# STUDENT COMMENTS

## THE HEALTH CARE CRISIS AND NATIONAL HEALTH INSURANCE

*The health of all the people is really the foundation upon which all their happiness and all their powers as a state depend.*

Disraeli

### INTRODUCTION

Defined by its technological advances and discovery of new phenomena, American medical science reputedly has no peer. Whether the organization and delivery of health care in the United States merits the same intensity of respect, however, is becoming visibly problematical. Medical and non-medical observers chart rising costs, insufficient insurance coverage and escalating premiums, a shortage of physicians, inefficient utilization of services and episodes of inferior or inaccessible care as symptomatic of a health care crisis. If there is a consensus that a crisis in fact exists, however, the varying proposed health insurance remedies that offer simply to increase utilization of commercial and federal insurance would seem to belie this consensus. For if the health care crisis is of such magnitude, reform of the very system of care and services is imperative, and modifications in its financing mechanism alone will not afford a resolution.

The first three sections of this comment will examine the health care crisis in terms of cost and quality of care, the present role of the federal government, and the function of private voluntary insurance. Since the thrust of the comment will be that increased funding of health care will not assure more or better care unless accompanied by a systematic restructuring of its organization and delivery, the final section will be an analysis of S. 3, The Health Security Act of 1971, which proposes to create a national system of comprehensive health insurance and to effect modifications in the health care structure. The comment will conclude with the submission that of the legislation proposed thus far, only S. 3 is sufficient to provide for comprehensive and universal health coverage, needed reform in the organization and delivery of care, and regulated financing, thereby averting the dilemma of a static federal bureaucracy or a critical disintegration of health care.

### I. THE HEALTH CARE CRISIS

#### A. *The Cost of Care*

If 1970 was an accurate barometer of the direction health care expenditures will take in this decade, there appears to be minimal likelihood that the present health care system can decelerate the rapidly rising cost of services. In fiscal 1969, total national health

expenditures were $59.9 billion and in 1970, $67.2 billion, an increase of twelve percent in only one year.[1]

[1] An analysis of the health care expenditures of the last six years shows several significant trends:

AGGREGATE AND PER CAPITA NATIONAL HEALTH EXPENDITURES, BY SOURCE OF FUNDS, AND PERCENT OF GROSS NATIONAL PRODUCT, FISCAL 1964–65 THROUGH 1969–70.

| Year | Gross national product (in billions) | Health expenditures | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | | | Private | | | Public | | |
| | | Amount (in millions) | Per capita | Percent of GNP | Amount (in millions) | Per capita | Percent of total | Amount (in millions) | Per capita | Percent of total |
| 1964–65 | 655.6 | 38,912 | 198.20 | 5.9 | 29,366 | 149.58 | 75.5 | 9,546 | 48.62 | 24.5 |
| 1965–66 | 718.5 | 42,286 | 212.74 | 5.9 | 31,464 | 158.29 | 74.4 | 10,822 | 54.45 | 25.6 |
| 1966–67 | 771.3 | 47,903 | 238.23 | 6.2 | 32,185 | 160.06 | 67.2 | 15,717 | 78.16 | 32.8 |
| 1967–68 | 827.4 | 53,650 | 263.97 | 6.5 | 33,726 | 165.93 | 62.9 | 19,923 | 98.02 | 37.1 |
| 1968–69 | 899.6 | 59,905 | 291.78 | 6.7 | 37,125 | 180.81 | 62.0 | 22,780 | 110.95 | 38.0 |
| 1969–70 | 956.2 | 67,240 | 324.32 | 7.0 | 42,258 | 203.82 | 62.8 | 24,982 | 120.50 | 37.2 |

Hospital care, including both inpatient and outpatient services, has been the most rapidly expanding category, consuming $25.6 billion or thirty-eight percent of total health expenditures for fiscal 1970.[2] In that year hospital expenditures increased by fifteen percent

Rice and Cooper, National Health Expenditures, 1929-1970, 34 Soc. Sec. Bull., No. 1 at 5 (1971) [hereinafter cited as National Health Expenditures].

In the last six years the Gross National Product has experienced a steady increase in health care costs. In fiscal 1969 they consumed 7% of the market value of all goods and services produced. Private health expenditures have markedly decreased as percentages of the Gross National Product, from 75.5% in 1965 to 62.8% in 1970. Concurrently, public expenditures increased from 24.5% in 1965 to 38% in 1969, but then declined in 1970 to 37.2%.

[2] Id. at 7. A multiplicity of factors is responsible for this inordinate rate of increase for hospital care. Population growth, escalating per capita utilization of inpatient facilities for diagnostic services, expanding numbers of specialized personnel and subsequent enlarged payroll expenses, spiralling construction costs, complex new medical procedures and expensive equipment all have conspired to propel hospitalization costs to annual rates of increase substantially higher than all cost-of-living indices.

An analysis of selected hospital data covering the last decade produces statistics indicating the growth of both hospital utilization and payroll expenses:

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44 J. of the Amer. Hosp. Ass'n 463 (1970). From 1960 to 1969 the number of hospitals increased by only 3.9%, and the number of beds, although increasing in community hospitals, decreased overall. Nevertheless, the number of admissions increased by 22.8%. The most radical increases were experienced by community hospitals, where total expenditures increased 162.5% and payroll expenses 180.5%.

For fiscal 1971 room charges in Boston hospitals are estimated to increase by 10% to 15%, ranging from $62 to $101 per day for private and semiprivate rooms. Most of the former cost $90 per day and some were as high as $113. Boston Evening Globe, Sept. 25, 1970, at 14, col. 1.

In 1969 the cost of a semiprivate room at the Massachusetts General Hospital in Boston was $70, analyzed as follows:

| | |
|---|---|
| Utilities, housekeeping, maintenance, plus business offices (hotel expense) | $6.96 |
| Food and special diets | $5.82 |
| Nursing | $18.42 |
| Labs, records, house staff, X-rays and pharmacy | $28.80 |
| Overcharge (to cover welfare debts) | $10.00 |
| | $70.00 |

M. Crichton, Five Patients, The Hospital Explained 66 (1970).

From this analysis it is clear that actual hospital costs—exclusive of room and meals —consume about 82% of per diem room charges. These are the costs that inhere in presumptively "quality care" and that simply cannot be reduced.

SELECTED HOSPITAL DATA, 1960 AND 1969

| Item | United States—Total | | | Community Hospitals[a] | | | Noncommunity Hospitals[b] | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1960 | 1969 | Percent Change | 1960 | 1969 | Percent Change | 1960 | 1969 | Percent Change |
| Number of hospitals | 6,876 | 7,144 | + 3.9 | 5,407 | 5,853 | + 8.2 | 1,469 | 1,291 | —12.1 |
| Number of beds (000s) | 1,658 | 1,650 | — 0.5 | 639 | 826 | + 29.3 | 1,019 | 824 | —19.1 |
| Number of admissions | 25,027 | 30,729 | + 22.8 | 22,970 | 28,254 | + 23.0 | 2,057 | 2,475 | +20.3 |
| Average daily census (000s) | 1,402 | 1,346 | — 4.0 | 477 | 651 | + 36.5 | 925 | 695 | —24.9 |
| Number of outpatient visits (000s) | 99,382[c] | 163,248 | + 64.3 | 70,727[c] | 120,831 | + 70.8 | 28,655[a] | 42,417 | +48.0 |
| Total expense (000,000s) | $8,421 | $22,103 | +162.5 | $5,617 | $16,613 | +195.8 | $2,804 | $5,490 | +95.8 |
| Payroll expense (000,000s) | $5,588 | $13,803 | +147.0 | $3,499 | $ 9,813 | +180.5 | $2,089 | $3,990 | +91.0 |
| Personnel (000s) | 1,598 | 2,426 | + 51.8 | 1,080 | 1,824 | + 68.9 | 518 | 602 | +16.2 |

[a] All short-term nonfederal institutions providing general and selected special services.

[b] All federal institutions, all psychiatric institutions, and all other long-term nonfederal hospitals.

[c] 1962 figure. No data available for 1960 or 1961.

over the previous year, a minimal decrease from the annual rate of increase of more than sixteen percent for the prior three fiscal years.[3] The second largest expenditure in 1970 was for physicians' services, consuming $12.9 billion or nineteen percent of total health expenditures.[4] From fiscal 1966 to 1970 total health expenditures accelerated by $25 billion, an increase of fifty-nine percent in only a five year period.[5]

Medicare[6] and Medicaid[7] have also contributed substantially to increased health expenditures since their enactment in 1965 and 1966. For example, in fiscal 1969, when personal health expenditures reached $52.6 billion,[8] approximately $13.5 billion of this total was expended for the care of persons sixty-five and older, a group comprising only one-tenth of the total population.[9] In the same year Medicare paid

[3] National Health Expenditures, supra note 1, at 7 and 11.

[4] Id. at 6, 8. Other categories included drugs and drug sundries ($6.7 billion), dental services ($4.1 billion), eyeglasses and appliances ($1.8 billion) and other professional services ($1.4 billion). Id. at 6.

[5] No category of health services has failed to increase during this period. Annual rates of increase ranged from a maximum of 19.2% for nursing home care to 5.2% for research. Total health care expenditures during this period averaged as follows:

| Type of expenditure | Annual rate of increase |
|---|---|
| Total | 12.3 |
| Hospital care | 16.0 |
| Physicians' services | 9.9 |
| Dentists' services | 9.7 |
| Other professional services | 5.9 |
| Drugs and drug sundries | 7.6 |
| Eyeglasses and appliances | 8.3 |
| Nursing-home care | 19.2 |
| Expenses for prepayment and administration | 9.4 |
| Government public health activities | 18.2 |
| Other health services | 11.3 |
| Research | 5.2 |
| Construction | 15.9 |

National Health Expenditures, supra note 1, at 11. See also U.S. Dept. of Health, Education and Welfare, Social Security Administration, Research and Statistics Notes, No. 25, Table 5 at 9 (1970).

[6] 42 U.S.C. §§ 1395a-*ll* (Supp. IV, 1968).

[7] 42 U.S.C. §§ 1396 a-g (Supp. IV, 1968).

[8] Cooper, Medical Care Outlays for Aged and Nonaged Persons, 1966-69, 33 Soc. Sec. Bull., No. 7 at 3 (1970). Personal health expenditures include all categories of expenditures for all hospital and medical services. Excluded are expenditures for construction of medical facilities, medical research, public health disease prevention and control, the net cost of insurance (the difference between health insurance premiums and benefits paid), selected expenses of philanthropic organizations, and administrative expenses of selected public programs. Id.

[9] Id. Given the frequency of sickness, accident and disability incurred by elderly persons, and the concomitant need for extended hospitalization, close medical supervision, repeated medication and convalescence in extended-care facilities, it is not surprising that the average annual health care bill in 1969 for a person 65 years and older was more than three times greater than for a person under 65:

Estimated per capita personal health expenditures, by type of expenditure, source of funds, and age, fiscal year 1969:

| Type of expenditure | All ages | | | Under age 65 | | | Aged 65 and over | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Private | Public | Total | Private | Public | Total | Private | Public |
| | 1969 | | | | | | | | |
| Total | $256.04 | $164.81 | $91.23 | $210.30 | $161.84 | $48.45 | $692.22 | $193.04 | $499.08 |
| Hospital care | 109.75 | 54.89 | 54.86 | 86.09 | 57.19 | 28.91 | 335.28 | 32.89 | 302.39 |
| Physicians' services | 58.04 | 44.88 | 13.16 | 52.91 | 47.36 | 5.55 | 106.99 | 21.24 | 85.75 |
| Other professional services[1] | 24.92 | 22.83 | 2.08 | 24.64 | 22.93 | 1.71 | 27.61 | 21.86 | 5.75 |
| Drugs and drug sundries | 30.58 | 28.99 | 1.59 | 25.45 | 24.66 | .79 | 79.48 | 70.25 | 9.24 |
| Nursing-home care | 11.75 | 2.99 | 8.76 | 1.30 | .50 | .80 | 111.40 | 26.79 | 84.62 |
| Other health services[2] | 21.01 | 10.23 | 10.78 | 19.91 | 9.20 | 10.71 | 31.46 | 20.01 | 11.44 |

[1] Includes expenditures for dentists' and other professional services.

