"National Health Insurance—
Problems and Prospects"

By

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THE SPEAKER

WILBUR J. COHEN, former Secretary of Health, Education, and Welfare, is Professor of Education at the University of Michigan at Ann Arbor, and Dean of the School of Education. In the course of a distinguished career in the broad fields relating to health and welfare he has been identified with authorship of the original Social Security Act, Medicare, federal aid for medical education, and other national health and social security enactments and proposals. He came to Washington in 1934, and served subsequently as technical adviser to the Social Security Board, director of research and statistics of the Social Security Administration, assistant secretary for legislation of Health, Education, and Welfare, HEW undersecretary, and secretary. Between 1956 and 1961 he was professor of public welfare administration at the University of Michigan, and in 1960 was chairman of President Kennedy's Task Force on Health and Social Security. Mr. Cohen was born in Milwaukee; he took a degree in economics from the University of Wisconsin; he holds honorary degrees from Wisconsin, Adelphi, Yeshiva, Brandeis, Kenyon, Detroit, and Louisville Universities, and is a fellow of Brandeis University. He is the author of numerous books and articles on social security, health, welfare, and education, and has received many awards and citations for distinguished service in health, education, and welfare, including a Rockefeller Public Service Award and the Bronfman Prize for Public Health Achievement (both awarded in 1967) and the Murray-Green Award (1968).

THE SERIES

THE LECTURE SERIES was established in the name of Michael M. Davis, medical care pioneer, by his friends and admirers. Mr. Davis opened the series in 1963 with an address entitled "America Challenges Medicine." Each year a distinguished leader of medicine, the social sciences, hospital care, social welfare, government, labor or management is invited to address persons interested in the improvement of medical services. The intention is to stimulate free and open discussion and to furnish a forum in which medical care programs may be proposed, examined, and presented for public consideration.

THE OCCASION

DEAN COHEN delivered this talk at Billings Hospital, the University of Chicago, on April 15, 1970.

ON JANUARY 20, 1969, when I involuntarily vacated the office of Secretary of Health, Education, and Welfare, I transmitted to the President, the Congress, and to my successor, Secretary Robert H. Finch, a list of unresolved domestic problems which required continued attention. High on my 44 printed pages of recommendations was the extension of health insurance coverage "to reduce the need for Medicaid," along with 33 other recommendations in the field of health.

All of Secretary Finch's seven precedessors struggled with various health insurance proposals in one way or another, as had Oscar Ewing, the Federal Security Administrator who was head of the agency prior to its elevation as a cabinet department. Mr. Ewing had endorsed President Truman's 1945 health insurance proposal and, as a consequence, became the victim of the vigorous opposition of the American Medical Association which had employed the California public relations firm of Whittaker and Baxter to help develop the biggest and most high-powered attack ever launched on "socialized medicine." As a result, the Truman-Ewing plan was stopped dead in its tracks in 1950. The Medicare plan, which arose from the ashes of that defeat, overtook and overwhelmed its opponents in 1965 and eliminated the political stigma of the "socialized medicine" label which had been pinned on every proposal for health insurance.

Mrs. Oveta Culp Hobby, the first Secretary of H.E.W., recommended federal legislation in 1954 to encourage private health insurance carriers to extend coverage to high-risk persons, such as the aged, by re-insurance subsidies of any losses

surance. Among people under age 65, 55 percent have no insurance to cover home or office visits by a physician. Even for people age 65 and over, Medicare covers only about 45 percent of their personal health bills. Many of the expenditures not covered are for drugs, long-term institutional care, physical checkups, eyeglasses, hearing aids, and dental care. There are similar exclusions for many people under age 65 who have some health insurance coverage.

Although about 75 percent of all hospital costs are now met through health insurance, only 40 percent of physician's bills are covered by insurance and only 5 percent of other types of care. The room for expansion of health insurance coverage of medical costs is still substantial.

