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THE PUBLIC HEALTH CRISIS:
AN ANALYSIS OF THE RISING COST OF HEALTH
CARE IN THE UNITED STATES

A MONOGRAPH

by

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An analysis depicting the cost of living with the costs of health care in the United States. Discusses current health care delivery and compares it to other systems. The hypothesis developed is: as health care costs increase, the cost of the public sector in health care delivery increases. This was developed from academic journals, periodicals, government documents, and newspapers. Charts and graphs are used to summarize essential data. This paper is submitted in format to meet requirements for research for a Master's Degree in Public Administration at Shippensburg State College, Pennsylvania.

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PREFACE

This Research Paper was prepared to meet format requirements for the graduate program at Shippensburg State College. The contents analyze a fundamental issue in the formulation of United States domestic policies; the crisis in health care delivery which is a major factor in formulating the national budget. Current trends indicate a change in budget priorities for the decade of the 1970s with increased emphasis on human resource programs. This paper focuses on one phase of that program, on the increased role of government and the attendant increased costs of health care. Future trends are projected indicating the adaption of a national health insurance system during the 1970s.

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THE PUBLIC HEALTH CRISIS:

An Analysis of the Rising Costs of Health Care in the United States

"The more we are able to see,
the more we look for.

The more we question,
the more there is to question....

The more we experience,
the more we want to experience....

The more we contemplate,
the greater our need for contemplation."¹

THE PROBLEM

The problem of providing satisfactory medical service to all the people of the United States at costs which they can meet is a pressing one. At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequitably distributed. The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency and social waste. Furthermore, these conditions are largely unnecessary. The United States has the economic resources, the organizing ability and the technical experience to solve this problem.²

I can not state the problem better than Ray Lyman Wilbur, President Hoover's Secretary of Interior, in the final report of the Committee on the cost of Medical Care, dated October 31, 1931. The crisis in health care delivery is apparent and real forty years after

¹Bass, Saul and Associates. "The Searching Eye," documentary film shown in the Kodak Pavilion at the New York Worlds' Fair, quoted in This Week June 21, 1964, as quoted in Doctoral Dissertation, Patterns of Reading Instruction, Creativity and Problem Solving, David A. Thatcher, 1965, University of California, p. 1.

²Irving J. Lewis, "Government Investment in Health Care," Scientific American, 224:4 (April 1966), p. 17.

the Wilbur report. This paper examines the increase of public finance in health care delivery and the growth of the "industry" of health in the United States.

I have limited my discussion to the past thirty years. Basic source material is restricted to academic journals, periodicals, government documents, and newspapers. This is a contemporary problem, rooted on contemporary research. Charts and graphs are used to succinctly summarize essential data. Supporting material, not essential to the basic paper, is presented in the appendix.

Summary

This paper compares the rise in the cost of living with the costs of health care; discusses the problems of current health care delivery; and explores future systems. It is my hypothesis: that as the cost of health care delivery increases, the role of the public sector in health care increases. Therefore, a National Health Insurance Plan in the United States will probably be implemented during this decade.

INTRODUCTION TO THE HEALTH CARE CRISIS

In 1969 President Nixon stated that the United States faced a massive health care crisis and immediate action was required to avert a complete breakdown of the U. S. medical care system.³

Health care, employing more than three million people, is now the third largest industry in the United States in terms of people employed and dollars spent. Approximately seven percent of the gross national product, over sixty-seven billion dollars, is spent on health. This compares with thirty-nine billion dollars, approximately 5.9 percent of the gross national product, spent on health five years ago.⁴ These data are graphically portrayed at Table One.

As the costs of health care have increased, the roles of the public sector in the delivery of that health care have also increased. The present financing of health is: thirty-eight percent public and sixty-two percent private. From within the public sector the federal government spends twice as much money as state and local governments.⁵

Health care in the United States is a combination of private enterprise, charity, and socialism. Individuals are treated by private practice physicians, dentists and others; they pay individual funds for

³The World, American Survey, "Healthy, Wealthy, But Not Very Wise," The Economist, July 19, 1969, p. 45.

⁴Lewis, p. 17.

⁵U.S. Department of Health, Education, and Welfare, Report Of Task Force on Medicaid and Related Programs, (Washington:Government Printing Office 1970), p. 10 (hereafter referred to as Task Force).

TABLE ONE
National Health Expenditures



Health Expenditures have risen steadily. Public spending increasing more rapidly than private spending.

Data from Lewis, p. 19.

that care. There are profit and non-profit health insurance plans to pay for medical care. In addition, there are federal and state health care plans which employ medical personnel and obtain health care from the private sector. Group practices and pre-paid plans are also becoming widely popular.

The primary federal programs are Medicare and Medicaid. There is also the Champus program for the uniformed services. Champus will not be discussed in this paper.

The Ways and Means Committee of the House of Representatives reported the Medicare bill for vote in 1965, thirty years after the concept of compulsory national health insurance had been introduced in the Franklin D. Roosevelt Administration (see appendix).

The bill was vigorously supported by the Johnson Administration. Republican opposition led to counterproposals which were defeated, April 8, 1965, 191-226 (Democrats voted 63-226, Republicans 123-10). On the same day the Administration measure passed 313-115. There was some switching on this vote, apparently to "get on the bandwagon" (Democrats voted 243-42, Republicans 65-73).⁶

The Senate vote followed the same basic pattern, July 9. The Republican attempt to delete Medicare from the Social Security Act was defeated 26-64 (Democrats voted 8-53, Republicans split 18-11). Subsequently Medicare passed the Senate easily 68-21 (Democrats 55-7, Republicans 13-14).⁷

⁶ Congress and the Nation, II (Washington D. C.: Congressional Quarterly Service, 1968), p. 755.

⁷ Ibid, pp. 755-756 and Appendix 3a.

The Medicare program presently reaches approximately ninety-five percent of the aged, but pays only about one-half of the medical expenses of this aged group.⁸ Costs of the Medicare program have far exceeded the original estimates. This has led to a series of fiscal readjustments.⁹ Estimates of expenditures for 1971 indicate that over seven billion dollars of federal funds will be spent financing Medicare.¹⁰

A sister act to Medicare was also passed in 1965. The Medicaid program, a new title XIX to the Social Security Act, gave each state the right to determine "medically needy" and to give aid to those people who were so defined. Federal Government assistance, based on the greatest share to the poorest states, meets from fifty to eighty-three percent of the cost of this program.¹¹

Medicaid costs have been skyrocketing since the program began. During the first year of the program, 1966, 372 million dollars were expended. By 1967 the program cost 1.9 billion dollars. Estimated expenses for 1971 are projected to reach 7.4 billion dollars. At present spending rates the Federal Trust Funds that should back the program for another decade will be completely gone by 1976.¹²

⁸Task Force, 1970, p. 19.

⁹The Economist, pp. 45-46.

¹⁰"Breaking the Bank, Lush Fees are Leading the Medicaid Program into Deep Troubles," Science News, 95:21 (May 24, 1969), p. 497.

¹¹Congress and the Nation, II, p. 753.

¹²Science News, p. 497.

Although Medicaid only reaches about one-third of those who are legally defined as indigent or medically indigent, the cost of covering this third exceeds the estimated cost of covering the entire group--a result of poor estimation, inflation, and poor control.¹³ An outstanding example is portrayed by Bill Shipp, Political Editor of The Atlanta Constitution, July 5, 1971, and reproduced as an appendix to this paper.¹⁴ Some additional examples of fee gouging as evidenced by some unscrupulous doctors and dentists who have used the program to their own gain are: in 1968 two dentists earned 90,000 dollars each, a Florida doctor took 191,000 dollars and a Georgia surgeon 131,000 dollars--all from the Medicare and Medicaid programs.¹⁵

ANALYSIS OF THE PROBLEM

Comparisons of the Consumer Price Index (CPI) and the cost of medical care give broad indications of the problem of financing health care in the decade 1970-1980 and beyond. The rise in price of medical services over the past few decades exceeds the total for all items on the CPI.¹⁶ The cost of medical care remained below the norm of other expenses until 1959 when these costs exceeded the CPI and they

¹³Task Force, 1970, p. 8.

¹⁴Bill Shipp, "Georgia's Medicaid Migraine," The Atlanta Constitution (Georgia), July 5, 1971, p. 1.

¹⁵Science Mag., p. 497.

¹⁶Yoram Barzel, "Productivity and the Price of Medical Services," Journal of Political Economy, 77:6 (December 1969), 1014-1027.

have remained above the average through June 1970.¹⁷ These data are portrayed at Tables Two and Three.

Personal outlay for medical expenses accounts for seven percent of the family dollar, by 1980 it is estimated to reach eleven percent.¹⁸ The increase of costs is spread across all aspects of health support. The greatest increase is in hospital care. In 1950 thirty-five cents of each dollar spent on medical care went to the hospital. In fiscal year 1970, forty-four cents of each dollar was spent for hospital care. During the same period the physicians share shrank from twenty-five percent to twenty-one percent. As the hospital consumed more of the medical dollar, each of the other areas was reduced proportionately.¹⁹ See Table Four.

