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NATIONAL HEALTH INSURANCE

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TWO HEALTH INSURANCE PLANS—EACH WITH PROBLEMS

The financing of American health care is in the process of rapid, mushrooming change. In 1966, Government financed Medicare programs for the old, and Medicaid programs for the poor, began sharply to increase demand for health services and added substantially to a pre-existing inflationary trend in health costs for ever more complex services. These rising costs made health insurance increasingly necessary. But the insurance itself—by encouraging expenditures and reducing market mechanisms for holding down costs—added to the inflation.

It quickly became evident that the Government had a responsibility to be sure all citizens were encouraged (or required) to have such insurance at costs they could afford and that steps be taken to halt the inflation. The means of doing so were, however, highly controversial. And many believe that far-reaching changes in the organization of health services are necessary not only to control costs but also to ensure equity.

Senator Edward M. Kennedy did much to publicize the plight of the uninsured and he introduced, as a vehicle for discussion, a far-reaching bill: that would have covered all citizens through Government administered insurance; that required no direct payments at all to doctors or hospitals; and that used payroll taxes and general funds for financing. While providing free choice of physicians, its methods of disbursing funds would eventually have discouraged the standard method of paying (i.e. " fee-for-service" in which each visit or treatment is charged separately, in accordance with the doctor's desire) in favor of prepaid group practices in which doctors undertake to handle all patient complaints in return for regular installment-like payments.

Forced to respond, the Administration eventually came forward with a fairly well worked out but less far-reaching plan with three parts. For employed persons, insurance companies would provide the coverage, but employers would be required to offer to pay 75% of the costs. The coverage would not be complete. But the $150 deductibles, the 25% co-insurance (required on further expenditures) and the $1500 limit on patient liability for covered services would be scaled down for groups whose income was

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Approved by the Federation Executive Committee, the above statement was reviewed and endorsed by:

Dr. George Silver **Dr. David Banta**

(See page 2 for credentials)

METHODS OF PAYING DOCTORS

In the Middle Ages, doctors used to be paid "per case", undertaking for a fee to see the patient through the illness. With the development of many differentiable medical procedures, this approach waned. Today doctors are paid by salary, by fee-for-service or by capitation.

Capitation is used most extensively in Great Britain. Under this system the general practitioners are paid "per capita" for the number of patients whom they undertake to service throughout the year. In effect, each agrees to be the doctor for between 1,000 and 4,000 patients and is reimbursed by the National Health Service in accordance with the size of the list of patients he submits.

This system was accepted by the British Medical Association because it feared having the Government put the doctors on salary and the development of a large medical bureaucracy. Fee-for-service methods were considered too expensive and unpredictable in expense to be considered.

Capitation has important advantages over "fee-for-service" or salary in motivating doctors. Unlike salary, the doctor is paid more for undertaking more work, thus he is motivated to work longer hours. Unlike fee-for-service he is also motivated to avoid unnecessary medical services; he does not get paid for such service. But he does have to worry about the patient and prescribe what is necessary since, if the patient gets still sicker, he will have additional work to do.

However, these advantages pertain especially to the general practitioner. The specialist—who only sees the patient when the patient suffers from special problems—is much harder to fit into a capitation system. And the general practitioner may, if not monitored, seek to avoid older patients with greater expected illness.

The fee-for-service system is especially prominent in America where the doctor simply charges a fixed fee differing for differing services. He sets the fee according to such diverse considerations as: expenses incurred, time

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respectively below $10,000, $7,500, $5,000 or $2,500. A second plan is an extension of Medicare and a third, for the poor, would be administered by states under Federal supervision. Unfortunately, the two new plans are voluntary and several million people ultimately might not be covered.

For those who believe that far-reaching change is required in the health system, the Kennedy bill is preferable. This is not simply because it goes further in uniformity and completeness of population coverage as well as emphasizing prevention. It is more likely to provide a context in which further change would be required in the character of the health delivery system. Under its program, budgetary allocations would seek to hold down costs. If, nevertheless, costs rose more rapidly than funds were provided from payroll taxes, general revenues would have to take up the slack. When this became awkward, administrative controls would be placed on fees, especially those of fee-for-service doctors.