Some 30 to 40 million people, today, have no health insurance whatsoever. Some 60 million additional people under the age of 65 have health insurance coverage which is grossly inadequate or at least less than that provided to the aged under Medicare. Comprehensive national health insurance, therefore, would expand coverage for at least some one hundred million people.

HEALTH INSURANCE coverage has expanded during the decades of the '50s and '60s, and has been continuous despite rising costs, and in large part due to them. For nearly 20 years the campaign to provide universal national health insurance for everyone has remained in the shadows, but it has served as a constant impetus to the medical profession and the insurance carriers for the extension of private health insurance. The political and legislative situation has changed dramatically since the '50s and the early '60s. The sharply rising cost of Medicare and Medicaid in federal and state governmental budgets and the persistently rising medical prices have alarmed the silent majority.

Today, almost everyone is for some kind of health insurance coverage for the entire population.

With all the hundreds of different private health insurance plans, the question now is, how will it be possible to achieve what is generally desired—comprehensive insurance coverage for all, at a reasonable cost, with assurance of high-quality services, delivered efficiently and economically, with tender loving care, through a personal doctor-patient relationship which provides to everyone the benefits of the medical miracles and scientific advances as they are shown on television? Who will lead us to this promised land?

The question is being asked today, more and more: Can these desirable goals be achieved by relying on the present methods of delivering medical care? Or must we make more far-reaching changes in our medical arrangements?

It is significant that health insurance has been "as American as apple pie." In 1798 Congress enacted a contributory hospital insurance program for merchant seamen. Nevertheless, extension of health insurance to the rest of the population has been a perennial controversial issue in American politics for nearly 60 years.

The passage of a health insurance law in Germany under Chancellor Bismarck in the 1880's stimulated interest in the subject in the United States among people interested in labor legislation and economics. The passage of health insurance in Great Britain in 1911 under Prime Minister Lloyd George gave special impetus to legislative proposals in the United States. The movement for state health insurance began in 1912 when the American Association for Labor Legislation took up the issue as an outgrowth of its campaign to obtain state workmen's compensation legislation. The medical benefits portion of such laws consti-

tutes a form of state health insurance, but it was limited to workmen injured on the job. The Association was interested in broadening that concept to cover health benefits off the job.

Twenty states considered health insurance legislation during the years 1914–1920, and special commissions dealing with the subject were appointed in nine states. The movement for health insurance, however, almost died in the "affluence" and apathy of the '20s.

Interest in health insurance was rekindled in 1932 when the Committee on the Costs of Medical Care made its report. The majority report proposed a basic change in the structure of medical practice. It advocated group practice of medical care (as opposed to individual practice), and experimentation with voluntary health insurance. Other members of the committee advocated compulsory health insurance.

A minority report of eight physicians and one layman recommended that if an insurance program were to be adopted, "the sensible and logical plan would be to adopt the method to which European countries have come through experience, that is a compulsory plan under governmental control."

The majority report was attacked in an editorial in the American Medical Association *Journal* on December 3, 1932. The editorial referred to its recommendations in terms of "socialism and communism—inciting to revolution." So the lines became drawn for the next 33 years in one of the longest and most bitter controversies in the history of social legislation.

ATTEMPTS by Democrats and Republicans, liberals and conservatives, to obtain passage of some type of health insurance legislation failed repeatedly: in 1934 by President Roosevelt's Cabinet Committee on Economic Security; in 1939 and 1943 by Senator Robert F. Wagner; in 1944 by Governor Earl Warren of California; in 1945 by President Truman; in 1946 by Senator Robert Taft; in 1949 by then Congressmen Nixon, Senator Javits, and others; and in 1950 by Federal Security Administrator Oscar Ewing. The list of advocates and types of plans is long and varied.

