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National Health Insurance: Comments on Selected Issues

Robert M. Ball

National health insurance has been debated for so long now, and there has been so much talk about the politics of national health insurance and the details of one plan versus another, that it seems to me it might be helpful to go back to fundamentals—to review the bidding. What is national health insurance all about?

1) The most important objective of national health insurance is to make sure that everyone can get good medical care at a price he or she can afford. This may seem obvious but it needs to be repeated because in recent years other important, but nevertheless subsidiary, objectives have almost stolen the show. In discussing national health insurance today we hear almost as much about the objectives of cost control, the improvement of the quality of care, and changing the system to make it more responsive to patients' needs as we do about removing the economic barriers to the receipt of care and the protection of the patient's pocketbook. The subsidiary objectives are of great importance, but I doubt if we should be talking about a national health insurance program unless we are concerned principally about protecting the individual against the cost of care and the equity question of making adequate medical services available to all.

2) In spite of the current intellectual fashion of arguing the contrary, national health insurance assumes that medical care is worth having. Although it is useful to examine how effective some personal medical services are—and, indeed, whether some of them do more harm than good—the desirability of having medical services available is not open to serious question. By and large, even the most skeptical critics of American medicine seek medical services for themselves and their families and so confirm the widely held belief that such services are useful in the prevention of disability and premature death, the relief of pain, the reassurance of those who are ill, and the promotion and restoration of health. Overall, genetic and environmental factors and personal habits may have more effect on health than medical care services, but that is not inconsistent with the conclusion that medical care frequently does make the difference between sickness and health and life and death. And it is this conclusion that makes ability to pay an unacceptable way to ration medical care in a democratic society and leads to

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the national health insurance objective of making good medical services available to all.

3) Theoretically, the objective of universally available medical services could be achieved without national health insurance. If we had a comprehensive means-tested program, we could remove the economic barriers to care without insurance. So why not an extended Medicaid program as the solution to our problem—let the government take care of the poor and other people take care of themselves?

The major difficulty with this is that it is not only poor people who are concerned about their ability to buy care. Most American families do not have enough savings to face the prospect of extended illness with equanimity. No one wants to use up his or her resources as the price of becoming eligible for a plan based on a test of means. At any one time the economic barrier to obtaining adequate medical care may affect only a minority of the population—the poor—but a very high proportion of working people, including those who are quite well-off, are concerned that the cost of illness may wipe out what savings they have and push them into debt. No, the perceived need is for insurance, protection before one becomes poor, and that perception is just about universal.

Then, too, most people are quite reluctant to depend on means-tested programs such as Medicaid for other reasons. The adequacy of such programs expands and contracts with the politics of the budget process, and very often such programs provide second-class care. For example, less than half the physicians in the country will take Medicaid patients because, to save money, Medicaid pays far less than the going rate for medical services. Thus people are quite correct in believing that a means-tested program alone will not serve them adequately. National health insurance is a way of removing economic barriers to care for the poor, but it is also a way of seeing that other people get care without becoming poor in the process.

4) "All right," one might well say, "everyone needs insurance, but why isn't private insurance enough? Why a government plan?" Private insurance protection is much more widespread than it used to be and has made a substantial contribution to the objectives of removing the economic barriers to care and protecting people against the cost of care. Group insurance, usually automatically accompanying employment with a particular employer, can do a good job for the individuals covered. Federal employees, for example, are well protected and so are auto workers and many other people employed in large industries. Why can't we just count on the expansion of private insurance to do the whole job?

The problem is that the protection is only as good as the industry can afford. Private health insurance is a business. The carriers provide what unions can get at the bargaining table and what a particular industry or company can pay for. There is very little pooling of risks from one employed population to another. The auto workers and manufacturers (and purchasers of automobiles) do not contribute, say, to plans for laundry workers. The predictable result is that many millions of Americans have no medical insurance where they work, and many millions more who do have such protection have inadequate protection.

Moreover, group coverage tied to the place of employment has certain inherent weaknesses. It is not suited to coverage of the self-employed, household employees, most farm workers, and some of those regularly outside the labor force—say, widowed mothers staying home to care for young children. Then, too, continuity of coverage may be affected by unemployment, changing employers, retirement, and disability—all changes in status which affect not only the worker but members of his family.