The rapid rise in hospital costs are currently under study by government, business and the academic community. Lave and Lave see the hospital as a multi-product firm. They state that it is difficult to measure hospital efficiency per dollar spent due to the inexactitude of standards of medical quality, i.e. the appropriateness and competence of treatment. They reiterate that the rise of hospital costs exceeds the rise in the CPI.²⁰

Hospital bills today are higher than ever. A semi-private

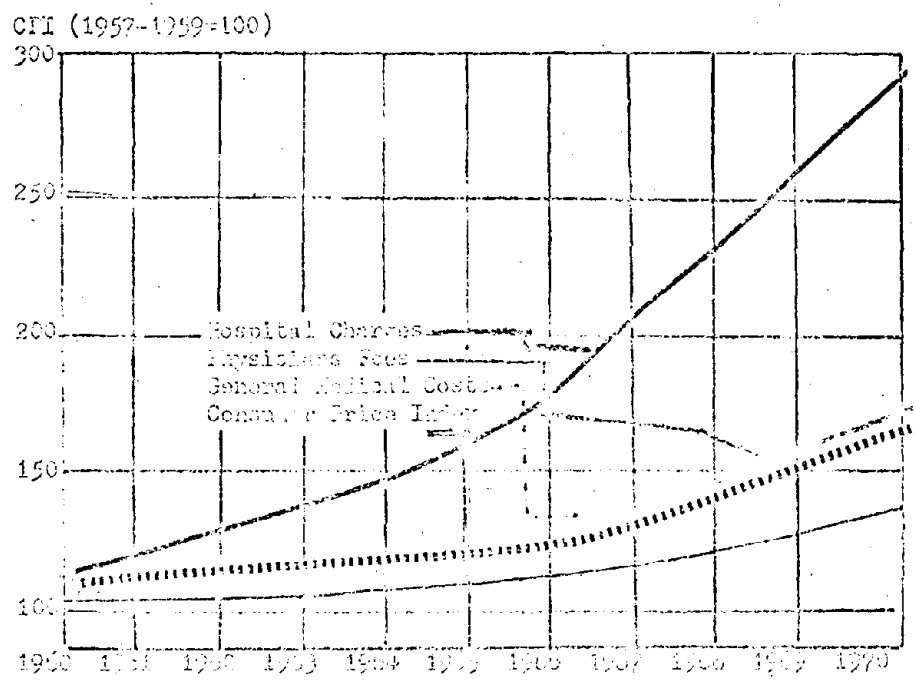
¹⁷Lewis, p. 19.

¹⁸"Push is on for Added Federal Health Aid," US News and World Report, February 8, 1971, p. 35.

¹⁹Lewis, p. 23.

²⁰Judith R. Lave and Lester D. Lave, "Hospital Cost Functions," The American Economic Review, 60.3 (June 1970), 379-395.

TABLE TWO
COMPARISON OF HEALTH CARE COST WITH
CONSUMER PRICE INDEX



Source: Lewis, p. 19.

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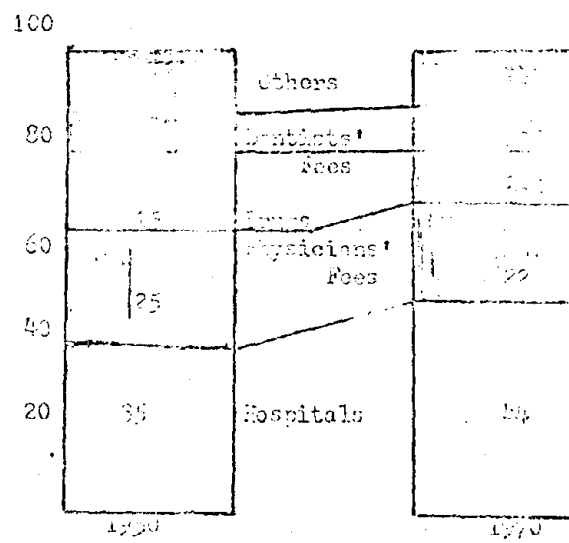
TABLE THREE

Consumer Price Index (1957-59=100)
(Source U. S. Bureau of Statistics)

ITEMS	1941	1945	1954	1959	1966	1967	1968	1969	July 1970
All Items	51.3	62.7	93.6	101.5	113.1	116.3	121.5	127.7	135.7
Total									
Food	44.2	58.4	95.4	100.3	114.2	115.2	120.0	125.5	133.4
Apparel	51.9	71.2	97.3	100.7	109.6	114.0	119.7	127.1	131.4
Housing									
Total	61.4	67.5	93.4	101.3	111.1	114.3	119.5	126.7	136.2
Rent	64.3	66.1	93.5	101.6	110.4	112.4	115.1	118.8	123.8
Gas & Electric	88.3	86.4	92.5	102.8	108.1	108.5	109.5	111.5	115.7
Fuels	45.2	53.6	90.6	100.2	108.3	111.6	115.7	N/A	N/A
Furniture	54.4	73.9	101.9	99.8	105.0	108.2	113.1	117.9	123.0
House Opns.	53.3	62.9	89.5	102.4	105.0	108.2	113.1	117.9	123.0
Transporta- tion	51.2	55.4	90.8	103.8	112.7	115.9	119.8	124.2	131.4
Medical Care	<u>50.6</u>	<u>57.5</u>	<u>85.5</u>	<u>104.4</u>	<u>122.7</u>	<u>126.7</u>	<u>145.1</u>	<u>155.0</u>	<u>165.8</u>
Personal Care	47.6	63.6	88.5	102.4	112.2	115.5	120.4	126.2	130.6
Reading & Recreation	57.3	75.0	92.4	102.4	117.1	120.1	125.9	130.5	136.6
Dollar Purchasing Power		1.727	1.069	.985	.884	.860	.825	.783	

Source: U. S. Bureau of Statistics as cited in the 1971 World Almanac
1969 Information Please Almanac.

TABLE FOUR
Major Medical Costs 1950-1970



Source: Lewis, p. 23.

room which cost twenty-one dollars a day in 1960, costs fifty-five dollars a day in 1971. Increasing construction costs and operational costs indicate some of the reasons for the general rise. Bennet J. McCarthy, President of the Michigan Blue Cross, as reported in US News and World Report, states that it costs 50,000 dollars per bed to construct a hospital in Detroit. Operational costs average 25,000 dollars per bed each year. Salaries of hospital workers rose 320 percent in twenty-one years, 1946-1967. The same salaries rose thirty-seven percent in 1970. The complexities of modern medicine require one-hundred ninety workers to care for each one-hundred patients.²¹

Charles W. Baird in a recent issue of the Journal of Economic Issues advances the proposition that one of the prime reasons for the increase in hospital costs is that the United States relies primarily on voluntary non-profit hospitals. He argues that lacking the profit motive, hospitals are inefficient and that all hospitals should be run for profit.²²

In the same issue of the Journal of Economic Issues, Leahmae McCoy takes an opposite view. McCoy proposes nursing homes be operated as a public utility.²³ This approach seems to be compatible with that

²¹US News and World Report, February 8, 1971, pp. 35-36.

²²Charles W. Baird, "On Profits and Hospitals," Journal of Economic Issues, V:1 (March 1971), 57-66.

²³Leahmae McCoy, "The Nursing Home as a Public Utility," The Journal of Economic Issues, V:1 (March 1971), 67-76.

of Seymour Harris who wrote in The Economics of American Medicine, as quoted by Baird, "hospital care is at least the area where the pursuit of profit does not yield good results."²⁴

The Economist states that the Medicare and Medicaid programs have given an extra boost to the pace of medical inflation. This has caused a direct impact on the federal budget that forces the administration to seek solutions.²⁵ In a subsequent issue of The Economist, John Gardner, former Secretary of Health, Education, and Welfare, is quoted as stating that much of the money spent on health in the U. S. is wasted.²⁶

The total health bill in the U. S. is fairly evenly divided between governmental agencies, profit and non-profit insurance companies, and individuals. Almost all of the 22.5 billion dollars spent on hospital care is paid by the government or one of the non-profit insurance organizations.²⁷

An analysis of the end result of the huge dollar outlay on health care would lead one to believe that the United States must have the best health results in the world. With doctor bills rising twice as fast as other prices and hospital costs up fifteen percent per year, the total medical bill is expected to double in the seven

²⁴Baird, p. 65.

²⁵The Economist, July 19, 1969, p. 46.

²⁶"Nasty Medicine," The Economist, December 20, 1969, p. 45.

²⁷Martin S. Feldstein, "An Econometric Model of the Medicare System," Quarterly Journal of Economics, LXXXV (February 1971), 1-20.

year period 1968-1975.²⁸ The United States has over 330,000 doctors, most of whom are extraordinarily well trained. This is one doctor for every 650 people in the country. There are over 7000 hospitals in the U. S., most are modern and well equipped with the latest medical material. Cost of medical care is now at an all time high, 324 dollars per capita each year.²⁹ But - what about health?

Comparison of major health statistics illustrate the results of the health care crisis. In maternal mortality the U. S. has dropped from first to seventh place among nations during the past fifteen years. The U. S. fares poorly in infant mortality, ranking thirteenth. Life expectancy rankings indicate the U. S. is eighteenth for males and eleventh for females.³⁰ It may not be completely surprising to find some Scandinavian countries ranking above the U. S. in health care statistics, but it is shocking to many people to find Eastern European countries such as Bulgaria, the U. S. S. R., East Germany and Hungary ahead of the U. S. in these statistics.³¹ The portrayal of these data, from Lewis is at Table Five (also at appendix).

Much of the crisis in quality of medical care is attributed to the inequities of health care delivery among the U. S. population. A study, Personal Health Expenses, by the U. S. Department of Health,

²⁸"National Health Insurance: The Next attack on Medical Costs," Changing Times, January 1971, pp. 1-44.

²⁹Time, June 7, 1971, p. 86.

³⁰Lewis, p. 19.

³¹Ibid.

