Report from America

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Prospects for a national health service or for comprehensive health insurance*

During the mid-1940s, when prospects for the British National Health Service were being debated, I was a medical student and house officer, too busy on the whole to pay much attention to the political infighting of the various pressure groups that emerged. I have vivid recollections, though, as I perused my special-rate-for-students *British Medical Journal* and *Lancet*, of a feeling of deep disappointment with some members of my chosen profession. Being young and idealistic I thought everybody would want only what was best for patients – all patients, regardless of age, race, sex or social status. Trained in the voluntary hospital system, by a group of ‘honorary’ physicians whose freely given services qualified them for their honourable title and teaching role, and also by their salaried registrars, I found it hard to stomach the letters and articles in the journals of that period from practising doctors whose main, or even only, concern seemed to be what level of compensation they would get on transfer of their privately owned practices to the state. Property rights loomed large, and much wheeling and dealing must have gone on between all the various factions. And yet it all seemed to be resolved quite quickly and with a wealth of enthusiasm and goodwill on all sides.

My first few years as a permanent resident in the United States have coincided with a period of intense debate about the prospects for a US national health service. Again, I have found myself too busy with other things to be anything more than a sideline spectator of a scene which is far more complex (not to say bewildering) than anything I remember in Great Britain thirty years ago. By comparison, American football and baseball (which are confusing enough, in all conscience, to a new immigrant) are child’s play to follow. The forces pressing for a national health service, or at least for a

comprehensive national health insurance scheme have been gathering strength here in recent years. It seems generally to be thought inevitable that, before the end of the decade, some scheme or other will be approved by both Houses of Congress, and will not be vetoed (as, depending on its precise provisions, it might have been under the previous President) by Jimmy Carter. Sickiness is too threatening financially to the average family today, and something must be done to alleviate at least that part of the anxiety associated with illness.

Spiralling costs in the ‘American health empire’

In every advanced country in the world the cost of health services has in the past three decades been increasing at a rate far beyond the expectations of a national health service in the mid-1940s in Britain. Nowhere has the cost inflation been as high as in the US where the annual rate is frequently at least twice that of the overall inflation rate. Partly, this is due to the extraordinarily advanced technology that is available. Partly it is due, no doubt, to the provision (on a fee-for-service basis) of unnecessary services. Mostly, I suspect, it is due to increased consumer expectation and demand: for example, whereas in most parts of the world a patient will accept all kinds of mild pathology as a normal condition of living, any middle-class patient in America is likely to expect to receive medical or even major surgical therapy whenever he or she feels the mildest discomfort or distress. It is probably the unbridled expectations of the general public concerning the ‘miracles of modern medicine’, and the inevitable disappointments that result, that have contributed most to the recent malpractice crisis, and thus to a further increase in medical costs. Insurance premiums for doctors have reached fantastic levels, and the cost, of course, is passed on to patients or their insurers. Everybody seems to make money out of medicine here: not merely the health-care providers, at all levels, and in a thousand different groups, but the building industry, the insurance companies, private investors in both profit-making and non-profit-making hospitals and nursing homes, bankers and lawyers and the complex and vast pharmaceutical and bio-engineering companies, and the commercial laboratories ready to do any clinical test you want.

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Medicine is truly 'big business', and that in the country where concern for business and profits is regarded as the fundamental drive which, together with the drive for 'rugged independence', has made the country so great, so powerful, so successful. Effecting changes in the 'American health empire'¹ is no easy task. The more radical the proposals, the less likely they are to receive proper attention: short of a revolutionary upsurge of protest against the 'health empire', it is unlikely that anything like the British NHS will come about. A recent survey of the history of the British experience opened as follows:

'The National Health Service was established in July 1948. Public provision for medical care was not, of course, new. The service was built upon older foundations whose shape was sometimes all too evident in the administrative arrangements, buildings, and even attitudes carried forward into the new structure.