And individually sold health insurance policies are not an adequate way of filling in the gaps in group plans because individual policies are much more expensive to sell and to administer. In some commercial plans only 50 percent or so of the premiums paid for such policies actually goes for health care. Individual health insurance is just an inefficient way of providing protection.

It is clear that only a national plan can guarantee that the population as a whole is covered by adequate health insurance without regard to changes in status and at a cost that people can afford. Although there must be a national plan, in all probability some of the protection will continue to be furnished by private insurance, providing either supplementary protection to a basic government plan or possibly, under government regulation, providing the entire coverage for most groups. Although there is much argument about the proper government and private mix, there seems to be little disagreement about the desirability of achieving universal insurance protection. Let us, then, proceed to discuss some of the elements that need to be taken into account in planning a universal program, particularly that part of the plan to be provided directly under government auspices.

Summary. The primary objective of national health insurance is to make sure that good medical care is available to everyone at a price he or she can afford. Any plan when first adopted will have a role for both private and government insurance but, regardless of the mix, the combined system should meet the following goals: (i) to the extent possible the needs of low-income people should be met through plans that cover others; (ii) the part of the plan to be operated by government should be built on the administrative structure of Medicare, but with changes in reimbursement to encourage more efficient delivery of care; (iii) direct capital and manpower controls should be included; and (iv) rather than acting primarily as an insurer protecting people against the cost of medical care, the plan should be an aggressive buyer of health services, defining the product it is willing to buy and the price it is willing to pay.

The Administrative Structure

It sometimes seems to be forgotten that we have had a national health insurance system for the last 12 years. There are many things about Medicare that can and should be changed but, by and large, it has fulfilled its purpose, and it has been well administered (*1*). Medicare has relieved older people and disabled people of the major expenses connected with hospital care and, to a lesser extent, with the cost of physician treatment. And it has done so in a way that protects the dignity and savings of the recipient.

Although the population and range of services covered by Medicare are limited, its administration involves all the major functions, institutions, and health personnel that would be involved in an extended plan. Under Medicare, just about every hospital in the country has been part of our national health insurance system, and about a third of the nation's hospital costs are paid for by Medicare. Practically all of the physicians in the country participate in the program, and most at one time or another file Medicare claims for at least some of their patients, some of the time. Blue Cross–Blue Shield and a large number of com-

mercial insurance companies are directly involved as intermediaries and carriers in performing specified administrative tasks under the program. State health departments inspect and certify institutions for participation in the program. Then, too, in contrast to the situation in 1965 when the Medicare law was passed, we now have in the United States a large number of people trained in claims review, record keeping, bill paying, and all the other administrative tasks that are a necessary part of a national health insurance system. And the administrative system is much more sophisticated than in the private health insurance plans that preceded Medicare: computer technology has made a major contribution to good administration and much has been learned about the auditing of hospital and other records. In setting up national health insurance, then, we would not be starting from scratch. From an administrative point of view, it is undoubtedly easier to move from Medicare to universal coverage than it was to establish and develop the Medicare system in the first place.

I think it would be wise to keep the Medicare administrative arrangements much as they are for whatever part of an extended national health insurance plan we intend to operate under direct government auspices. The federal government would, then, continue to perform the functions of determining the eligibility of individuals, maintaining records of utilization, overseeing the total administration of the program, letting contracts to and monitoring the performance of the intermediaries and carriers, establishing standards which institutions must meet in order to participate in the program, providing assistance to beneficiaries in filing claims, taking the major responsibility for information about the program, and doing all the other things that the government now does under Medicare. On the other hand, it seems to me it would be unwise for the government to take over the direct reimbursement operations or directly to inspect institutions to determine their conformity with standards of participation. The present contracting-out arrangements for these functions work quite well, and it is a mistake to spend time trying to fix things that don't need fixing. The use of a going administrative structure would prevent a lot of the inevitable start-up difficulty that accompanies a new plan; we should build on what we have. This could be done even though there is a major shift in program policy, as I believe there should be.