By contrast, the Administration bill does not contain the seeds of ultimate reform of the payment method. Instead, it tries to retain market-mechanism control over health care through deductibles and coinsurance while ameliorating the deterrence effects of these costs by relating them to income. And it seeks to allay the inflationary costs that escape this control by requiring employers to pay a minimum percentage (75%) of whatever the insurance companies charge—these charges themselves being partially controlled by competition among companies. Politically the Administration program conceals the inflation better. It could therefore preserve both the good and the bad in the present system longer.

The problem with more far-reaching change is the lack of popular and expert consensus on the changes required, with one exception—Health Maintenance Organizations (HMOs), the notion of prepayment for a contract to supply needed health services. Encouraged administratively in the Kennedy plan, these are encouraged in the Nixon plan by requiring the employer to offer to finance membership in an HMO as an alternative to ordinary insurance.

In short, the Nixon plan is a method of financing that would generally resolve the financing crisis brought on by partial population coverage. (In this regard, its most serious flaw is its voluntary character.) It would buy time for a consensus to emerge on changes in health systems, retaining for a longer period the plurality of methods that now exists.

Finally, there is serious doubt that either plan is administratively workable. And neither bill is likely to solve many of the real problems that underlie the popular concern: the shortage of primary (family) physicians and their maldistribution; the health care statistics about infant mortality and the like which require, for their solution, social programs other than medical ones; and the inflationary rise in health costs as a share in the gross national product.

CREDENTIALS OF COSIGNERS OF PAGE 1 EDITORIAL

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	Type of System*	Payments of Specialists		Payment of General Practitioners	
		Unit	Method	Unit	Method
Cyprus	Service	Salary	Direct	Salary	Direct
Egypt	Service	Salary	Direct	Salary	Direct
France	Insurance	Fee	Reimbursement	Fee	Reimbursement
Germany (Federal Republic)	Insurance	Fee	Direct	Fee	Direct
Great Britain	Service	Salary	Direct	Capitation	Direct
Greece	Insurance	Salary	Direct	Salary	Direct
Israel	Insurance	Salary	Direct	Salary	Direct
Italy	Insurance	Salary	Direct	Capitation, fee	Direct
Lebanon (until late 1960's)	None	Fee	Private	Fee	Private
The Netherlands	Insurance	Salary, Fee, Case	Direct	Capitation	Direct
Poland	Service	Salary	Direct	Salary	Direct
Spain	Insurance	Capitation	Direct	Capitation	Direct
Sweden	Insurance	Salary, Fee	Reimbursement	Fee	Reimbursement
Switzerland	Insurance	Fee	Direct, reimbursement	Fee	Direct, reimbursement
Turkey	Insurance	Salary	Direct	Salary	Direct
U.S.S.R.	Service	Salary	Direct	Salary	Direct

* National Health Service or National Health Insurance.

Continued from page 1

required, ability to pay, success or failure of the service rendered, importance of the disease, complexity of the treatment, customary fees in the community, legal limitations and so on. Needless to say, doctors prefer this system with its great flexibility in assessing charges.

However, the world trend seems to be toward putting the doctors on salary. In underdeveloped countries, the doctors need the salary and cannot depend upon fees from their impoverished patients. In developed countries, the expense associated with fee-for-service, and the vulnerability of this system to doctor exploitation, keep it under attack.

All of these three methods for payment can be linked to a *national health insurance program* or a *national health service system.* National health insurance is, of course, simply a method of collecting funds and disbursing them on a country-wide insured basis.

A national health service is characterized by large contributions from the general treasury funds, nationalization of some or all of the health facilities (e.g. hospitals), and some systematization of the health delivery process. By contrast, a national health insurance program can sit on top of a chaotically organized health delivery system.

The box above, taken from *Paying the Doctor* by William A. Glaser (Johns Hopkins Press, 1970), shows which system exists in 16 countries for payment of general practitioners and specialists, in the context of health insurance or a national health service. Note that virtually all possible combinations of system and payment exist.

However, the national health services tend to avoid fee-for-service and to prefer salary. The specialists tend to be paid by salary rather than fee-for-service although, in the countries represented, the general practitioners are paid as often one way as the other.