While governmental health insurance has had hard sledding, socialized medicine curiously enough has evolved in the United States for people in the armed forces and veterans, with the full and enthusiastic support of the military and the veterans. In 1969, medical services for the military and veterans totalled over $3 billion. Other forms of socialized medicine are hospitalization for the tuberculous, the mentally ill, and the mentally retarded, and medical services for Indians—all of which has not been very controversial and has been accepted by the most conservative members of our society.

STRICTLY DEFINED, socialized medicine means medical services paid for by governmental general revenue funds, and in which the physicians are employees of government and the hospitals are owned and operated by government. Using this definition, socialized medicine presently accounts for about $6 billion a year, or only about 10 percent of the nation's health expenditures. But the term socialized medicine used in a more popular and political sense encompasses all medical expenditures by government (including Medicare and Medicaid). In 1950, public funds represented 25 percent of all medical expenditures. By 1966 this had increased to only 26 percent, but by 1969 it had risen to 37 percent.

Health insurance and socialized medicine are not clearly distinguished in the minds of many

people. Health insurance tends to be a system of financing medical costs provided by either public or private sectors. Socialized medicine tends to be a system of financing medical costs by organizing the delivery of care and, most important to physicians, determining the methods of payment to them and the amount of their incomes.

In the professional literature, socialized medicine is referred to by less volatile terminology as public medical service. Great Britain and Russia have public medical service programs for the entire population. Most other industrialized countries have health insurance plans covering all or nearly all of the population. Which road will the United States take?

Medical costs, socialized medicine and health insurance, undoubtedly will be major public policy issues in the Congressional and Presidential campaigns of the '70s.

There are many participants in the 1970 cast of health insurance actors and activists. Senator Ralph Yarborough of Texas has promised to schedule comprehensive hearings on national health insurance this year. As Chairman of the Senate Subcommittee on Health, and Chairman of the Senate Committee on Labor and Public Welfare, he is in a strategic position to advance the issue in Congress. At the same time, Representative Wilbur D. Mills, Chairman of the powerful House Committee on Ways and Means, and Senator Russell Long, Chairman of the influential Senate Committee on Finance, have indicated they intend to consider changes this year in Medicare and Medicaid. The recent report of the staff of the Senate Committee on Finance, relating to Medicare and Medicaid problems, issues, and alternatives, will precipitate discussion of many changes which may affect the

provisions of present and future private and public health insurance programs.

While there is divided jurisdiction among the Congressional Committees, the likelihood is that the House Committee on Ways and Means will assert jurisdiction over any national health insurance plan financed in whole or part with payroll taxes. The Constitution provides that all taxes must originate in the House of Representatives—and the Ways and Means Committee guards this duty with special rites and care. This places Chairman Wilbur D. Mills in a crucial and influential role. Yet neither he nor Russell Long, the Chairman of the Senate Committee on Finance, have ever expressed themselves publicly on the issue, nor are they likely to do so before the decision is to be made.

NATIONAL HEALTH INSURANCE legislation has been introduced in every session of the Congress since the Wagner-Murray-Dingell Bill was first introduced in 1943, 27 years ago. In recent years it has been introduced by Congressman John Dingell of Michigan, the son of one of the original sponsors. A fellow Congressional colleague, Congresswoman Martha W. Griffiths, introduced a national health insurance bill in Congress on February 9. Her bill is especially notable not only because Mrs. Griffiths is a member of the House Committee on Ways and Means, but because her bill is supported by the AFL-CIO. With the introduction of a national health insurance bill by a member of the Committee on Ways and Means, the campaign for such legislation has been greatly accelerated and intensified.

