

THE SPEAKER

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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

PROFESSOR FALK delivered this talk at Billings Hospital, The University of Chicago, on May 20, 1971.

I. Basis for National Health Policy

In the United States, for decades we have been in process of formulating a national health program. We do not yet have a good or altogether acceptable formulation broad enough to embrace environmental, community-wide, and personal health services, though one is gradually taking form. We do, however, have a declared national policy on a major portion of the health field, asserting that good medical care should be available to everyone in the nation, and this policy is now in search of a program toward effective achievement.

It is widely agreed that medical care is now "in crisis" in the United States. We are in trouble with respect to medical care not so much because we have failed to recognize existing needs or to anticipate prospective inadequacies, but more because we have lacked the courage and determination to take needed action over the resistances of those who were content with current practices or who feared change. Again and again, we have identified goals and declared good intentions, but we have stultified many of our undertakings through shackling compromises. The time has arrived, I believe, when the nation demands and intends action suited to the needs.

The medical care "industry" is now one of the largest in the country, measured by the annual national expenditure of about \$75 billion (about \$365 per capita) for health services and goods, construction of facilities, and performance of research. It is also in many respects the most com-

plex, especially because of its labor-intensive characteristics and the almost endless intricacy of its technology. It is therefore not surprising that, when such an industry is "in crisis" on a national scale, the problems and the needs for dealing with them are diverse and difficult.

THE MAJOR CAUSES of crisis in medical care start with the fiscal difficulties of relatively high costs and comparatively steep annual escalations, but the causes go on to areas which present even more complex and more perplexing questions than concern the finances. A hundred problems which could be enumerated can be subsumed under *four* categories, and, usefully, in the following sequence—

1. National shortages in various categories of health manpower and facilities,
2. Steeply rising costs and their financing,
3. Inadequacies in the system for the availability and delivery of care, and
4. Lack of sufficient controls for the assurance of quality of care.

These causes of crisis are not discrete and separate. On the contrary, they are interlocked one with another. Therefore, if we would surmount the crisis, we must deal with all four and with their interrelations.

There are some who counsel and advocate that we should deal with each category separately, pursuing each as opportunity, need, or pressures dictate—essentially continuing what we have been doing for decades. This is a counsel of caution but not of wisdom, requiring us to know nothing of even recent history and to continue without even new mistakes. It will avail us little if we merely try to produce more manpower or facilities without

assuring the availability of funds and a better system for their utilization. It is unlikely we can contain the escalation of costs without a better system for the containment of unit costs of service and for the assurance of reasonable economy in volumes of utilization. It is not reasonable to expect we can have, or can afford, either adequate health manpower and facilities or acceptable financing without a better system of delivery. Neither the professions nor the public can go much longer without better protections for quality and adequacy of care. And merely providing more purchasing power for medical care will further strain the resources for service and will surely increase the upward push of prices. Commitment to attack any one problem area does not stay a heightening crisis from the others.

Consequently, whether we take shortage of resources, or costs and their financing, or system improvements, or quality assurances as a starting point, we must also look to all the others. If we do less than this, and if we delay in choosing the road, we will surely find ourselves in a worsening crisis from which our escape will be increasingly difficult and heroic. Any doubt on this score should be resolved by the now-frightening prevalence of dissatisfactions and by the prospect that health care expenditures, rising twice as fast as other essential costs, will more than double within the present decade if left to pursue their current course.

II. *Design for a National Medical Care Program*

The current crisis in medical care has been two generations in the making. In the 1920s, the outlook for prospective difficulties was foreseen, and it led to the studies of the Committee on the Costs

of Medical Care and to the inaction that followed total reliance on professional leadership and voluntarism. In the 1930s, there were comprehensive proposals for dealing with current difficulties and for anticipating prospective needs, and they failed mainly from political timidity in high places. In the 1940s, we began a patchwork of categorical programs for development of needed personnel and facilities, beginning with the post-war Hill-Burton Act and a miscellany of other specialty commitments. In the 1950s, lulled to torpor by the newer promises of voluntarism and the allegedly constructive forces of the marketplace and private insurance, we got massive developments in the private sector and their bulwarking of the *status quo*. In the '60s, with much turmoil and fanfare, we made fractional provisions for the aged, for mothers and children, and for the poor and the near-poor, but—with the major specifications laid down mainly by the *opponents* of the enactments—we got both inadequate programs and newer cost escalations. The result is crisis in the '70s.

