accept lower incomes in order to enjoy the amenities of those neighborhoods. Many physicians are therefore willing to settle in the attractive regions even though their incomes are lower there.

In unattractive regions — inner city neighborhoods for example — physicians will be willing to settle only if they can get high incomes to compensate for the relative lack of amenities. In fee-for-service practices, as in Canada, high incomes are generated by having patients waiting in queues, so each day's time can be fully spent taking care of these patients and earning the consequent high income. High income is possible only if the patient load available in an unattractive neighborhood is shared by relatively few physicians.

These conclusions are generally supported by an econometric analysis carried out by Lindsay and his associates. This analysis suggests that physicians in Canada are particularly attracted to urban areas. When some Canadian specialists objected that this was contrary to their experience, a check was made with counties in Quebec. Between 1965 and 1975, for the most part, the physician population of different counties increased in a manner roughly corresponding with the degree of urban population. The least urban counties of Quebec increased their physician population only 7.3 percent over this decade, while the counties that were more than 60 percent urban increased the number of their physicians by between 29 and 45 percent.[39]

Lindsay and associates also probed whether other categories of Canadian government spending suffered because of the market increase of NHI expenditure from the 1950s to the 1970s. In 1958, when the hospital insurance plan was inaugurated in Canada, total NHI-type spending in

39. *Ibid.*, pp. 18-25.

Canada, in constant 1976 dollars, was $637,470,000; by 1976 this cost, again in constant 1976 dollars, increased to $6,387,510,000, i.e., almost 10 times.[40] Lindsay, *et al.* engaged in an econometric analysis and concluded that, "provincial HIDS and MCA spending has been financed in substantial part through social welfare cutbacks . . . ." Their full conclusion is worth quoting verbatim:

> "Finally, our study has sought to find out who actually pays for National Health Insurance. Our results here indicate cause for genuine alarm. We find that both the hospital and medical care parts of the program have been financed by displacement in the budgets of other social welfare spending categories. While it has been shown that, in the short run, low-income groups seem to get somewhat more care than they would have been able to obtain before NHI, they are not the only groups consuming care under this program. Sixty cents of every dollar spent on these combined programs is taken from cutbacks in funds for aid to the blind and disabled, workmen's compensation, and family allowances. Such an arrangement seems inconsistent with at least some of the broader aims of all these programs."[41]

We may update the preceding analysis of the Canadian situation by noting that, in 1979, a major confrontation developed between administering authorities for NHI in many provinces and Canadian physicians. This arose from the toll wreaked on the latter's living standards by the disparity between Canada's rapid inflation and the much slower rise of physician income.

The tension expressed itself most vividly in Ontario, where many physicians announced they would not accept government fees for their services, but would charge patients higher fees. The political storm that followed produced strong pressure that forced the Ontario Medical Association to give assurances that physicians accepting government fees would be available everywhere in the province. When the Conservatives under Joe Clark took power in mid-1979, doctors hoped his government would improve the situation. But Mr. Clark's period in power was brief, and by early 1980 the Liberals again held power.[42]

The Lindsay examination of the British experience is a fundamental and many-sided study. It begins with an examination of what medical care is really about, and whether this care can or should be distributed according to "need." Most medical care (given and received) has very little

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40. *Ibid.*, p. 28.

41. *Ibid.*, pp. 36-38.

42. Harry Schwartz, "Medicine in Canada," *Private Practice*, August 1979, pp. 35-37.

relationship to "need" as it relates to the avoidance of life-threatening conditions, crippling injury, or the like. Most doctor visits in a highly developed industrial country like the United States or Britain are for relatively trivial reasons. Most ailments people complain to doctors about are trivial in the sense that they are self-limiting and will go away whether or not a doctor is consulted. What the patient really seeks, and usually gets in these encounters is reassurance, which is important but hardly vital to life. A good deal of primary care is devoted to psychosomatic ailments or to assuaging a patient's loneliness. Some doctor visits are for preventive care, as when one goes to get vaccinated against tetanus. Others tend to be routine or needed for credentialing purposes only, as when one gets a physical examination before entering a new job. Correspondingly, much of what a doctor does is to show compassion for, and interest in, an unhappy patient, or to prescribe medicines that will give symptomatic relief from complaints that range from insomnia to coughing and sneezing. These and related services are *not unimportant*; on the contrary they do much to determine a patient's satisfaction with his medical care and his estimate of its quality. A doctor striving to obtain a fee for his services knows that his manner, his interest and his reassurance are at least as important in most patient encounters as his knowledge of technical medicine.