Insurance Against Financial Loss Versus Buying Care

Generally speaking, health insurance—both private and governmental—has logically been concerned with the economic problem of helping people pay for the medical care they get. That is what insurance is all about—spreading the risk of financial loss. It is true that insurers try to rule out services that are clearly useless or injurious or too expensive; but, by and large, the definition of proper care and seeing that such care is available have not been central to the responsibility of the insurer. Perhaps we ought to forget about the term "insurance" and talk about a national health plan in which the government and its agents would adopt the role of a buyer acting aggressively on behalf of the covered population. Under such an approach, a central task of the plan would be the definition of the product which it was willing to pay for. There would be a shift from the relatively passive posture of insurance—protecting the patient from having to pay for whatever care he gets—to a bargaining process concerned with what should be delivered and at what price. The plan should certainly not get down to the kind of detailed specifications one finds in the purchase contracts let by the Department of Defense. Deciding in detail what medical services should be provided in an individual case is, of course, the province of the treating physician, but there would be specifications. A national health plan which adopted the role of purchaser would push toward norms and guides, defining what is worth buying and what is not and negotiating with providers for a fair price (*2*).

This approach might be acceptable today; it certainly would not have been acceptable in 1965 when Medicare was passed. At that time the general concern was that Medicare not try to influence how the medical care system operated. The concern in Congress and elsewhere was that this government program confine itself to keeping the economic burden of illness from overwhelming old people and their sons and daughters. Its object was to prevent economic disaster and to do so without questioning in any serious way the kind of medical care being delivered or how much it cost (*3*).

Now, however, the atmosphere is different. Although the major objectives of national health insurance are still to make good medical care available to all and to protect people against the economic consequences of the cost of care, any plan will increasingly be expected to take responsibility for preventing the risk and pain of unnecessary and poor quality care and to define positively the level of care it is willing to pay for and how much it is willing to pay. In particular, Medicare and any national health insurance plan will be expected to do something about the rising cost of care.

This is not entirely a matter of speculation. Medicare, by law and administrative regulation, has been shifting from the relatively passive role of insurer to taking an increasingly active role as a buyer of a defined product. The professional services review organization (PSRO) requirement for a peer review of the necessity of service and the quality of care is perhaps the most notable example of the move toward product definition. But there are an increasing number of instances of basing payment policy on value and the effectiveness of the services offered. Medicare decided not to pay for body scans until use of the CT scanner (computed tomography) for this purpose is shown to be effective; there is legislative authority to withhold reimbursement to practitioners who abuse the program; there is now a limitation on the reimbursement of hospitals whose costs are out of line with those of comparable size and type; and capital costs are not reimbursed if the expenditure had been disapproved by the appropriate planning body. It seems clear that just paying bills is not going to be considered enough for any national health insurance program and that the program will be judged by more than whether it gives financial security. In addition to seeing that everyone can get adequate care at a cost he or she can afford, the further question will be: "Will the program promote the health of the American people, and will it promote the efficiency of the health care system?"

Looking at a national health plan as an aggressive buying agent for the covered population creates a new set of dynamics. It means, for example, that instead of looking to licensing laws to determine who can be reimbursed for what, the plan could decide (if it seemed desirable) to pay only Board-certified specialists at specialists' rates and only after referral by a primary care physician. It means that (if it seemed desirable) the plan could decide to pay for some surgical procedures, for example, only after a second opinion; and that (if it seemed desirable) expensive services requiring high technology or rare skill might be paid for only in hospitals where the procedures are performed frequently

enough so that they are performed well. It also means that the plan might pay extra for a family practice service that provided the health counseling and other services of a nurse practitioner.

The point is, simply, that the plan would not need to pay for whatever care could be given the patient legally. It could define the product it was willing to buy in order to advance quality and lower cost.

Then, too, a plan following the principles of a buyer rather than an insurer would take responsibility for seeing that the services covered were actually available within reasonable distance of where the patients lived. It would not be enough, for example, for Medicare, as it does now, to pay for home health services if the person lived where home health services were available. The plan would have to take responsibility for seeing that such services were, in fact, generally available.

Instead of accepting what is, the plan would have to decide what is good. A national health plan which took this point of view couldn't leave entirely to some other part of government the promotion of a proper distribution of physicians by specialty and geographic area, or leave entirely to others the proper distribution of various types of institutions in relation to population needs. The national health plan itself would have to devote attention to bringing about the configurations necessary for providing the quality of care it wanted to buy. It would be the responsibility of the plan to figure out how more primary care services could be delivered to rural areas and the central cities. Its payment policies would have to take such goals into account. For example, should fee schedules for primary care—instead of taking account of cost-of-living differences between rural and suburban areas—be the same or even higher in rural areas? The plan would have to devise ways of getting service to people in areas too small to support a physician, for example by encouraging nurse practitioners to work in such areas under general rather than on-the-spot supervision by physicians. The plan would have to design a method of reimbursement that would encourage the development of neighborhood and community health centers concerned with providing a variety of support services as well as strictly medical services. Adopting the viewpoint of a purchaser requires an amalgam of health planning and payment for care because a purchaser is interested in much more than protection against financial loss (*4*).