[2] Includes expenditures for eyeglasses and appliances and other health services.

$6.3 billion in benefits to the elderly, approximately one-third of all personal health care expenditures made under public programs, while vendor medical payments for the elderly, provided primarily through Medicaid, contributed $2.1 billion.[10] Total medical benefits paid through public assistance exceeded $4.4 billion.[11]

Conditioned by a variety of factors both medical and non-medical,[12] the cost of health care within its present structure of delivery appears likely to escalate at annual rates exceeding contemporaneous cost-of-living indices, and to consume even greater percentages of the Gross National Product.[13] It is submitted, however, that the increasing consumption of the Gross National Product by the cost of health services is as imperative as it is inevitable. Comprehensive health care services, as they become consistently refined and improved by medical research and discovery, must receive increased requisite funding from the private sector and from government:

> [I]n medicine as in education, law enforcement, sanitation, and a variety of other services, you get what you pay for. If you are going to enter a high-quality acute-care facility that has six employees (most of them non-physicians) for every patient, and if you are going to pay these employees a decent wage, then your care will be expensive. If you are going to purchase technological hardware, maintain it, and keep it up to date, this costs money. If you are going to keep

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Id. at 5.

[10] Id. at 7.

[11] Id.

[12] See note 2 supra.

[13] Total health care expenditures in 1975 are estimated to exceed $111 billion, twice the expenditure for fiscal 1968. By 1980 the figure will surpass $156 billion, consuming 8% of the Gross National Product. U.S. Dept. of Health, Education and Welfare, Social Security Administration, Research and Statistics Notes, No. 18, at 4 (1970).

Similarly, hospital care expenditures for fiscal 1969 are projected to triple by 1980, and physicians' services will more than double. If a formula of maximum rates of increase is used, expenditures for services in 1975 and 1980 would be substantially higher:

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Id. at Table 1.

Projections of national health expenditures, 1975 and 1980
(In millions)

| Type of service | 1975 | | | 1980 | | |
|---|---|---|---|---|---|---|
| | Low | High | Percent difference | Low | High | Percent difference |
| Total | $110,716 | $120,051 | 8.4 | $155,703 | $189,242 | 21.5 |
| Health services and supplies | 104,829 | 113,480 | 8.3 | 148,916 | 180,600 | 21.3 |
| Hospital care | 48,197 | 52,425 | 8.8 | 76,393 | 92,604 | 21.2 |
| Short-term | 37,997 | 41,405 | 9.0 | 62,420 | 76,414 | 22.4 |
| Long-term | 10,200 | 11,020 | 8.0 | 13,973 | 16,190 | 15.9 |
| Physicians' services | 22,097 | 23,980 | 8.5 | 29,200 | 36,453 | 24.8 |

> the hospital in continuous operation twenty-four hours a day, three hundred sixty-five days a year, this costs money.[14]

From the phenomenon of spiralling medical costs one clear inference can be drawn. If these costs represent uncontrolled financial infusions into the existing limited system of health care, and if they are unaccompanied by reform of its organization and methods of delivery of care, they can produce only marginal improvement in the quality of care. They may even be counterproductive, contributing to an actual reduction in quality by imposing upon the system an increased patient demand for services that it is unable to adequately supply.[15] In order to reverse an inverse ratio between escalating costs and reduced quality, the financing mechanism in any health care structure must serve as a catalyst to produce needed reorganization and modifications of the very delivery of that care.

### B. *The Health Manpower Shortage*

Four years ago a national commission advised that, even if the supply of physicians continued to grow at an annual rate five percent greater than that of the increase in population, a shortage would still exist by 1975.[16] Three years later another commission recommended that the number of medical school entrants be increased from the estimated 10,800 in 1970-71 to 15,300 by 1976 and to 16,400 by 1978, through the reduction of M.D. programs from four to three years, the expansion of existing schools and the establishment of nine new schools.[17] The shortage of physicians could clearly be alleviated in part by increasing the present number of medical schools[18] and their respective class sizes,[19] but whether federal aid will be sufficiently forthcoming

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[14] M. Crichton, Five Patients, The Hospital Explained 67 (1970).

[15] See notes 142-65 and accompanying text infra.

[16] Report of the National Advisory Commission on Health Manpower, Vol. 1 at 15 (1967) [hereinafter cited as Health Manpower Report].

[17] Higher Education and the Nation's Health, Policies for Medical and Dental Education, A Special Report and Recommendations, The Carnegie Commission on Higher Education 43-45 (1970). Other goals recommended to be achieved by 1980 were curricular integration of preprofessional and professional training, an increase of 20% in dental schools, and functional expansion of university health science centers to include co-ordination of health manpower education programs and regional health care delivery planning. The development of approximately 126 satellite health education centers, affiliated with the parent centers and designed to serve sparsely populated rural or densely populated urban areas, was also recommended. Id. at 99.

For the American Medical Association's acknowledgment of the shortage of physicians, see The Need for More Physicians, 213 J. of Amer. Med. Ass'n 1027-28 (1970) (editorial).

[18] In the fall of 1970 there were 108 medical schools in the United States and Puerto Rico which considered applications for the class of 1974. Medical School Admission Requirements, U.S.A. and Canada, 1970-71, Ass'n of Amer. Med. Colleges (1970).

[19] See Sanazaro, Class Size in Medical Schools, 41 J. of Med. Ed. 1017 (1966). Contrary to the traditional argument of medical school pedagogy, this study concludes that class size does not adversely affect achievement in Part I of the National Board Examinations, career choice, attrition or academic productivity.

for this purpose is conjectural.[20] The shortage of physicians could also be alleviated by terminating the peremptory use of health manpower by the military:

> The use of compulsion to recruit manpower for nondefense tasks is no more acceptable in the military services than anywhere else, and the fact that a job is in a military service does not necessarily mean that it is essential for national security. The ease of recruitment through the draft has permitted the military services an unlimited supply of health manpower, and we believe that there has been inadequate control over the purposes for which these men have been used and over the efficiency of their use, even where clearly defense-related.[21]

However, if the shortage of physicians is characterized by type of practice, the gradual disappearance of the family physician or general practitioner, the traditional provider of primary health services, is one phenomenon that contributes substantially to the absence of continuing and comprehensive health care in the United States.[22] Within the past few years two attempts have been made to render the

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[20] In its proposal for health care reform, the Nixon Administration, in response to the declarations of financial distress by more than half the nation's medical schools, submitted that the substance of federal assistance to medical schools should be in the form of capitation grants. Set at $60,000 per graduate, the volume of assistance would then be conditioned by the size of the graduating class. Although the concept of such an incentive is attractive and might provoke otherwise reluctant medical schools to augment their enrollment, its implementation would have to make provision for those schools that could demonstrate that their enrollment had attained an optimal maximum, and that additional funding would be necessary for the continuation of quality education. The Administration does propose for fiscal 1972 a $500 million program of loans, but whether this would be sufficient to initiate the construction of new schools and the enlargement or renovation of existing ones is uncertain. Message from the President of the United States Relative to Building a National Health Strategy, H.R. Exec. Doc. No. 49, 92d Cong., 1st Sess. 8-9 (1971).

[21] Health Manpower Report, supra note 16, at 53.

[22] In 1931 there were 91.2 general practitioners in private practice and 18.0 specialists in private practice per 100,00 population. In 1967 these figures were 31.5 and 63.9, respectively. See Family Practice of Medicine, Hearings on S. 3418 Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare, 91st Cong., 2d Sess. 89 (1970) [hereinafter cited as Family Medicine Hearings].

For an analysis of how the pool of potential family physicians, even including internists and pediatricians, still declined in the last decade, see Overpeck, Physicians in Family Practice, 1931-1967, 85 Pub. Health Rep. 485 (1970).

Arguably, physician shortage can be said to attach only to the general practitioner. For example, by the end of 1969 the number of physicians in a general practice compared to the total physician population was 19.2%. Haug and Roback, Distribution of Physicians, Hospitals and Hospital Beds in the U.S., 1969, Amer. Med. Ass'n, Vol. 1 at 7 (1970).

In 1968 the AMA's Physician Placement Service received 208 requests for professional opportunities from family physicians and it placed 1,060. In the same year this service received 448 requests from surgeons for 170 available positions, and 224 requests from obstetrician-gynecologists for 158 positions. Family Medicine Hearings, supra note 22, at 75 (testimony of Dr. Edward Kowalewski, President, Academy of General Practice).

practice of family medicine attractive to young medical graduates who might otherwise be disposed to medical or surgical specialization. In 1969 the American Board of Family Practice, an organization similar to medical and surgical examining boards, was created to substantiate medical concern about the demise of primary health care.[23] One year later a bill[24] was introduced into Congress which would have amended the Public Health Service Act[25] in the following ways:

1. to provide grants to public and non-profit private medical schools to form separate departments of family medicine;[26]
2. to construct facilities needed for instruction, either as an integral part of the school or as a separate outpatient facility;[27]
3. to operate special programs for paraprofessionals in family medicine;[28] and
4. to establish teaching programs for prospective instructors in family medicine.[29]

Financial assistance in the form of scholarships, fellowships or stipends would have been provided for interns, residents and other personnel enrolled in accredited family medicine programs offered by participat-

[23] Grounded in preventive care and early diagnosis, the specialty of family medicine requires a one-year internship and a two-year residency with training in internal medicine, surgery, pediatrics, obstetrics and gynecology, psychiatry and community medicine. The essence of family medicine is summarized as follows:

> 4. SPECIAL REQUIREMENTS FOR RESIDENCY TRAINING IN FAMILY PRACTICE
>
> Residencies in family practice should be specifically designed to meet the needs of graduates intending to become family physicians. The family physician is defined as one who: 1) serves as the physician of first contact with the patient and provides a means of entry into the health care system; 2) evaluates the patient's total health needs, provides personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care; 3) develops a responsibility for the patient's comprehensive and continuous health care and when needed acts as a coordinator of the patient's health services; and 4) accepts responsibility for the patient's total health care, including the use of consultants, within the context of his environment, including the community and the family or comparable social unit. In short, family physicians must be prepared to fill a unique and specific functional role in the delivery of modern comprehensive health services.

Essentials of Approved Residencies, Directory of Approved Internships and Residencies —1969-1970, Amer. Med. Ass'n 318-19 (1969).

[24] S. 3418, 91st Cong., 2d Sess. (1970).

[25] 42 U.S.C. §§ 201-99 (1964), as amended, (Supp. IV. 1968).

[26] S. 3418, 91st Cong. 2d Sess. § 761(a)(1) (1970).

[27] Id. § 761(a)(2).

[28] Id. § 761(a)(3).

[29] Id. § 761(a)(4).

ing teaching hospitals.[30] The special programs for ancillary health personnel[31] could have been instrumental[32] in relieving some beleaguered general practitioners of routine tests and procedures that do not require their expertise. Assisted by both paraprofessionals and nurses, whose scope of medical responsibility should be expanded,[33] the physician could then be released to perform the diagnosis, administer the personal care and make the professional judgments of which he alone is capable. Despite its limited objective of producing 4,840 physicians in six years,[34] the bill was vetoed.[35]

[30] The hospitals themselves would have been eligible for federal assistance to fund their family medicine programs. Id. §§ 761(b)(1), (2) and (4). Section 762(a) would have authorized $50 million for fiscal 1971, $75 million for 1972 and $100 million for 1973 and for each of the next two years thereafter.

[31] Several prototypal physician's assistant programs, identified by the acronym "Medex," are already in existence at the Duke, Dartmouth and University of Washington medical schools. At Duke the program extends for two years, at Washington for three months concluded by a nine month preceptorship with a doctor, and at Dartmouth for a three month university training program and a twelve month preceptorship. Usually, only former military corpsmen are selected for these programs, thus excluding persons who did not serve in the military medical corps, who are ineligible for military service due to age or exemption, or who, though eligible for the military, assert consclentious objection to personal participation in it. See Estes and Howard, Potential for Newer Classes of Personnel: Experiences of the Duke Physician's Assistant Program, 45 J. of Med. Ed. 149 (1970); Family Medicine Hearings, supra note 22, at 103 (statement of Dr. Bassett, deputy director of Medex in Washington); and Medex, Northern New England (publication of the New Hampshire Medical Society and Dartmouth Medical School) (1970).