It must be clear that merely instituting a bigger or even a better health insurance program, whether governmental, private, or mixed, will not suffice. Better fiscal provisions must be accompanied by other provisions—for more adequate resources, their more effective utilization, achievement of economies without sacrifice of quality standards, moderation if not containment of cost escalations, and better access to medical care services, especially for those of modest or small means who now have difficulty in obtaining needed care.

Surely it must be clear, now, that delimited categorical plans have been inevitably less than adequate and inherently expensive. Although

some have been enormously valuable in their several fields, they have always been too small to meet the national needs, and they have always lacked the leverage to effect substantial improvements in the medical care system as a whole. As a consequence, we have large and diverse national needs. Nothing less than national action based on the national resources can serve the national policy adequately. On this, fortunately, a consensus has been emerging, and the increasing intensity of the crisis demands that action be taken soon.

IT IS THEREFORE not surprising that the nation now has a wide range of program proposals. Some are still categorical continuations from the past—national supports for more and newer health manpower, for more and more diverse facilities, for utilization review or for other specific measures to enhance or assure quality of care. Each of these, however virtuous of itself, carries the potential of being an expensive exercise in futility. Other proposals which are being advanced are broader and more comprehensive, embracing but not confined to the limited categorical programs. I submit that only these which are of scope and magnitude commensurate with the national needs deserve our attention.

There are many alternatives for the major specifications in the design of a national program for medical care and a plan for its financing. However much the diverse proposals differ in other respects, they agree that in the United States we should not move toward a national health service in which government owns and operates the facilities and employs the providers of medical care. Rather, they intend that we should go toward a system in which government under-

writes funding to assure the means for compensating private providers, leaving the provision of care to evolving patterns of private services. The crucial problem in such an alternative to a national health service is the effective and yet acceptable interlocking of the public and the private roles. More specifically—

1. What should be the role of government in providing the *framework* for a better hopefully, an adequate—system of medical care?
2. What should be the role and the mechanism for the public sector in the *financing* of the better program?
3. What *improvements* should the financing system undertake to stimulate in the private sector for the provision and availability of services?

These generic questions should lead us to face the issues concerning the roles of government at different levels and in relation to the principal vested interests—especially the personal and institutional providers with respect to services, and the insurance carriers with respect to financing and the management of money.

Unless there is a massive infusion of fiscal resources from the Federal to the state level, it is wholly out of the question to look elsewhere than to Washington for the implementation of the primary role in the public sector. Indeed, relieving the states of current and prospective medical care costs is one of the obvious ways in which the Federal Government can contribute to a fiscal strengthening of the states. This reinforces other reasons why a program that would meet national medical care needs must be national, since in no

other way can such a program rest—as it must—upon the national economic resources. This is not to deny the opportunities for consequential roles to the states, but the opportunities are primarily functional and not fiscal.

The providers of service are not secondary to any other element in any sensible plan, and basic policies must never forget this precept. But a corollary policy is that the providers do not stand alone, though we see everywhere about us evidences today that they have tended to forget—as an old English maxim has it—that “he who reckons without his host must reckon again.” The providers, however dedicated, are consequential only as they serve their clientele. Both are involved with the economy, and the consumer of services is clamoring, insistently, for policy roles as to the services that are to be available and the price at which they are to be had.