Education, and Welfare during July-December 1962 and published in February 1966 showed that inequity existed in health care by age, color, income, education, and family size.³² Lewis indicates that these inequities continue today.³³ This problem is further highlighted in The Report of the Task Force on Medicaid and Related Programs, U. S. Department of Health, Education, and Welfare, September 1970. The Task Force found that a great disparity in health care existed and continues to exist in access and utilization of health services, with related disparities among different income, racial and ethnic groups, and among geographical areas (see appendix).³⁴

These data apparently indicate a basic anomaly: as more is spent, less is achieved. This may or may not be true, but it is evident that the United States does not rank first, not even among the first five or ten in important health statistics. This leads many politicians, businessmen and scholars to seek solutions to the health care dilemma. The disparity in access to and utilization of health care services and the related disparities in health status among different income, racial and ethnic groups, and geographical areas demand that solutions be found.

Dr. Walter C. Bornhaefer, President of the American Medical

³²Personal Health Expenses, U. S. Department of Health, Education, and Welfare, February 1966, pp. 17-18.

³³Lewis, pp. 20-21.

³⁴Task Force, 1970, p. 8.

TABLE FIVE

Order of Rank, Major Nations, Selected Health Statistics (1968)

Infant Mortality (Rate per 1000 live births)	Maternal Mortality (approx.) (Rate per 100,000 live births)	Life Expectancy (Years)	
		MALE	FEMALE
Norway	Sweden	Sweden	Netherlands
Sweden	Denmark	Norway	Sweden
Netherlands	Netherlands	Netherlands	Norway
Finland	Norway	Denmark	Denmark
Japan	Belgium	Switzerland	Australia
Denmark	Ireland	New Zealand	Canada
Switzerland	United States	Canada	United Kingdom
Australia	Czechoslovakia	East Germany	Switzerland
United Kingdom	Finland	Ireland	U. S. S. R.
New Zealand	France	U. K.	New Zealand
East Germany	Poland	Australia	U. S.
France	Canada	Bulgaria	West Germany
United States	Switzerland	Japan	East Germany
	Ireland	West Germany	Japan
	Austria	Greece	Austria
		Italy	Ireland
		Hungary	Hungary
		U. S.	Finland

Source: Lewis, p. 19. Other sources vary slightly.

Association (AMA), has stated that the AMA has accepted the responsibility for furnishing medical care to the United States. He sees change as being extraordinarily rapid and that it would be easy to fall a decade behind. Bornemeier recognizes that government is taking an increasing role in health care as costs continue to rise. He says that the poor must have access to care the same as the most affluent. He expects that all people in the U. S. will have some form of prepaid health insurance by the end of the 1970's and there will be no more charity clinics.³⁵

The Task Forces of both President Johnson and President Nixon made recommendations for sweeping changes in the system of health care in the U. S. In 1967 the report to President Johnson urged sweeping changes in the nation's health care systems. The group recommended that existing practices of physicians, hospitals, medical schools and insurance companies should be drastically changed in order to extricate the country from the health crisis.³⁶

President Nixon's Task Force in 1970 echoed the earlier report and spoke of the rising public concern with the cost and availability of health services. It reported that millions of Americans get medical care on a "hit or miss" basis and indicated that health services were "badly fragmented", "in a crisis" and "in serious trouble." The Task

³⁵Walter C. Bornemeier, MD, "Shapes of the Future, the Need for the Doctors," Vital Speeches of the Day, XXVII (March 1971), 315-317.

³⁶Congress and the Nation, II, p. 691.

Force recommended a national policy for financing health care.³⁷

The September 1970 Social Service Review projects that the 1970s may be the decade in which a national health plan is finally created.³⁸ This thought is reinforced in the May 3, 1971 issue of US News and World Report which states that cradle to the grave health insurance for all Americans is beginning to look like a distinct possibility by 1972. The old cries of socialized medicine are no longer being shouted and even the AMA position seems to have mellowed.³⁹

Proposals to revamp the U. S. health care system have been submitted to Congress (five major proposals are included in the appendix). All gradations of political and economic theory are represented by the advocates of health care reform. It is evident that something must be done and there are indications that dramatic changes will be made in the system.

Recommendations of the 1967 Task Force of the Johnson Administration included proposals to: institute a new system for paying hospitals that would reward efficiency and penalize inefficiency; re-license doctors and dentists periodically; include mandatory refresher training for all medical personnel; establish peer reviews to evaluate professional personnel, hospitals and medical insurance;

³⁷Task Force, 1970, p. 1.

³⁸"Health Proposals," Notes and Comments, The Social Service Review, 44:3 (September 1970), 325-327.

³⁹"Health Care for Everybody, How Various Plans would Work," US News and World Report, May 3, 1971, pp. 36-38.

and offer direct federal loans to doctors, dentists and others.⁴⁰

The 1970 HEW Task Force reinforces the earlier ideas and stresses the development of a management system within the Department of Health, Education, and Welfare. Economy and efficiency are achieved through a system based on a "corporate management model" adapted to the peculiar requirements of public administration.⁴¹

Dr. Robert O. Egeberg, Assistant Secretary for Health, Department of Health, Education, and Welfare told President Nixon that revamping the U. S. health care system requires changes that would shake the present system literally to its foundations. He stated that the time for change was now, since the problem was grave and becoming critical. It is obvious that the AMA does not want to be shaken to its foundations. There is mounting pressure for change.⁴²

President Nixon's program, as reported in the Social Service Review, stresses development of a national norm for health care to replace the separate state norms presently in use. He proposes a revision of present plans without significant increases in federal funds for 1972.⁴³ The New York Times stated April 6, 1971 that delay in presenting President Nixon's health plan was due to possible impact

⁴⁰Congress and the Nation, II, pp. 691-692.

⁴¹Task Force, 1970, pp. 71-130, passim.

⁴²The Economist, July 19, 1969 pp. 45-46.

⁴³The Social Service Review, pp. 325-327.

on unemployment statistics.⁴⁴ The Times stated earlier in an article by Tom Wicker that the administration should realize that their task is to develop the most effective plan-- not to provide an insurance scheme. "The private insurance scheme will only be useful to the extent that it accomplishes the goal of meeting the medical care needs of all," Wicker said.⁴⁵

The American Medical Association at its June 1970 meeting seemingly moved from its long-standing total opposition to national health insurance. The AHA now indicates interest in a variety of national health plans, but emphasizes the necessity for peer review in place of review by government officials. The Association called for exploration of methods to finance comprehensive health care for all American people. The AHA has not weakened its strong opposition to government sponsored medicine. It proposes a national health insurance program which uses tax credits and local taxes to provide health care for the poor. Estimated cost of the AHA plan is sixteen billion dollars for the first year.⁴⁶

A report from the Committee for National Health Insurance, one hundred prominent citizens organized by the late Walter P. Reuther, proposed a substitute plan for Medicare and Medicaid in July 1970.

⁴⁴The New York Times, April 6, 1971, p. 1.

⁴⁵Ibid, March 18, 1971, p. 39.

⁴⁶The Social Service Review, pp. 325-327.

The plan emphasizes prepaid group practice with stress on prevention. Financing for this comprehensive coverage is proposed to be divided: 40 percent from general taxation, 35 percent payroll deduction tax, and 25 percent individual contribution withheld from income.⁴⁷

Financing of the Nixon plan, which would cost the government about 5.5 billion dollars the first year, is divided between employer and employee contributions. During the first two years employers would pay 65 percent of the health insurance premium, the employees 35 percent. After the two year period the premium contributions would be 75 percent from the employer, 25 percent from the employee. Blue Cross, Blue Shield and other insurance groups would be responsible for operating the system. One of the features of the plan is comprehensive medical support which is prepaid at a fixed fee and uses group practice orientation.⁴⁸

Increasing numbers of Americans are paying fixed fees for comprehensive medical care. Approximately seven million people pay for their medical support in advance through Health Maintenance Organizations (HMO) such as the Kaiser Plans which have over two million members served by over 2,000 full time physicians in twenty-one hospitals and fifty-four medical offices.⁴⁹

⁴⁷The Social Service Review, pp. 325-327.

⁴⁸Ibid.

⁴⁹Ibid. It is interesting to note the article also adds that the concept of HMO's began in Elk City, Oklahoma in 1929 as an outgrowth of agricultural cooperatives. The first HMO was formed by Dr. Michael A. Shadid and a group of farmers.

The American Hospital Association, the American Medical Association, and both Presidential commissions cited in this paper favor the development of Health Maintenance Organizations as a step in the improvement of health care delivery in the United States.

The United States is the only industrialized nation without some form of national health insurance.⁵⁰ US News and World Report points out that there are major problems with national health care systems abroad. In France the program operates with a financial deficit. In Great Britain there are long waits for patients to see doctors and there are delays of months or years for elective surgery. Low salaries of British physicians has been a factor in the emigration of many of these doctors to Canada and the United States. West Germany has shortages of staff doctors causing patients to complain of inadequate treatment. Long waits, too many forms and inadequate care are the major problems voiced in Sweden.⁵¹

Lewis forecasts that the national health insurance problem will be a major domestic issue in the 1972 presidential campaign.⁵² The problems of Medicare and Medicaid, the rising costs of medical treatment, the imbalance and the shortage of medical personnel make the search for solutions imperative. Dr. Russel B. Roth, Speaker of the

⁵⁰Changing Times, January 1971, pp. 41-44.

⁵¹"Prepaid Medical Care for all - When----Who'll Pay the Bill," US News and World Report, August 10, 1970, p. 29.

⁵²Lewis, p. 17. Additional note in Time, June 7, 1971, p. 85 states that the first national health care plan was introduced by Chancellor Otto von Bismarck for German workers in 1887.