A doctor in fee-for-service practice is concerned with these issues, because his patient can change physicians if he is not pleased by the caliber of services received. But when the government provides medical care, as it does in Britain, it knows that whatever resources it provides will be used because they are "free" at time of use. Moreover, even with the best will in the world, the government supervisors of the British NHS have only limited capability of overseeing the physicians who give the actual care. As Lindsay and associates point out:[43]

"Certain characteristics of products — particularly services — are excessively costly to monitor. Government must depend on agencies themselves for most of the information concerning how much of each characteristic has been produced. The value of such information will therefore depend on the likelihood that government can verify its validity. It will depend, in other words, on whether the information is easily audited. The actual production of certain characteristics is not easy to audit. The number of appendectomies performed can be verified by contacting those on whom the operations were allegedly performed. Other characteristics are quite costly to audit. Consider the counseling of patients, the words of encouragement, and the examinations and tests that yield negative results. The production of these characteristics cannot be monitored. Validation of their production would be excessively costly; hence the government will make no effort to ascertain whether they have been produced."

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43. "British," p. 55.

Lindsay and associates argue that "invisible" aspects of medical service — privacy, courtesy, pleasant surroundings, reassurance — will be given less importance in government medical systems since they cannot be measured and counted. Hence, no effort will be made to budget these characteristics nor will health service managers be concerned about them. "Because it does not spend on such invisible output, the NHS finds it possible to operate at a much lower per capita expenditure level than does the health care sector in the United States . . . . This does not imply necessarily that their organization is more technically efficient at producing health care than ours. It is rather an implication of organization of health care under a bureaucratic system. Medical care in the U.S. is more costly because it is a more varied, higher quality product, at least in the important eyes of the patients."[44]

Because the NHS cannot count the invisible quality characteristics of medical care, it does not pay doctors to provide them. As a result, British physicians have an incentive to spend as little time as possible with each patient. "We would therefore predict that the health service may 'get along' with fewer physicians since each is providing a narrower range of services and doctor time is not devoted to providing these invisible characteristics. We are not surprised to find therefore that since 1960 there have been consistently between 21 to 27 percent more doctors per capita in the U.S. than in England and Wales."[45]

In the United States, an unsatisfied fee-paying patient can go to another physician. That freedom of patient choice inevitably exerts useful pressure on American doctors to meet their patients' expectations.

At this point some may object that the "invisible" aspects of medical service are the non-essential frills. Is it not possible that the national health insurance schemes of Canada and Britain, by concentrating on "essentials," do a better job and produce more health than does the United States system? The same question has occurred to Lindsay and associates, who have carried out an econometric analysis of the relationships between such indicators as cancer deaths, death rates, life expectancy of males and females, and infant mortality; and the changing medical organizations and resources of the three countries. Here is their answer:[46]

> "In summary, we find no evidence that government intervention in the organization of health care better satisfies the needs of the public for health care. Neither the NHS of the United Kingdom, the HIDS and MCA insurance programs in Canada, nor Medicare-Medicaid in the U.S. have influenced indicated health status when other

44. *Ibid.*, p. 55.

45. *Ibid.*, p. 55.

46. *Ibid.*, p. 27.

influences have been taken into account. The idea of resource allocation in the health area, based on need, appeals to our sense of ethical priority. This imperative contains no useful advice, however, concerning either the allocation of these resources or governmental health policy. Health care resources apparently find their way to people in genuine medical need regardless of the organizational setting."

The core of a national health insurance system of a comprehensive nature is that it reduces the apparent price of medical service to zero. How do consumers react to this situation of "free" care, and how do those charged with providing medical resources decide, with no price figures available to guide them, what resources to make available, in what amounts, and at what places? These are the basic economic problems of comprehensive NHI.