THE INSURANCE carriers pose a dilemma. Private health insurance, through the Blue plans and the insurance companies, has made massive and successful efforts to reach *with some insurance* nearly everybody who needs and can afford insurance protection against the costs of medical care. It is now widely agreed, however, that this has also been an equally massive failure toward providing *adequate insurance protection*. The effectiveness of private health insurance has achieved the coverage of only about one-third of private costs with an annual improvement of about one percent a year, leaving about two-thirds still to be met by out-of-pocket expenditures. In the course of this mixed success and failure, millions have been served beneficently, and millions have also been left with little insurance or with none. And the whole medical care scene has been corroded by the frac-

tiation of services, by under- and over-utilizations of particular kinds of services, and by cost escalations which have been fostered and supported by insurance patterns useful to the insurance carriers and to the vested interests of providers which they have served.

If the insurance industry is unhappy about criticism leveled at it, the blame rests largely with itself because of its historic opposition to governmental participation in health insurance activities. Now, it seems to me, the time is past when the nation can continue in the health field to place primary reliance on private insurance, though there is still an open question how large a role the industry can play usefully as an administrative agent of governmental authority.

Requiring a national health insurance to satisfy the nation's needs, the financing must invoke the fiscal resources of the whole nation, and the system must therefore be truly national. National social policy now demands that this be a system which, as far as it can, undertakes to assure the availability of personal health services to everybody—without means tests, without financial barriers at the time care is needed or financial burdens afterwards, and with access to all needed available services and not merely to those which it is convenient for private insurance carriers to insure. Such a system should absorb Medicare, Medicaid and a long list of other fractional and categorical programs for personal health services that complicate the current scene. An affluent and health-conscious nation should be satisfied with no less.

IF A NATIONAL program is to be financed toward these objectives and responsibilities, the system must have the resources not only to pay for ser-

vices that can already be provided but also to do what it can to assure the availability of the needed services. The program must therefore be able to encourage and support the development of needed health manpower and of organization for their effective and efficient use in the delivery of good quality care. This is the basic duality of objectives.

The new undertakings must be able to support large-scale development of organized comprehensive group practice, because no other system of delivery has the promise of meeting modern needs. Technological progress compels this; and manpower, cost, and quality problems demand it. Such organized service should become available for free-choice participation by the providers of care, and for free-choice election by the people to be served; and it should have systematic prepayment support through the national program.

The present steep escalation of costs has to be at least greatly moderated and at best contained. A new system of national health insurance must therefore make an end to public guarantee of unlimited, full-cost reimbursement of hospitals and other institutions, and equally an end to unlimited public guarantee of charges determined solely by the professional providers. In short, a sensible program will go to a budgeting process under which institutions will learn how to operate under negotiated budgets, and practitioners will learn how to be reasonably reimbursed from within identified pools of budgeted funds.

It is almost gratuitous to remark that a budgeted system will be painful for the providers to accept, and that it will be resisted. However, it may not be gratuitous to remark that providers of health care should nevertheless prepare to live

with such a development. Even more, I believe they should participate cooperatively in the design of the system that is needed. An undertaking by providers of health services to dictate a system which would merely preserve present financial practices would be interpreted as an irresponsible invitation to future financial crisis or even disaster. The nationwide criticisms now being generated by fiscal experiences under private insurance, under Medicare and under Medicaid should encourage commitment to cooperative planning.

FROM THESE considerations of policy, goals, and precepts emerges a series of specifications developed by a Technical Subcommittee of the Committee for National Health Insurance which, I believe, should guide the design of a good and adequate national proposal for medical care.

1. The whole population should be eligible for all the benefits of the program, according to the need for health care and without financial tests or barriers.
2. The program should undertake to assure the availability of all useful and promising medical care services within the spectrum of its benefits.
3. The desired organizational pattern and delivery system should, as a practical matter, be achieved on an evolutionary course which starts with acceptance of current patterns and practices, and with provider incentives and supports for developments toward the declared goals.
4. The national economy as a whole should be the underlying source of financing, both

for the development of needed resources for the provision of services, and for adequate and assured support of continuing functional performances.