'The most important new feature of the NHS was the assumption by the state of major responsibility for financing and planning medical care in order to bring it within the reach of the whole population. Eckstein (1964) called it the only piece of pure socialism enacted by the post-war Labour Government. That government left its mark in two particular ways. One was the virtually complete nationalization of the hospitals formerly owned by local authorities and charitable organizations. Since non-hospital services were treated differently, this had the effect of institutionalizing the growing separation of hospital from community medicine. The other was the commitment in principle to provide medical care without charge to the user at the time of consumption. The new service was to be universal, in the sense that it covered the whole population, comprehensive in that it was intended to meet any need for medical care, and for the most part free (although, as we shall see, this principle had to be modified in those parts of the service that were least able to resist consumer demand). It thus differed from the pattern of medical services in many other countries where some payment is made by the user, or state services are limited to particular classes of citizen (eg, the elderly, the indigent or insured workers) or otherwise restricted in scope.'²

This, then, is a form of 'socialized medicine', a term which causes many Americans (especially those who are members of the ruling classes in the 'empire') to quake and quiver as though it were the road to hell or to communism. The prospect of control from Washington (by 'the feds', as federal agencies are derisively, and universally, described) is anathema to a nation composed of fiercely independent states, and of fiercely independent local communities within those states. Some idea of the size and complexity and powers of local elected groups in the field of health services may be gained from the following extracts from a newspaper report

(*Los Angeles Times*, 13 October 1976) on the financial problems currently faced by the five (only!) members of the Los Angeles County Board of Supervisors in this (population 6 992 300) area of the State of California. The supervisors are local politicians, elected by popular vote, whose powers and responsibilities are of awesome dimensions in a wide variety of areas:

'Nightmares of budgets to come occupied Los Angeles County supervisors Tuesday as they faced a projected \$17.9 million shortfall in health revenue for the next fiscal year and little prospect of prompt property-tax reform from Sacramento.' (Sacramento is the State capital. The \$17.9 million is simply the projected deficit. The overall health budget for LA County is \$2 942 113 268. The cutbacks in hospital services that have so far resulted locally have been extremely disquieting not only to providers but also to consumers.)

'To deal with the revenue gap between projected tax resources and current health costs, the supervisors:

... Again pleaded with Gov Brown to call a special legislative session to deal with tax reform the week after the Nov 2 election.

... Ordered the scope of potential cuts in health services next year expanded to cover a wider range of options. ...

"I'm quite disappointed in the governor," said Supervisor Ed Edelman. "He can't stand simply on symbols and expect the needs of the poor and needy to be taken care of. We've done all we can at the local level".'

The story points up, of course, the inevitable shift of effective (economic) power from the local to the state level. Increasingly, too, the state is dependent on the Federal Government, for instance, for funding programmes such as 'Medicaid' which, since 1965, has provided health insurance to the poor by means of federal funds administered through state agencies. Much of the health budget is financed from Washington, either by contracts with the state or directly with local communities, hospitals or with individual providers. Government contracts may be for research into or for the provision of health care in some special field, or for a varying mixture of the two. Increasingly, then, the providers of funds want reassurance that those funds are being used responsibly and well. A very complex system of checks and balances, of 'professional standards review organisations', 'health-systems agencies', 'state health planning and development agencies' and the like have come into being.

The most recent attempt to provide a comprehensive framework within which bureaucracy can operate efficiently at all levels, towards the end of improved health services, is the National Health Planning and Resources Development Act of 1974, which, as Public Law 93-641 'melds the Hill-Burton program, Regional Medical Program and Compre

hensive Health Planning into a new network for health planning and resources development. Health-systems agencies will possess broader powers than predecessor agencies, particularly in the areas of regulation, control of federal funds, resources development and implementation. PL 93-641 thus offers the possibility of transforming the basic concept of health planning from reactive to "proactive". Successful legislative implementation will require each health-systems agency to build local legitimacy, ensure constructive consumer/provider dialogue, and respond to state and national managerial requirements. Many questions about planning implementation, the role of subarea councils, agency co-ordination and local governance remain unresolved. The new health-planning network has the potential to assume the function of active system transformation, but will be critically dependent on adequate program budgeting to fulfill this promise.³

An editorial in the same issue of the *New England Journal of Medicine* commented on this article, in summary, as follows:

'Finally there is the question whether, even if PL 93-641 succeeds, Congress and the federal bureaucracy will relinquish their ultimate prerogatives to legislate and administer national health policy. After all, PL 93-641 creates a system of grass-roots health planning and policy implementation based on local decisions reflective of local needs. At some point, this "bottom-up" planning may conflict with national health priorities enumerated by the Congress and the federal bureaucracy. The final question may be, in fact, who will be "proactive" and who will be "reactive" - the HSAs, or Congress and the federal government.'⁴

There is undoubtedly a steady pull towards Washington as the ultimate seat of power in the Union, and as the only source of funds sufficient to meet the growing costs of health care. It seems clear that, before the Congress will be prepared to give any kind of approval for either a national health service or for comprehensive national health insurance, it is going to require proof that the controls incorporated into PL 93-641 can be made to work, and that runaway inflation in the 'health empire' can be checked.

Government plans for national health services

In recent years many plans for national health have been developed in the Congress and by the Administration, and a number of Bills are currently awaiting debate before both the Senate and the House of Representatives. In a short article it would be impossible to spell out all of the variations, out of which, presumably, compromises will ultimately be worked out to a point of achieving enough votes for passage of such a Bill. The list of references^{5, 6, 7, 8} contains the major and most easily accessible publications on impending legislation, of which

probably the most powerful will be that proposed by Senator Kennedy. He has sponsored three major efforts towards comprehensive health insurance (Kennedy-Griffith, Kennedy-Mills and, most recently, the Kennedy-Corman bill) in recent years, and his proposals seem to gain ground steadily except with some of the key providers such as some self-interested physicians and owners of hospitals, etc.

There is only one major thrust towards a true national health service in the British sense. It is well described by Hyman as

... 'a concept developed by the Medical Committee on Human Rights and advocated by Congressman Ronald V Dellums of California. Although this plan is unlikely to attract widespread popular support, it is important to consider as an alternative to the more conservative measures that form the mainstream of thought on national health insurance. To the overwhelming majority of the theorists Congressman Dellums' proposal is radical and untenable, but it serves well as an illustration of the kind of proposal that might be adopted were the political and medical establishment more flexible.'

'On 17 October 1974, Congressman Dellums read into the Congressional Record his proposal for a community based health care system which would provide a comprehensive approach to improvement of the health situation in America. This proposal, as the Congressman himself phrased it, "would bring about major changes in the complete health care system as we know it". There are a few basic assumptions that are essential to the proposal. First, Dellums believes that health care is a human right that should not be allocated on the basis of a family's ability to pay. It must be easily available to every person without direct charge. Included among the services available to every person regardless of income are diagnosis, treatment, and prevention of medical, dental, and mental problems. All visits to doctors, hospital stays, drugs, lab tests, home and extended care costs would be provided routinely.'

'Second, Dellums believes that the provision of health care cannot be dependent on profit making. No provider, industry, or institution should be allowed to gain excessively from the human misery of illness. Therefore, he advocates that physicians be placed on salary (approximately \$30 000-\$50 000 per year) and that private health insurance be abolished.

'A third basic change from the status quo comes with the transfer of health-related decision-making power to consumers through a system of Community Health Councils. Rather than perpetuate the unsatisfactory record exhibited by the health establishment, Dellums would permit those who receive the services to participate in the planning and review processes. . . . This concept is obviously much too radical and drastic to be given any real consideration in the Congress of the United States. . . . Although Dellums' proposal will most

certainly not have great impact on the character of the final legislation, it does show clearly the kinds of alternatives that are being dismissed in the political process.⁶