On the demand side, if we look at the NHS hospital situation, the most obvious fact at any given time is the existence of a queue, of numbers of people waiting their turn to be admitted to a hospital to be treated for some disease, or cured of some physical infirmity or injury. In 1949 the number of persons in England awaiting hospital admission was 460,000. By 1976, it was 607,000, and by March 31, 1979, it was 752,450.[47] Of the latter, 52,950 were awaiting "urgent" admission. Lindsay and associates suggest that people join a hospital queue if they have a condition they wish remedied and if they believe they will still have that condition when they are finally admitted to the hospital. Thus, a man with an eye cataract will be willing to wait for an eye operation in an NHS hospital even if he knows he will have to wait a year or two, because he will still have the cataract at the end of that time. Similarly, in some areas of Britain, it is necessary to wait up to five years for a hip replacement operation. The arthritic woman waiting that length of time will probably be worse, not better, after having waited five years.

If we look at the supply side of the problem, administrators of a "free" medical care system lack any meaningful price system to guide them. In this situation decisions tend to become arbitrary. Sometimes they derive simply from current fashion as in the era when British medical planners thought that very large hospitals were desirable because they centralized care for extensive regions. The planners forgot that patients and their families want hospitalization to be close to home, so as to make visits to the sick family member as easy as possible. Or, key decisions may be made purely on political considerations as part of the ruling party's effort to keep power. Lindsay and associates conclude from their mathematical analysis that in the NHS, capital construction allocations have tended to be made to districts and regions where close races were anticipated in the next

47. *Ibid.*, p. 40; also *British Medical Journal*, November 17, 1979, p. 1300.

parliamentary election. Each additional close contest, they find, is worth 48,000 British pounds of capital spending in the area involved, during each of the two years before the election.[48]

Americans cannot afford to be superior in this respect. The abundant government intervention in the United States medical system has often been both arbitrary and politically motivated. One thinks of all the hospitals built in the United States under funds made available by the Hill-Burton Act. In the 1970s, many of these hospitals were suddenly discovered to have much more capacity than really needed, as government policy went through a 180-degree swing and focused on trying to shut down hospitals and eliminate beds. In 1979 and 1980, residents of New York City could watch a political contest decide whether three of the city's hospitals — Brooklyn Jewish, Metropolitan, and Sydenham — would close or remain open. In the first two cases, the political pressures were strong enough to override economic considerations. Federal and city officials bowed to the political necessities generated by the large amount of employment each hospital provided for neighborhood people, and also the reluctance of the population living near each hospital to face the prospect of having to travel farther to a hospital if any one of the three was closed down. It was hard, watching these feats of political acrobatics by some of the highest elected and appointed officials of New York City, New York State, and the United States, to disagree with the cynics who held that hospitals exist for the benefit of their employees, regardless of what they may or may not do for the sick. Arthur Seldon, a veteran observer of the British NHS, makes much the same point in a contribution to the Lindsay book on Britain:[49]

> ". . . although the NHS operates in a country with long classical liberal traditions in public debate and policy, it has in 30 years added to its emotional origins the muscular occupational interests from professional organizations of doctors, to trade unions of porters, laundrymen and cooks. They will understandably resist reform and use their monopoly powers over life and death to induce government into providing the tax revenue to maintain the NHS, whatever the advances in medical technology or patient preferences that indicate reform or replacement . . . . The NHS can thus no longer be analyzed as the original aim of constructing a means to better health; it has become an end in itself which provides the livelihood for approaching a million people and their families. It will require far-reaching change in the conditions of supply and demand to reconcile them to reform . . . . The evidence came at the turn of the year

48. "British," p. 99.

49. *Ibid.*, pp. 103-104.

1978/9 with strikes by NHS employees for higher pay, and with all the unavoidable consequences for patients, followed by refusal by some doctors to work with operating theater staff who had stopped surgery by striking."

What are the specific lessons we can learn from the Canadian and British experiences with NHI?

1. NHI politicizes the entire health system of a nation, as well as its personnel, so that instead of depending upon need, the health care personnel and resources of every region come increasingly to depend upon the region's *political influence* in the capital of the nation, or in the state where the central decisions are made regarding resource allocation.