5. To be acceptable as well as viable, the program design should be based on a partnership of—(a) national public financing, and (b) private provision of medical care services, through self-selected diversities among providers of services, their location, organization, professional and fiscal operations, and participation in planning and administration.
6. Continuing financial supports should be assured through—(a) taxes which are earmarked for medical care and which automatically adjust to the state of the national economy, (b) matching or supporting appropriations from general revenues, made as nearly automatic as possible, and (c) utilization of the total yield through the mechanism of a permanently appropriated trust fund, avoiding the uncertainties of annual appropriations.
7. The program's fiscal operations should rest on prospective annual budgets for the support and compensation of providers of medical care services and goods, in order to bulwark planning and to contain costs within levels determined by national decisions.
8. To assure the worth of services supported by public funds, the design of the program should provide for standards of quality and the administration should be required to

implement all practical measures for the observance of such standards.

9. Administration of the program should involve not only the public authority but also the authoritative participation of representatives of consumers as well as providers of services.
10. There should be mandatory provisions for public accounting of program operations and performances.

This series of specifications also identifies the major criteria by which, I believe, we should measure the prospective promise of any national program for medical care and by which we should weigh the relative advantages of one proposal over another.

III. *Current National Proposals*

It may be instructive to consider some of the program proposals already on the national scene, disregarding those which would deal only with some limited portion of the medical care spectrum.

A. The proposal for a national "*catastrophic illness expense plan*" has been submitted to Congress by Senator Long and other members of the Senate Committee on Finance. It intends to provide a supplement to current private insurance protection for substantially everybody under 65 and for those who are eligible for support under the Federal-state Medicaid programs. It follows the pattern of Medicare as to benefits, deductibles, coinsurance, and administration, but its benefits would begin beyond where the benefits end in most private insurance. It would be financed at a

self-maintaining level by taxes like those of our national social insurance. This "catastrophic" insurance proposal is illustrative of limited interim measures which would deal with a weakness in the prevailing insurance patterns. But it would make no new attack on the current or prospective problems of cost escalations, inadequacy in resources, or deficiencies in the delivery of medical care; and it may strengthen the inflationary trends.

B. The "*Medicredit*" proposal developed by the American Medical Association is a more widely advertised plan. It seeks new financial support to enlarge the purchase of private insurance—about \$15 billion a year initially from the U.S. Treasury. Individuals under 65 and having no income tax liability would be eligible to receive a certificate to be used in paying the full premium for a "qualified" health care insurance policy; others with some tax liability could receive either a credit offset against such liability for insurance premiums incurred or a certificate for use in paying a "qualified" insurance carrier. The tax credit amount would range from 100 percent of the allowable premium for those with no tax liability down to 10 percent (plus the cost of "catastrophic" insurance benefits) for all with liability exceeding \$890 in a year. Minimum required benefits—including those for so-called catastrophic cases—are specified, as well as deductibles and coinsurances. Payments for services shall be according to usual and customary charges. National administration would be assigned to a Board in which practicing physicians would be a majority among the public members.

The implementing bills introduced in the House and Senate have no limit on the premiums

or the potential expenditures; they make no provision for raising the funds that would be expended; they include no quality or utilization controls; and they provide no explicit incentives to augment or improve the resources for delivery of care. There is, to be sure, an expression of interest in the search for improvements through insurance carriers and providers of care, but this is not explained and it is not funded. Reliance is apparently placed on the play of "market" forces. In essence, the proposal intends a draft on the Federal Treasury to provide more money for the purchase of more private insurance; and it would surely invite more and steeper escalation of prices, charges, and costs. Its enactment would, I believe, be at the best an inconsequential but expensive exercise and at the worst an act of national folly.

C. The "Healthcare" proposal from the insurance companies also relies heavily on private insurance by providing financial incentives to individuals and employers in the form of full offsets against otherwise taxable income for premiums paid for "approved" policies. A corresponding system is proposed, through the states, with respect to the poor, near-poor, and "uninsurables," with the poor paying no premiums, and others premiums graduated against income, and with the Federal Government providing 70-90 percent of the benefit costs under approved state plans. Systems improvements are proposed through support funds for the education and training of personnel, for production and operation of health centers, and for comprehensive health planning. "Healthcare" leaves Medicare intact, but would absorb into private insurance pools substantial parts of Medicaid.