[32] See, for example, Family Medicine Hearings, supra note 22, at 141-42 (letter of Assistant Dean Hansen of the University of Wisconsin Medical Center, June 17, 1970). As of June, 1970, Wisconsin had been operating a Program in Primary Care to attract physicians to the practice of family medicine in rural areas. Dean Hansen averred that he had been able to secure no federal support for the program and described the support given by the Health Manpower Division of the National Institutes of Health as "pitifully inadequate." Fortunately, special state legislative action saved the program.

[33] For an analysis of how the nursing profession could participate more effectively in ambulatory, direct patient care, especially in pediatrics, see Yankauer, Connelly, Andrews and Feldman, The Practice of Nursing in Pediatric Offices—Challenge and Opportunity, 282 New Eng. J. of Med. 843 (1970).

[34] Six years after funds for S. 3418 would have been made available, 4,840 physicians would have been graduated from family practice residencies, 310 hospital residency programs would have been functioning, and 85 medical school programs would be producing 1,600 family practice residents per year. This projection of family practice residencies is fewer than the present 416 residency programs in internal medicine and 393 residency programs in general surgery. See Family Medicine Hearings, supra note 22, at 77 (statement of Dr. Kowalewski).

[35] S. 3418 suffered a curious and unfortunate legislative fate. The bill easily had passed the Senate 64-1 and the House 346-2. On December 26 the Administration announced that it had pocket-vetoed the bill, thus successfully killing it under the adjournment provision of Article I, Section 7 of the Constitution, which states that "[i]f any Bill shall not be returned by the President within 10 Days (Sundays excepted) after it shall have been presented to him, the Same shall be law, in like Manner as if he had signed it, unless the Congress by their adjournment prevent its Return in which Case it shall not be a Law." Had the bill been returned, it most likely would have captured the necessary two-thirds vote of Congress. Challengers argued that the term "adjournment" should have been interpreted to describe the termination of a session or term of

A demand for more physicians, particularly family practitioners, may be inferred simply from the health needs of a growing population. However, an accurate definition of the precise shortage of, and need for, physicians and other health personnel in the United States unfortunately appears to be elusive in view of their maldistribution and the deficiencies, duplication and inefficient utilization of health care resources and facilities.[86] Whatever the precise need, increases in the numbers of physicians and health personnel should be directed by careful planning of how they can be effectively and efficiently employed to expand the delivery of care. Simply increasing the input of health practitioners into a system whose organization is faulty will arguably neither substantially improve the quality and availability of care nor avert a threatened crisis.[87]

### C. *The Quality of Care*

The quality of health care in the United States today is a paradox. While medical research has discovered new phenomena that can prolong life where death would have resulted only a few years ago, alarming numbers of persons still do not receive the primary and continuing medical care that allows a life relatively free from disease, disability and sudden death. Medical discoveries in the United States are a justifiable source of pride, but the quality of primary care as compared to other industrial nations is inferior in terms of infant mortality,[88]

Congress. Thus, they reasoned, the bill, having been sent to the Administration on December 14, became law on December 26, the day the veto was announced, since Congress had only *temporarily* adjourned on December 22, returning six days later to finally conclude the term. N.Y. Times, Dec. 31, 1970, at 24, col. 2.

[86] See notes 78-95 and accompanying text infra.

[87] See note 166 and accompanying text infra.

[88] A comparison of mortality rates for infants is particularly distressing:

INFANT MORTALITY PER 1,000 LIVE-BORN

| | 1968 | 1969 | 1970* |
|---|---|---|---|
| Australia | 17.8 | 17.9 | 18.3 |
| Belgium | 21.7 | 21.7 | — |
| Canada | 20.8 | — | — |
| Denmark | 16.4 | 14.8 | — |
| England/Wales | 18.3 | 18.0 | 15.8 |
| Finland | 14.4 | 13.9 | 9.6 |
| France | 20.4 | 19.7 | 16.9 |
| Ireland | 21.0 | 20.6 | — |
| Japan | 15.3 | — | — |
| Luxembourg | 17.0 | 17.5 | — |
| Netherlands | 13.6 | 13.2 | 12.2 |
| Norway | 13.7 | 13.8 | — |
| Sweden | 13.0 | — | — |
| Switzerland | 16.1 | 15.4 | — |
| United States | 21.8 | 20.7 | 19.0 |

* July through September

24 World Health Statistics Report, World Health Organization, No. 3 at 197-98 (1971).

maternal mortality,[39] and life expectancy.[40] However lamentable, these statistics reveal greater discrepancies in the quality of health care in the United States when such care is analyzed according to race. In 1967 white infant mortality was twenty deaths per 100,000 live births; nonwhite mortality was nearly double.[41] The absence of prenatal and postnatal care, and the immunizations that are unavailable for many young children, especially those who are not white, provides some explanation.[42] Lassitude in implementing the discovery of a vaccine licensed in March of 1963 probably prevented reduction of the

[39] In 1966 the maternal mortality rate per 100,000 live births in the United States was 29.1, lagging behind six other countries. Sweden was first with only 11.3 maternal deaths per 100,000 live births. 22 World Health Statistics Report, World Health Organization, No. 6 (1969).

[40] In 1965 the United States ranked 18th in male and 11th in female life expectancy as compared to other leading industrial nations. Higher death rates continue to exist for U.S. males between the ages of 40 and 50. In 1965 the rate was 3.1 percent per 100 deaths in Sweden compared to 5.8 percent in the United States, a mortality rate which placed the U.S. behind fifteen other nations. See Hearings on S. 4323 and S. 3830 Before the Senate Comm. on Labor and Public Welfare, 91st Cong., 2d Sess., pt. 2, at 543-45 (1970).

It should be remembered that these comparative international health statistics must be qualified by factors such as completeness of reporting, quality of diet, decent housing, epidemics and degree of biospheric contamination.

[41] 1970 Statistical Abstract, U.S. Dept. of Commerce, at 55. Interestingly enough, it is debatable whether desired mortality and life expectancy norms in the U.S. should be predicated upon the white experience. In California the Japanese community enjoys health indices far superior to those of whites. See Hearings on S. 2898 Before the Subcomm. on Executive Reorganization and Government Research of the Senate Comm. on Government Operations, 91st Cong., 2d Sess., at 5 (1970) (statement of Dr. Breslow) [hereinafter cited as Health Council Hearings].

S. 2898 recognized the severe deficiencies of health care in the United States and proposed the creation of a Council of Health Advisors, whose functions and responsibilities would be analogous to the Council of Economic Advisors in preparing annual reports which would include: 1) current health conditions of all persons in the United States, and their ability to acquire care; 2) incidences of death, disease and illness in each state; and 3) a program to implement national health care policy allowing everyone to have equal access to health care. Id. at 3.

[42] Recent immunization statistics of the U.S. Public Health Service are particularly revealing:

| | Poliomyelitis | DPT | Smallpox |
|---|---|---|---|
| | (Proportions under five years of age) | | |
| Urban | | | |
| Upper | 79.0 | 92.6 | 74.1 |
| Middle | 76.2 | 93.7 | 59.4 |
| Lower | 43.9 | 66.7 | 34.2 |
| Rural | 45.8 | 67.7 | 16.6 |
| Nonwhite | | | |
| Urban | 27.7 | 51.1 | 10.6 |
| Rural | 30.9 | 66.1 | 16.6 |

Health Council Hearings, supra note 41, at 103.

460,000 cases of measles and 421 resulting deaths reported in 1964.[43] Cardiovascular disease and cancer cause thousands of deaths each year,[44] but the marshalling of resources and manpower that characterizes military defense has only recently been instigated in their research and exploration.[45] How many of these lives could have been saved by earlier diagnosis, better care or intensified research can only be surmised.

If the quality of care received by the general population is susceptible to criticism, the quality of care offered to indigents is visibly injurious to their health.[46] For those unable to purchase the benefits of private or semiprivate rooms, with accompanying services and privileged attention, the alternative of ward care leaves much to be desired, if the quality offered in a prestigious university teaching hospital is illustrative:

> We are critical of the care ward patients received. These poor people hoped for adequate care and the hospital attempted to provide it, but the attempt was limited. We think many sick poor were turned away from the hospital because they were not sick enough, were weak teaching cases, or could not afford the schedule of charges which the hospital had to maintain to remain solvent. Against their wishes many were investigated without their understanding who was probing or why. Their personal and social problems which were often severe prior to illness were aggravated with the illness. Those who cared for them found them uninteresting but their diseases usually convenient for learning. Although their diseases technically were treated as effectively as those of patients in other accommodations, the ward patients generally were viewed as ignorant, unintelligent, and unworthy of devoted service.[47]

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[43] In 1965, 262,000 cases and 276 deaths were reported. Even in 1969, 25,000 cases were reported. Health Council Hearings, supra note 41, at 7 (statement of Dr. Breslow).

[44] In 1967 heart diseases claimed 720,829 lives or 38.9 percent of all deaths for that year. Cancer was the second leading cause of death, claiming 310,983 lives or 16.8 percent of all deaths in 1967. In 1971 an estimated 335,000 persons in the United States will die from cancer, and an estimated 635,000 new cases will be diagnosed. Cancer Facts and Figures, 1971, publication of the American Cancer Society, at 3 and 9 (1971).

[45] See notes 117-26 and accompanying text infra.

[46] For a thorough documentation of the quality of care received by poor people, see Heal Yourself, Report of the Citizens Board of Inquiry into Health Services for Americans (1971).

[47] R. Duff and A. Hollingshead, Sickness and Society, 380-81 (1968). This study of Yale-New Haven Hospital, a nationally respected university teaching hospital, arrives at its conclusions by focusing essentially upon the social environment, reflective of societal class structure, that apparently inheres in a modern hospital and upon the manner in which it consequently affects patient illness, diagnosis and treatment. Patients in private and semi-private rooms were those who could pay for both room and sponsoring physicians, while patients in the wards were sponsored by the hospital and were cared for by house staff, medical school students and faculty. Commenting further on the quality of ward care, the authors asserted:

If this treatment offered to ward patients in a teaching hospital was indicative of insensitive personnel attitudes, the inferior treatment dispensed in financially disturbed municipal hospitals would seem to be reflective of the more comprehensive attitude of a bureaucracy. Should this administrative response to health care continue, the causes of action reflected in the following instances of unprecedented litigation could proliferate elsewhere.

In *Fisher* v. *County of Los Angeles*[48] the plaintiff-physicians, suing on behalf of their patients, alleged that the county hospital permitted such an excessive number of admissions to its medicine wards that medically sound and ethical care could not be provided. Partial alleviation of this alleged "hallway hospitalization" resulted from pretrial negotiation in which the county agreed to provide for full indigent care in the sixty contracting community hospitals which had previously breached their contracts and which had "dumped" indigents upon the county hospital because they were covered only for hospitalization.[49] In *Boone* v. *Tate*[50] the City of Philadelphia, attempt-

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> On the wards suspicion, distrust, and confusion were extreme and common. The performances of physicians tended to keep alive this distrust. The patient hoped for the best care and an explanation of what was being done. Although he may have been given optimal treatment, if he did not get an explanation of what was being done he often felt that he was being used as a "guinea pig." He thought that the physicians did not "talk my language." In fact, physicians often misinformed the patient concerning his illness and the intended treatment. In some instances, young physicians were embarrassed when they realized that they had carried out without sufficient justification the most elaborate of diagnostic and treatment maneuvers. They recognized that a consultation with selected specialists might have obviated some of the procedures which were expensive and painful for the patient. At other times, they questioned the humanity of some diagnostic and therapeutic measures.

Id. at 367.