There are many advocates of health insurance. Governor Nelson Rockefeller has been advocating health insurance coverage at both the state and national levels. He succeeded last year in get-

ting virtually all the Governors—Republicans and Democrats alike—to endorse federal legislation which would extend health insurance coverage. The burden of rising Medicaid costs was a major factor in their unprecedented action. Senator Javits has indicated that he will introduce in the Senate a Rockefeller-Javits health insurance bill. Senator Edward Kennedy is formulating a health insurance proposal which he has promised to introduce. The American Medical Association has a "Medicredit" proposal to accomplish universal coverage through tax credits and subsidies for private insurance; it is estimated to cost about $12 billion a year. Walter Reuther has organized the Committee for National Health Insurance, consisting of 100 prominent leaders, to develop and promote a plan which is to be unveiled shortly. The Nixon Administration has asked a task force led by Walter McNerney, the head of the Blue Cross hospital insurance plans, to report on the feasibility of national health insurance.

There has certainly been a remarkable change in attitude in only a few years! I recall how caustic were the cries of "socialized medicine" from physicians and community leaders during the last 30 years when national health insurance coverage was suggested. Very few are frightened by the term any longer. In fact, health insurance has become the bulkwark against socialized medicine.

Unless some satisfactory solution to present conditions is found, the inevitable tendency may be for socialized medicine to supercede existing arrangements. This should not be necessary if the organized medical profession takes a statesmanlike position and works toward some constructive, far-reaching changes which would make an acceptable "system" out of the present haphazard arrangements. I believe we must find a way to make it possible for the organized medical profession to exercise a statesmanlike role in the formulation of a new policy.

DESIGNING a national health insurance plan would be relatively easy if we didn't have to start where we actually are in 1970 but could start with a clean slate. If national health insurance had been adopted 25 years ago, the administrative and policy problems involved in putting it into operation would have been somewhat easier. There would have been fewer vested interests in private plans such as Blue Cross, Blue Shield, and commercial insurance.

Today there are some 75 Blue Cross and Blue Shield plans selling primarily hospital insurance and insurance to cover physicians' services. There are over 1,500 health insurance plans of all shapes, sizes and dimensions in operation. There are hundreds of private insurance companies selling coverage which reimburses in part for medical expenditures and which includes "major medical expense" policies. There are numerous independent plans such as HIP in New York, Group Health Association in Washington, and the Kaiser plans on the West Coast. The consumer of medical care is bewildered by the variations in costs, coverage, and performance of these plans.

Blue Cross plans in 1968 collected premiums of $3.7 billion, Blue Shield plans $1.5 billion, private insurance companies $7 billion, and all other plans $740 million. Out of this total of $12.9 billion it required $1.9 billion to administer these programs, or 14.8 percent of premium income. A national plan which used the existing Social Security collecting system instead of the hundreds of separate collecting units of private plans probably could reduce total administrative costs by about one-third. Since a comprehensive national health insurance plan probably would initially

involve some $35 to $40 billion in medical expenditures, use of the Social Security collection mechanism could save from $1 to $2 billion a year in administrative costs.

When you look at the private plans you can see some which insure payment of the full cost of the services; others reimburse and indemnify for part of the cost paid; most pay on the fee-for-service system so revered by many physicians, while group practice plans pay physicians on a full-time or part-time salary. Some physicians are in solo practice, others are in groups. There are a great many different arrangements. Should a national health insurance plan permit any type of reimbursement? Should it encourage a particular method such as group practice?

Had everyone in the nation at the present time been covered by health insurance for 10 or 20 years, we could now concentrate on experimenting with methods of payment, reforming the antiquated delivery of medical services, reorganizing the arrangements, trying to introduce more economical and efficient methods of providing care, and redirecting priorities to areas of highest need such as preventive measures, training of additional personnel, and expansion of research.

Today we are being asked to accomplish all of these objectives at the same time, a formidable task.

The dilemma we are faced with is to bring millions of additional people under health insurance coverage which they urgently need without placing undue stress on our medical system, without encouraging prices to rise, and without creating further tensions among patients and taxpayers on the one hand, and physicians and hospital and health administrators on the other.