A survey of these countries reveals the potent power of the doctors to bargain over their financial rewards and the methods by which they are paid. And it reveals a very plausible course of development for the United States —namely, not much change.

The doctors prefer payment systems they control completely but are forced to give ground when costs rise uncontrollably. They move toward collective bargaining with the agencies in charge of insurance or the health service. When controversies break out over payment, these are resolved by further standardization, in order to minimize controversy. This tends to reduce incentives to work either hard or well.

Most important, the countries tend to modify what system they are using, rather than confronting the doctors with a new (and to the doctors unpredictable) "ideal" system. Thus the existing system, with occasional modifications, becomes imbedded in concrete.

Especially important, health benefits never move backward; once full services are offered, resistance from the left prevents offering any less. The significance of this observation for the present debate is substantial since a far-reaching plan would tend to lock itself in. Any system which offered less (or even the same amount but in a different way) would become infeasible. □

HEALTH INSURANCE IN AMERICA

National health insurance has been under consideration for more than 50 years. The American Medical Association (AMA) itself drafted model bills for this purpose from 1915-1919 until, subsequently, it adopted the long familiar stance of complete opposition to federal health legislation. Health insurance never quite made it into the package of Social Security legislation pushed through by Franklin Roosevelt in 1935 under the pressure of the depression; the AMA's opposition was the reason.

During the next thirty years, there was increasing struggle over the issue, struggle which eventually focused on health insurance for the aged. Their poverty, their enhanced need for health care, and the respect due them all combined to make them the perfect opening wedge for an eventually total health insurance scheme.

In 1965, Congress passed the Medicare program for the aged (over 65) and a Medicaid program for the poor. Both programs were basically financing methods which reimbursed the patient or paid his costs directly. For example, under Medicare, in a single bout of illness, a patient gets 60 days in the hospital free, except for $40 deductible, and 30 additional days at $10 a day. For physician services, Medicare pays 80% of all "reasonable charges" made except for a $50 deductible in each calendar year. In 1969, Medicare was covering, however, slightly less than 50% of health-care expenditures of the aged due not only to the deductibles and the co-insurance (i.e. the 20% not covered) but to the costs of drugs and long-term care, including nursing care, that were not covered.

By comparison with Medicaid, however, Medicare was reasonably successful, covering 95% of the aged. Medicaid suffered from the burden of being fragmented into state programs, 52 of them, with differing coverage and separate State Administrations. By 1969, it was serving only one-third of the poor.

Effect of Medicare-Medicaid

The effect of these two programs was to stimulate an extraordinary inflation in health costs. The reason was simple enough. The old and the poor constituted an enormous pool of previously unfinanced health care needs. Once their needs began to be financed, demand for health care jumped still farther ahead of supply.

For those who provided health services, these programs were a bonanza. The doctors were committed only to "reasonable charges." They were released from worrying about what and whether these patients could pay. Naturally, their charges rose.

The hospitals found that one class of patients from whom it had been most difficult to collect bills was now able to pay. Indeed, since hospitalization was completely covered, and outpatient services only partly covered, there was a bias in favor of putting patients in the hospital. And the coverage of hospital services freed the hospitals, as the doctors had been freed, from worrying over much about the charges being run up by the covered patients. Net income per patient day rose from $1.50 to $2.50 from 1965-1971 for non-profit hospitals. For profit hospitals' net income rose from $2.00 to over $6.00!