Plans for varying forms of health insurance

All other plans and bills are for varying forms of health insurance. The ingredients in the various recipes are of bewildering complexity, and serve every one of the competing interest groups in one way or another (see reference no. 8 for details of some of them). They go all the way from the most conservative to the most liberal. Some advocate minimum coverage except for 'catastrophic illness' (and even there some proportion of costs might have to be borne, in a truly conservative plan, by an insured to whom even 10 per cent of a seemingly 'infinite sum' is bound to seem no less 'infinite' in his circumstances). The more liberal plans call for compulsory, universal insurance with sliding scales of premiums incorporated into the federal and state tax systems. As always, Republicans (equivalent of the British Conservative party, by and large) want to do the least, and prefer that the free market operate according to time-honoured principles of American capitalist economics and 'rugged individualism'. The Democrats (who embrace many of the principles of the British Labour and Liberal parties, but also contain not a few solid conservatives in their ranks) want reforms of a kind, but may well settle for a plan that leaves the present 'health empire', with its almost universal insistence on a 'fee-for-service' remuneration system intact. These considerations have led one radical but responsible and scholarly group to comment as follows:

'National health insurance will fail because it fails to face the fundamental questions about our health system – control, accountability, accessibility, priorities, responsibility to the community. And it fails this test precisely because it is national health insurance. Under an insurance mechanism, no matter how liberal, the private delivery system performs a certain service and the public funding (insurance) system pays for it. The public users may try to persuade the controllers of the private delivery system to change the system, but no attempt is made to take the power to control away from them. The key issues about the health system are thus removed from the discussion right from the start.

'To this dead end we can only propose the fundamental alternatives: the only way to fundamentally change the health system so that it provides adequate, dignified care for all is to take power over health care away from the people who now control it. Not merely the funding of the health system, but the system itself must be public. It then becomes possible to face such questions as how such a 'national health system' can be made responsive to the community and accountable to it, how to insure

that patient care is the primary priority of the system, how to insure equal access to health institutions and to practitioners, and so on.

'Many people have suggested that national health insurance might be a step toward such a national health system. Others argue it will be regressive. By providing financing, it will stave off the collapse of the present system for a few short years, and will strengthen some of the enemies of change. At the same time, though, it will establish the necessity for the government to guarantee the right to health care for all, and it will arouse even greater expectations of adequate health care. Thus national health insurance is not clearly either a step towards or a step away from a national health system – it's more of a shuffle sideways.'¹

Interestingly enough, it may turn out that the very abuses of the fee-for-service system, some of which have recently been revealed and given wide publicity, might prove its own downfall. Practitioners may come actually to prefer to be salaried rather than run the risk of heavy fines, or further increase in malpractice insurance costs, or be the butt of jokes and a general suspicion that private practitioners are all involved in the rip-off scandals. The recent disclosures of flagrant dishonesty by doctors and laboratories who deal with Medicare (elderly) and Medicaid (poor) patients have shocked the conscience of the nation and its legislators. On a 'fee-for-service' basis, when the charges are to be sent to 'the feds' for payment, it is all too easy to cheat. Those who have done it on a scale amounting to grand larceny are now being investigated by Congressional committees. The Senate Special Committee on Aging has heard testimony (*Los Angeles Times* 18 November 1976) that 'the conspiracies to defraud the public in the health-care field are enormous in scope and complexity and pervasive through every area of our nation. To cope with them effectively will require a massive effort on the part of the federal government.' Doctors, dentists, pharmacists, clinics, laboratories, nursing home operators and those who sell supplies to nursing homes were characterized as 'corrupt profiteers at the ready, seeking opportunities to line their pockets at public expense'. The chairman of the committee, Senator Frank Church (Democrat), who is known as a supporter of reforms in health insurance, said: 'We can't move to national health insurance until we eliminate fraud'. The fraud schemes are said to be so complex and sophisticated that 'they require a special staff of highly trained professionals working full time to even provide the ghost of a chance of coping with them'.

If it turns out that they *cannot* be adequately controlled, and if this becomes a major factor preventing reform, then even the American Medical Association and other conservative groups might look more favourably on the prospect of a (largely) salaried service, and might be prepared to sacrifice

their ideal of a free-enterprise system of medicine in favour of one that would not only protect the profession in many areas where it is currently very vulnerable but would meet the major purpose of improving services to the public. In recent years there has been a great increase and improvement in delivery of services by the Veterans Administration hospitals. They have demonstrated to increasing numbers, and at all levels of society, just how good a government hospital service can be. There are many physicians these days who actively seek employment in such hospitals in preference to private practice. They profess that as well as not being subject to anything like the 'hassles' of private practice, they generally come off better financially in the long run, because they have no office overheads, no nurses, secretaries, radiographers, etc, to employ, and in particular, no malpractice insurance premiums to pay out of their earnings.