Under private health insurance, as well as under

Medicare and Medicaid, it is clear that the effective demand and utilization of health services has increased. According to the Social Security Administration about 31 percent of the increase in medical costs since 1950 is due to increased use of services. (About 19 percent is due to increased population and the other 50 percent to increased prices.) The bulk of such increased utilization probably represents the inefficient use of resources such as using in-hospital facilities when out-patient care would be appropriate. Some physicians have indicated to me that up to 30 percent of the people in hospitals on a given day need not be there if there were alternative facilities and services such as out-patient or convalescent care.

An increase from $4 to $5.30, effective July 1, was recently announced by Secretary Finch in the monthly premium for aged persons' Medicare insurance for physicians' services. This increase was based upon the assumption that physicians' fees would increase about 6 percent during a year and utilization would increase about 2 percent. Recognizing the possible error in any such estimates, Secretary Finch included a 4 percent margin for contingencies, which implies the assumption that there could be a rise in prices and utilization totalling 12 percent during one year.

IF WE EXTEND coverage to millions of people and broaden the scope of services at the same time that prices and utilization are rising so rapidly, the medical services of the country could be overwhelmed and there would be unprecedented numbers of criticisms and complaints to the government, physicians, and hospitals.

We must find acceptable ways of financing a broadened program which are compatible with medical resources, and with a step-by-step expansion of coverage which takes into account the

realistic ability of the present medical system to supply the needs. This raises complex problems.

I proposed several years ago giving priority to mothers and children for medical care, and President Johnson advocated this as a "Kiddie-Care" program to parallel Medicare. Senator Edward F. Kennedy has picked up the idea and has recommended establishing medical insurance coverage in 1971 for all children from infancy through 14 years and in each of the following four years expanding coverage by approximately 10-year age groups. Under his plan, by the mid-'70s all people up to age 65 would be covered by the program, and the existing Medicare program could be phased in completely with the new comprehensive insurance.

Unresolved difficulties are present in the Kennedy proposal (as they are in almost every plan). The proposal to cover infants and children should also involve mothers so that prenatal and postnatal care can be coordinated with pediatric care and family planning services to assure proper spacing of children, adequate nutrition, and health education. But fathers could ask how medical services for them and their older children will be financed. Two separate financing plans in a family would be confusing and complicated.

A plan to phase-in services by age would undoubtedly involve payment of the costs out of federal general revenues rather than payroll contributions by employers and employees. Why would employees be willing to pay a payroll contribution for such coverage if they had no eligible children? On the other hand, why would Congress be eager to pay all the new costs out of general revenues for persons who did not have low incomes when there would be so many pressures on Congress first to use any available funds to extend coverage to the poor?

ANY NEW PROPOSAL involves difficult questions of where to get the additional money. Some of these financing problems could be resolved by other variations of the phased-in age approach, such as extending Medicare in steps by reducing the age from 65 to 60, then a few years later to 55 or 50, and ultimately to the entire population. This could be coupled with extension of coverage at the other end of the population spectrum, beginning with pre-natal and post-natal care up to age one, then in following years extending coverage up to age three or six, and then to 16, 18, or 21.

In some plans employers are now paying all or a large part of the health insurance of their employees. The unions and employees who find themselves in this favored position have little reason to promote a different method of financing. Their employers, on the other hand, might welcome any change which would transfer all or part of the cost to the general taxpayer, or place part or all of any new costs on the employee. The unions can be counted on to press for more of the costs being borne by the employer and the general revenues. The Griffiths Bill proposes that the employer and the government each contribute 3 percent of payroll (up to $15,000 a year per employee) with the employee contributing 1 percent.

The A.M.A.'s proposal to achieve broader coverage through requiring each individual to buy protection from private insurance carriers is certain to be vigorously opposed by the unions but supported by the insurance companies. The unions want a plan which puts the legal responsibility for entitlement to benefits and payments to providers in the hands of a public authority. Physicians and commercial insurance carriers want these responsibilities to remain in the hands of the private sector. As yet there is no plan which

the unions, employers, the health insurance carriers, the health professions, the experts, and Congress can agree on as a satisfactory solution to the problem.