2. With NHI, demand for "free" care expands, while those in charge of medical care expenditures find themselves under ceaseless pressure to cut the size of the health care budget or at least to restrain its rocket-like ascent into the stratosphere. Faced by demand that exceeds supply, equilibrium can be created only by a new rationing system, long waiting lists for service or hospitalization, or by physicians' lowering the quality of services by decreasing the time spent with each patient, etc. The personal and human relationships in medical care, which fee-for-service tends to promote, become less and less important under NHI because the contribution to quality of care made by these "invisible" elements cannot be counted by the authorities. The tendency, therefore, is for care to become more impersonal, more routine and more bureaucratized.

3. A short-run result of NHI may well be to increase the use of the medical care system by the poor at the expense of the more affluent. This tendency has already been observed in the United States as a consequence of Medicare and Medicaid. But over the long run, NHI, as praticed in Canada, tends to make outlying rural areas, inner cities, and other areas of physician shortage even less desirable to doctors than before NHI.

4. Once a nation adopts NHI it finds that in each year's budget planning a huge amount is being claimed by the medical system. The tendency, as shown by the Canadian experience, is to compensate in part by reducing or holding down the growth of other social welfare programs in the budget, even those aimed at helping victims of adversity such as the physically handicapped, retarded children, etc.

5. There is no persuasive evidence that in a country which already has a highly developed medical system, the conversion from private medicine to NHI will make any significant contribution to the national health. In such a highly developed medical system, whatever its organization, improvements in health result from technical and scientific progress — such as the polio vaccines which have virtually wiped out infantile paralysis in the United States, Canada, and Britain — which are available regardless of organization. Or they come from mass changes in individual habits of life: the cessation of smoking; changes in diet; adequate, healthful exercise;

etc. If anything, a private medical system tends to adopt a technical gain more rapidly than a country with socialized medicine. The CAT scanner, the most important advance in medical diagnosis since the discovery of the x-ray, became available to millions of Americans very quickly, while in Britain — where the CAT scanner had been invented — very few hospitals were able to get one at all. And many of the few British hospitals that did secure this vital diagnostic tool were able to buy it only because their local communities contributed the needed funds. The British resorted to private resources because the NHS authorities were unwilling to budget money for these machines.

Finally, and most ironically, countries with NHI tend soon to develop pressure for at least partial reinstatement of private medical care, complete with fee for service. In Canada, the demand of physicians to be able to set their own fees caused a mini-crisis in Ontario Province in 1979. In recent years, Britain's Labor Party has pressed hard to wipe out private medical practice in NHS hospitals by outlawing "pay beds" for private patients. The Labor Party campaign achieved partial success, but recent British data suggest a growing popular interest in greater access to private medicine. Arthur Seldon has described the consequences of the Labor Party campaign:[50]

> "The phasing out of the 4,500 pay beds (out of 450,000 NHS hospital beds) has led to the predictable but unexpected effect of phasing in the two standards (of medical care) by increasingly segregating the impersonal NHS from the 'personal' health services. No doubt the intention of the ideologues is to emphasize the contrast and thus generate public support for the prohibition of private medicine *in toto*. In that event it would probably move to Ireland, or to British enclaves such as Gibraltar, or to the nearby countries of Europe. Whatever the ultimate political intention, the short-term effect is to accelerate the increase in private insurance, attract American hospital companies to build in Britain and provoke new forms of financing, such as interest-free credit by American Medical International for private hospitalization of people waiting for non-emergency surgery . . . .
>
> "Two further indications of trends in 'the next 30 years' are the offer of (a private medical insurance policy) by IBM . . . to all of its employees, blue- as well as white-collar, and the first national trade-union agreement, negotiated by the electricians' union with the employers, to cover 40,000 workers on building sites, for (private) screening and treatment. It is hardly likely that either will be the last of its kind."

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50. *Ibid.*, p. 113.

Since the United States is a much richer country than Britain, it seems likely that any effort to create an inferior and mediocre NHS would provoke a far larger movement to preserve large areas of private medicine, with its superior and more compassionate care.