AMA House of Delegates, has stated that pouring billions of dollars into a system that is already overstrained will not work. The new President of the American Hospital Association, Jack A. L. Hohn, predicts that the health care system will be operated as a public utility within the next decade. Walter J. McNorney, President of the Blue Cross Association states the time is ripe for action.⁵³

Adoption of any of the proposed plans will not come without opposition. Dr. Paul Ashton, President of the California Professional Guild, as quoted in Vital Speeches, takes strong exception to the group which he calls, "A new breed of experts... A highly educated group of technocrats, system analysts, economists, statisticians, social planners and administrators... a new race of healthocrats...." Dr. Ashton does not believe that the healthocrats are the people who should solve the problems. He feels that these non-medical experts are a direct affront to the medical profession. His speech is a strong plea to turn medical planning back to the medical profession. I have included a copy of his speech in the appendix.⁵⁴

The opposite view is expressed by Michael Crew in The American Economic Review. Crew says, "the restrictive practices of the medical profession in the U. S. do raise prices and result in a type of rent

⁵³US News and World Report, August 10, 1970, pp. 27-23.

⁵⁴Paul Ashton, "Health Security Program, Medicine in the Free Enterprise System," Vital Speeches of the Day, XXXVII (December 1, 1970), 100-104.

payment to the profession."⁵⁵

Ashton, the physician, and Crew, the "healthocrat" represent the extremes of approach to the solution of health care planning for this decade.

⁵⁵Michael Crew, "Coinsurance and the Welfare Economics of Medical Care," The American Economic Review, 59:5 (December 1969), 906-908.

SUMMARY AND CONCLUSION

This paper demonstrates that the cost of health care in the United States has been increasing more rapidly than other costs. Not only are more dollars being spent on medical support but also these dollars represent a greater portion of the total earnings of the American people than ever before. Since 1960 the costs of health care have increased more than fifty percent; this is far greater than the thirty-one percent rise in the CPI.⁵⁶ During the period of increasing health care costs the role of federal, state and local governments has increased. Medicare and Medicaid became realities after years of much talk and little action. Both Medicare and Medicaid have become more comprehensive and more costly during the 1965-1971 period. Government spending on personal health care has increased from 2.5 billion dollars in 1950,⁵⁷ to an estimated 21 billion dollars in 1971.⁵⁸

The battlelines are drawn; medical care in the United States in this time of rising expense and shortage of trained personnel presents a challenge to politicians, citizens and medical personnel of all political beliefs. John D. Twinnam, Administrator of Health, Education, and Welfare's Social and Rehabilitation Service, stated that Medicaid patients would not be put in human warehouses and

⁵⁶Time, June 7, 1971, p. 86.

⁵⁷Statistical Abstract of the United States: 1969 (90th ed.)
U. S. Bureau of the Census, Washington D. C., p. 62.

⁵⁸Lewis, p. 17.

forgotten. This is the mood of change for the future.⁵⁹

The Presidential campaign of 1972 will bring many domestic issues to the attention of the American people. If the Vietnam war is not a major issue, the focus will be on the economy, unemployment and welfare. Health care is a base issue of all of these programs. Republicans and Democrats have entered health care bills before the present Congress; more will come.⁶⁰

The position of the U. S. vis a vis other nations in health care statistics indicates that return for dollar spent must be better. In view of the changing position of the AMA, AHA and the health care insurance companies, the climate of opinion is right for the passage of a National Health Care Insurance Program. The final form of the program is not yet decided. There will be opposition and cries of socialism, but it appears evident from review of current literature that the role of government in health care has increased proportionately to the cost of delivery of that medical care. Further, it appears that with the rise of group practice and Health Maintenance Organizations that the system of American medicine is in rapid evolution. As a result of these factors and social change which is ongoing, I conclude that a national health insurance plan will be implemented during the decade of the seventies.

⁵⁹"Health and Welfare," Facts on File, XXXI:1589 (April 8, 1971), 275.

⁶⁰Time, June 7, 1971, p. 8, et al (see appendix).

"Greatness requires not only educated people but a healthy people. Our goal is to match the achievements of our medicine to the afflictions of our people," President Lyndon Johnson stated on January 4, 1965 in his State of the Union Address.⁶¹

⁶¹Congressional Quarterly Almanac, Vol. XXI (Washington, D. C.: Congressional Quarterly Service 1965), p. 1349.

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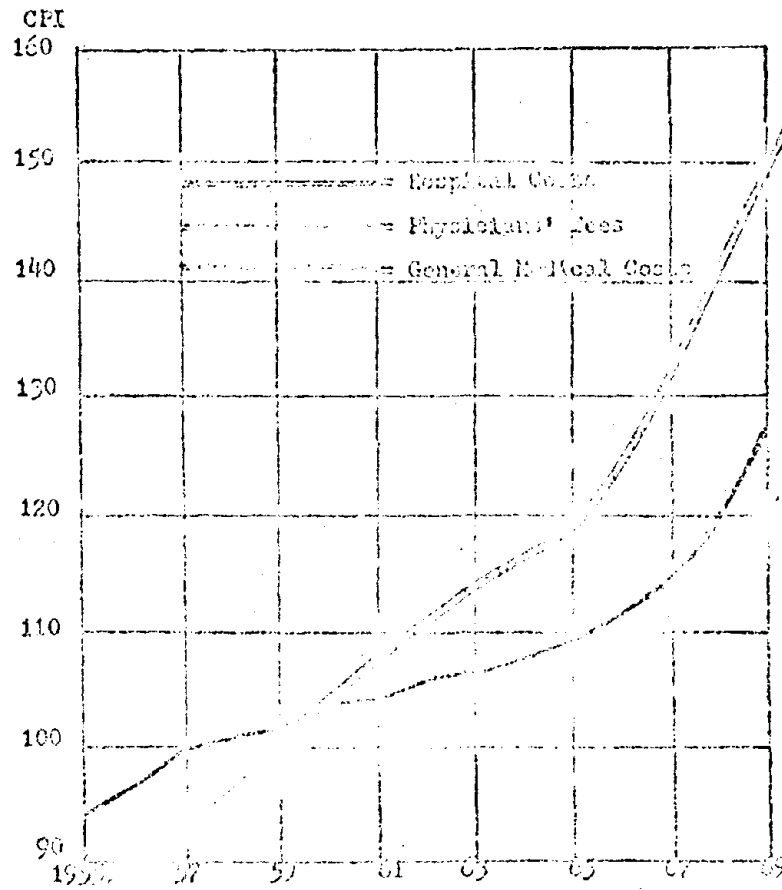
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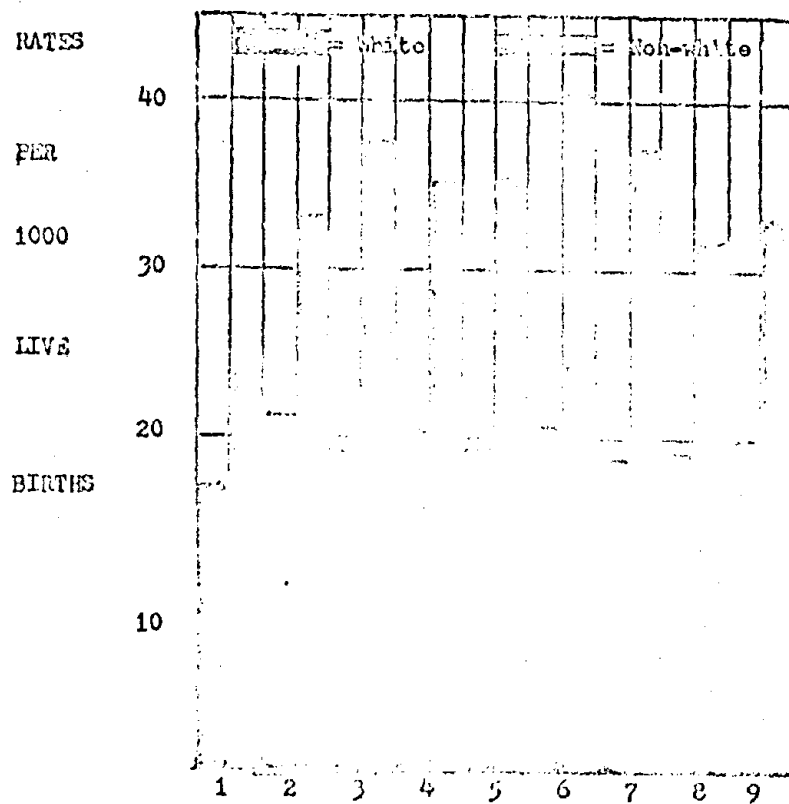
APPENDIX

TABLE SIX
 Consumer Price Index 1955-1969



Source: Statistic Abstract of the United States - 1970

TABLE SEVEN
 Infant Death Rate



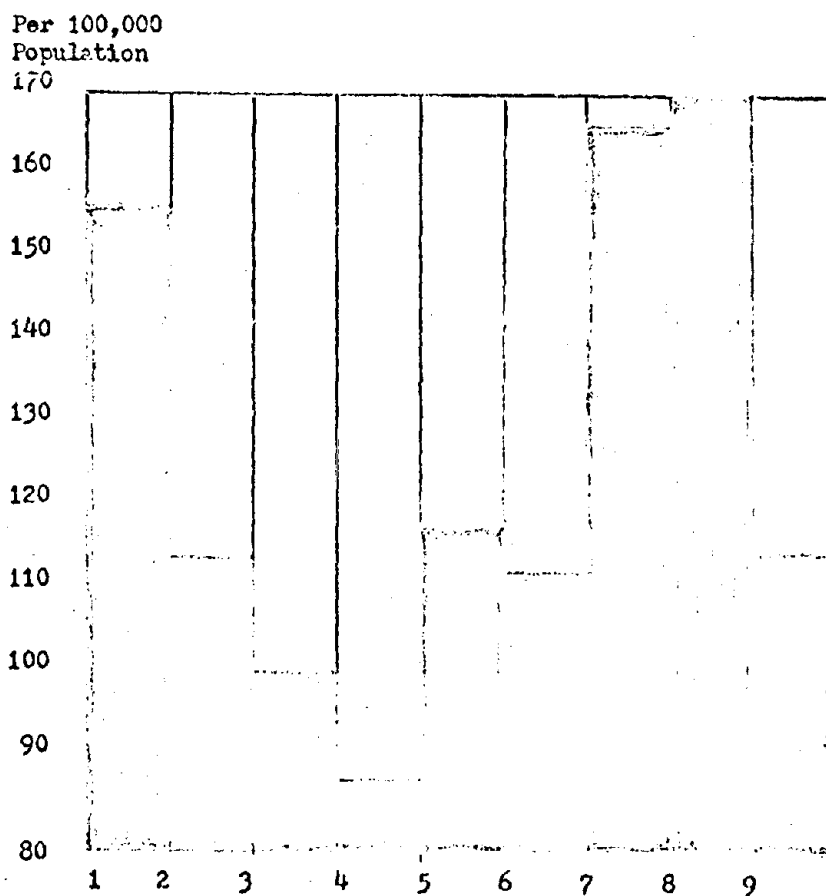
AREAS

- | | |
|-----------------------|-----------------------|
| 1. Pacific | 6. East-South Central |
| 2. Mountain | 7. Middle Atlantic |
| 3. West-North Central | 8. New England |
| 4. West-South Central | 9. South Atlantic |
| 5. East-North Central | |

Source: From data in Lewis, p.21.