The Improvement of Quality

The role of a buyer of services naturally leads to concern about what one is buying. Today we make strenuous efforts to determine the safety and efficacy of drugs and medical devices but we have no organized way of eliminating outmoded and dangerous medical procedures and quickly substituting procedures scientifically demonstrated to be superior. The PSRO's today are charged with responsibility for setting norms of practice for hospitalized illness but they, almost necessarily, reflect prevailing medical opinion. There is nowhere else to turn. They need to be backed by national research devoted to testing current and proposed medical procedures so that insofar as possible the PSRO's can be given a scientific basis for their decisions. Surely a national health plan viewed as a purchaser of care on behalf of covered persons would want such testing and should be prepared to pay part of the cost of a good testing system. Under the national health plan the PSRO mechanism should be gradually applied to practice outside the hospital and should become a way of transmitting the latest tested developments in medicine and a way of eliminating outmoded practice.

Viewing a national health plan as a purchaser of care leads also to the possibility of using some of the funds of the system for health services research, for increasing the efficiency of technology, and even for basic research into those disease processes that cause great expense to the system. Medicare will soon be spending a billion dollars a year on kidney dialysis and kidney transplants and it would be worth a lot to the program to reduce the need for such care.

The Promotion of Health

Nowhere is the contrast between "insurer" and "purchaser" so sharp as in the differing approaches to low-cost services designed to prevent illness and promote health. If the object is to protect against the cost of care (the primary insurance objective), it does not make very much sense to include low-cost items that the patient can readily pay for himself (*5*). If the approach taken were that of a purchaser, however, rather than an insurer, the plan would cover the types of care that should be encouraged, whether expensive or inexpensive. A prudent purchaser for the users of health services would seek out—without any barrier of copayment—those inexpensive personal health services that have been demonstrated to be cost-effective, and would be particularly interested in preventive services such as prenatal care, contraception, immunizations, and various screening tests for groups at high risk—for example, Pap smears, mammography, and screening for hypertension. A "purchaser" would exploit the fact that contributory insurance is a built-in educational device for getting people to use preventive services, and would make sure that people knew that preventive services, such as the right to consultation with a physician at an early stage in pregnancy and the right to well-baby care, were part of what they, or someone on their behalf, had paid for. When preventive services are subject to a means test or even when they are "free," there is frequently the problem of persuading people to use the services. In a contributory plan, the plan administration can foster the attitude of: "I paid for it; it is mine; I want it."

Although the scope of personal preventive services covered at the beginning of the national health plan might be relatively narrow, a special board could be established to approve additional services for coverage after they have been tested and evaluated. Those proposals which might have important cost effects—either because of the costs of the preventive services themselves or because of the cost of follow-on curative services—ought to have congressional approval. For example, payment for physical examinations and screening tests at predetermined points in the life cycle, such as provided in the Breslow-Somers Lifetime Health Monitoring Program (*6*), would be a major policy decision and ought either to be included in the initial legislation or added as an amendment. On the other hand, the plan ought not to have to go to Congress each time a new screening test is found to be useful.

Other ways of tying the national health plan to prevention and health promotion should be explored. Could communities be given incentives to take specified health promotion steps? For example, could the payments to the health plan from state governments for their indigent populations be reduced if some specified percentage of the population in the state lived in communities that had taken steps aimed at the prevention of illness: fluoridating water supplies, for example? It is estimated that one-fifth of the cost of medical care today arises because of tobacco and alcohol abuse (*7*). Could the national health plan contribute directly

to a reduction in the use of these substances? Would it be feasible, for example, to charge a lower premium to those who avoided cigarettes and alcohol or perhaps followed other health-promoting regimens? At the very least, in fairness to nonusers, tobacco and alcohol taxes should be increased and the proceeds used to pay for a part of the national health plan.