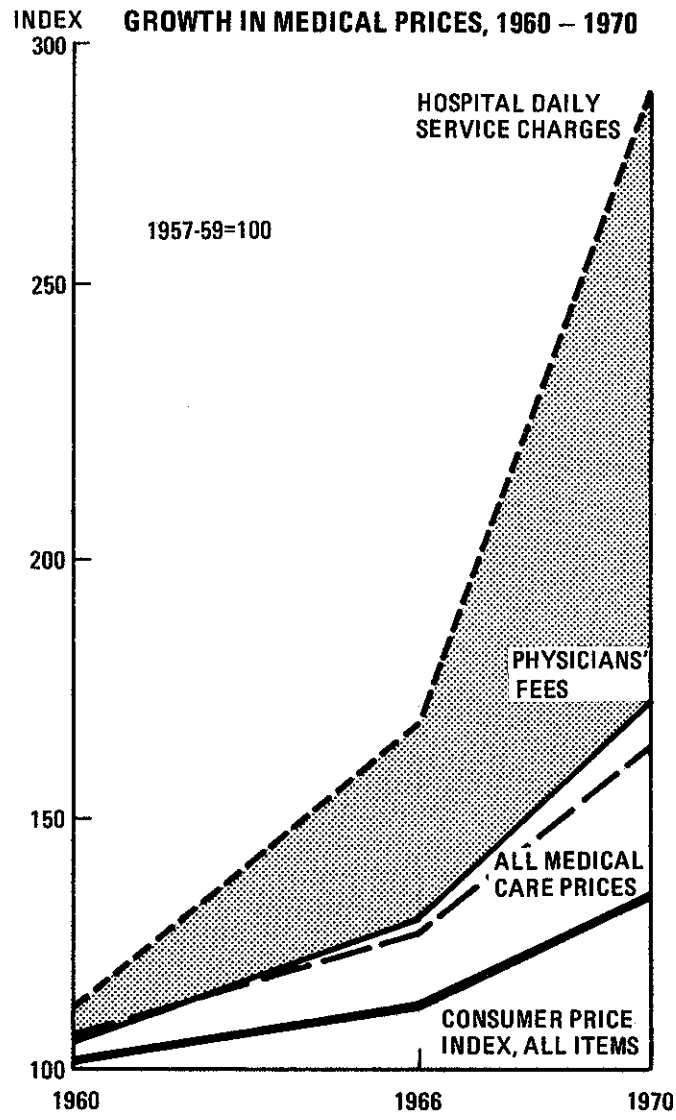
The drug industry also saw benefits. Medicare covered drugs provided by extended care facilities and drugs that could not be self-administered. In general, the stepped up number of visits to physicians increased the number of drugs prescribed and, therefore, bought.

Resultant Inflation

Finally, the insurance companies saw benefits in national health insurance so long as private insurance was utilized. Indeed, the existence of Medicare and Medicaid, by driving up health care prices, made private insurance all the more necessary. However, it is important to note that the same rising costs made it difficult for the insurance companies to make profits; they would insure at one rate and pay out at another. On group policies, they frequently lost money and paid out the premiums collected at about the same rate as the Blue-Cross Blue-Shield operation (93%). On individual health insurance, however, large percentage profits were made.

How Great Was the Inflation?

The growth in medical prices from 1960-1970 is shown below. It reveals an extraordinary rise that picks up



enormous momentum in 1966, just after the passage of Medicare and Medicaid. This rise is most pronounced in hospital charges, which increased annually at percentages varying from 14% to 10% during 1969-1972. This rise has outpaced even the rapidly growing gross national product; medical care expenses were, as a percentage of GNP, 5.2% (1960); 5.9% (1965); 7.1% (1970); and 7.6% (1972). Thus, by now, medical expenses exceed expenditures for defense (6% of GNP in 1973).

As a basis for comparison, one notes that, as of 1968, the total cost of the health services in England was 5.2% of national income and in Sweden 8.1%, while in the U.S. it was 7.5%. (National income exceeds GNP by capital consumption allowances and indirect business tax and non-tax liability.) During the interval from 1950-1968, Sweden increased its expenditures for health services nine times as rapidly as the consumer price index, the U.S. seven times as rapidly and Great Britain 2.5 times as rapidly.

There were fears that, by 1980, health expenditures might rise to 10% of the gross national product. No one is quite sure whether the demand for health care is saturable. Evidently no country exists which does not ration this care either by financial means, by queueing, by red tape or whatever. It is entirely possible, even likely, that the demand for health care if free would be virtually unlimited within the present range of discourse.

Medicare and Medicaid made a major shift in the character of the U.S. health delivery system if measured in source of expenditures. Before Medicare and Medicaid, in 1966, public funds provided 22 cents of the medical care dollar; by 1972 it was 37 cents. These are revolutionary shifts to take place within 6 years. Meanwhile, direct patient outlays dropped from 51¢ to 35¢.