Since the authors acknowledge that the patients' "diseases technically were treated as effectively as those of patients in other accommodations . . ." their criticisms seem to attach more to the art of healing than to the science of healing. Because the art of healing can probably never be pedagogically imparted, it is understandable how physicians and medical students, responding to the rigors of clinical medicine, could regard patients, especially in the ward service, as passive repositories of diseases and other phenomena which comprise the subject matter of a medical text. If a medical student lacks the disposition to practice the personal art of medicine, an art impervious to formal instruction, the only manner in which he could be impressed with its necessity would appear to be through exemplary preceptors. Thus, it would seem that the quality of care in a hospital would be well served by a reassertion of a personalized patient-physician relationship, honesty with the patient, and respect for his right of informed consent. Presumably, such a reassertion would not be incompatible with the activity of a teaching hospital, ideally an acute-care center where the medical judgments of specialists and a multitude of services offer a quality of care probably not duplicated elsewhere.

[48] Civil No. 968621 (Super. Ct., City of Los Angeles, Cal., filed Jan. 12, 1970).

[49] The causes of action in this case are noteworthy, if only because they may have to be utilized again. First, violation of state hospital licensing requirements were alleged to constitute grounds for an injunction against nuisance. Second, the plaintiff physicians alleged that they were compelled to practice medicine which violated their affirmative duty under the state's medical licensing act to practice medicine that was proper and ethical. Third, violations of several state statutes providing for medical relief for the

ing to erase a budgetary deficit, dismissed 550 city employees who staffed the psychiatric, pediatric, and obstetrical services departments and the school of nursing education of Philadelphia General Hospital. Findings of fact stated that the resultant staff shortages increased the risk of mortality and morbidity, that pediatric inpatients with communicable diseases were housed with other inpatients on the same floor, and that cockroach and mice infestation, particularly in the Medicine Department, created dangers of contamination.[51] The court found that there was an "obligation upon the City of Philadelphia to provide general hospital care"[52] and that the residents had "the right to expect that medical care will be available to themselves, their families and others in the community."[53] However, the court noted that in such a budgetary matter "[j]udicial discretion cannot be substituted for executive discretion."[54]

In the foregoing cases the patients at least received care, inferior though it may have been. The most invidious form of health care extended to the medically indigent is its simple refusal. In *Cook* v. *Ochsner Foundation Hospital*[55] medically indigent plaintiffs alleged that ten public and private hospitals in the New Orleans area, all recipients of Hill-Burton[56] moneys, violated their commitment to provide a reasonable volume of free services to persons unable to pay[57]

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indigent were cited. Fourth, the patients were alleged to have been deprived of their constitutional right to equal protection of the law since no other federally-subsidized hospital in the county offered care as inferior as that offered at the hospital in question. Fifth, the risk of injury or death in an atmosphere where medical practitioners could not provide proper care was alleged to deprive patients of their right to life without due process. Finally, it was alleged that the county's failure to provide suitable working conditions violated house staff employment contracts with the county. Id. Complaint at 3-12.

[50] Equity No. 713 (Ct. of Common Pleas, Phila. City, March 4, 1971).

[51] Id. at 9-11.

[52] Id. at 18.

[53] Id.

[54] Id. Boone v. Tate appears to be the first judicial decision to affirm the notion that a municipality has an actual obligation to provide hospital care, and to define the right of the citizenry to the availability of that care.

[55] 319 F. Supp. 603. (E.D. La. 1970).

[56] 42 U.S.C. § 291 (1964), as amended (Supp. IV, 1968). Enacted as the Hospital Survey and Construction Act of 1946, the Hill-Burton Act provides funds to assist the states in implementing programs for the construction and modernization of hospitals and related medical facilities.

[57] As a condition to receiving such aid, participating states must adhere to both the specific statutory language and the regulation pursuant to it:

> The Surgeon General, with the approval of the Federal Hospital Council and the Secretary of Health, Education and Welfare shall by general regulations prescribe . . . (e) that the State plan shall provide for . . . adequate hospitals (and such other facilities) to furnish needed services for persons unable to pay therefor. Such regulations may also require that . . . assurance shall be received by the State from the applicant that . . . there will be made available in the facility or portion thereof to be constructed or modernized a resasonable volume of services to persons unable to pay therefor . . . .

42 U.S.C. § 291c (e) (1964).

Accordingly, the Surgeon General promulgated the following regulation:

by charging all persons for the full cost of all services, by requiring a deposit of $52 from indigent recipients of Medicare as a condition of admission and treatment, and by refusing to care for persons who received welfare or Medicaid benefits.[58] On the motion to dismiss, the court ruled:

> [W]e hold that the Hill-Burton Act is designed, at least in part, to benefit persons unable to pay for medical services . . . the act, by its own terms, makes it plain that persons unable to pay for medical services are one of the chief sets of beneficiaries of this legislation. It is a matter of the clearest logic that the only real beneficiaries of a hospital program are the people who need or may need medical treatment. This includes people of all classes, whether rich or poor.[59]

Similarly, in *Organized Migrants in Community Action, Inc.* v. *James Archer Smith Hospital*,[60] plaintiffs sought declaratory relief and an injunction prohibiting the defendant hospital from refusing to provide a reasonable volume of free medical care and from consequently discriminating against persons on account of race or economic status. Relying on *Cook* v. *Ochsner Foundation Hospital*, the court denied the motion to dismiss.[61]

Equally integral to the quality and maintenance of health care is adequate mental health care and psychiatric treatment. In *Wyatt v. Stickney*[62] a class action was brought on behalf of the 5,000 patients at Bryce Hospital in Tuscaloosa, Alabama, to enjoin the dismissal of ninety-nine employees, including twenty-six persons involved in patient activity and recreation, nine in the department of psychology, eleven in the social service department, three registered nurses and two physicians. Of the remaining staff members involved in direct patient care and therapy after the dismissal, only one had received a doctorate in clinical psychology, three medical doctors had only minimal training in psychiatry and only two social workers held Master of Social Work degrees. Reduction in the tax revenue available

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(b) [t]he facility will furnish below cost or without charge a reasonable volume of services to persons unable to pay therefor.

42 C.F.R. § 53.111(b) (1971).

For an analysis of the duty of federally-subsidized hospitals to provide care to those unable to afford the cost, see Rose, The Duty of Publicly-Funded Hospitals to Provide Services to the Medically Indigent, 3 Clearinghouse Rev. 254 (1970).

For an analysis of decisional and statutory law requiring hospitals to dispense emergency medical services to this same class of persons, see Cullen, Hospital Duty to Provide Emergency Medical Care for the Indigent and Medically Indigent, 4 Clearinghouse Rev. 297 (1970).

[58] Complaint at 2-3, Cook v. Ochsner Foundation Hospital, 319 F. Supp. 603 (E.D. La. 1970) (originally filed July 24, 1970).

[59] 319 F. Supp. at 606.

[60] 325 F.2d 268 (S.D. Fla. 1971).

[61] Id. at 271-72.

[62] 325 F. Supp. 781 (N.D. Ala. 1971).

to the State Department of Mental Health allegedly compelled the dismissal. Although the hospital had been undergoing reorganization in the previous two and one half years, the patient population still included between 1,500 and 1,600 geriatric patients who were being provided custodial care, and therefore improperly confined since they were not mentally ill. Approximately 1,000 mentally retarded patients were similarly confined, most of whom received only custodial care and no psychiatric treatment. The remainder of the patients were involuntarily committed through civil proceedings and were thus not afforded the constitutional protections of due process available in criminal proceedings. Citing *Rouse v. Cameron*,[63] *Covington v. Harris*[64] and *Ragsdale v. Overholster*,[65] the court ruled:

> There can be no legal (or moral) justification for the State of Alabama's failing to afford treatment—and adequate treatment from a medical standpoint—to the several thousand patients who have been civilly committed to Bryce's for treatment purposes. To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane, therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.[66]

Nor did the court limit its decision to hortatory language. The defendants were ordered to submit, within ninety days, a precise definition of the mission and function of the hospital, specific plans whereby adequate treatment could be provided, and a report detailing the progress in implementing the unit-team approach of therapy,[67] all to be evaluated for the benefit of the plaintiffs and court by the Department of Health, Education and Welfare. In the event the defendants should fail within six months of the court order to form and implement standards of treatment for these mentally ill persons, the court would be prepared to appoint a panel of experts in mental health care to inspect the facilities, to suggest methods of therapy, and to recommend changes necessary to provide adequate care. How responsive to federal court orders this state facility and the legislature will be should soon be demonstrated. It also remains to be seen whether this precedent will stimulate litigation in other states where mental hospitals provide inadequate treatment.

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[63] 373 F.2d 451 (D.C. Cir. 1966).

[64] 419 F.2d 617 (D.C. Cir. 1969).

[65] 281 F.2d 943 (D.C. Cir. 1960).

[66] 325 F. Supp. at 785.

[67] As part of its reorganization the hospital was in the process of moving from a departmental system of organization to the unit-team system of delivering therapy to patients. The unit-team system would divide the state into county units. Patients from each geographical area would be assigned to one of ten hospital units, directed by professional staff members. Such organization of delivery of care would assertedly afford patients individual attention commensurate with their needs. Id. at 783.

In all of these foregoing episodes of marginal health care, whether medically or litigatively documented, poor families and individuals, nonwhite and white, consistently appear as the recipients of treatment that has been termed "health brutality."[68] The unofficial cause of death in 1970 for approximately 1,000 persons in Chicago was ascribed to health care neglect, according to the city's assistant director of the Hospital Planning Council.[69] Fifty deaths were attributed to the refusal by private hospitals to provide any care, and the subsequent referral of patients to the one public hospital.[70] This municipal hospital, the only one available for five million residents, treated thirty percent of the one million emergency-room visits in the city.[71] Of those receiving emergency treatment at Cook County hospital, forty percent were children, most of whom were black and who waited an average two hours for treatment.[72] However, even superior medical care cannot be sustained so long as health is impaired in other ways. In the Kenwood-Oakland ghetto of the same city, for example, the health of 50,000 residents is constantly jeopardized by rodent and vermin infested housing.[73] Health care has also been impaired by national bureaucratic non-response to documented cases of hunger.[74] The toll exacted by hunger and malnutrition, especially among children, in terms of re-

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[68] See Breslow and Cornely, Health Crisis in America, Amer. Pub. Health Ass'n (1970) [hereinafter cited as Health Crisis in America]. In 1969 the President and President-elect of the American Public Health Association undertook an inquiry into health conditions in a diversity of areas that ranged from a juvenile and adult detention center in Atlanta and a Mexican-American barrio in Houston, to the homes of off-reservation Indians in Montana and the fields of migrant workers in California. Their observations are documented in this report.

[69] N.Y. Times, Jan. 21, 1971, at 29, col. 1.

[70] Id. Other causes cited were delays that compelled patients to leave emergency rooms before they received care, inadequate prenatal care which caused 3 percent of the city's infants to die before their first birthday, and a shortage of doctors.

One woman allegedly lost three children in three years because they were refused immediate medical attention at the local hospital, forcing her to seek assistance at Cook County Hospital, twelve miles away. The first child, taken by police paddy wagon, arrived three hours later at the hospital. The second child was taken by a fire department ambulance and arrived in two hours. The mother took the third child by elevated subway, waited three hours in the emergency room, only to have the infant refused admission and die on the subway returning home. Id.

The problem of transportational accessibility to emergency care has only begun to receive the recognition it merits. See, The Ambulance Scandal: A Hazard to Life and Health, 11 Medical World News 24 (Dec. 4, 1970).

[71] Id.

[72] It should be emphasized that the hospital emergency room is now the point of entry into the health care system for many urban dwellers. Many emergency room visits are therefore probably not of an acute, emergency nature, and a waiting period does not necessarily constitute any deliberate or negligent delay in providing emergency treatment. Of particular concern here would appear to be even minimal delay in treating a true emergency case simply given the excessive totality of demands made upon a limited number of emergency room personnel.

[73] Health Crisis in America, supra note 68, at 21-24.