Thus, this program has elements of realism. But it still would rely mainly on private insurance plans likely not to be much better than those that have already failed us, especially through their support of fractionated services and open-end private and public expenditures with inadequate guides or controls.

D. "Ameriplan" has been submitted, but only in outline form, from a committee of the American Hospital Association to deal with both the delivery and the financing problems of medical care. It envisions "Health Care Corporations" (HCC's) which would organize arrangements for the availability of care as comprehensive as feasible, in geographically defined areas. The scheme contemplates four categories of benefits (health maintenance, "standard benefits," catastrophic illness benefits, and supplemental coverages), to which four categories of eligibles (the poor, the near-poor, the aged, and all others) would have various avenues of entrance. Support would come from three sources of funds (federal general revenues, social security payroll taxes, and private funds), categorically applicable to various combinations of benefits and eligibles. The plan is intended to function under national enabling legislation, enactment of complementary legislation by the 50 states, and state directives and approvals for the HCC's, their organizational patterns, services, charges, utilization controls, etc.

Perhaps when Ameriplan has taken on legislative form it will seem simpler and more realistic. Now, however, it assures us that we cannot afford to rely on a program which promises certainly not less and apparently even more complexity than that with which we are already plagued. Pluralism in financing multiplied by pluralism in

the provision of care should be out of the question. Compounded by dependence on national legislation and annual appropriations, and by elective actions by each of the 50 states, Ameriplan's tactical exercises carry flexibility and accommodation to an unprecedented and unacceptable extreme.

E. *Senator Javits* has submitted bills which propose extension of an improved Medicare program to the whole population, to become a plan for national health insurance and systems improvement. The extensions of population coverage and benefits would be effected in stages, and the administrative pattern would follow that of Medicare. The declared intention is to make extensive use of the private insurance industry by making the required benefits available under contracts with carriers. Employer-employee plans may opt out of the system if their benefits are better than the statutory minima. There is also a provision to utilize Federally chartered national health insurance corporations if the insurance industry is not prepared to cooperate. Financing would lean on social security type taxes, with one-third of the costs met by appropriations from Federal general revenues. Systems improvements would rest principally on fiscal supports to encourage the development of local comprehensive health service plans which meet various specified requirements, whether to function through group or solo practice.

Thus, Senator Javits' proposal has various features which are in accord with our guidelines. But it has a potentially fatal weakness in that, intending to rely on the private insurance industry, it stops short of proposing budgetary restraints or adequate alternative controls.

F. *President Nixon* has submitted, as the Administration's program, "a new National Health Strategy." It includes, among others, three major elements: a two-pronged insurance program for employed persons and for low-income families; systems improvements mainly through the development of "Health Maintenance Organizations" (HMO's) which meet prescribed standards; and supports for health manpower needs and better organization.

All employers would be required to provide basic insurance for all persons with substantial employment, wholly at the expense of the employers and employees. Employers may opt out of the system through self-insurance. Low-income families with children, qualifying on periodic income tests, would be covered by a compulsory separate Family Health Insurance Program (FHIP), to be implemented through public or private agencies or through insurance carriers, with a sliding scale sharing of costs by the families and the Federal Government. Each insurance plan has its specified minimum benefits, and its deductibles and copayments, but no specified ceilings or controls on costs. Under both plans there would be an option for covered individuals to be served by an HMO (if there is one in the community). Payments to providers would follow the open-end Medicare patterns, with global or capitation payments for HMO's. Insurance carriers would establish separate pools for self-employed persons and others not enrolled in the basic plan or not covered by FHIP. There would also be a separate pool for Medicaid eligibles (the aged, blind, disabled, and medically needy). In addition to supports for education and training, the proposal includes special supports (planning grants, loans and loan guarantees for facilities,

and initial operating supports) to develop, expand, and utilize HMO's, especially in medically underserved areas. State laws or regulations which might interfere with HMO contractual operations would be declared inapplicable.