Significance of Public Financing

The significance of these changes has been to reduce further the market character of the health delivery system. The medical system has always had the problem that the seller (the doctor) told the buyer (patient) how much the buyer would have to buy and also set many of the prices. In the past, exploitation of this system was limited by the integrity of doctors, the compassion for patients, and the fact that high prices would drive the patients to another doctor or to no doctor at all. But even these restraints are being eliminated by third-party payment of the medical bills. Increasingly, one party gets the services, one party provides them and a third party pays for them. Under these circumstances, virtually no market mechanism is left. Doctors, who are only human, find it all too easy to put in charges freely, to let "customary charges" rise and to encourage more visits.

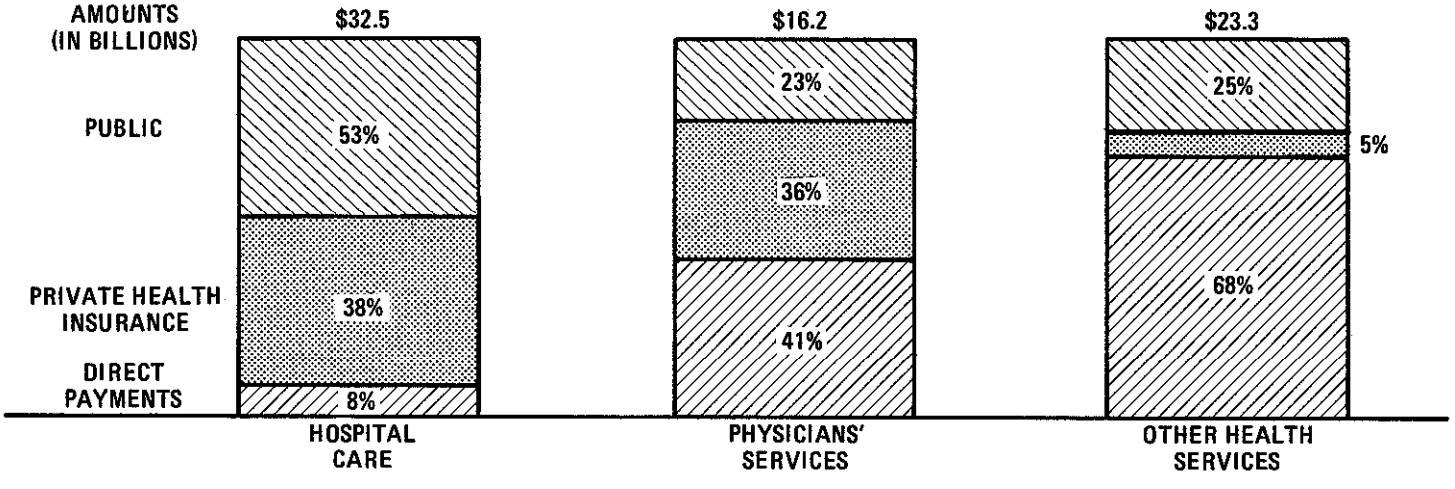
This development has moved farthest along in the hospitals. The patient paid, in 1972, only 8% of the hospital bill directly. He did pay 38% through private health insurance. But few patients have any idea for which benefits they are insured; it is evident that existing competition among insurance companies is severely limited by that fact. Indeed, the high costs of health care induce the insurance companies to compete in offering cheaper policies—which only *seem* to provide substantial protection—simply because adequate ones would not sell. It is hard to avoid the speculation that the hospitals have the highest rate of inflation, among health care components, simply because they are also farthest advanced along the spectrum of freedom from market controls due to the high degree of third party payments.

Even for physician services, direct patient outlays were only 41% with 36% from private health insurance and 23% from Government. Increasingly the doctor's "customary charge" is simply a customary charge to insurance companies or Government—combined, perhaps, with exceptions made for the poorer uninsured customers. Would still higher percentages of third party payment lead to still higher rates of inflation in the cost of physicians' services? It seems likely.

Of course, there are methods of control under consideration. The Professional Standards Review Organizations (PSROs) are, for example, devoted to monitoring the more obvious examples of exploitation of the system (See FAS Professional Bulletin of December, 1973). But the doctor (especially the general practitioner) can in a variety of ways subdivide and multiply his procedures to turn, in effect, one visit into two and so on. This is not easy to control.