Health promotion is served by the early detection and treatment of disease. Thus a national health plan which adopted the role of a purchaser on behalf of the covered population would value improved access—both geographical and economic—to primary care providers at least as much as it would the insurance goal of protecting people against the economic consequences of very expensive care. If we follow the insurance concept too literally we will move in the direction of catastrophic coverage and add to the incentives for further development of high-technology medicine. If we deemphasized "insurance" and emphasized the objectives of a health plan instead, we would cover not only catastrophic situations but primary care and preventive services, as well, and give their development a much needed boost.

Scope of Supplementary Plan for the Poor

No national health insurance plan that would be proposed by any administration (or could be passed if it were proposed) could cover all types of benefits from the beginning. Nor could a politically acceptable plan cover even the basic benefits provided now by Medicare without having most patients pay part of the cost of at least some of the benefits. That is, the plan would have to have some "copayments," as well as premium payments, or it would just seem too expensive. Since low-income people could not make copayments or pay themselves for services left out of the plan, special arrangements would have to be made for them. It is desirable to keep these special arrangements to a minimum and to the extent possible include services for low-income people in the same plan as the one that covers everyone else.

It is difficult to prevent separate plans designed specifically for the poor from becoming second-class plans. Most of us have charitable feelings from time to time but for sustained year-in and year-out interest we are most likely to give our attention to what affects us directly. Everyone will be interested in seeing that a universal plan is a good one and well administered; few will be interested in seeing that a special plan for the poor meets high standards. Low-income people are likely to receive equal treatment in medicine only when they are free to go to the same hospital or clinic and to the same physician under the same conditions as everyone else.

For services covered by the universal plan, forgiveness of the copayment for low-income people could be handled in a way that would not reveal their identity to providers. The plan could make full payment to providers for all patients through a credit card system, then collect copayment later from those who can pay and forgive it for those who cannot. Such an approach has formidable administrative problems, but it seems to me that the advantages make it well worth exploring.

To the extent that there has to be a separate plan for low-income people, the recipients must be separately identified and such a plan is always also in danger of being under-funded. This argues for the universal plan including a broad range of services. If copayments have to be somewhat higher to balance the cost of including additional services, such copayments can be forgiven for the poor, but if mental health services, dental services, or long-term care services, for example, are not covered at all, then the special plan for low-income people has to include more. Some services will, at least at first, probably have to be included in a separate plan for those with low incomes—say, eyeglasses, over-the-counter drugs, possibly dentures, and so on—but the scope of the low-income plan can be narrow if the coverage of the general plan is broad.

Reasonable people can differ on this issue. The important *disadvantage* of covering a broad range of services in the universal plan is that for any given expenditure it makes copayments higher for those who are not poor. At the beginning of the program there is no escaping copayments of some size for some services in any event, but the amount can be lower if the benefit coverage is narrow. I find this a difficult choice because I would rather not have copayments for most services at all. They do not seem to me a good way of controlling costs and they can be a barrier to the receipt of care. It is true that copayments give the *patient* an incentive to use services sparingly, but in medicine it is usually the physician who makes the decisions. Moreover, if copayments are large enough to prevent a patient from seeking medical care, they are as likely to prevent him or her from seeking care at an early (and cost-effective) stage as to prevent unnecessary services. In any event, copayments would be likely to be effective in controlling the use of services for only a minority of those covered; those who could afford it would buy supplementary protection from private insurance and fill in the copayments, and those who could not afford it would have their copayments forgiven on an income-tested basis.

Nevertheless, in spite of my dislike of copayments, in making the difficult practical choice at the beginning of a national health plan between one which covers a wide range of services with higher copayments and one which has a narrow range of services and lower copayments, I would choose the former because it is the better choice for low-income people.

The Control of Growth

A national health plan does not need to cost more than we would be spending on health care in the absence of such a plan. We are already spending a great deal and the amount is growing. In fiscal year 1976 we spent $120 billion for personal health services, 7.5 percent of the gross national product (GNP), and we spent another 1.1 percent of GNP for other health expenditures. Total health expenditures have gone from 5.8 percent of GNP 10 years ago to 8.6 percent today (*8*). Without a national health plan these figures will continue to go up rapidly both because more services are being rendered and also because the prices charged for services are increasing.

A national health plan will cost more than we are spending today, but we should be able to finance services for the unserved and the underserved out of the savings from controlling the rate of growth. If we do a good job on cost controls and in promoting more efficient ways of delivering services, we can fill in the gaps for those who need more care and improve the general ability of services at the same time. What we cannot afford is continued uncontrolled growth and medical price increases that greatly exceed the general level of inflation.