Thus, the Administration's proposal includes many essential ingredients for a good program; but all this is offset by its obvious deficiencies: reliance mainly on required private purchase of private insurance, with no restraints or protections against inherent wastes, inefficiencies, and extravagances, against fractionation of services, and against invitations to newer cost escalations and resistances to system improvements.

References to "cost consciousness" were prominent in the President's Message and in the Congressional testimony of the Secretary of HEW, but cost controls are strikingly lacking in their bills except in reference to the HMO's. Further, the program would be little more than an aggregation of independent parts, with countless marginal problems of jurisdiction, changes of status between parts and in consequent financing. This is more an attempted placation of dissatisfactions, a gesture to need for systems improvement, and a rescue operation for the insurance industry than an integrated or even a coordinated program. It is not credible that this "strategy" could lead to a promising or an acceptable program.

G. The "*Health Security*" proposal developed by the Committee for National Health Insurance and the AFL-CIO, and introduced by Senator Kennedy and others, and Representatives Griffiths, Corman, and others, by contrast, presents an orderly, systematic, and integrated national program. It has the declared objective of making personal health services of good quality available

to the entire population as rapidly as feasible. It therefore includes national health insurance to pay for privately provided services, and provisions for improvement of resources and delivery. Eligibility for the benefits would extend to substantially everybody, according to medical need, without either contribution histories or means tests.

The benefits would include all personal health services from all available qualified individual and institutional providers, with no cut-offs and with no deductibles or copayments, and with only four limitations: on dental care (by age), on skilled nursing home care (by duration), on psychiatric consultations (when not provided by an organized service or participating institution), and on prescribed medicines (limited to those to be used within institutions or for treatment of illness which is chronic or involves costly drug therapy). Quality controls would go beyond those in Medicare, e.g., requiring referrals to specialists from primary physicians, board certification for various specialists and continuing education, in addition to utilization reviews. Methods of payment to those who choose to be individual providers would be left to their election (fee-for-service, capitation, stipends, etc.). But to institutional providers, payments would be made according to negotiated prospective budgets; to comprehensive health service organizations and professional foundations which meet prescribed qualifications, by global capitation amounts or according to negotiated global payments, including or supplemented by sharing and cost savings; and to other providers of goods or services, on adaptive bases.

Financing is proposed through taxes (on individuals and employers) in the social security pat-

tern and through matching amounts from Federal general revenues paid into a trust fund. After fixed portions are earmarked for a health resources development account, the annual available amount (initially in relation to current levels of expenditures) would be allotted first among regions, then for categories of services, and finally to sub-regional health service areas. Except for emergency adjustments, these allotments would become the budgeted global amounts for payments to providers. The allotment procedure has an injunction to work toward reducing differences in resources and expenditures in the several regions of the country.

Extensive and explicit guidelines are laid down for resources developments in consultation with regional and state planning agencies—to improve supply and distribution of personnel and location of facilities, and for organization and delivery of health services. Support funds (grants, loans, or interest subsidies) would be available for expansion and development of ambulatory services, especially through the development or expansion of comprehensive care organizations based on group practice; for recruitment, education and training of urgently needed health personnel; for systems improvement, resources, studies and evaluations; etc. Restrictive state laws as to licensure and inter-state mobility, the permitted functions of providers, development and operation of group practice plans, etc., would be inoperative in relation to this program. The development funds are to be used to supplement, not to supplant, other available Federal assistance.

Administration would be assigned to public authorities (national, regional and local) with advisory councils which include consumer and professional members. Medicare and the Federal

employees program would be absorbed; Medicaid and various other programs would be largely phased out. The effective date has a two-year lag, but resources development would proceed without delay initially through appropriated funds and subsequently through support from the trust fund.