Inflation seems to have been slowest in the sector of "Other Health Services" besides hospital and physician services where the public pays directly 68% of costs.

In general, all these figures reveal the dangers of uncontrolled demand in a system without market mechanisms. □



THE BILLS IN CONGRESS

The easiest way to understand the Kennedy and Nixon plans is to consider the ideologies that shaped them.

The Kennedy plan assumes that all Americans should be covered, and that they should all be covered by a single program administered by the Government rather than by insurance companies.

The result is a method of financing that takes 50% from assorted payroll taxes (e.g. 3.5% from employers and 1% from employees) and 50% from general revenues, mixes them together, and distributes them according to administrative rules of thumb into different areas for different specified purposes. Estimating available funds would, however, be difficult: for example, a recession, by reducing payroll revenues, would undermine the planned program. If, as would be virtually certain, the budgets were exceeded from time to time, proportional reductions would be applied to fees of doctors being paid on a fee for service basis. Their fees cannot be carefully estimated in advance. But when the amounts allotted to paying them were surveyed, the political problems would be fierce.

The Kennedy plan reflects the view that out-of-pocket costs, through deductibles or co-insurance, would deter persons from seeking medical care. The result is a plan that contains no deductibles or co-insurance for anyone. While it would succeed in removing financial barriers, at least, to equal access to health care, it must be expected to increase the pressure on health cost inflation and hence on the general revenues required of Congress. One can argue that Medicare and Medicaid, for the old and the poor, have tended to dry up the pool of uninsured illness. But one would be foolhardy to expect that a sudden removal of all out-of-pocket costs would not give rise to new pressures from these same groups, and from the large group of already insured persons.

The Administration plan is shaped by its own preconceptions. Its planners must have had these guidelines:

- Finance the care, as far as possible, through employer-employee taxes.

This would have the politically desirable effect of hiding future cost-inflation in business profit-and-loss statements rather than in Government appropriations. But it requires the plan to be fragmented since not all persons are employed. The result is a separate plan for the unemployed, and another for the old. The decision was made to have the employers pay at least 75% of the cost and the employee 25% or less.

The old are covered by an extension of Medicare; the unemployed would be covered by a Federal-State program that would replace Medicaid.

- Maintain a substantial degree of deductibles and co-insure to deter overutilization of health services by patients, doctors or hospitals and to hold down costs of the insurance.

Unfortunately, these patient costs can deter the sick from seeking help; hence the costs had to be related to the income of the insured. This induced a scheme that will be complicated to administer. Premiums, deductibles, and co-insurance are adjusted by income classes: $2,500 or less; $5,000 or less; $7,500 or less; $10,000 or less; and over $10,000. Thus premiums would be $0 in the first two income classes and, in the next two classes, 50% or 100% respectively of what employed persons would pay. Deductibles (for other than outpatient drugs) would rise for family groups in these different classes as follows: $0; $50; $100; $150; $150. Co-insurance for family groups would rise as follows: 10%; 15%; 20%; 25%; 25%.

These costs would rise rapidly and hence there would have to be an overall limit on the liability of the insured: this would also be related to annual income as follows: 6%; 9%; 12%; 15%; 15%.

Among the problems raised by these complications: determining the annual income fairly precisely of everyone under $10,000; adjusting a person's category every time these annual incomes shift by a few thousand; adjusting the categories as a whole for inflation; shifting insured persons from the employed plan to the unemployed plans when they lose their jobs and vice versa; shifting persons into the plan for the old when they reach 65. Above all, if the out-of-pocket costs are not set appropriately, the system may discourage use.

- Leave the plan voluntary as far as the insured is concerned.

For a Republican Administration, compulsion was probably considered out of the question; also the AMA and others would be likely to oppose it. But this leaves a problem: what to do with the young or broke who do not want to participate but who fall ill. And can they opt to join after they fall ill—insurance companies won't like that.

- Let the insurance companies continue to do what they are doing but try to ensure minimum benefits in the packages that they sell.