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TABLE EIGHT
Geographical Imbalance of Physicians



AREAS:

- | | |
|-----------------------|-----------------------|
| 1. Pacific | 5. East-North Central |
| 2. Mountain | 6. East-South Central |
| 3. West-North Central | 7. Middle Atlantic |
| 4. West-South Central | 8. New England |
| | 9. South Atlantic |

Source: "Health: An Rx for 'Massive Crisis' in Medical Care," The New York Times, February 2, 1971, p. E-1.

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TABLE NINE

62 Vital Statistics, Health, and Nutrition

No. 78. NATIONAL HEALTH EXPENDITURES: 1950 TO 1969

(In millions of dollars, except percent. For years ending June 30. Prior to 1959, private expenditures exclude Alaska and Hawaii.)

TYPE OF EXPENDITURE	1950	1955	1960	1965	1967	1968	1969 (prelim.)
Total	14,139	17,921	26,367	38,912	48,191	53,869	60,312
Percent of gross national product	4.6	4.7	5.3	5.9	6.2	6.5	6.7
Private expenditures	9,604	13,367	19,822	29,395	37,311	41,458	47,501
Medical and dental services	8,812	12,114	17,637	26,030	32,933	35,633	40,681
Dental payments	7,116	9,438	13,687	17,531	19,016	19,554	21,315
Insurance benefits	879	2,341	4,098	8,281	9,311	10,127	11,722
Expenses for prescriptions	277	566	792	1,212	1,492	1,556	1,750
Indirect charges for services	150	210	265	339	360	380	400
Public charges	34	53	65	81	91	76	76
Medical research	37	55	121	162	173	180	185
Medical facilities construction	215	325	524	1,198	1,798	1,355	1,335
Public expenditures	3,065	4,421	6,395	9,516	1,588	19,711	22,611
Percent of total	21.7	24.7	24.3	24.7	3.3	36.6	37.5
Health insurance, workers' compensation, and Veterans Administration	2,439	3,862	5,636	7,947	14,727	12,236	12,113
Temporary disability and other medical benefits	(X)	(X)	(X)	(X)	3,355	5,312	6,568
Workers' compensation and medical benefits	2	20	40	51	51	55	58
Workers' compensation and medical benefits	163	315	430	589	695	782	850
Public assistance (veterans' medical payments)	51	212	424	1,367	2,583	3,581	4,421
General hospital and medical care	886	1,298	1,973	2,916	2,822	2,865	3,027
Defense Dept. hospital and medical care	316	45	829	859	1,333	1,489	1,593
Military Department hospital and medical care	(X)	(X)	61	78	109	162	169
Maternal and child health services	39	93	111	229	310	337	382
School health, tubercular, and venereal	31	44	101	112	178	190	204
Other public health programs	351	584	491	671	1,010	861	1,072
Veterans' hospital and medical care	5-3	722	829	1,121	1,229	1,372	1,478
Medical vocational rehabilitation	7	9	18	31	47	102	125
Other health and medical care	(X)	(X)	(X)	6	100	101	135
Medical research	73	109	171	1,229	1,429	1,616	1,449
Medical facilities construction	222	319	528	1,222	722	329	311
Defense Department	1	33	41	31	51	27	29
Veterans Administration	162	21	61	81	46	46	53
Other	30	52	178	567	623	766	802
Personal health care expenditures, total	10,569	15,865	23,296	31,265	41,791	45,917	52,554
Private expenditures	8,417	12,306	18,337	26,751	33,114	36,776	42,835
Public expenditures	2,152	3,559	4,959	6,514	8,677	9,141	9,719
Percent from:							
Private expenditures	80.1	78.1	78.8	78.2	79.1	63.6	61.4
Public expenditures	19.9	21.9	21.2	21.8	20.9	36.4	38.6

X Not applicable. (X) Omissions, surveys, of ability, and health insurance.
 * Health care data from 1950 to 1969 under public law by private insurance carriers and self-insurers.
 † Bureau of Economic Opportunity.
 ‡ Includes all "health care" expenditures, except for "expenses for pharmaceuticals," "pharmaceutical" expenditures of private hospitals, "other public health activities," and "other health care expenditures for health insurance for the aged," "maternal and child health programs," and "veterans hospital and medical care."
 Source: Dept. of Health, Education, and Welfare, Social Security Administration; *Social Security Bulletin*, December 1969.

No. 79. INDEXES OF MEDICAL CARE PRICES: 1950 TO 1969

(1957-59=100. Prior to 1950, excludes Alaska and Hawaii. These indexes are components of the consumer price index which is revised biannually. For explanation of the index, see text, section 12.)

YEAR	Total medical care	Drugs and prescriptions	PROFESSIONAL SERVICES				Hospital daily service charges
			Physicians' fees	Obstetrical care	Gynecology and adenoidectomy	Dentists' fees	
1950	73.4	89.6	78.0	67.7	81.5	81.5	89.5
1955	88.6	92.7	90.0	93.8	92.7	93.1	93.8
1960	108.3	102.3	106.6	105.0	103.9	104.7	103.7
1965	127.3	95.1	124.5	117.8	123.2	117.6	115.0
1966	127.7	98.4	128.5	127.0	127.5	124.4	118.1
1967	131.7	97.9	131.6	132.3	131.3	127.5	121.8
1968	145.0	98.1	145.3	139.2	140.9	134.5	125.7
1969	155.9	99.2	155.4	150.2	148.2	141.9	131.1

Source: Dept. of Labor, Bureau of Labor Statistics; *U.S. Indexes for Selected Items and Groups, Annual Averages*.

TABLE TEN

Health and Medical Care

No. 80. NATIONAL HEALTH EXPENDITURES, BY OBJECT: 1950 TO 1968

[Calendar data; the base data from 1950 to 1967, which are for fiscal years]

OBJECT OF EXPENDITURE	AMOUNT (mil. dol.)				PERCENT			
	1950	1960	1965	1968	1950	1960	1965	1968
Total	12,867	26,973	40,591	57,103	100.0	100.0	100.0	100.0
Spent by:								
Constituents.....	8,501	18,911	28,174	34,299	66.1	70.1	69.4	59.9
Government.....	3,858	6,637	10,075	21,197	29.8	24.6	24.8	37.1
Philanthropy and other.....	788	1,425	2,343	2,794	6.1	5.3	5.8	4.7
Spent for:								
Hospitals.....	3,845	9,014	13,530	20,751	29.9	33.4	33.3	36.3
Federal.....	728	1,221	1,660	2,151	5.7	4.5	4.1	3.8
State and local.....	1,175	2,827	3,970	6,000	9.1	10.5	9.8	10.6
Nongovernmental.....	1,942	4,966	7,900	12,592	15.1	18.5	19.5	22.0
Physicians' services.....	2,755	5,684	8,741	11,563	21.4	21.1	21.5	20.2
Dentists' services.....	875	1,777	2,808	3,612	7.6	7.3	6.9	6.3
Drugs and sundries.....	1,730	3,677	4,850	6,147	13.4	14.6	12.9	10.8
Eyeglasses and appliances ¹	140	778	1,290	1,718	1.1	2.9	3.0	3.0
Nursing home care.....	112	256	438	2,287	0.9	2.0	3.3	4.0
Research.....	117	692	1,199	1,275	0.9	2.5	3.8	3.1
Medical facilities construction.....	811	1,618	1,912	2,260	6.3	3.9	4.7	4.0
Other.....	1,373	3,559	4,729	7,091	10.6	13.2	11.7	12.3

¹ Includes the cost of eyeglasses and expenditures for hearing aids, orthopedic appliances, artificial limbs, crutches, wheelchairs, etc. ² Includes the services of dentists, dental hygienists, dental radiologists, dental x-ray technologists, dental nurses, physical therapists, dental prosthetists, chiropodists, chiropodists, naturopaths, and Christian Science practitioners. ³ Includes the net cost of insurance and administrative expenses of Federally financed health programs.