Those who believe in pluralism in our educational, economic, and health systems ardently advocate the position that we should keep a mixed system, which utilizes both the private and public sectors, to handle health insurance. Those—such as the private insurance companies and the A.M.A. —who advocate that the federal government should require every person to take out health insurance are mostly concerned with keeping the federal government out of the determination of fees, administrative costs, profits, and forms. But even this approach does not keep the federal government out of many of the crucial details which concern the physician, the hospital, and the private sector.

It should be pointed out that if everyone is covered by a private insurance policy, paid for substantially by public funds, the private carriers inevitably become "affected with a public interest" and it would be only a question of time, in my opinion, before the private insurance business would be regulated and supervised by the federal government. Neither the private insurance companies nor the physicians would be happy with that—nor would Ralph Nader and his supporters.

UNIVERSAL COVERAGE could be achieved through one of several different approaches. The A.M.A. approach provides for a tax credit with specified benefit provisions. Those with no tax liability, or a liability of less than $500, would receive a voucher in an amount sufficient to purchase a private insurance policy. This plan would be administered completely by the federal income tax agency and is supported by the A.M.A. because

that organization believes it would keep the government out of control of the quality of care, fees, prices, utilization, or any other matters relating to the organization or delivery of care. The federal government would bear the cost—in the neighborhood of $12 billion a year in the beginning—but would be shut off from having any direct relationship with physicians, hospitals, or other health providers by virtue of the legislation.

While anything is possible, it is difficult for me to conceive of Congress enacting such a plan into law at this time. Recent experience with increasing medical prices, increasing shortages, and increasing utilization and demand do not encourage the kind of abdication of public responsibility which the A.M.A. is advocating, at a cost of $12 billion a year to the taxpayers, all paid out of general revenues.

The approach in the Griffiths Bill is at the other end of the spectrum. Mrs. Griffiths' plan provides for entitlement to benefits under federal law and recourse to federal administrative agencies and the federal courts for redress of grievances. Another significant difference from the A.M.A. proposal is that there would be a uniform national contribution schedule under the Griffiths Bill instead of the great variations in premiums charged by private plans. The private plans utilize flat premium rates unrelated to family income, and this has a regressive effect on lower income families. A flat-rate payroll contribution on wages, salaries and self-employment income tends to relieve part of this burden for families with children, especially when coupled with employer and general revenue contributions which reduce the initial burden of the employee tax.

DURING the past five years, the major public policy problem in Medicare has not been the delicate

professional and other relationships relating to diagnosis or treatment of illness, but the question of how much to pay the physician and the hospital. The Medicare law provides that the hospital shall be paid its "reasonable cost" and the physician shall be paid his "reasonable charge." The law then goes on to say that in determining the reasonable charge there shall be taken into "consideration" the "customary" charges for similar services as well as the "prevailing" charges in the locality for similar services. Finally, the law provides that any private insurance carrier administering the Medicare law must assure that any charge will not be higher than the charge applicable for a comparable service "and under comparable circumstances" to the policyholders of the carrier.

The recent staff report of the Senate Committee on Finance advocates limiting Medicare payments to physicians to the average for a given service paid by the Blue Shield plan. The report recommends 10 additional changes which affect payment of charges by physicians.

The most satisfactory and appropriate method of paying physicians under a public health insurance plan is an old and recurrent one. The 1969 Dingell Bill authorizes four different methods of payment: fees-for-services rendered according to a fee schedule; payment on a per capita basis related to the number of persons who had selected the physician as their doctor; payment on a salary basis, whole or part-time; or payment on such combinations or modifications of the three previous bases, including separate provision for travel and related expenses. For specialist service the bill adds two additional methods: payment per case, or payment per session.