Unlike the Kennedy plan which would leave the insurance in the hands of the Government, the Administration sought to ensure that private plans qualifying for the Government program had minimum benefits. It would then leave it to the insurance companies to compete by cutting the costs at which they could offer those benefits, by streamlining their administration of the program and so on.

Since the insurance companies are large enough for almost all economies of scale, a plausible case can be made that the Government is not likely, for Parkinsonian reasons, to be any more efficient. In fact, the insurance companies have not made large profits—but usually losses —on the group policies with their rapidly and unexpectedly inflating costs.

Analysis of the Bills

By the end of 1973, there were about 15 national health insurance bills introduced in Congress.

Three of these bills simply provided "catastrophic protection"—protection against having one's medical bills

exceed a fixed amount. They vary in coverage. At one extreme, the Roe-Beall bill called for a voluntary program administered by private insurance companies and financed by private premium payments (with some federal subsidy). On the other hand, the Long-Ribicoff bill would cover all persons now covered by Social Security, and would provide medical assistance for the poor and the medically indigent (i.e. those who are unable to cope with medical expenses though not otherwise qualifying as poor).

The Long-Ribicoff bill would provide the kind of benefits that Medicare now provides but would pay them only when expenses reach specified catastrophic proportions. Each person's expenses would be limited to $1,000. The program would be administered by Medicare and financed, as under Medicare, by a special social-security-type tax on income tax from .3% to .4%. In short, the Long-Ribicoff bill would move on from aiding the old and the poor to aiding everyone afflicted with very large medical costs, by expanding the Medicare program.

Tax Credit Plans

A second approach to national health insurance emphasizes tax relief and voluntary programs; this is the favored approach of the American Medical Association (AMA). These programs would make no changes in delivery of health care or existing programs.

The AMA bill (Fulton-Broyhill-Hartke bill), for example, would simply provide credits against personal income taxes to offset the premiums paid for private health insurance. Depending upon how much tax an individual paid, he might get tax credits varying from 10% to 100% of his insurance policy. The private insurance carriers would administer the program simply by issuing the policies. State insurance departments would ensure that the policies met certain standards. The AMA bill would permit the general public complete flexibility about what insurance programs it wanted to purchase. A program of this type would be a boon to the insurance industry.

About five bills try to mix public and private participation. The Ullman bill (H.R. 1), supported by the American Hospital Association, would be administered by private insurance carriers under state supervision according to Federal guidelines. This plan would require employers to provide coverage to employees, and would provide also for individual participation, thus covering all subject to Social Security tax as well as those who elect it. Meanwhile, a separate plan would provide for low-income, aged, and medically indigent persons.

The insurance industry, represented by the Health Insurance Association of America, has a bill (H.R. 5200) introduced by Congressman Burleson and Senator McIntyre. With many similarities to the Hospital Association plan, H.R. 5200 would be phased in over ten years, and provide for a limit on cost sharing of $1,000 per family for employee-employer plans. Basically the premiums, whether paid by employer or employee, could be subtracted from taxable income.

Still another approach, introduced by Senator Jacob Javits, would simply extend Medicare to the general population, administer it through the Federal Government, and pay for it under payroll taxes (3.3% of earnings for employers, and also for employees and self-employed up to $15,000). The Government would further contribute from general revenue an amount equal to 50% of that gained from tax receipts. □

RATIO OF PHYSICIANS TO POPULATION, INTERSTATE COMPARISONS

PHYSICIANS PER 100,000 POPULATION

219	N.Y.	139	N.J.	113	Iowa	98	W.Va.
199	Mass.	139	Ore.	113	Kan.	97	N.M.
178	Conn.	136	Ohio	113	Tex.	96	Ky.
177	Colo.	135	Del.	113	Va.	96	Wyo.
173	Calif.	135	Hawaii	111	Okla.	91	Ida.
170	Vt.	133	Ill.	111	Tenn.	91	N.D.
169	Md.	132	Fla.	109	La.	81	Ark.
155	R.I.	129	Ariz.	103	Nev.	81	S.D.
154	Pa.	129	Utah	100	N.C.	79	Ala.
143	Minn.	126	N.H.	99	Ga.	77	S.C.
142	Mo.	119	Wis.	99	Ind.	73	Miss.
141	Mich.	116	Maine	99	Mont.	71	Alaska
141	Wash.	114	Nebr.				