No. 81. HEALTH SERVICES AND SUPPLIES—PER CAPITA NATIONAL AND PRIVATE CONSUMER EXPENDITURES, BY OBJECT: 1950 TO 1968

[As of July 1. Based on Bureau of the Census data for total U.S. population in the Annual Prices and Federal Expenditures Annual and the civilian population of outlying areas. Excludes expenditures for research and construction]

OBJECT OF EXPENDITURE	1950	1955	1960	1965	1966	1967	1968
Total, national	\$77.00	\$101.55	\$117.86	\$188.13	\$208.09	\$231.69	\$259.97
In 1968 prices ¹	152.08	196.24	181.87	229.18	209.15	217.93	259.97
Hospital care.....	21.81	35.21	41.35	68.47	77.13	81.21	101.03
Physicians' services.....	17.81	21.85	31.02	44.58	47.82	50.99	56.03
Dentists' services.....	6.30	9.06	10.74	14.22	14.83	16.64	17.09
Other professional services ²	2.53	3.32	4.70	5.20	5.62	6.08	6.57
Drugs and drug sundries.....	11.18	14.10	15.96	24.56	29.27	28.08	30.12
Eyeglasses and appliances ³	3.17	3.55	4.23	6.33	7.07	7.91	8.41
Nursing home care.....	0.92	1.32	2.87	6.72	7.94	9.19	11.19
Expenses for prepayment and health activities.....	1.94	4.65	4.71	6.57	8.11	8.72	9.05
Government public health activities.....	2.33	2.24	2.25	3.52	4.13	4.79	4.75
Other health activities.....	5.93	7.19	7.98	8.69	10.59	12.29	13.94
Total, private consumer	\$51.95	\$71.77	\$101.20	\$142.67	\$149.81	\$159.65	\$162.65
In 1968 prices ¹	108.82	121.68	138.14	190.68	170.78	169.04	192.65
Hospital care.....	12.70	18.27	28.31	41.78	41.48	42.61	48.57
Physicians' services.....	16.70	20.59	28.37	41.41	43.84	41.08	44.28
Dentists' services.....	6.24	8.96	10.77	14.94	15.55	16.94	16.53
Other professional services ²	2.39	3.15	4.31	4.93	5.24	5.51	5.71
Drug and drug sundries.....	11.62	13.99	16.03	23.84	25.62	26.92	28.68
Eyeglasses and appliances ³	3.12	3.48	4.15	6.08	6.91	7.71	8.18
Nursing home care.....	0.71	1.09	2.24	4.08	4.66	5.29	6.13
Expenses for prepayment.....	1.94	3.65	4.61	6.41	7.12	7.72	7.90

¹ Based on medical care component of the consumer price index. ² Services of registered and practical nurses in private duty, visiting nurses, podiatrists, physical therapists, dietitians, psychologists, chiropodists, naturopaths, and Christian Science practitioners. ³ Includes eyeglasses, contact lenses and expenditures for hearing aids, orthopedic appliances, and artificial limbs, crutches, wheelchairs, etc. ⁴ Includes the net cost of insurance and administrative expenses of Federally financed health programs. Source: Tables 90 and 91, Dept. of Health, Education, and Welfare, Social Security Administration, Social Security Bulletin, January 1950.

TABLE ELEVEN

How Consumers Spend Their Dollar

Source: U. S. Department of Commerce.

Group	on millions of dollars)										1959 % of total
	1929	1932	1939	1945	1949	1954	1959	1968	1969		
Food and liquors	21,029	17,695	20,925	43,520	56,593	67,573	47,510	154,914	131,943	72.9	
Clothing, accessories, and jewelry	11,191	6,742	8,407	19,645	24,443	23,829	33,012	55,263	53,337	10.3	
Personal care	1,115	817	1,064	1,972	2,579	4,654	5,734	9,014	9,665	1.7	
Housing	11,570	9,411	9,149	12,479	13,157	41,137	45,995	77,514	83,579	14.5	
Household operation	19,765	6,704	9,634	15,510	25,528	42,274	46,969	76,394	81,546	14.1	
Medical care	7,937	2,117	2,834	5,642	8,119	15,422	13,116	22,013	42,579	7.4	
Personal business	4,184	2,695	3,313	4,479	6,210	12,761	11,997	29,779	31,921	5.5	
Transportation	7,617	3,681	6,749	6,919	23,793	25,634	43,194	71,723	78,662	13.5	
Education	4,391	2,452	3,452	6,193	10,010	15,317	19,755	33,641	35,325	6.3	
Private education and research	1.4	579	133	95	7,971	3,159	5,718	8,737	9,693	1.7	
Religious and welfare activities	1,199	673	675	1,758	2,159	4,178	4,743	7,678	8,161	1.4	
Foreign travel and other-int.	511	285	269	1,182	651	1,824	2,179	3,819	4,291	0.7	
Total personal consumption expenditures	77,272	48,563	65,631	119,791	176,003	290,009	325,641	535,834	577,453	100.0	

Consumer Price Index (1957-59 = 100)

Source: U. S. Bureau of Labor Statistics.

Items	1911	1945	1954	1959	1968	1969	1970
All items	51.3	67.7	93.6	101.5	121.2	127.7	135.2
Total food	45.2	57.4	55.4	103.3	119.3	115.5	152.7
Food	51.9	71.2	93.3	107.7	150.1	177.1	132.2
Housing total	61.1	67.5	93.4	101.3	119.1	126.7	135.6
Rent	61.3	69.1	94.5	101.6	115.1	113.8	123.4
Gas and electricity	62.3	64.4	92.5	107.3	109.5	111.5	115.3
SAI and other items	45.7	51.6	93.6	104.2	115.1	117.3	121.2
Household operation	54.4	73.9	101.9	92.5	101.8	105.5	102.3
Household operation	53.3	67.9	89.5	102.4	113.0*	117.9*	122.8*
Transportation	51.2	55.4	93.8	103.9	119.6	124.2	139.6
Medical care	51.6	57.5	84.6	101.4	145.0	155.9	164.7
Personal care	47.5	63.5	83.5	102.4	119.3	125.2	150.2
Leisure and recreation	57.3	75.9	92.4	102.4	125.7	132.5	125.1

* June. * Combined house furnishings and household operation.

MEDICAID COSTS SOARING, NO RELIEF IN SIGHT

GEORGIA'S MEDICAID MIGRAINE

BY

Bill Shipp

"Medicaid (sic) programs are essential. They are part of the system we believe in. In the good old American tradition, we put a hand out and help..."

- Dr. William Dowda, president-elect,
Medical Association of Georgia.

"Over-usage is inherent to the system. I'm sure that if you had a card that allowed you to go to the steak house and get free steak, you'd eat more steak."

- Dr. H. K. Heath Jr., Waycross
physician who was paid \$148,779
in Medicaid fees in 1970.

Mrs. Eva Mae Watts, 22, of Atlanta is the mother of two small children, draws \$114 a month in welfare, and is worried about her weight. Two months ago she visited a doctor who advised her to go into a hospital "to find out what was really wrong."

Medicaid paid the bill. Mrs. Watts still has a weight problem. She has switched to a weight specialist now, and Medicaid will pay for that, too.

Medicaid is a state-federal program that provides free medical care to poor people. Free, that is, to the recipients. But not the taxpayer who picks up the steadily growing tab.

There is no evidence that Mrs. Watts took undue advantage of the program. She used Medicaid for the first time in seeking a way to

reduce.

"I didn't know exactly what was wrong," she said. "One day I wasn't feeling good so I said, 'I'm going to the doctor to see about losing some of this weight.' When I pull the steps, I get real tired.

"So I know this girl and she told me about this doctor she went to. So I called and made an appointment with him. I asked him if he accepted Medicaid, and he said, 'Yes'.

"So I went and he gave me a thorough examination. And he asked me how I would like to go in the hospital for a few days to find out what was really wrong with me. So I did.

"They gave me all kinds of X-rays and everything. He told me I had three kinds of infections. I don't remember what they were... I stayed in there six days... He gave me seven prescriptions to have filled... Then I went back to see him two or three times... I seen the bill, but I forgot how much it was... No, I didn't have to pay anything."

Between March 25 and April 13, Medicaid paid \$486.75 for in-hospital care and \$185 in physicians' fees for Mrs. Watts, state records show.

State records also show that Mrs. Watts' physician specializes in Medicaid cases. He received nearly \$75,000 in Medicaid fees in 1970.

Mrs. Watts still weighs 190 pounds. She says her normal weight is 137. Last Tuesday, she went to Grady Hospital "just to see what they would say about me gaining so much weight." But she had to wait too long and left before being examined.

Next week, she has an appointment with another physician, a weight specialist who will try to help Mrs. Watts. "He accepts Medicaid," she said.

Mrs. Watts is typical of 423,875 Georgians - almost one out of 10 - now eligible for Medicaid. By the end of 1971, one of every eight Georgians will be eligible. The welfare rolls and thus the Medicaid eligibility list is growing at the rate of 6,000 per month in Georgia.

Source: The Atlanta Journal and The Atlanta Constitution,
July 5, 1971.

THESE ARE THE PRINCIPAL PLANS THAT HAVE BEEN PROPOSED

THE PROPOSAL

Health Security Program (Kennedy bill)

Back by the committee of 100 for National Health Insurance (UAW)

WHAT YOU PAY

Minimal cost for lowest-income earners; up to \$3 a year for those earning \$15,000 or more.

WHAT YOU GET

Comprehensive health benefits for all U. S. citizens and residents, the major initial exclusion being dental services for adults (to be covered later). Limitations on drugs and nursing home and mental health care. Benefits would be available without cost-sharing on the part of the insured.

HOW IT'S RUN

By HEW through a federal board, and regional, sub-regional and local offices.

HOW IT'S FINANCED

Tax of 3.5% of employers' payrolls, 2.1% of individual income up to \$15,000 and general tax revenues equal to 40% of total program costs. According to sponsors, program would cover 70% or 57 billion dollars of health-care costs in fiscal 1974, first full year of operation. HEW estimates costs considerably higher by then -- 77 billion dollars. Would absorb Medicare, but Medicaid could continue to provide noncovered benefits.