Moderating the continued increase in medical costs requires moderating the growth in services. There are undoubtedly many inefficiencies in the present system and their elimination would make price reduction possible, but overall cost will continue to rise markedly if we continue to allow largely uncontrolled growth of expensive services. If we are serious about controlling total expenditures, we will need to control the

expansion of institutional capital—both hospital beds and expensive equipment—and at the same time we will need to increase the number of primary care physicians compared to those who specialize in providing and ordering the most costly services. If we have the capacity to provide more high-cost services than we need, costs will be higher than necessary. It is as simple as that. There is considerable evidence that we already have too many hospital beds (*9*) and that we will soon have more highly specialized physicians compared to primary care physicians than we can use well (*10*).

In the area of capital expansion, it seems to me that Title II of the Administration's cost-control bill is the most useful idea yet. Under the provisions of this part of the bill, the federal government would set a ceiling on the funds that could be spent for capital expansion in a particular area, thus forcing the local planning process to make choices. As it is now, there is no strong motivation for local bodies to turn down requests for capital expansion. Frequently the institution can borrow the money, and the operating costs and debt-servicing costs associated with the expansion are, to a considerable extent, paid by third parties and spread over a paying population much larger than the planning area (in the case of Medicare, over the whole country). If the approval body had to operate under a ceiling and make choices among competing requests, we would have a very different situation indeed. I do not see anything else on the horizon that is likely to restrain the rate of expansion of institutional facilities and services.

Similarly, the number, type, and location of physicians and physician specialists will be a major determining factor in the future utilization and cost of medical care. Since the patient seldom is in a position to have an independent judgment about what the physician says the patient needs, within very broad limits, physicians create the demand for their own services. This does not impute to physicians any exceptional degree of cupidity. There is no agreement on just how much medical care is excessive, and what the physician sees as desirable will expand with his capacity to render more services. Given this basic situation, it is undoubtedly true that an increasing supply of physicians—instead of bringing down prices through competition (as would be the case in most markets)—will result in increases in the total bill for medical services. And the more specialists there are—compared to primary care physicians—the more likely it is that high-cost services will be the ones ordered. The current voluntary programs of cost control now being undertaken by the hospitals and the medical profession, while highly desirable, do not strike at the root causes of the trend toward higher and higher expenditures for medical care; a national health plan will also have to be accompanied by direct capital controls and manpower controls. Otherwise, medical care costs as a proportion of GNP can be expected to continue to increase rapidly, with or without a national health plan.

Reimbursement Policy

Although I do not consider the method of reimbursement the major factor in expenditure control, reimbursement design can be important in improving efficiency. If possible, the method of reimbursement should encourage shifting to more efficient methods of medical care delivery. It seems clear enough that when providers collect a set per capita payment from a defined population and agree in return to provide all needed medical services to that population (as in group practice prepayment plans), the economic incentive is quite different from fee-for-service practice. In fee-for-service, the economic incentive is to provide additional units of care; in a group practice prepayment plan, since the per capita payment remains the same regardless of the amount of service, the economic incentive is to spend as little as possible while still maintaining good relations with the plan's enrollees. Thus it is not surprising that subscribers to group practice prepayment plans, such as Kaiser-Permanente, have substantially lower hospital utilization rates than the general population.

How can reimbursement under the national health insurance plan be designed so that per capita prepayment gets a fair chance as compared with fee-for-service? One way would be to reimburse prepayment plans at a rate related to the per capita expenditures for a population covered on a fee-for-service basis that has similar characteristics to the one covered by the per capita plan. If a particular prepayment plan were, in fact, more cost-effective than fee-for-service arrangements, it would then have a surplus out of such reimbursement which it could use to fill in copayments or to provide other additional benefits so as to attract more subscribers and to finance growth. Since the economic incentives under such a plan shift toward providing as little care as possible, it becomes important that the savings not be at the expense of adequate care for the patient. The national health plan needs to guard against the possibility that enrollees of such a plan may not be good enough judges of the services provided to make dropping out of the plan a sufficient deterrent to poor service.

There are organized methods of providing care other than group practice prepayment that need to be taken into account in the reimbursement design. For example, the neighborhood or community health center which brings together in one place general health services, mental health services, and social and other support services has clear advantages for some populations over reliance on individual practitioners. The reimbursement method needs to have sufficient flexibility so it can pay for such organized care without drawing too fine a distinction between what are strictly medical services and the services which give social and psychological support.