CONCLUDING OBSERVATIONS

The decision between the Kennedy and the Nixon approaches turns on ideological preferences and Parkinsonian perceptions.

Should the Plan be Voluntary?

Is the freedom not to participate largely illusionary—applicable for the most part precisely to that ill-educated and impoverished group that most needs health insurance? After all, 80% of the country now has some kind of health insurance. Should we not be taking the steps necessary to ensure coverage for that 20% which have not yet seen the advantages of, or had the income for, health insurance?

Is the choice for administration of the plan properly posed as:

1. a "uniform social security type" administration in Washington rather than profit-making insurance companies supervised by inadequate state plans; or
2. a "national bureaucracy" making thousands of allocative decisions for funds rather than insurance companies competing to offer standardized plans at the lowest costs private initiative can manage?

One thing is certain. If the insurance companies are not sufficiently well monitored, they can always be further controlled and, if necessary, the business can be taken out

of their hands and moved to Washington. Obviously with all this money at issue, they will be watched carefully. On the other hand, if the Washington bureaucracy cannot administer the Kennedy plan in a way that will satisfy most constituencies, there can be no turning back. For better or for worse, the country will move further into health service controls.

Do deductible and co-insurance play a useful role in "maintaining market mechanisms"? Or are the market mechanisms already absent and the out-of-pocket payments serving only to deter the use of medical services by those who are poorest?

There do seem to be some market mechanisms left—at least compared to a system in which there are no out-of-pocket costs. Doctors and hospitals do show some concern for the costs to patients; without any direct payments, a certain element of total cynicism could arise in setting charges. It is true that some studies suggest that utilization of medical services is independent of direct payments for all but the underprivileged. But the inflationary increases at issue could easily arise by biases in utilization that are hard to identify in these studies.

Finally, direct payments do permit consumers of health care to vote for more efficient, rather than less efficient, health delivery methods. This encourages the medical delivery system to move toward more economic institutions such as HMOs or whatever. In this regard, those who argue for consumer representation on relevant boards might well ponder the consumer sovereignty lost by removing economic controls.

Obviously, out-of-pocket costs could be set in such a way as to deter needed utilization even if set in some proportion to income. This is the greatest danger. And there is reason to believe that the Nixon plan requires somewhat too high co-payments by those with income below $10,000. In particular, they must pay full and rising charges for their initial visits to doctors since these are covered only by the deductibles. Since it is early visits which are the most important ones *not* to discourage, this can be an important omission. But perhaps one would be throwing out the baby with the bath if one assumed that this problem could not be solved for the underprivileged and therefore eliminated direct payments for everyone. If necessary, one could just eliminate them for the low-income groups.

If, as the Nixon plan provides, the underpaid and unemployed pay only specified charges—not "reasonable" charges—should we view this as 1) an outrageous manifestation of a "two-tier" medical system in which many doctors simply will not treat the underprivileged or 2) an opening wedge toward the elimination of the sovereign immunity of doctors to pay what the traffic will bear or 3) a bureaucratic necessity to prevent exploitation of the system by doctors treating poor people?

If, as the Kennedy plan provides, the fee-for-service doctors are squeezed when and if the health administration cannot pay all of its bills, should we consider this: 1) a sneaky way of putting them out of business and moving toward a national health system; 2) a healthy way of removing an impediment toward a national health system; or 3) a sure formula for a revolutionary crisis for which there is, at present, no consensus for a revolutionary cure?

Obviously, there is room in these and similar considerations for debate not only about means and ends but about likely effects. In these debates the life experiences of people with analogous institutions and with human nature will loom large, as will their personalities and values.

National health insurance is not only a distributional problem of who will pay how much to heal himself and his less fortunate fellow citizen. It is also a test of our shrewdness concerning our own institutions, our ability to run them, and our likely tolerance for their inevitable errors. It needs analysis: we've tried to provide some. But in the end, it requires—in the best sense of the word—decisions that are ultimately political. Perhaps this is what we pay our Congressmen for. ☐

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