[74] See Hunger, U.S.A., A Report by the Citizens Board of Inquiry into Hunger and Malnutrition in the United States (1968).

tarded physical growth, protein deficiency, brain damage, anemia, bacterial and parasitic infection, chronic fatigue and despondence would probably defeat the best of medical care. Conclusions reached in the early sixties about the correlation between health and poverty have since received sufficient substantiation:

> Comparing men aged 45-64 who earn less than $2,000 a year with those earning $7,000 or more, the incidence of heart disease in the lower income group is almost three times as as high; orthopedic impairments nearly four times as frequent; high blood pressure more than four times as common; arthritis and rheumatism nearly five times as prevalent; and the incidence of mental and nervous conditions and vision impairment more than six times as frequent.[75]

Similarly substantiated are the findings by the United States National Health Survey that "the poor get sick more frequently, take longer to recover, seek and receive less medical, dental and hospital treatment, and suffer far more disabling consequences than persons with higher incomes."[76]

## II. The Federal Role in Health Care

### A. *Program Diffusion*

If health care can be successfully provided to the general population only upon evolution into some form of national responsibility, the locus of articulating and directing a coherent national health policy should be in the Congress and the Executive. There is compelling evidence, however, that un-co-ordinated federal health programs are actually contributing to what has been characterized as a fragmented system of health care. One study concluded that "[m]edical care in the United States is more a collection of bits and pieces (with overlapping, duplication, great gaps, high costs, and wasted effort), than an integrated system in which needs and efforts are closely related."[77] When recently questioned about the formulation and implementation of a national health policy, the Department of Health, Education and Welfare responded:

> Up to and including the present there has never been a formulation of national health policy, as such. In addition, no specific mechanism has been set up to carry out this function. As a consequence, the national health policy is a more or less amorphous set of health goals, which are derived by various means and groups within the Federal structure.
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[75] L. Keyserling, Progress or Poverty 67 (1964).

[76] Poverty in America 187 (Ferman, Kornbluh and Haber eds. 1965).

[77] Report of the National Advisory Commission on Health Manpower, Vol. 1 at 3 (1967).

> In the absence of specific mechanisms for national health policy formulation, the role [of formulating a national health policy] has been served over the years by the President, the Congress, and the Federal agencies with health responsibilities, acting individually or in various combinations, as necessary.[78]

This candid admission by the federal agency primarily responsible for the nation's health, that there is no nationally coherent pattern of health care objectives, is hardly encouraging. However, challenge of the present federal system could still have been muted had the federal programs at least advanced the accessibility and delivery of health services. The opinion of the former director of the National Institutes of Health affords minimal optimism: "a simple extension of present activities, coupled with a further patchwork approach to critical needs now apparent, will provide no long-term solution. An examination of present programs yields little comfort that in any reasonable time they will have modified present conventions governing the distribution of cost of health care."[79] In the absence of centralized health planning, the development of duplicative and competitive federal programs and services is unfortunately inevitable.

The Veterans' Administration (VA), for example, originally provided care for men with war-related injuries or disabilities. After World War II the demand for such care subsided, so that today seventy-five percent of VA patients receive care for nonservice related injuries, increasing numbers of veterans are becoming eligible for Medicare, and medically indigent veterans also qualify for Medicaid benefits.[80] Ironically, it is often fortunate that such duplication does exist in view of the recently exposed conditions of neglectful care that exist in many VA hospitals.[81]

The Veterans' Administration has also undertaken biological

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[78] Federal Role in Health, Senate Comm. on Government Operations, S. Rep. No. 809, 91st Cong., 2d Sess. 14 (1970) [hereinafter cited as Federal Health Role].

[79] Id. at 528.

[80] Id. at 515.

[81] See Oversight of Medical Care of Veterans Wounded in Vietnam, Senate Hearings Before the Subcomm. on Veterans' Affairs of the Senate Comm. on Labor and Public Welfare, 91st Cong., 2d Sess. (1970).

For representative deficiencies of a VA hospital, i.e., inadequate or insufficient beds, research space, resources, funding, equipment, supplies, personnel, teaching facilities and special services, see id. at 510-25 (statement of Dr. Dudrick).

For an exhaustive study of a VA hospital in severe deterioration, see Patient Care at Wadsworth Hospital VA Center, Los Angeles, California, id. at 599-822.

Given the painfully disfiguring and incapacitating injuries received by Vietnam veterans, and the consequently required intensive and continuous care, it would appear to be a curious phenomenon that an Administration purportedly committed to the welfare of its combatant military would permit such inferior care and facilities, and even reduce fiscal resources available for their support.

For budgetary reductions ($52 million) in VA medical care for fiscal 1970, see pt. 1, at 71.

research, training of paraprofessionals and administering to the special needs of nearby communities, thereby further duplicating functions and responsibilities delegated to other federal programs:[82]

> Thus, they are not subject to central review in the development of overall national objectives for biomedical research, medical education, residency training, and the production of other health manpower. These VA activities are not meaningfully related to broader community planning directed toward the evolution of more rational means of provision of health care. Further, they are not considered in relationship to other Federal health programs. . . .[83]

The concept and the realization of health care legislated in the Comprehensive Health Planning and Public Health Services Act of 1966[84] have been arguably obscured by analogous, even competitive, programs in the Department of Health, Education and Welfare. Programs for the mentally ill and retarded are administered by the National Institute of Mental Health and the Health Services Administration, as are regional medical arrangements for victims of heart disease, cancer, strokes and related diseases. Maternal and child health care services are also administered by the Children's Bureau of the Social and Rehabilitation Service.[85] In addition, the Office of Economic Opportunity (OEO) contracts for the operation of neighborhood health centers, but whether this diffusion of programs[86] and the multiplicity of available funding mechanisms have expedited the development of such health centers is questionable.[87]

Although hospital construction and modernization is usually associated with the Hill-Burton Act,[88] this responsibility has been fragmented into six different departments and agencies. The Departments of Health, Education and Welfare, Housing and Urban Development, Commerce, and the Small Business Administration all finance civilian

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[82] Federal Health Role, supra note 78, at 515-16.

[83] Id. at 516 (statement of Dr. Shannon).

[84] 42 U.S.C. § 246 (Supp. IV, 1968).

[85] Federal Health Role, supra note 78, at 516-17.

[86] Functional repetition also exists elsewhere:

1. The National Center for Health Services Research and the Office of Comprehensive Health Planning and Development also conduct planning and operational research for comprehensive health centers;

2. funding for operating neighborhood health centers is available not only from OEO but also from comprehensive health grants to the states from the Public Health Service;

3. OEO programs for family planning in a community are also duplicated in the community programs of the Social and Rehabilitation Service.

Id. at 517.

[87] For example, the Massachusetts General Hospital spent several years attempting to work its way through the numerous funding arrangements of HEW and OEO before it was able to initiate a model community health center in Boston. Id. at 4.

[88] See notes 56-57 supra.

hospital construction, which amounted to $191 million in fiscal 1970.[89] The Departments of Defense, Health, Education and Welfare, and the Veterans' Administration all finance the construction of federal hospital facilities, for which $124 million was expended in fiscal 1970.[90] Although memoranda of agreement have been established among these agencies directing them to co-ordinate their programs with the state Hill-Burton agency,[91] duplication has inevitably resulted. In 1963, for example, a Hill-Burton grant of $635,000 was approved for the construction of a new $1.6 million, seventy-five bed hospital in a rural community in southern Florida, where, after completion in 1965, it now experiences an occupancy rate of fifty to fifty-five percent.[92] In 1965 the Small Business Administration (SBA), which assists in the construction of proprietary (profit-making) hospitals, approved a loan of $60,000 that enabled a hospital holding corporation to build a thirteen bed hospital in the same community, a hospital that was converted into a nursing home four years later.[93] In three states where SBA loans were reviewed, some hospitals had converted their status from proprietary to nonprofit, thereby giving rise to the suspicion that personal tax shelters may have been erected in the process.[94] Until substantive reform of the health care system can be effected, even this disjointed federal policy of hospital financing could be tolerated if sufficient funding for needed hospital construction and modernization could be assured. However, the present Administration offers no such assurances, if a judgment may be formed from its response to the Hill-Burton appropriations passed for fiscal 1971.[95]

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[89] Federal Health Role, supra note 78, at 22.

[90] Id.

[91] Id. at 23.

[92] Id. Similarly, in 1966 a California hospital received $606,973 in Hill-Burton funding to modernize a 62-bed facility and increase its total to 99 beds. Unfortunately, underutilization of these beds has been caused by the growth of a nearby former convalescent home into a 90-bed general hospital, partially assisted by a $380,000 loan from the Small Business Administration.

In San Francisco the General Accounting Office and private hospital planners advised construction of a joint hospital facility for Army and Navy personnel. These military organizations refused to consent to any joint facility, claiming that medical training and morale would be impaired. The cost of dual facilities increased initial construction costs by $10 million and annual maintenance and operating expenditures by $8.2 million. Id. at 23-27.

[93] Id. at 24.

[94] Id. at 26.

[95] The Nixon Administration first vetoed and later termed a bill authorizing Hill-Burton appropriations of $2.79 billion for a 3-year period "a long step down the road of fiscal irresponsibility" since it exceeded the Administration's budget by $350 million. The veto was overridden by the House, 279-98 and the bill became law when the Senate voted in its favor, 76-19. N.Y. Times, June 26, 1970, at 1, col. 5; July 1, 1970, at 1, col. 1.

One estimate places the need for new construction of health facilities at $6 billion and for modernizing existing facilities at $10.5 billion, including $7 billion for general hospitals alone. Why Health Security (publication of the Committee for National Insurance, Washington, D.C.), at 9 (1970).

### B. *The Budgetary Commitment*

Based upon such a proliferation of un-co-ordinated programs, an inference of a federal commitment to improving national health care and increasing its funding is dubious. Depending upon the interpretation given to fiscal data for federal health programs in 1971,[96] federal expenditures for health purposes can be construed to have either increased or decreased from fiscal 1970.[97] When budgetary proposals are evaluated according to their impact on the budget rather than to their effect upon existing or proposed programs, the term "outlay"[98] may be interpreted to mean only the totality of expenditures and net loan disbursements, and not new federal obligational authority for program planning. Accordingly, this absence of obligational specificity obscures budgetary restrictions, or even cutbacks, imposed on the development of new programs and the expansion of existing ones.[99] Furthermore, available data clarifies neither the sources of funding nor the national health goal to be attained by their expenditure.

The Shannon[100] analysis of health care outlays for fiscal 1971 has reduced from a declared $20.6 billion to only $4 billion those federal outlays that in fact contribute to the improvement and maintenance of national health care.[101] In this analysis federal outlays are characterized as effecting:[102]

1. the support of major federal objectives unrelated to health;
2. the satisfaction of obligations to special federal beneficiaries;
3. income maintenance; or

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[96] See Special Analyses, Budget of the United States, Fiscal Year, 1971, Bureau of the Budget, Table K-2, at 148, and Table K-16, at 171 (1970) [hereinafter cited as U.S. Budget].

[97] See J. Shannon, Health Activities: Federal Expenditures and Public Purpose, Senate Subcomm. on Executive Reorganization and Government Research, of the Senate Comm. on Government Operations 91st. Cong., 2d Sess. 7-10 (1970) [hereinafter cited as Shannon Health Budget Analysis].

This examination by the former Director of the National Institutes of Health focuses upon federal health expenditures, their sources, agencies and objectives. The conclusions constitute multiple challenges to the federal commitment to health care in the budget for fiscal 1971.

[98] U.S. Budget, supra note 96, at 148, 178.

[99] Shannon Health Budget Analysis supra note 97 at 9:

> The tabulations, though accurate, obscure rather than clarify the Federal commitment to the Nation's health. They imply substantially higher Federal expenditures for health purposes than actually obtain. Neither the summary tables nor the text portray in a clear and unambiguous manner or [sic] origin of the funds for these activities or the end purposes for which the expenditures are made.

See also note 112 and accompanying text infra.

[100] See Shannon Health Budget Analysis, note 97 supra.

[101] Id. at 10, 12-35.

[102] Id. at 10.

4. amelioration of the organization and delivery of health care to the general population.