Social services which make it possible for people to stay out of hospitals and nursing homes, such as homemaker services, also need to be considered in any reimbursement plan for the chronically ill and the very old. It seems anomalous not to pay for the services that make it possible for an older person to stay out of an institution while offering to pay for expensive institutional care.

The reimbursement system for a national health insurance plan should be fundamentally different from the present Medicare reimbursement approach. Retroactive cost reimbursement of hospitals and nursing homes—the method followed by Medicare and most Blue Cross plans—does not contribute to a careful approach to cost decisions. Within limits, the institution can decide to spend what it thinks is desirable and depend on collecting from its major payers for the additional cost.

If a national health plan were broad enough so that most people were covered for hospital care, it would be possible to substitute a system of budget approval for retroactive cost reimbursement. Under such a system, hospitals would know ahead of time the amount that they would have for operating expenses in the coming year, and they would have to live within the amount negotiated. (In practice, to avoid the great administrative problems of detailed budget review of some 7000 hospitals each year, budgets that fell within reasonable screening guides related to the previous year's expenditures would ordinarily be approved, although all hospital budgets

should be reviewed occasionally.) Another advantage of a budget-approval process as part of a comprehensive plan is that the plan would not have to process each patient's bill in order to determine how much to reimburse the hospital. Reimbursement would be decided ahead of time by the budget and by workload measurement during the year.

Under a universal plan, the method of reimbursement of physicians would also need to be changed. The "customary and prevailing" approach now followed by Medicare rests for its validity on the idea that only a small percentage of the population is covered and that Medicare can follow along with what is charged patients who are not under Medicare. With general coverage there would not be enough patients outside the system to cause any restraint on the unilateral establishment of new fee levels by physicians. It would be necessary, therefore, to establish fee schedules for those physicians and groups that continued to practice on a fee-for-service basis. In all probability a national health plan would have to start out paying fees at about the level being charged when the plan went into effect and with fees for varying services and in different localities close to current practice. Over time, however, the relations between fees charged in one area and fees charged in another, or between services of one kind and those of another kind, could be gradually modified in the negotiating process to bring about incentives for the production of more primary care services and the location of physicians in underserved areas.

Conclusion

The objective of seeing that everyone has good medical care at a price he or she can afford can be achieved in different ways. Certain issues need to be faced, however, whatever form the national health insurance plan takes—that is, regardless of the extent to which the plan is a direct government-financed and government-controlled plan like Medicare, or the extent to which it mandates benefits through private insurance, or the extent to which there is a universal government plan but with options for employers and individuals to elect out of the plan. It seems to me that whatever the form of the plan, we should meet as much as possible of the need of low-income people through the plan that covers others. It seems important to me, also, that we take advantage of the administrative structure and experience of the Medicare program in designing that part of universal health insurance to be operated by the government. We should include in the plan both capital and manpower controls and redesign the reimbursement arrangements so as to encourage more efficient delivery of care. Finally, it seems to me that the plan will contribute most toward the improvement of the quality of care, the promotion of health, and the encouragement of the efficient and responsive delivery of care if we give the plan the responsibility to purchase care on behalf of the covered population and not confine its role to paying the bills for the care which people have been able to obtain on their own. We need to have a health plan, not just an insurance plan.

References and Notes

1. There has been much confusion in the public press between Medicare, the federal program of insurance for the elderly and the disabled, and Medicaid, the state-administered program for low-income people. In many states Medicaid covers benefits—such as drugs, dental care, and long-term nursing care—that are more difficult to administer than the more limited Medicare program, and in most states it cannot be said that Medicaid has been well administered.
2. The major alternative to a national health insurance plan acting as an aggressive purchaser on behalf of the covered group is a continued reliance upon provider competition, with the hope that the desires of the individual purchaser of health care services would influence providers to create arrangements that give reasonable assurance of quality at fair prices. It is argued by some that we can avoid the tedious and perhaps overwhelming task of determining what is good care and what is a fair price by giving people the money to buy care in the open market and hoping that the forces of competition will operate so as to give consumers the opportunity to choose good arrangements and avoid bad ones. In the opinion of others, the medical market is enough different from the classical model to make it unlikely that this approach would, for most people, result in good care at a reasonable price. It should be said, in fairness, that few of those who would rely heavily on the marketplace would do so completely. Most would favor a regulated market and, as with automobiles, require some standards of safety and economy.