The well-known reluctance of most physicians at the present time to abandon the fee-for-service

basis has resulted in the Griffiths Bill providing for payment of fee-for-service only when the individual physician handles his services through a group which negotiates an overall contract with the government. A city, county or state medical society could be a group. Any group would have to establish a committee of physicians to improve the quality of care, improve efficiency, and provide for continuing education of health personnel. If the physician did not wish to associate with a group having such responsibilities, he could choose reimbursement only on a capitation basis, or a salary basis, or a combination of these two methods. The objective of this proposal is to control costs and improve quality by encouraging practitioners to join together in groups.

IT IS CLEAR that no one has yet devised a foolproof method to control the charges, costs, and incomes of hospitals, physicians, and other providers of health care. There is a general "conventional wisdom" which holds that if physicians were to practice in groups, rather than as individuals, the quality of medical care would be improved, more services would be available, and costs could be kept down. The difficulty is that most physicians are highly individualistic and don't want to practice in a group setting where their medical diagnoses, treatments, fees, and income will be under constant surveillance by their colleagues and their patients. Also, many consumers of medical care have been conditioned to prefer direct contact with a physician who has no immediate responsibility to anyone other than himself and his patient for his medical judgment, his time, or his income.

It is doubtful whether it is desirable or even possible for a unilateral decision, either of government or physicians or hospitals, to resolve these vexing problems. That is one of the lessons

learned from Medicare. The many years of opposition of physicians to the initial Medicare law precluded their helping to develop its major provisions. But once the law was passed, they accepted the invitation which I extended to them in 1965, on behalf of the government, to help solve many of the nitty-gritty problems of administration. What is needed now is a mechanism which will resolve the differences over nationwide coverage.

Today, as in 1965, the man who could probably resolve these differences is the Chairman of the House Committee on Ways and Means, Wilbur D. Mills, the Representative from Searcy, Arkansas. He is the man at the present time who must endorse the solution if it is to be viable in our existing political system. AsWilbur Mills looks at the problem he will find that health expenditures in the nation increased $6.4 billion last year—11.9 percent over the previous year. As a result, health expenditures as a proportion of gross national product rose to 6.7 percent compared to about 6 percent in 1966, 5 percent in the late '50s, and 4 percent in the late '40s. Will the costs rise to 7 percent or 8 percent during the decade of the '70s? There is good reason to believe they may.

If we extrapolate present trends, health expenditures probably will increase an average of about $5 billion a year during the decade of the seventies—reaching $100 billion a year around 1977—or even before. Average daily hospital costs still are increasing by approximately 12 percent per year (recent figures place this as high as 17 percent!) with the result that the average cost of a hospital room may well exceed $100 a day within the next few years.

It appears to me that the extension of voluntary health insurance, or the enactment of federal legislation covering everyone in the nation under private or public health insurance, cannot be expected to stop or even significantly slow these rapid increases. As a matter of fact, providing insurance coverage to millions now without coverage will increase demand, and if the supply of personnel and facilities remains relatively limited over the short-run, and the free play of economic forces is allowed, prices may rise even more sharply.

But the solution to these vexing problems does not involve postponement of a better method of financing health care for everyone or the adoption of a system of freezing premiums, prices, and wages in the health industry. Unless some reasonable solution to these problems is found in the very near future, the nation may discover some day that the inevitable consequence will be governmental operation and control of health services—and that is really socialized medicine.

THOSE WHO FAVOR national health insurance do not simply wish to find a financing mechanism to cover more medical bills for more people. They recognize the need to improve the organization and delivery of health services by promoting comprehensiveness, continuity, and accessibility of services, with emphasis on group practice to assure quality of services and effective cost controls.

But the economic, medical, administrative, and emotional aspects of implementing these objectives have many ramifications. The health insurance plans of many other countries show that there are different ways of resolving these matters with various results and varying degrees of satisfaction.