Subsumed under the first category are those programs whose expenditures ($2.2 billion) serve designated mission-oriented agencies, such as the Department of Defense ($1.8 billion) and the National Aeronautics and Space Administration (NASA) ($111.8 million).[103] While some health care benefit from these programs may inure to the civilian population, it can be argued that health expenditures by the Department of Defense primarily serve the tactical policies, logistical operations and general needs of the military. Similarly, expenditures by NASA presumptively pertain to health problems encountered in or caused by manned space exploration, and they would therefore essentially benefit the health of the general population only in a futuristic sense.

In the second category, research and medical education benefits may affect the general public, but the operations of the separate federal hospital systems of the Veterans' Administration and the Public Health Service ($2 billion), serving primarily merchant seamen, the Coast Guard, American Indians and native Alaskans, effect the improvement of general health care only indirectly.[104] The third category of expenditures, consuming $12.3 billion or sixty percent of federal health outlays for fiscal 1971, may be interpreted dually: either as outright federal purchase of some health care benefits from private vendors for the aged and indigent, or as services or payment of services to supplement the income of these classes of persons. In conformity with these two interpretations, Medicare, funded from Social Security trust funds, is termed a dubious federal "expenditure"; Medicaid and community health centers serve to remove the adverse effects of inadequate income for a defined class of persons; and federal employee health benefits, analogous to normal private employee benefits, are regarded as the federal operating costs of bargaining with employees. Clearly, these programs have effected some alleviation of health insecurity for the aged, the indigent, and a limited diversity of other persons. But a substantial question still arises as to whether their costs have simultaneously contributed to the improvement of the organization, delivery and financing of the health care system to merit inclusion in the budgetary classification of federal "health" programs per se.[105]

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[103] Id. at 12-13.

[104] Id. at 10, 15-17.

[105] Dr. Shannon concludes:

They have not had a noticeable impact on the problems of maldistribution of resources and services. To the contrary, the regulations governing the operation of medicare and medicaid and some associated programs have in many ways made these programs counterproductive to the development of more effective and more economical medical services. . . . [T]he overloading of the health care

The balance of outlays for programs whose primary objective is to improve national health care is $4 billion.[106] According to the Bureau of the Budget nearly seventy-five percent[107] of these expenditures is located in the Department of Health, Education and Welfare, the primary national health agency which has admitted that it has no coherent vision of its own health goals.[108] This limited funding and the diffusion of the health care system would be disturbing enough, without accumulating evidence that the federal government is not only freezing, but even reducing, specific outlays. In fiscal 1971 outlays for health research were approximately $1.7 billion compared to $1.6 billion in 1970 and $1.6 billion in 1969.[109] Assuming an annual inflationary rate of only five percent, the budgetary request for fiscal 1971 is actually less than the $1.7 billion required to equal expenditures in 1969, and substantially less than the $1.8 billion necessary to maintain the level of expenditures of 1968.[110] A demonstration of the budgetary disparity between outlay and obligational authority[111] can be found in the National Institutes of Health budget where research grants and research training have sustained consistent cutbacks since 1969, but whose "total outlays" have shown annual increases.[112] A comparative analysis of budgetary figures for federally funded health

system with no parallel provision for adequate expansion, has contributed to the present shortages in health personnel and health services facilities.

Id. at 19-20.

[106] Id. at 10.

[107] U.S. Budget, supra note 96, at 171.

[108] See note 78 and accompanying text supra.

[109] U.S. Budget, supra note 96, at 148.

[110] Shannon Health Budget Analysis, supra note 97, at 23.

[111] See notes 98-99 and accompanying text supra.

[112] Shannon Health Budget Analysis, supra note 97, at 24:

NIH RESEARCH INSTITUTES, OBLIGATIONS AND OUTLAYS, 1969-71
(In millions of dollars)

| | 1969 comparable | 1970 comparable | 1971 request |
|---|---|---|---|
| Obligations: | | | |
| Research grants | 575 | 553 | 546 |
| Research training | 197 | 179 | 177 |
| Intramural research | 88 | 95 | 103 |
| Collaborative research and development | 124 | 116 | 166 |
| Other Institute direct operations | 42 | 43 | 44 |
| Total obligations | 1,026 | 985 | 1,036 |
| Total outlays | 950 | 965 | 995 |

It is this form of budgetary inconsistency that provoked the author to conclude:

> The Congress is consequently not presented with an intellectually honest analysis of Federal funds that will be expended for the health maintenance of the population.

Federal Health Role, supra note 78, at 508 (letter to Senator Ribicoff).

centers reveals an even more serious inconsistency for the same year.[113] Unexplained variations like these clearly impeach the accuracy of the statistics of the Bureau of the Budget, or at least render the task of accurate interpretation more difficult.

The recipients of the retrenchments in the federal health care budget appear to be both the hospital[114] and medical research.[115] How representative of other hospitals in the country is the recent experience of one New York City hospital, where an unexpected rescission of federal funding for a mobile coronary unit and for a new program for asthmatic slum children has terminated their feasibility, can only be surmised.[116] However, reductions in the availability of funding for health research potentially affects everyone. Cancer research provides a compelling example. In 1971 an estimated 335,000 persons in the United States will die from cancer.[117] But in 1969, per capita expenditure for cancer research was only 89 cents, compared to $410 for national defense, $125 for the Indo-Chinese war, and $19

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[113] Shannon Health Budget Analysis, supra note 97, at 30:

FEDERALLY FUNDED HEALTH CENTERS

| | Special Analysis L, 1970 | | | Special Analysis K, 1971 | | | |
|---|---|---|---|---|---|---|---|
| | 1968 | 1969 | 1970 | 1968 | 1969 | 1970 | 1971 |
| Total Federal Outlays (millions) | 119.7 | 191.5 | 245.1 | 146.5 | 193.7 | 228.7 | 288.5 |
| Number of centers funded | 502 | 622 | 754 | 318 | 396 | 444 | 497 |
| Number of persons served in year (thousands) | 1,125 | 1,742 | 2,400 | 692 | 1,155 | 1,578 | 1,976 |

Since the figures for 1969 and 1970 in Special Analysis L presumably were estimations, their dissimilarity in Special Analysis K may be excused. Yet both analyses, both presumptively using "actual" figures for already expended outlays in 1968, show severe discrepancies. Analysis K reveals increased funding, but, for some inexplicable reason, substantially fewer centers funded and people served. If varying criteria were in fact used for these two years, the analyses are silent as to the reason why.

[114] See text accompanying note 96 et seq. supra.

[115] See note 112 and accompanying text supra.

[116] The coronary care unit, operating on a budget of $62,262 per year since its inception in October of 1968, halved the fatality rate for the patients it served. The program for asthmatic children received $59,962 per year. Its director, the chief of pediatrics at St. Vincent's Hospital, responded to its termination:

> This erratic approach in the provision of medical care to the indigent does not recognize the fears and feelings of the people the programs are for.
>
> The hard, cold, impersonal approach to these people—with the turning of programs on and off, dictated by a hodgepodge budgetary picture and changing priorities—only causes further deterioration of already fragmented health programs and unrest among the peoples of the ghetto.

N.Y. Times, March 16, 1971, at 11, col. 1.

[117] Cancer Facts and Figures, 1971 Publication of American Cancer Society at 3 (1971).

each for the space program and foreign aid.[118] Pursuant to the recommendations of a national panel of consultants,[119] a bill[120] has been introduced in the Senate which would consolidate present cancer research under an independent National Cancer Authority,[121] to be located within the executive branch. Disregarding the question of whether an autonomous agency would have greater merit than the present National Cancer Institute, a component of the National Institutes of Health in HEW, there should clearly be no dispute about the panel's funding recommendation of $400 million for fiscal 1972, increasing by $100 million to $150 million each year thereafter and attaining a level of $800 million to $1 billion by 1976.[122] The Senate bill would authorize for appropriation whatever sums found to be necessary.[123] However, given the fact that the Nixon Administration for fiscal 1970 budgeted only $180.7 million to the National Cancer Institute, a figure Congress subsequently increased to $190.4 million,[124] its recent demonstration of concern for cancer research by requesting an additional $100 million[125] in the budget for fiscal 1972 is paradoxical. Such concern must also be evaluated in light of annual federal expenditures of $68 million for promoting and supporting the production of tobacco.[126]

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[118] National Program for the Conquest of Cancer, Senate Comm. on Labor and Public Welfare, S. Rep. No. 1402, 91st Cong., 2d Sess., pt. 1, at 1 (1970) [hereinafter cited as Conquest of Cancer Report].

[119] Id. The findings and scientific report of this select committee, on which Drs. Sidney Farber and Joshua Lederberg served, provide a fascinating documentation of the present status of cancer research and treatment, but above all emphasize the need for acutely intensified research and funding. For example, about 6,000 chemicals have been tested over a period of years and more than 1,000 have been proven to be carcinogenic (cancer-producing) in animal bioassays. Two years and 200 mice, at approximately $200 per animal, are required to test a chemical compound. A study of one compound will therefore cost about $40,000. Id., pt. 3, at 187-88.

[120] S. 34, 92d Cong., 1st Sess. (1971).

[121] S. 34, 92d Cong., 1st Sess., § 2(b) (1971).

[122] Conquest of Cancer Report, supra note 118, pt. 1, at 7.

[123] S. 34. 92d Cong., 1st Sess. § 113 (1971).

[124] Conquest of Cancer Report, supra note 118, pt. 3, at 219.

[125] Message of the President of the United States Relative to Building a Health Strategy, H.R. Exec. Doc. No. 49, 92d Cong., 1st Sess. 11-12 (1971).

[126] Federal tobacco support expenditures have been analyzed for fiscal 1969:

| | |
|---|---|
| $28,000,000 | Export Subsidy Program |
| 210,000 | Advertising Cigarettes Abroad |
| 4,900,000 | Price Support Program |
| 4,200,000 | Inspection and Market in News Service |
| 31,200,000 | Tobacco in the Food for Peace Program |
| $68,510,000 | |

Letter from Sen. Frank E. Moss, Chairman, Consumer Subcomm. of the Senate Commerce Comm., April 27, 1971 (on file with the Boston College Industrial and Commercial Law Review). Senator Moss has introduced a bill which would terminate all price support programs for tobacco beginning with the 1972 crop. S. 322, 92d Cong., 1st Sess. (1971). One estimate has placed costs of growing, grading, promoting and shipping

## III. The Adequacy of Private Health Insurance

### A. *The Commercial Carrier*

The acceleration of health care costs in the last decade has contributed to an attenuation of the coverage afforded by private insurance, even though benefit expenditures by commercial carriers exceeded $13 billion in 1969.[127] In that year, of the 181 million persons in the United States under sixty-five, nineteen percent did not have any hospital insurance, twenty-one percent did not have surgical insurance, thirty percent did not have insurance for in-patient visits, thirty-five percent did not have insurance for x-ray and laboratory examinations, fifty-seven percent had no insurance for physicians' office and home visits, ninety-five percent had no dental care insurance and fifty-two percent had no insurance for out-of-hospital prescription drugs.[128] Besides revealing that thirty-four million persons under sixty-five in the United States have no hospital insurance and that thirty-eight million have no surgical insurance at all, these figures would also seem to indicate that private coverage encourages hospitalization rather than ambulatory care. Consequently, primary medicine, preventive care and early diagnosis are disparaged in favor of coverage for crisis care and the treatment of acute illness, incipient or advanced. In order to qualify for benefits, patients are often compelled to arrange for a hospital admission for diagnostic work and routine testing that could properly be performed in an out-patient clinic. By inference, insurance carriers themselves have become a catalyst for the accelerating costs of hospital care, the unwarranted demands made upon hospital personnel, the unnecessary utilization of hospital facilities[129] and the subsequent escalation of premiums. Another inference that can be drawn from the character of private insurance is the incentive it provides to practice surgery. Although the extent of surgery that could be described as unnecessary is usually a function of the illness and condition of the individual patient, there is a developing belief that tonsillectomies and some gynecological sur-

tobacco at $84 million annually. Transcription from WCBS-TV editorial, in New York City, April 16, 1971.

[127] See Mueller, Private Health Insurance in 1969: A Review, 34 Soc. Sec. Bull., No. 2, at 3 (1971) [hereinafter cited as Private Insurance].