Chapter 4:
Implications for the United States

The early 1980s have not, so far, been happy years for the most enthusiastic proponents of comprehensive, government-dominated national health insurance. For instance, in March 1980, President Carter submitted his second budget for that year — one that took account of the unprecedentedly high peacetime inflation raging at that time. The president declared his determination to cut government spending, adding that "I will defer or reduce or cancel most of the new or the expanded programs which were originally proposed" in the first 1981 budget sent to Congress earlier in 1980.[51]

In the campaign for the Democratic nomination for president, NHI was largely ignored by President Carter. Even Senator Kennedy was forced to recognize the paucity of popular enthusiasm for NHI by downplaying the issue in his campaign. And while the 1980 Democratic Party platform gave a ritual endorsement to NHI, when Kennedy supporters at the August convention sought to have the platform demand immediate institution of NHI, they were soundly defeated by the majority Carter forces. When Senator Kennedy addressed the Democratic Convention, he was reduced to claiming NHI was good because the top officials of the federal government have free and quick access to government doctors when they get a cold, or something of the sort.[52] He neglected to add that when these high officials have a really serious illness, they often turn to private doctors who require payment. The late Senator Humphrey, for example, turned to surgeons in New York City and Minneapolis when he was fighting the cancer that eventually killed him.

In the Reagan-Carter presidential contest of late 1980, the issue of NHI played virtually no role. Instead, the emphasis was on the serious inflation wracking the United States, and on the oppressively high rates of interest that inflation had brought. The Reagan victory was properly seen as a public revolt against the mindless spending policies of the past. In 1981, Congress gave President Reagan some important victories in budget battles centering on the need to restrain spending levels. Democratic liberals in Congress concentrated on trying to preserve as much as possible of past spending programs for health purposes, and they took it for granted that the climate was not propitious for pushing new programs such as NHI.

Nevertheless, it would be wrong to assume that NHI is a reform whose time has passed and shall never return. Our review of its history shows that

51. *New York Times*, March 15, 1980.

52. *Ibid.*, August 13, 1980.

NHI is a phoenix which rises again and again. *We must assume it will reappear.*

What can be said about NHI in the United States in the light of available evidence, particularly the preceding analysis?

- First, as we have shown earlier, the United States is far closer to having all of its people protected against the costs of illness than common discussion supposes. We have a pluralistic, partially overlapping and duplicative, untidy combination of arrangements, which gives full or partial protection against medical costs to well over 90 percent of Americans. The crude notion — so beloved of Soviet propagandists and some American cartoonists — that the average American cannot afford to consult a doctor or enter a hospital for treatment or surgery is simply untrue. Since much of this existing protection by government or by employer-paid insurance costs the beneficiaries little or nothing, the problem in United States medical economics is not that medical care costs too much — but that for millions of Americans it appears that medical care is free and, therefore, not worth economizing on. On a per capita basis, the poorest Americans consult physicians more often, and spend more time in hospitals, than do more affluent Americans.
- Second, by every conventional measure of national health — death rate, infant mortality, etc. — the United States population is now healthier than ever before in our history. A corollary of that fact, of course, is that the number of Americans over 65 and over 75 years of age is now increasing rapidly. This development poses ever more difficult problems for our society, which has never before been required to provide care and shelter for so many older persons, many of whom cannot be self-supporting and many of whom have no families that feel any obligation to take care of them.
- Third, the United States has never had such abundant human and other resources for delivering health care as it has now. And those resources are far more effective in fighting disease and death than they used to be. The number of American physicians has increased by more than 100,000 in the past decade or so, growing at a rate of three times that of the population. The result is that even the United States government — so long preoccupied with "the great physician shortage" — is now worried about doctor surpluses and is trying to reverse the incentives it created to stimulate the production of more and more doctors.

  With regard to hospitals, whose construction and expansion were so long fostered by the Hill-Burton Act, a similar 180-degree policy shift has occurred. Now government officials talk only of

"bed surpluses" and the need to close down or reduce the size of hospitals, which in many cases would not even exist if it had not been for earlier government action. The supply of modern life-prolonging and life-saving technology in our hospitals is greater and more useful than ever. It is, however, now seen as a curse by our bloated government and private health bureaucracy, whose chief instruction is to reduce costs. But the rest of the world sees, respects, and envies the excellence of the American medical system. When King Khalid of Saudi Arabia needed heart surgery some time ago, he went to the Cleveland Clinic in the city of that name. When high-ranking Kremlin figures have needed major surgery in recent years, they have imported Dr. Michael DeBakey of Baylor and skilled ophthalmologists from Johns Hopkins University. This is certainly only the tip of what is undoubtedly a huge iceberg of resort to American medical care by the powerful and affluent of the outside world.