The next few years will be a fascinating time in the further advance (or decline) of the American system of health care.

The debate during the Presidential campaign

During the Presidential campaigns the following statements were made. They may give an index of the current state of political feeling in health matters. While neither Reagan nor Ford will have any direct influence on Congress now, one can be sure that their indirect influence, via Republican members of both House and Senate, will be considerable:

1 REAGAN

'I do not believe that compulsory federal health insurance would improve the quantity and quality of health care available to the American public. Nearly all Americans who want health coverage have it available by means of private insurance policies, group policies, Medicaid, and a myriad of state and local health programs. From our experience of Federal involvement in the health arena through Medicaid and Medicare, we know that health costs have skyrocketed as the government has intruded. We don't have to live through compulsory national health insurance in order to see the results. All we need to do is to look at the health care system in Britain. The "National Health Insurance System" has had the opposite impact of what was hoped for. They have poorer quality at higher costs.'⁹

2 FORD

'I did not recommend a Government sponsored national health insurance program. I did not for two reasons.

'Number one, I don't think that a national Government sponsored health insurance program has worked very well as far as the patient is con-

cerned in any country where it has been tried, and that is particularly true in Great Britain and several other countries, so I don't think it is the best way to improve health care.

'Number two, it would be very expensive, and don't think we could afford it. But the principal reason I am opposed to it is that it has not worked and I don't think it will work.'¹⁰

3 DELLUMS

'In response to your question about the possible effects upon the proposed health care legislation that Rep Dellums has in the draft stage, it doesn't seem that any of the possible new administrations would have any substantive impact - except that perhaps under a Carter administration the issue may be brought before the Congress for serious consideration earlier. In that case the pressure to introduce our measure would increase. Given Gov Carter's apparent views on health care though, it would appear that even a health security-type legislation is much too progressive, since Carter says that the focus of delivery must remain with the existing providers. As for the "strengths" of the current Congress in the health care area, there are none; remember that proposals to give persons jobless from the recent recession some continuation of health insurance never progressed past the hearing stage. Incidentally, Rep Dellums opposes all health insurance, and is against all current health insurance schemes.'¹¹

4 CARTER

'National health insurance alone cannot redistribute doctors or raise the quality of care. So we must plan and decisively phase in, simultaneous reform of services and refinancing of costs. Reform will enable us to set and secure the following principles of a national health insurance program:

'Coverage must be universal and mandatory. Every citizen must be entitled to the same level of comprehensive benefits.

'We must reduce barriers to early and preventive care in order to lower the need for hospitalization.

'Benefits should be insured by a combination of resources: employer and employee shared payroll taxes, and general tax revenues. As President, I would want to give our people the most rapid improvement in individual health care the nation can afford, accommodating first those who need it most, with the understanding that it will be a comprehensive program in the end.

'Uniform standards and levels of quality and payment must be approved for the nation as part of rational health planning. Incentives for reforms in the health care delivery system and for increased productivity must be developed.

'We must have strong and clear built-in cost and quality controls. Necessary machinery for monitoring the quality of care must be established.

'Rates for institutional care and physician services should be set in advance, prospectively.

'Maximum personal interrelationships between patients and their physicians should be preserved; freedom of choice in the selection of a physician and treatment center will always be maintained.

'Consumer representation in the development and administration of the health program should be assured.

'National priorities of need and feasibility should determine the stages of the system's implementation. While public officials have continued to dispute whether coverage should be catastrophic at first or comprehensive immediately, the system has become a comprehensive catastrophe. We must achieve all that is practical while we strive for what is ideal, taking intelligent steps to make adequate health services a right for all our people.

'A basic concern shall be for the dignity of the person, not for the individual's wealth or income.

'Incentives for the reorganization of the delivery of health care must be built into the payment mechanism.