Private, voluntary insurance includes both group and individual insurance underwritten by commercial carriers such as Blue Cross-Blue Shield, and other plans, such as those that serve a particular community or that are purchased through an employer-employee union.

[128] Id. at 5.

[129] In Boston alone, reputedly the medical center of the world, it has been estimated that 10 to 20 percent of hospital beds are wasted because of insurance purposes. Dr. David Rutstein (Professor of Preventive Medicine, Harvard Medical School), The Integrated Whole—A National Health Program, lecture on the future of American health care, in Cambridge, Massachusetts, Feb. 18, 1971.

Even for hospitalization that is necessary, the actual percentage that could have been avoided is arguably substantial had the availability of primary medical care precluded the cause of hospitalization in the first place.

gery are medically unwarranted.[130] Significantly, the United States has twice as many surgeons in proportion to the population as does England and Wales, and they perform proportionately twice as much surgery, a phenomenon whose causation has also been ascribed to the fee-for-service system, solo practice and a more aggressive therapeutic approach.[131]

With the exception of pre-paid, preventive medical insurance plans, the irony of private voluntary insurance is that its coverage for crisis-oriented health services has so increased hospitalization costs that the insurers' ratio of claims expenses paid to subscription income received is now nearly equal, and has generally provided marginal or no net income despite substantial increases in premium schedules. In 1969 premium income from all private insurance totalled $14.7 billion, benefits or claims expenditures amounted to $13.1 billion and operating expenses consumed $2.1 billion, resulting in a net underwriting loss of four percent or $544.5 million.[132] Blue Cross-Blue Shield plans had a subscription income of $6.2 billion and administrative costs of seven percent, but still incurred a net underwriting loss of more than three percent.[133] Commercial carriers received $7.6 billion in premium income, one-fourth deriving from individual policies and three-fourths from group subscriptions, but they spent a substantial twenty-one percent of that income for administrative expenses.[134] Individual policies sustained a net underwriting gain of four percent and group policies a net underwriting loss of seven percent.[135] However, actual net underwriting gains could have been realized through insurer selection of low-risk enrollees, and losses could have been absorbed through investment of income from other sources. Other plans—prepaid community plans, employer-employee unions, private group clinics, and dental service corporations—showed a net underwriting gain of nearly

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[130] A recent study showed that the rate of performed tonsillectomies was about twice as high under Blue Cross-Blue Shield coverage than under the Health Insurance Plan of greater New York, a prepaid group practice plan. Hearings on S. 2898 Before the Subcomm. on Executive Reorganization and Government Research of the Senate Comm. on Government Operations, 91st. Cong., 2d Sess. 8-9 (1970) [hereinafter cited as Health Council Hearings].

[131] Bunker, Surgical Manpower, 282 New Eng. J. of Med. 135 (1970). In England there is also a more frequent use of consultation and closely regulated practices and procedures.

The fee-for-service practice of medicine, as opposed to prepaid practice, requires the physician to bill each patient for each service performed. Solo practice, as opposed to group practice, affords the physician almost unchallenged autonomy. Clearly, physician autonomy should be posited as integral to professional health care. But whether solo practice consistently serves sound medical judgment, by insulating many physicians from any peer consultation and counsel, is highly questionable.

[132] Private Insurance, supra note 127, at 12-13.

[133] Id.

[134] Id.

[135] Id.

one percent and operating costs of seven percent.[136] Some evidence of the relativity of the comprehensiveness of coverage offered by various plans in 1969 can be shown if the per capita benefit expenditures for hospital care and physicians' services are compared.[137] Blue Cross-Blue Shield plans led all other carriers with an average $56.76 paid per enrollee for hospital benefits, substantially exceeding average group and individual hospital benefits of $39.84 and $15.77 in commercial carriers' plans, and average hospital benefits of $46.63 for other plans.[138] Significantly, benefits paid for physicians' services in these other plans exceeded those of both Blue Cross-Blue Shield and commercial insurers.[139]

The most compelling evidence of the inadequacy of private insurance is the proportion of consumer expenditures defrayed by that insurance. Excluding the net cost of purchasing health insurance, which is the difference between annual premiums and benefits paid, only thirty-seven percent of the total consumer expenditures for health care in 1969 was met by private insurance.[140] Private disbursements by consumers—direct out-of-pocket payments and the net cost of purchasing insurance—paid for the balance. For hospital care private insurance paid for seventy-one percent of consumer expenditures and forty-three percent of physicians' services. In view of these circumscribed benefits, substantial doubt remains as to whether even moderate income families are adequately protected against catastrophic major, or even minor, illness. [141]

[136] Id. Even here a disparity exists. Private group clinics experienced a gain of 6.1 percent and community plans a loss of .3 percent.

[137] Id. at 15.

[138] Id.

[139] Id. The causes of these disparities have been traced accordingly:

> These averages reflect (1) the high utilization rate of hospital care under Blue Cross-Blue Shield contracts that provide more days of coverage and more comprehensive coverage of hospital costs than group policies of insurance companies, (2) the generally meager coverage under individual insurance policies, and (3) the relatively lower utilization rates under community group-practice plans.

Id.

[140] Id. at 18.

[141] For actual case descriptions of the degrees of hardship—economic, emotional and social—visited upon families of varying incomes, see R. Duff and A. Hollingshead, Sickness and Society 352-59 (1968).

Not surprisingly, Duff and Hollingshead found a direct correlation between type of hospital accommodation purchased and the economic impact of the patient's illness:

| Economic Impact on Family | Total | Private | Semi-private | Ward |
|---|---|---|---|---|
| Minor Change | 40% | 57% | 35% | 21% |
| Moderate Hardship | 31% | 32% | 32% | 29% |
| Severe | 20% | 8% | 28% | 29% |
| Very Severe | 9% | 3% | 6% | 21% |
| N = | (161) | (65) | (54) | (42) |

Id. at 359.

### B. *Medicaid and Medicare*

Medicaid,[142] the federal-state program of reimbursing health care vendors for providing services to the medically indigent, has afforded limited relief to some persons who otherwise would have been deprived of all health care services.[143] But, although meritorious in its enactment, Medicaid utilizes the existing system of health care delivery, stipulates no restructuring of services, and incorporates into its system of reimbursement to vendors no incentives for reducing or stabilizing costs.[144] Consequently, the absence of any cost-control, inflation, and the escalating cost of modern health care have all conspired to produce sharply rising program costs. The irony and injustice of this phenomenon is that these increases prevail despite state-imposed eligibility[145] and budgetary[146] restrictions that reduce the number of medically indigent served by the program. Besides bearing the stigma that attaches to participation in any form of public assistance,[147] recipients of Medicaid are further demeaned by unjustly incurring culpability for its rising costs.

If the experience of Medicaid demonstrates the futility of continuing the indiscriminate funding of the present health care system without regard for needed resources, personnel or reorganization, Medicare[148] demonstrates the inadequacy of coverage that can result, especially in a period of paradoxical recession/inflation, when budgetary retrenchments assume priority.[149] Although reimbursements to

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[142] 42 U.S.C. § 1396, a-g (Supp. IV, 1968).

[143] For analyses of Medicaid, see Stevens and Stevens, Medicaid: Anatomy of a Dilemma, 35 Law and Contemp. Prob. 348 (1970); Bernard and Feingold, The Impact of Medicaid, 1970 Wisc. L. Rev. 726; Heal Yourself, Report of the Citizens Board of Inquiry into Health Services for Americans 34-37 (1971).

[144] See Heal Yourself, Report of the Citizens Board of Inquiry into Health Services for Americans (1971):

> Merely to pump additional amounts of money into such a system, either through an insurance mechanism, Medicare or a welfare scheme, Medicaid is a basic abdication of government's social responsibility. A program that simply reimburses for services allows the providers to determine which services should be rendered and for whom. It delegates the power to providers to allocate federal money.

Id. at 35.

[145] In Massachusetts, for example, new eligibility requirements reduced the number of medically needy children by nearly half when 44,000 "cases" were dropped from the rolls in late 1969. The action resulted in state savings of 7 percent. Boston Globe, March 18, 1971, at 25, col. 1.

[146] The state of California recently attempted to reduce its public assistance and Medicaid bills by $740 million. N.Y. Times, March 16, 1971, at 23, col. 3.

In late April, 1971, the Commonwealth of Massachusetts stopped payments for 90 percent of its Medicaid services for fiscal 1971 due to exhaustion of funds. Unless a deficiency budget of $20 million is passed by the legislature, medical care for thousands of recipients will be severely jeopardized. Boston Globe, April 28, 1971, at 1, col. 1.

[147] For the quality of medical care occasionally afforded this class of persons, see notes 46-76 and accompanying text supra.

[148] 42 U.S.C. §§ 1395 a-*ll* (Supp. IV, 1968).

[149] See note 159 and accompanying text infra.

vendors under hospital insurance[150] increased from $2.5 billion in fiscal 1967 to $4.6 billion in 1969, and under supplementary medical insurance[151] increased from $668 million in 1967 to $1.6 billion in 1969,[152] significant disparities exist among the various states. For example, in fiscal 1969 the average hospital or extended-care facility reimbursement per enrollee ranged from $145 in Arkansas and $153 in Mississippi to $312 in Massachusetts and $314 in California.[153] Similarly, state supplementary medical insurance reimbursements to physicians in 1969 ranged from $54 in Iowa and South Dakota to $136 in California.[154] Although differences in the demographic composition of the elderly population and in the cost of hospital care, physicians' fees and other medical services in a given area may help to explain these discrepancies in the amount of reimbursement, differences in the availability and quality of such care and services are also substantially causative.[155]

The quality of care offered in nursing homes is a disturbing example. One congressional representative, disguised as an orderly, recently investigated nursing homes in the Washington, D.C. area and discovered criminal abuse of patients,[156] apparently not unrepresentative of the treatment found in many extended-care facilities elsewhere.[157] Profiteering owners (who often sell shares of stock in this new enterprise), lax federal and state licensing and regulation, and poorly trained, even callous, personnel have produced a character of care in some nursing homes that can be cited as more evidence of health brutality.[158] Unfortunately, a recessive economy is restricting the response of the federal government to the nursing and health care needs of the elderly to a proposed annual reduction of $350 million from Medicare.[159] However, it is submitted that because of noncovered

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150 42 U.S.C. §§ 1395c-i (Supp. IV, 1968).

151 42 U.S.C. §§ 1395j-w (Supp. IV. 1968).

152 Russell, Health Insurance for the Aged: Amounts Reimbursed, 33 Soc. Sec. Bull. No. 6, at 3 (1970).

153 Id. at 6.

154 Id. at 8.

155 Nationally, there was an average of 42.9 participating hospital beds per 1,000 enrollees, but among the individual states the disparity ranged from 31 to 102 beds. Health Insurance for the Aged: Participating Health Facilities, July, 1970, Health Insurance Statistics, Social Security Administration, Office of Research and Statistics, Jan. 15, 1971, at 16-17.

156 Pryor, Where We Put the Aged, 162 The New Republic, No. 17, at 15 (April 25, 1970).

157 Address by Rep. David Pryor before the National Council on Aging, Washington, D.C., March 30, 1971.

One bill, H. Res. 850, 91st Cong., 2d Sess. (1970), would have created a "Select Committee to Investigate the Care of Aged in the United States." As of March 30, 1971 the resolution still had not passed, evidence of the priority of concern both government and society give to the aged.

158 Id. See also note 68 and accompanying text supra.

159 N.Y. Times, April 3, 1971, at 30, col. 1.

services,[160] deductibles,[161] co-insurance[162] and premiums[163] of Medicare, what financial security the elderly now have would appear to be sufficiently attenuated without further increasing their burden of medical care costs.[164]

Affluent individuals excluded, the deteriorating condition of health insurance coverage[165] in the United States affects nearly all ages and classes, reserving its most threatening deprivation for the aged and the poor. Accordingly, fundamental assumptions about the substance of health care, its organization, delivery and financing are now urgently in need of an evolving redefinition. If this redefinition is to be implemented legislatively, continuing delay can only exacerbate the existing health care crisis.