In 1968, I recommend to the President and the Congress that a Commission on Health Insurance Coverage should be established, consisting of dis-

tinguished representatives of the consuming public, the health professions, and the insurance carriers. The commission's responsibility would be to recommend the precise form of comprehensive protection which would result in universal coverage on an economic and efficient basis. Such a commission would present a specific plan to overcome personnel shortages and to introduce some professional controls over unnecessary utilization and too rapid increases in prices, and to assure the delivery of high quality, comprehensive services.

It is doubtful whether any such commission would make an unanimous report. Nevertheless, it could clearly set out the pros and cons of the different proposals and present a clearer picture of the implications of each proposal in terms of cost, quality, and administration.

IF A COMMISSION should be appointed to work on this large task, the Congress should not delay in taking additional steps to improve what now exists and on which there is general majority opinion. The Medicare program should be extended this year to cover two and one-half million disabled persons receiving disability insurance benefits under the Social Security Program. This action was recommended by a distinguished advisory council appointed pursuant to Congressional direction. The chairman of the council was Dr. Henry H. Kessler, Director of the Kessler Institute for Rehabilitation. The three businessmen and the A.M.A. official on the council submitted a minority report which indicates that opposition in Congress will not be lacking.

Prescription drugs on a limited basis should be included in the Medicare plan for the aged and disabled. Several proposals have been presented to the Congress, including a bill introduced by Senator Montoya. The problems involved in extending health insurance coverage to prescription drugs are quite formidable. We could gain valuable experience by extending such coverage first to the aged and disabled. Based on this experience we could then extend prescription drug coverage to the rest of the population.

Another immediate step which should be taken is to extend comprehensive pre-natal and post-natal care for women in all low income families, initially through the federal-state maternal and child health provisions which are financed out of general revenues. These services could be phased into a national health insurance program. In addition, family planning services should be provided to all who voluntarily want to use them (estimated at four million additional families). Such maternal, child, and family planning services would give us the basis to say that all children, as far as possible, would be born well and wanted.

We must also extend additional financial aid to medical, dental and nursing schools and double the enrollment of entering freshmen in medical schools by 1980. Changes in curriculum are also needed, with the possibility of reducing the total time in medical school, internship, and residency. But we cannot make medical care available to all without additional qualified personnel. Unless we increase the supply of physicians, nurses, and other health personnel—and learn how to use them productively—the increased demand for services will cause even greater shortages and higher prices.

I BELIEVE the federal government must take the leadership in these gigantic undertakings. But the government cannot do it alone. It must enlist the full cooperation of physicians and other personnel in the health professions, hospitals, consumers, business, labor, the universities, and state health

agencies. We must have both leadership and co-operation.

That great British leader, Winston Churchill, spoke of health and other social insurance as "bringing the magic of the average to the rescue of the millions." We need now the magic of national leadership which will bring the resolution of these issues to the rescue of the millions who have little or no health insurance protection, and to the millions who are faced with increasing costs.

As we survey the situation today, there does not appear to be any "perfect" medical care plan which will satisfy everyone. We must, however, not allow the problems and complexities of the present to prevent the development of a better system. We must grapple with the shortages and inadequacies of the present. But if we take the steps we can take now, we could have a comprehensive national health plan ready to begin operation in 1976, when we commemorate the 200th anniversary of the Declaration of Independence.

MICHAEL M. DAVIS LECTURERS

1963: MICHAEL M. DAVIS, *America Challenges Medicine*

1964: MARION B. FOLSOM, *Responsibility of the Board Member of Voluntary Health Agencies*

1965: DR. GEORGE BAEHR, *Medical Care—Old Goals and New Horizons*

1966: DR. LOWELL T. COGGESHALL, *Progress and Paradox on the Medical Scene*

1967: DR. WILLIAM H. STEWART, *New Dimensions of Health Planning*

1968: ARTHUR G. W. ENGEL, M.D., *Planning and Spontaneity in the Development of the Swedish Health System*

1969: GEORGE E. GODBER, D.M., F.R.C.P., *The Future Place of the Personal Physician*