'We must have resources set aside to encourage development of alternative approaches and to spur new distribution of health personnel.'¹²

5 CARTER

'Q: You favor a national health insurance plan, governor. So does the AMA and so does Sen Edward M Kennedy. I had a hunch that you'd be more at Sen Kennedy's end of the spectrum. And yet, in a statement we had last week from Plains, based on the amount of money that you would move from the private sector to the public sector, (it) doesn't sound like it's enough money to support a Kennedy-type national health plan. Could you explain, in more detail, the kind of a plan you favor?'

'A: We now spend about \$550 in this country for every man, woman and child for health care—much more than any other nation in the world, per person or as a percentage of gross national product. But the distribution of health care is grossly unfair, inequitable and the emphasis on prevention of diseases is much less than it was 40 or 45 years ago when I was a child. At that time, almost all my health care was to prevent diseases like polio, diphtheria, whooping cough, mumps, measles, typhoid, typhus and so forth. That is something we need to change.

'I have not wedded myself to the Kennedy-Corman bill. I have my own—my ethic would be to minimize government responsibilities as long as I could guarantee an equitable quality of health care for our people throughout the country. If it took extra money, I would try to provide it through increased tax revenues or from some other mechanism. I think that the net increase in cost of health care would be relatively minor. By that I mean less than \$10 billion. But now, how much of that money

would come from the federal government I have not yet decided. . . .

'I've reserved the right to decide how much of the insurance program should be administered by private insurers and also how much of the administrative responsibility for health delivery would be absorbed by the government. But I think that the overall increase in net cost would be much less than has been generally supposed. And the other aspect of my proposal that would be different from the Kennedy-Corman bill is that I'm going to set—in every major aspect of life, including welfare, health, education—what I hope to see this country doing at the end of my term in the fiscal year of 1981 and work back from there. I want to have a comprehensive health care program fully established in this country in four years but how much we do each succeeding year will have to be determined by what we have available.

'Q: This implies a phased program that would cover certain groups the first year, like maybe children.

'A: That's not exactly what I have in mind, but phased—yes. It might take the first year just to make the present health care systems work. We now have an almost uncountable number of agencies in the federal government responsible for health care—I think 72 in physical health care, 37 in mental health care.

'We have two congressional committees responsible for health care (major ones) five responsible for welfare, Medicare and Medicaid, and two different agencies, and so forth. Just to make the present delivery system work would be a major goal the first year—that is, Medicare and Medicaid. And then I think the other three years would be utilized in expanding our present health services to recipients who don't presently have any.

'Q: So by the end of four years, everybody in the United States would be covered by the same kind of universal plan? Or would we still have these pockets of Medicare and Medicaid?

'A: I would like to have it universal, but I also would like to have the option, which I am maintaining, of providing a basic package of health care to be provided to everyone. With the indigents, the cost would primarily come from government revenues which it is now. For those who are working, I would like to have the option of having that financed by employer and employee contributions. And those who decide to have extraordinary health needs met—for instance, plastic surgery and so forth—they would pay for it themselves. But I think that the overall net increase per year would be in the range that I've described at our meeting in Plains.

'Q: How are you going to control the inflation? Medicare and Medicaid are pretty much responsible for the current spiral. If you're adding more people, how are you going to prevent an additional inflation from occurring from that?

'A: Well, there are many ways this can be done. We now have an almost uncontrollable inclination to build health care facilities that are not needed. We've got too many beds for instance in some areas of our country and still building them. (There is) very little correlation between meeting a community's need between the private and the public installations.

'We've got too much emphasis on in-patient care – sometimes almost forced on the patient – by the unwillingness of the insurance companies to pay unless a patient is an in-patient. I think we need to have more emphasis on out-patient care. I think we've gotten too much advanced technology going into medicine when sometimes the return on the investment is very slight. We've got too much emphasis on the treatment of disease once it's become serious, and inadequate routine preventive care. We've got too little monitoring of the inclination of doctors and insurance companies to kind of orient the patients into accepting health care beyond their own needs.'¹³

Well, campaign promises are one thing, We shall have to wait and see how the new Administration really faces up to one of the major challenges of the American way of life.

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