Since the specifications for the Health Security proposal were drafted to be in accord with the guidelines which I summarized earlier, the plan meets all the criteria which many of us believe should be used in judging how well a program promises to meet the national needs. The Health Security design has limitations and deficiencies, but these reflect the unavoidable consequences of the fact that we cannot start afresh—that we must start with what we have and that we must proceed on an evolutionary course. In general, however, the proposal is designed to be moving toward availability of comprehensive services for everybody, assured financing with moderation of cost escalations so that they will parallel those of the economy as a whole, and relative simplicity and understandability in the delivery of medical care for the whole population.

The Health Security proposal has been criticized on the ground it would raise high expectations and would promise more than it could deliver. Admittedly, neither the Health Security nor any other service program can undertake to meet all national health care needs or demands on an appointed day. It can at the best only undertake to assure doing its utmost for making the resources for the delivery of needed care more nearly adequate than they are now, and to fund the services to be made available and furnished. That is all that is proposed for this program, its promise should not be exaggerated, and effort

should be made to have its potential and its limitations understood. If the program's best still would not suffice to meet all needs, this would reflect what already obtains and what the new program would inherit, not what it would create. With vigorous and prompt undertakings for system improvements, the present gaps between need and delivery should not persist and should not continue to widen; instead the gaps should begin to narrow—in some measure at once and in greater measure year by year. Only that much should be promised or expected. In these respects, there is a greater potential for progress in this proposal than in its alternatives.

The national structure of the proposed Health Security program has led to criticism that it would be “monolithic”; but this is exaggerating rhetoric. *Financing* would be “monolithic,” as in the efficient and stable national social insurance, and as it must be if it is to support and guide the system; but the *services* would be “pluralistic,” as they are now and would become even more so as the services may evolve once they are unshackled from their present rigidities.

IV. *Costs*

You will have noticed that I have given scant attention to cost figures which have been or may be ascribed to each of the several proposals. This reflects no oversight. Rather it reflects my intention not to participate in the popular “numbers game.” A partial or limited proposal, or a part of a broader proposal, may have a seemingly small price tag; but if it adds something to the current and prospective levels of expenditure for health services without effecting improvements in the system, its cost may still be too much. Contrariwise, a comprehensive proposal intending to sub-

stitute for a large part of current services and their expenditures, may have a relatively large price tag; but if it would provide the means to improve resources and delivery and to contain prospective cost escalations, its costs may nevertheless be readily acceptable.

As mentioned earlier, total national expenditures for health services have probably reached \$75 billion this year (about 7.3 percent of gross national product), and expenditures for personal health services about \$68 billion; and these expenditures are apparently still rising at the rate of 10–15 percent a year. The Health Security proposal intends to absorb initially the services responsible for about 70 percent of personal health care expenditures, and a larger proportion later on. Since its budget and control designs would move these expenditures toward a year-to-year pattern of prices and costs like that for the economy as a whole, its program costs would continue to be manageable.

The precise allocations of costs among alternative sources of funding for the Health Security program is endlessly arguable, and I have no inflexible brief for the formula that has been proposed. As to its total costs, the first point to remember is that we would be dealing mainly with a rechannelling of funds we would otherwise be spending, rather than with new or additional expenditures; and the second is that whatever the price tag now it will be larger the longer we delay because of the rising level of expenditures.

V. *Advocacy*

As we consider the alternative proposals before us, I suggest we should ask of each its answers to critical questions:

1. What would it do toward relieving critical shortages in health manpower and facilities?
2. What would it do toward containing costs and their prospective escalations?
3. What would it do toward improving the system for delivery of medical care and its availability for everyone?
4. What would it do toward encouraging new assurances of good quality in medical care?
5. What would it do toward providing assured financial support of the services for the whole population?

The answers that we can expect lead to the conclusion that the Health Security proposal should be our choice. It—alone among those available—offers a design with which we could proceed. As remarked earlier, it has limitations, principally those which devolve from its compromises: It intends that we should proceed on an evolutionary path of gradualism; and it is not a physician's program, or a hospital's program, or a consumer's program. It therefore has elements which will not satisfy each group. It offers no panacea, but I believe it does offer a program the nation needs and can afford.

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*
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