- Fourth, one conclusion with implications for the future emerges from this analysis: If the United States could start all over again and think of NHI *de novo*, then the obvious solution would be a form of catastrophic health insurance. This would be based on consumers paying their own medical bills so long as these did not exceed some agreed percentage of their income (5, 8, 10 percent?), and then receiving first partial and then complete protection, as the medical bills for catastrophic illness mounted still higher.

A catastrophic-insurance-only plan would have two basic advantages:

First, it would restore both patients' and doctors' interests in economizing on the use of medical care, because patients would pay for most of their usual and routine visits to doctors and stays in hospitals. There is no better mechanism for inducing thrift in medical care than the self-interest of the patient who has to pay the bill.

Second, it would provide protection against impoverishment and bankruptcy that life-endangering illnesses like cancer; or chronic, disabling diseases like multiple sclerosis or amyotrophic lateral sclerosis can cause. Simultaneously, it would provide health care for the poor who have little or no income.

Yet, even this arrangement has hidden dangers. The rapid progress of medical science has made it possible to keep people alive — often as human vegetables — long after all possibility of recovery has vanished. The Karen Quinlan case is the most publicized example, and further medical progress is likely to create ever more numerous means of keeping tomorrow's Karen Quinlans engaged in meaningless metabolism at great cost. Therefore the catastrophic health system recommended here would have to have as an adjunct a "Life Committee" which would decide when all hope of useful intervention has vanished and further life support should be withdrawn.

But of course the assumption made that there would have been no existing medical insurance is an assumption contrary to fact. We repeat: The overwhelming majority of Americans have some kind of health insurance, and most of that majority has rather adequate protection against even health catastrophes. It is hard to deprive people of something they have and value. Nevertheless there are times when it must be done, or at least attempted.

As 1982 began, it appeared that President Reagan might attempt to make two important changes in Medicare and Medicaid.

One proposal was that Medicare recipients be required to pay 10 percent of the cost of hospital days that are now fully covered. This would be offered as a trade-off for catastrophic health insurance covering expenditures over $2,500 a year. Readers will see that this proposal is entirely in the spirit of the ideas stated above.

Second, there was a proposal that an attempt be made to require some level of co-payment from Medicaid recipients. The objective is not to bar them from receiving medical care but to encourage them to use medical care more economically and soberly than it is used when it is seen as completely free. This, too, makes sense except in the case of the completely destitute for whom, presumably, appropriate provision will be made. But as of mid-1982, the political paralysis that seemed to grip Congress and the White House as regards the 1983 budget made all near-term prediction extremely hazardous.

Nevertheless there is a need for incremental changes which will improve the lot of those Americans who have no health insurance at all, or who are seriously underprotected. It should be stressed that some of these people can afford to purchase medical insurance. A study cited earlier found that in the middle 1970s, one-third of the 12,000,000 plus people having no public or private protection against health care costs were in families with incomes of $10,000 a year or more.[53]

For them — and for others like them among those having grossly inadequate health insurance — the government might well encourage private insurance companies to offer catastrophic health insurance policies with a maximum out-of-pocket limit on the cost payable by those insured. Such insurance should not be very expensive if it covers millions of people, as it easily could. A similar program with government subsidies might aim at making analogous insurance available to unprotected and underprotected people earning less than the equivalent of $10,000 annually.

This prescription will, of course, disappoint those groups which for decades have dreamed of radical changes in the American medical care system. But, as our earlier survey of the British and Canadian systems showed, radical change brings its own problems, many of them

53. Sudovar and Sullivan, *op. cit.*, p. 18.

unexpected, which may be worse than our current problems. The old adage, "better the devil you know than the devil you don't know," would seem very apropos here.