   Yet there is considerable doubt whether even within a regulated market patient choices are a very useful way of shaping the future of medical care. This is what we have been doing. Choice within a regulated market is the way medical care has been provided in the United States for a long, long time, and it is the way it is provided today. The results have been mixed. Good medical care is available, but it is very difficult for any but the most sophisticated purchaser to find it or to recognize it when he does. One of the biggest problems is that the patient has little choice but to accept the recommendations of his physician as to what he should purchase, and the physician is frequently, of course, the seller of services as well as the patient's adviser on what he should buy. This often, perhaps usually, leads to good results, but it can certainly also lead to the overuse of medical services, to the phenomenon of unnecessary surgery, and probably, on the average, to more days in the hospital than we really need. It seems not unreasonable, then, to try another approach, an approach which uses the health plan as a sophisticated proxy for the individual buyer, defining what is worth buying and what is not, and negotiating with providers for a fair price.
3. This is something of an overstatement. Even the original program provided for quality standards for skilled nursing homes and hospitals, for utilization review and physician certification of the necessity of services, and for more intense claims review than had been typical in private insurance. The basic design of the program itself, compared with most private insurance at that time, was intended to guard against the overuse of the most expensive types of facilities by covering physician care *wherever* given, and by including lower cost skilled nursing care and home health services instead of just hospital care.

   Yet, by and large, the legislation accepted the going system of the delivery of care and with important modifications modeled its structure and administration on existing insurance programs. Reimbursement of institutions followed, in general, the principles of cost reimbursement of the American Hospital Association which were also followed by the majority of Blue Cross plans. Physician reimbursement was based on the indemnity policies of private commercial insurance—again, if not in detail, in direction—that is, paying the usual and customary fee up to some prevailing rate.
4. J. E. Lewis of the University of Oklahoma Tulsa Medical College has carried the idea of government as purchaser one step further. He suggests that the plan should seek competitive bids from organizations willing to supply a described level of care to a defined population group ". . . in much the same way that the government buys other goods and services." [See J. E. Lewis, *Shifting the Government's Role from Payor to Buyer: A Concept Paper on Controlling Health Care Costs* (multilithed) (University of Oklahoma Tulsa Medical College, 1978).]
5. Traditional insurance of any kind works best if a large number of people are exposed to the possibility of a large loss but the loss occurs for only a few. In such a situation—say, fire insurance on a house or the risk of dying in a particular year—each person can be protected by paying a relatively small premium related to the likelihood of the event occurring and thus avoid having to save enough to rebuild a house or to save enough to leave one's dependents with enough to live on. Insofar as health insurance follows traditional principles, it would try to protect people against the big bills and let them pay relatively small budgetable amounts themselves. Actually, group health insurance has not followed basic insurance principles very well but has developed more along the lines of prepayment or savings plans where everyone pays in and everyone gets something out. Consequently, risk sharing—the insurance feature—in most health insurance is weak. (Only major medical insurance follows traditional principles completely. In major medical policies there is a large risk transfer because a catastrophic illness costs the individual a lot, but the likelihood of any one person suffering such an illness is small.) Risk-sharing is weak for another reason as well. Private group plans covering medium-size and larger employers adjust the premiums paid to the covered medical care expenses of the employees of the particular employer so that the plans are more of an administrative service than a device for sharing risk among a large number of purchasers. Such group plans would undoubtedly be willing to cover from the first dollar a carefully defined set of preventive services if that is what the buyer wanted, but this is true only because the insurance element of risk-sharing is relatively weak.
6. L. Breslow and A. R. Somers, *N. Engl. J. Med.* **296**, 601 (1977).
7. B. R. Luce and S. O. Schweitzer, *ibid.* **298**, 569 (1978).
8. Public Health Service, Department of Health, Education, and Welfare, *Health, United States 1967–1977* (Government Printing Office, Washington, D.C., 1978), table 143, p. 348, and table 137, p. 343.
9. Institute of Medicine, National Academy of Sciences, *Controlling the Supply of Hospital Beds* (National Academy of Sciences, Washington, D.C., 1976).
10. _____, *A Manpower Policy for Primary Health Care* (National Academy of Sciences, Washington, D.C., 1978).