THE PROPOSAL

National Health Insurance Act (Griffiths bill)
Backed by the AFL-CIO

WHAT YOU PAY

Minimal cost for lowest-income earners; up to \$15 a year (by 1975) for those earning \$15,000 or more.

WHAT YOU GET

Comprehensive health benefits for all persons residing in the U. S. one year or longer, the major exclusion being dental care for adults. Patient cost of physician, dentist and other ambulatory services \$2 per visit after first visit. Maximum annual cost of \$50 for individuals, \$100 for families.

HOW IT'S RUN

By a federal board composed of HEW officials and nongovernment members, regional groups and advisory bodies.

HOW IT'S FINANCED

Taxes equal to 7% of the nation's total payroll: a 1% tax on employees, 3% on employers and the balance from general tax revenues. Maximum earnings to be taxed: \$15,000, adjusted upward as wages increase. Sponsors put the cost at \$6.2 billion dollars by 1974, the first full year of operation. Would absorb Medicare and Medicaid.

THE PROPOSAL

National Health Insurance and Health Services Improvement Act of 1970
(Javits bill)

WHAT YOU PAY

Minimal cost for lowest-income earners; up to \$49 a year for those earning \$15,000 or more. If employer provides adequate alternative plan, employee would pay no more than 25% of cost. Employee may "elect out" of government plan by buying qualified private coverage.

WHAT YOU GET

Would expand Medicare hospital and medical benefits and make this coverage available to all in two stages: aged citizens and aliens with five years' residence, widows 60 and over and widowers 62 and over by July 1971, all others by July 1973.

HOW IT'S RUN

By HEW or, under contract with HEW, by state governments. Claims would be processed by private companies or by quasi-government organizations.

HOW IT'S FINANCED

Employers, employees and general tax revenues, initially would each contribute 0.7% of covered payroll; this would rise to 2% by 1973 and to 3.3% by 1975 - to a total of roughly 10%. The tax would be levied on the first \$15,000 of earnings for employees and on the total payroll of employers. HEW estimates the 1975 cost at approximately 68.4 billion dollars. Plan would absorb Medicaid.

THE PROPOSAL

Medicredit (Fulton-Broyhill bill)

Backed by the American Medical Association

WHAT YOU PAY

Coverage would be provided at no charge for those who pay \$300 or less income tax. Graded scale of tax credits from 98% for tax liability of \$30 to 10% when taxes exceed \$1,300.

WHAT YOU GET

Would be offered on a voluntary basis to everyone under 65. Minimum benefits would include medical services, hospitalization up to 60 days, and optional benefits including catastrophic illness, all subject to cost-sharing and deductibles, which would be waived for the poor.

HOW IT'S RUN

By a federal advisory board (including HEW, IRS and other members appointed by the President), which would establish standards for use by state insurance departments in approving private health insurance plans.

HOW IT'S FINANCED

Would be financed from federal general tax revenues. The AMA estimates that the 1970 net cost of basic benefits, excluding optional protection, would have been 8 billion dollars; HEW sets it considerably higher - at approximately 16 billion dollars. Plan would absorb Medicaid.

THE PROPOSAL

Pottengill-Aetna Proposal (not introduced as bill in 91st Congress)
Erbodies approach favored by a number of health insurers.

WHAT YOU PAY

The poor would pay nothing, the near poor and uninsurables would pay part of premium costs. No exact figures are available.

WHAT YOU GET

The poor, near poor and uninsurables under age 65 could elect to receive state minimum benefits to be specified in federal law and to include ambulatory and institutional care. Catastrophic medical expense coverage would gradually be extended to all, starting with the poor.

HOW IT'S RUN

By the states through statewide insurance pools administered by an insurance company selected by each state with the approval of the federal government.

HOW IT'S FINANCED

Premiums paid by the near poor and uninsurables for minimum uniform health benefits would go into state insurance pools. Deficits would be made up by the state and federal governments. The catastrophic medical expense portion would be financed out of federal and state general revenues. Estimates of cost are not available. Plan would absorb Medicaid.

Source: "National Health Insurance: The Next Attack on Medical Costs," Changing Times, January 1971, pp. 43-44.

HISTORY OF MEDICARE

MEDICARE ENACTMENT ENDS 20-YEAR ISSUE

President Truman in 1945 made the first proposal for enactment of a federally operated health insurance program. The Truman plan would have covered the entire population, not just the elderly. The proposal immediately brought forth the lobbying might of the American Medical Assn., the organization which was chief opponent of federal hospital insurance through the years. The AMA was joined in opposition by the insurance industry and conservative business groups. Labor unions and liberal organizations worked for enactment of the Truman proposal and the more limited Medicare plan that followed, but there was no one organization that was as important in support of a Medicare program as the AMA was in opposition.

The lobbying campaign for and against the Truman proposal reached a peak when the President pushed for Congressional action in 1949-50. Hospital insurance became one of the major issues of the session; when Congress adjourned without taking any action, the AMA was considered to have won a notable victory. Its warnings that national health insurance would mean "socialized medicine" and Government interference in medical practice were generally credited with being the major factor in the outcome. The campaign had been costly; in 1949-50 the AMA filed the two highest lobby spending reports ever.

After 1950 the issue subsided for awhile; the Eisenhower

Administration, which came to office in 1953, opposed any such plan. But in 1957 the issue returned to public prominence with introduction by Rep. Aime J. Forand (D R.I.) of a bill which covered hospital and surgical costs of the aged under the Social Security retirement system. This became a major part of the legislative program of the AFL-CIO and the AMA began another nationwide publicity campaign in opposition. This marked the start of the struggle which ended with enactment of Medicare in 1965.

By 1960 the Forand bill (as Medicare was then tagged) had become a very hot political issue. However, the rules of the House were such that the proposal could not be brought to the House floor for debate unless it was reported by the House Ways and Means Committee. The Committee in 1960 voted 17-8 against the proposal, and was never to vote in favor of it until 1965.

With House action blocked, Medicare supporters worked on getting the bill through the Senate, even though there seemed to be little chance of enactment.

Kennedy Administration bills covered only hospital and post-hospital costs; not surgical bills as proposed by Forand. Medicare produced another major Senate fight in 1962. Concessions were made to win five Republican votes, but the Administration nevertheless suffered a stunning defeat when the plan was tabled, 48-52. Medicare finally passed the Senate for the first time in 1964, as an amendment to a

House-passed bill raising Social Security retirement benefits by 5 percent. But the bill died in conference when a majority of House conferees opposed any Medicare plan and a majority of Senate conferees held firm in favor. As the 1964 bill died, President Johnson spoke of hopes for a mandate in the November election, and pledged that he would try again for Medicare in 1965.

CHRONOLOGY

Following is a chronology of the major legislative landmarks in the drive for Medicare up to 1965:

1935 - The report of President Roosevelt's Committee on Economic Security, which formed the basis of the Social Security Act passed later that year, endorsed the principle of compulsory national health insurance.

1943 - Sens. Robert F. Wagner (D N.Y.) and James E. Murray (D Mont.) and Rep. John D. Dingell (D Mich.) introduced the first "Wagner-Murray-Dingell" bill, proposing a broadening of the entire Social Security Act, including a compulsory national health insurance system financed by a payroll tax.

1945 - President Truman's message on health legislation proposed a comprehensive, prepaid medical insurance plan for persons of all ages to be financed by raising the Social Security tax.

1949-50 - President Truman's health insurance proposals were among the hardest-fought of all issues before Congress, but no action resulted.

1951 - President Eisenhower's plan to help meet the cost of

health care proposed that the Government reinsure private insurance companies against unusually heavy losses on health insurance.

1957 - Rep. Aime J. Forand (D R.I.) introduced a bill proposing that Social Security payroll taxes be raised to provide hospital care for old-age assistance beneficiaries.

1960 - Democratic Presidential nominee John F. Kennedy (D Mass.), who had sponsored a Senate version of the Forand bill, announced in July 1960 that its enactment was one of his chief legislative goals for Congress' post-convention August session. Sen. Clinton P. Anderson (D N.M.) proposed a revised version of the Forand-Kennedy bill as a floor amendment to the omnibus Social Security bill. Opposed by President Eisenhower, the amendment was defeated 44-51 Aug. 23. The medical care provisions later added to the bill, and called the Kerr-Mills program after its sponsors, established a state-administered, flexible matching grant program for medical aid to needy persons not poor enough to qualify for public assistance.

1962 - President Kennedy's 1961 medical care proposal, sponsored by Sen. Anderson and Rep. Cecil R. King (D Calif.), died in the House Ways and Means Committee. When Sen. Anderson offered a revised amendment to the Public Welfare Amendments bill, it was tabled (defeated) by a 52-48 Senate vote.

1963-64 - Mr. Kennedy's 1963 proposals for health care were again introduced by King and Anderson. The Administration achieved a major but temporary victory Sept. 2, 1964, when a Medicare amendment

to the Social Security Amendments bill passed the Senate, 49-44. The amendment, sponsored by Sen. Albert Gore (D Tenn.), and similar to the Administration bill, died in conference.

Source: Congress and the Nation, p. 754.