The more basic problem, however, is that of the *system of rationing* we wish to impose upon our health system. The earlier growth of health insurance in this country has made medical care appear free or cheap to a large fraction of Americans who have extensive and comprehensive coverage. Predictably, Americans have responded by taking advantage of this increased access. Moreover — very much in the American spirit — our people have demanded access not just to the medical system, but to the medical system reinforced with every modern device or technique that may improve diagnosis and therapy. The clamor to impose cost controls is simply a demand to put in a new system of rationing health care, either by limiting patients' hospital stays (as policed by the Professional Standards Review Organizations); or by denying hospitals the right to buy expensive new equipment or to build new premises (as policed by the Health Systems Agencies); or by spurring the growth of medical care organizations, whose economic incentive is to do as little as possible for patients as inexpensively as possible (as is true of the so-called Health Maintenance Organizations, or HMOs).

The difficulty in these schemes is the increasing suspicion that some rationing measures may cost more than they save. Such charges have been levied repeatedly at the Professional Standards Review Organizations. Skeptics have asked whether growth of HMOs in recent years has really cut medical care costs, if one adds to the calculation the millions of dollars the government is spending to subsidize many of the new HMOs.

Unfortunately, it is unlikely that all major political leaders in this country will soon come to understand that the realization of NHI as free and comprehensive medical care for everyone is impossible, and that the only real question is how we wish to ration medical resources. The concept that the demand for "free" medical care is ultimately infinite is repugnant to many political leaders. To some, it is repugnant because it contradicts their sincerely held idealistic beliefs that a sort of "medical Utopia" could be reached — if only conservative opposition could be defeated. Others find this notion repugnant because they see present and future political gains accruing to themselves in their guise as determined and persistent advocates of NHI.

It seems fitting, therefore, to close with a quotation from the Harvard University Medical Center publication, *Focus*, reporting on the speech that Health and Human Services Secretary Patricia Roberts Harris gave when she attended the commencement services in June 1980, at the Harvard Medical School:

> "In my opinion, the major impediment to the speedy adoption of National Health Insurance is a concern that the health care cost rise is

inexorable, and that the best way to control health costs is by limiting coverage and access to health care . . . .

"The government's role in improving access to medical care and in controlling costs is here to stay," she declared, "and it is a question of when, not whether; of how, not whether, we shall have government-supported universal health insurance in this country.

"It may take two months, it may take two years, it may take two decades, but it will come. It may come in pieces, it may come in total, but full health insurance will come in our lifetime."

Faced with the fanaticism so explicit in that speech, proponents of a rational health policy, built on the reality of American life and on awareness of the finite nature of our resources, can only hope that continued debate may suffice to open the minds of even NHI proponents such as Mrs. Harris.

We can end on a more optimistic note, however, by realizing that the long debate over NHI and the actual experience with private health insurance, Medicare, and Medicaid, has taught most Americans some important truths. We live in an era when even a Senator Kennedy argues for NHI as a means of limiting health costs. But inevitably, that claim is unlikely to inspire the fervor and zeal that NHI inspired in an earlier and more innocent era. The head, rather than the heart, is likely to continue to dominate discussions of health care financing during the 1980s. We have paid a high cost for past illusions, but some important lessons have been learned and will continue to help shape the national debate in this important area.

About the Author

Dr. Harry Schwartz is currently Writer in Residence at the College of Physicians and Surgeons at Columbia University. Dr. Schwartz's many articles on health-related matters have appeared in the *New England Journal of Medicine*, *The New York Times*, *The Wall Street Journal*, *Newsweek* and *Fortune* magazines, *Private Practice*, the *Reader's Digest*, *Medical Economics*, and many other health publications. He served on the editorial board of *The New York Times*, writing often on health care, from 1951-1979.

Dr. Schwartz received his B.A., M.A., and Ph.D. degrees at Colombia University and was a distinguished Professor of Economics at the State University of New York (New Paltz). He was formerly a Professor of Economics at the Maxwell Graduate School at Syracuse University, and has also taught at Princeton and New York University.

He is the author of 19 books, the majority of them dealing with the Soviet Union, Eastern Europe, and China, and a prior book on medicine entitled *The Case for American Medicine.*

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