The Health Security Program

MEDICINE IN THE FREE ENTERPRISE SYSTEM

By DR. PAUL ASHTON, *President of the California Professional Guild*

Delivered before the California Professional Guild at Newport Beach, Calif., September 9, 1970

THE HOTTEST TOPIC in medical legislation today is the creeping plague of socialized medicine. Its most recent disguise is in the form of a national health insurance program for everyone, sometimes in conjunction with a prepaid health care plan. One program that would completely restructure the present delivery of health care is the one entitled "Health Security Program" recently introduced by Senator Kennedy and Congresswoman Martha Griffith, which is the Rumber Plan and is backed by AFL-CIO. The common cry of all of these programs is "Better Health Care at Lower Cost." This is a laudable goal, and everyone should work toward it, but let's see where we're going before we jump off the cliff. The Guild has made an in-depth study of the subject and some of the flaws in the various programs being advanced are so obvious that it is hard to believe they are not being presented with tongue-in-cheek. Let's examine a few of the main weaknesses. First, who are the masterminds who are planning the future of American medicine?

A new breed of experts has arrived on the scene. A highly educated group of technocrats, systems analysts, economists, statisticians, social planners and administrators . . . a new race of healthocrats . . . and they are going to solve the nation's health care problems because they have had special courses and studies to equip them for this monumental task? These self-

appointed guardians of our nation's health boldly say that WE (the medical profession) are too simple-minded to be entrusted with such a mission; consequently, there isn't a fumbling physician, a feeble pharmacist or a doddering dentist in the bunch. We have the experience, but they are going to save the world for us . . . and from us. The writing is on the wall, big and bold: "They (meaning all medical men) will no longer have a voice in the shape of the systems under which they practice." Here are a few direct quotes:

"The institutions and organizations of the medical community must respond to the challenges of the times. If they refuse, their punishment will be to live under the judgment of less knowledgeable men than themselves. Indifference to the social issues of medicine will ultimately guarantee Governmental intervention . . . this is not a threat, but a realistic assessment of current trends." (John G. Veneman, Undersecretary of HEW, former California Assemblyman)

"We are coming to recognize that there has to be a great deal more in-depth planning for the distribution of health care and manpower, and that this doesn't necessarily require medical knowledge." (HEW Deputy Undersecretary Frederic V. Malek, former toolmaker)

"I cannot help feeling that a major reason doctors have not

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had greater influence on such matters is that *they have usually not had enough educational background in the economic and social aspects of medical care to be able to grapple with this kind of issue . . . if the physician wants to be one of the molders of policy he is going to have to be equipped to do so.*" (Rishi Fern of the Harvard Center for Community Health and Medical Care)

The HEALTHOCRATS say they advocate "no formal Federal takeover of hospitals, no socialization of doctors . . . nor any compulsion." *Who's kidding whom?*

Let's examine the first part of the slogan . . . "Better Health Care at Lower Cost" . . . It is impossible to provide medical care to everyone in the country because there are simply not enough primary physicians to go around? If our medical schools would turn out more primary physicians, the natural law of competition fostered under the free enterprise system would take care of better physician distribution and better care to outlying areas. But until the experts realize this glaring deficiency in their planning, their program will just have to work with what doctors we now have.

Statistics from other countries show the patient load increases dramatically under socialized medical plans. Why can't we learn from this? In other countries, including some of the Canadian provinces that have similar health insurance programs, it has been shown that the patient load has increased tenfold; yet, interestingly enough, there has been no corresponding increase in the number of hospitalizations. This would indicate that there are no more really "sick" people—just more patients.

It's human nature for people to want something "free" whether they need it or not. So, if you are seeing around 40 patients a day now, you will be expected to see around 400 under the national health insurance program. And babies with diarrhea may have to wait weeks for an appointment because you are too busy with patients who need their band-aids changed. How can we handle such a patient load and call it "better care?" You will have to go into your waiting room and say, "All right, everyone with a headache please stand up" . . . Then you can give some group diagnosis and distribute printed sheets of do's and don'ts for back problems. Of course, if the program has enough money in it for X rays, then everyone in the group will get them . . . whether or not they are indicated. And there will be no time to help those who suffer from fear, loneliness, guilt, anxiety, or any other "illness" that is not on the fee schedule. And what about Grandma Jones who needs her gall bladder removed but your budget is overdone for the year . . . will she have her cholecystectomy or will the operation be postponed until the next fiscal year when the new funds are appropriated?

(When England instituted the socialized insurance program, the standing joke was the care given to pregnant women. At the first examination, she received a rubber stamp on her stomach which read: "When this gets big enough to read without glasses, come back for another appointment.")

When any system prevents the personal one-to-one relationship between patient and doctor, *with continuity of that care by the same doctor, then it is less than the best.* Nothing will ever replace the doctor sitting down with a patient in an examining room and listening to his history, complaints and problems. And it must be the same doctor, with the same patient, year after year . . . one who knows his personality, his family, his history, his peculiar foibles and anxieties. To change this personal relationship for assembly-line care would be disastrous. The only conclusion is that patient care will *not* be improved . . . it will deteriorate. Now what about the claim of lower costs?

A new new bureaucracy will administer health care to over two hundred million people with all the present Medicare

services, plus preventive medicine, plus predictive medicine, plus many other benefits and it will be for everyone, regardless of age or income, with no exclusions or deductions. This is the great giveaway . . . the biggest bargain since Barnum and Builey. Again, we say: "Who is kidding whom?" Who is going to pay for the health clinics that must be built (about 2,000 of them planned across the country, many of them duplicating present facilities)? Who is going to pay for the organization costs . . . the high salaries of the Healthocrats . . . the administrative costs . . . the crushing load of paper work? The employers are supposed to pay 35 per cent of the bill through a payroll tax, the employees will pay 25 per cent of the costs, and the Government is supposed to pay the remaining 40 per cent. Of course, this 40 per cent will be passed on to the public, making double payments by the taxpayers. Sounds like an automobile pitch! The demonstration ride is free, but who is going to make the monthly payments?

Last year 67 Billion Dollars were paid to the health industry by everyone, including the Government, private citizens and insurance companies. This is big business. Now the figures being tossed into the health hopper are that the budget will be only 57 Billion . . . a savings of 30 Billion Dollars . . . yet everything will be free to everyone. And all this will be accomplished by the magic of a medical budget. We recognize and agree with the crying need to provide medical care to the underprivileged and the poor, but the planning outlined by these social engineers will only compound the problems, and we resent the silly games they are playing with such vital issues. They cry "economics," but it makes one wonder *if it isn't more political than economical?* Is their goal really health to the poor, or votes at the polls? Could it also be a tool to demand the loyalty of the blue-collar-worker? And even if their program was economically sound, how would it be administered?

The Healthocrats are going to show us how to do it. They say there will be no "formal takeover" and no "compulsion," but what do you call it when all policies and administration is set by the Government? You will be handed a pre-packaged program and will submit annual budgets for health care to be reviewed by the Healthocrats. If your costs run over your budget, then you just fill in form No. 98865 (702962F-aS, and in about three years you might get partial payment. *You conform or you don't get paid.* It's that simple. And these trained brains say the Government can streamline health care delivery into an efficient operation. Do you agree? Federal expertise in "health care" has already been proven . . . just look at the Veterans Hospitals. And as for their experience in "delivery," well, the Government operates a unique mail delivery, so why wouldn't they do as well with *health care* delivery. Put the two departments together and we will have a sort of *Medical Post Office*.

Now, one final factor no one has bothered to consider.

Nothing much has appeared in print about this aspect, but it's as important, if not more so, as any of the others. To overlook it would be catastrophic. Now the Healthocrats don't seem to realize that a doctor is probably the most independent and complete individual left in captivity! And how long would he continue to function . . . *effectively* . . . if he were reduced to the status of a Government employee? The controls and restrictions being planned would soon reduce pharmacists to stock boys, dentists to plaster specialists and physicians to puppets (but all would be experts in filling out insurance forms!).

Under proposals now being submitted, there will be peer review, set fee schedules, no direct billing, monitoring of cases, established budgets, committee control on regional, sub-regional and local levels, working conditions, control of

privileges, fixed working hours, prescribed patient loads, etc. . . . and more and more and more insurance forms and paper work. You will accept whatever changes and restrictions are set down for you by the golden boys.

Well, the program might get medical men to conform . . . and keep on conforming . . . to a point, but no one is going to tell us how to practice medicine. The secret of medical science is in its freedom . . . its ability to soar off and explore new frontiers. That's what attracts many men into medicine. We are a different breed and are not geared to conform. If a doctor becomes a Federal employee on a 9-5 basis, he will soon become antagonistic, lose his dedication, incentive and Medical care *cannot* be stulted and the individual expression and enthusiasm . . . the very qualities that sent him into medicine, *cannot* be thwarted. It is doubtful if the heart transplant would ever have been attempted under the program being proposed, as it was not "on the tee schedule." And what about other organ transplants and all the wide open areas ahead for medicine? The research scientist will continue to need the experience of practicing physicians to keep medicine forging ahead with new discoveries and cures. Medicine is the highest type of science and demands freedom. It is burgeoning and simply *cannot* and *must not* be curtailed and regimented.

It would fill a book to critique all the flaws in the programs being packaged for us, but we have tried to look at just a few of the major ones. We must admit that it is easy to criticize and tear down, and answers to problems as complex as ours are difficult. It is not the intent of the Guild to disparage our Government. America is the greatest nation in the world and offers unparalleled benefits, opportunities, and challenges . . . and this is why we hate to see one of our most precious commodities become a political toy. America has the best medical care in the world and it comes from the free enterprise system.

The goals are good ones, but problems cannot be solved with money and insurance forms. Guidelines have to be carefully drawn and we believe this should be done by men who have had experience and practical knowledge, not by laymen. We believe medical men can come up with better solutions. We can no longer be apathetic and say, "Maybe this issue will be something for the next generation to fight, but I will be retired before it becomes a real threat." *It's* upon us *NOW!* and we must grasp the opportunity to be heard before it is too late. We don't *LIVE!* to quietly accept what we believe will be inferior health care. Maybe we won't be able to stop the trend, but at least we'll go down hollering!