## IV. S. 3: The Health Security Act

Any meaningful and effective health legislation enacted by Congress must take cognizance of the necessity for reform of the health care system itself. If legislation simply proposes increments of money and manpower, the deterioration of health services may be deferred, but it will not be arrested:

> There *is* a crisis in American health care. The intuition of the average citizen has foundation in fact. He senses the contradiction of increasing employment of health manpower and decreasing personal attention to patients. *The crisis, however, is not simply one of numbers.* . . . [I]f the additional personnel are employed in the present manner and within the present patterns and "systems" of care, they will not avert, or even perhaps alleviate, the crisis. *Unless we improve the system* through which health care is provided, care will continue to become less satisfactory, even though there are massive increases in cost and in numbers of health personnel . . . .

160 Until March 28, 1968, for example, out-patient hospital diagnostic services were covered under Part A, hospital insurance. Health Insurance for the Aged: Number of Persons Insured, July 1, 1969, Health Insurance Statistics, Social Security Administration, Office of Research and Statistics, Feb. 19, 1971, at 6.

161 42 U.S.C. §§ 1395e, *l*(b) (Supp. IV, 1968).

162 42 U.S.C. § 1395e (Supp. IV, 1968).

163 Effective July 1, 1971 premiums for Part B, supplementary medical insurance, rose to $5.60 per month, an increase of $2.60 per month from the program's inception. N.Y. Times, April 3, 1971, at 30, col. 1.

164 If Medicare cutbacks are finally approved, the period during which a beneficiary pays only the first day's cost, presently about $60, would be reduced from 60 to 15 days. Between the 16th and the 60th days, formerly cost-free, the patient would be billed one-eighth of the daily cost, about $7.50 per day, thus adversely affecting patients with medium or long-term illness. Furthermore, the $50 deductible of Part B could be increased in proportion to rises in physicians' fees. If physicians' fees increased 10 percent in a given period, the deductible would be adjusted accordingly. Id.

165 Underwriting losses of $600 million are estimated to have been incurred by health and accident insurers in 1970. Some carriers claim they are changing their policies to pay a flat weekly sum rather than the actual costs of the hospital stay. Under such a "hospital-indemnity" plan a hospitalized beneficiary would receive $100 to $200 regardless of

> [U]nless major changes are accomplished more quickly than has ever been possible in the past, a more serious "crisis" will be inevitable.[166]

It is submitted that S. 3, The Health Security Act of 1971,[167] is so far the only proposed legislation that can reform the present system of health services to provide adequate primary and acute health care without imposing a federal bureaucracy on the delivery of that care. In its declaration of purpose, the Health Security Act proposes

> through the operation of the system to effect modifications in the organization and methods of delivery of health services which will increase the availability and continuity of care, will enhance its quality, will emphasize the maintenance of health as well as the treatment of illness and, by improving the efficiency and the utilization of services and by strengthening professional and financial controls, will restrain the mounting cost of care while providing fair and reasonable compensation to those who furnish it.[168]

More accurately, the declaration should be termed one of purposes, if only because this multiplicity simply reflects the magnitude of the needs of the health care system. Substantial significance would then attach to the form of the operational mechanisms, whether required or incentive, to promote these purposes. These mechanisms would be ultimately successful only if they served to integrate health care into a unity whose diversity and responsiveness were preserved through regional and local health care planning.

### A. *Benefits and Coverage*

Under the Health Security Act,[169] every resident, nonresident citizen and alien[170] would be eligible for benefits covering all necessary physicians' services,[171] all inpatient and outpatient hospital, psychiatric,

his actual expenses. In many cases, this weekly payment would cover the costs for only one or two days of hospitalization. Wall Street Journal, March 10, 1971, at 36, col. 1.

166 Report of the National Advisory Commission on Health Manpower, Vol. 1 at 2-3 (1967) (emphasis in original).

167 S. 3, 92d Cong., 1st Sess. (1971) [hereinafter cited as Health Security Act].

168 Health Security Act § 2(b)(2).

169 The Act had been introduced initially as S. 4323, 91st Cong., 2d Sess. (1970).

170 Health Security Act, § 11. The two year interim between date of enactment and provision of covered benefits is stipulated in order to allow the present health care system to prepare itself for the program. 117 Cong. Rec. 90 (daily ed. Jan. 25, 1971) (remarks of Senator Kennedy).

171 Health Security Act § 22. Covered physicians' services would comprise both primary and specialized services. Nonemergency major surgery and other specialist services would be covered only when performed by a qualified specialist and generally only upon referral from a primary or family practitioner.

Ambulatory psychiatric services would also be covered for active preventive, diagnostic, therapeutic or rehabilitative services for emotional or mental disorders, if furnished by a comprehensive health organization, a hospital, or a community mental health center.

nursing home and home health agency services,[172] listed drugs,[173] and listed devices, aids and appliances.[174] The Act recognizes the necessity of supportive services for complete health maintenance and continuity of care. Accordingly, coverage is provided for psychological, physiotherapeutic, nutritional, social work and health educational services in a health institution or comprehensive health center.[175] Primary limitations attach to dental care,[176] skilled nursing home care,[177]

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If the patient consulted a solo practitioner, he would be limited to twenty consultations per benefit period.

[172] Health Security Act § 24.

[173] Health Security Act § 25. Drugs will be listed only if they have been reviewed and if they fulfill requirements of safety, efficacy and reasonable cost.

Public scrutiny of drug manufacture, a $3 billion a year industry, has been only sporadic. In early 1970, 45 to 50 marketable drugs were alleged to be ineffective or hazardous. See Health Council Hearings, supra note 130, at 25 (statement of Dr. Cornely).

[174] Health Security Act § 26. Therapeutic equipment, i.e., eye glasses, hearing aids and prosthetic devices, would be covered.

[175] Health Security Act § 27(b). The professional services of optometrists and podiatrists, the diagnostic services of independent pathology laboratories, the diagnostic and therapeutic services of independent radiology services, and ambulance or other emergency transportation would also be covered. Id. § 27.

The necessity for inclusion of these supportive services in a health care scheme, particularly mental health and social services, cannot be dismissed. One community health center concluded that nearly one out of every five of its patients in a recently representative period sought treatment for emotional conditions:

CONTENT OF CENTER PRACTICE, MARCH-JUNE 1970

| Percent of Consultation for Various Groups of Conditions | |
|---|---|
| Emotional | 19.1% |
| Respiratory | 17.0 |
| Preventative | 14.2 |
| Trauma and Muscular-skelatal Disorders | 11.5 |
| Dental Treatment | 6.1 |
| Dental Prevention | 6.0 |
| Cardiovascular | 4.5 |
| Endocrine | 3.9 |
| Obstetrics-Gynecology | 3.2 |
| Dermatology | 2.6 |
| Eye | 1.3 |
| Gastrointestinal | 1.0 |
| Genitourinary | 1.0 |
| Other | 9.0 |

Annual Progress Report of the Bunker Hill Health Center of the Massachusetts General Hospital, Boston, Massachusetts, at 3 (1970).

[176] Health Security Act § 23(b). On the effective date of benefits only those under fifteen years of age will qualify, but the covered age group will annually increase by two years until all persons under 25 are covered by the fifth year.

[177] Health Security Act § 24(c). Skilled nursing home care is limited to 120 days, unless the nursing home is owned or managed by a hospital, in which case the limit may be extended either for a specified period or indefinitely.

psychiatric care[178] and drug prescriptions.[179] Except for these limitations, the bill stipulates no premiums, deductibles, co-insurance, expense corridors,[180] waiting periods, cut-off points or other terms of restriction. The coverage provided by S. 3 differs substantially from that offered by the Nixon Administration's proposal[181] and by the Medicredit bill proposed by the American Medical Association.[182]

Under the Administration's proposal the only class of persons exempt from all the above coverage restrictions are those who qualify for a federally funded Family Health Insurance Plan[183]—families whose household head, either self-employed or unemployed, earns less than $3,000 annually. The chronic unemployed or underemployed individual, the indigent couple under sixty-five with no children, and the unemployed single child who no longer resides at home are all apparently excluded.[184] Those families whose income is between $3,000 and $5,000 per year are included in the Administration plan, but they are subject to graduated premium charges, deductibles and co-insurance, provisions designed to offer "an incentive for low-income families to improve their position."[185] All other families and individuals would receive coverage for physicians and hospital services, maternity care, well-baby care and immunizations, and laboratory services through the purchase of private insurance, the premiums for which are to be paid by employer-employee contributions.[186] Since each policy would be written by a voluntary insurer, deductibles and co-insurance would be inevitable features and could still attach substantial, even prohibitive, cost to low and moderate income persons visited by major or moderate illness or disability. Protection in the amount of up to $50,000 against catastrophic illness for each family member or individual is provided during the life of the policy,[187] but even this amount could be specious given the severity of some sickness and the cost of

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178 Health Security Act § 24(d). Psychiatric hospitalization is limited to 45 consecutive days of active treatment during a benefit period.

This limitation is designed to stimulate mental health institutions into providing optimal care and active treatment for a payment period. The fear that unlimited coverage might induce such institutions to maintain only fruitless custodial care is not unfounded. See notes 62-67 and accompanying text supra.

179 Health Security Act § 25(a), (c). Coverage of prescribed medicine would inure to those persons in a hospital or organized patient care program, or to those who have chronic diseases or need costly drug therapy.

180 For a definition of an expense corridor, see text accompanying note 196 infra.

181 Message from the President of the United States Relative to Building a National Health Strategy, H.R. Exec. Doc. No. 49, 92d Cong., 1st Sess. (1971).

182 H.R. 4960, 92d Cong., 1st Sess. (1971).

183 H.R. Exec. Doc. No. 49, supra note 181, at 16-17.

184 Id. at 14-17.

185 Id. at 17.

186 Id. at 15. During the first 2-½ years employees would contribute 35 percent and thereafter 25 percent to the cost of premiums.

187 Id.

treatment.[188] For example, in 1968 a kidney transplant cost $15,000[189] with subsequent home dialysis treatment adding a similar amount per year,[190] coverage for which the Administration proposal fails to provide.

The Medicredit bill offers similar coverage[191] under a "qualified health care insurance policy,"[192] purchased from a commercial insurer. This coverage also has restrictions, subjecting the holder to a $50 deductible for each hospital or extended-care facility stay,[193] and to co-insurance of twenty percent on the first $500 of the annual expenses incurred through hospital emergency room or outpatient services,[194] medical, dental and ambulance services.[195] Costs of catastrophic illness would be subject to an expense corridor of ten percent of taxable income not in excess of $4,000, fifteen percent between $4,000 and $7,000 and a substantial twenty percent in excess of $7,000.[196] Unlike the Administration proposal, Medicredit would permit both family heads and individuals whose income resulted in no tax liability to receive a health insurance certificate of entitlement[197] for the full payment of premiums on the qualified health care insurance policy. Otherwise, the holder of the policy could elect a credit against his income tax liability or a certificate of entitlement toward partial premium payment, the quantum of the credit and the value of the certificate both determined by the amount of the holder's income tax liability for a base year.[198] However, the proposed minimum credit of ten percent is afforded to all beneficiaries whose income tax liability is $891 or above.[199] By so failing to recognize within its tax credit structure the disparity of income levels that exists above a tax liabil-

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188 See, for example, Hearings on S. 4323 Before the Senate Comm. on Labor and Public Welfare, 91st Cong., 2d Sess., pt. 2, at 368-71 (1970). One family incurred medical expenses of $80,000 in a two year period.

189 Hearings on S.J. Res. 145 to establish a National Commission on Health, Science and Society, Before the Subcomm. on Government Research of the Senate Comm. on Government Operations, 90th Cong., 2d Sess. 20 (1968) (statement of Dr. Najarian).

In 1968 only 200 to 250 kidney transplants were performed in the United States. If funding and facilities were available, the lives of 8,000 to 15,000 persons who have renal disease could be saved each year. Id.

190 Id. See also N.Y. Times, Feb. 19, 1971, at 18, col. 3, for an account of a family whose dialysis (mechanical support of kidney purification) treatment, necessary for the remainder of his life, costs $1300 per month.

191 H.R. 4960, 92d Cong. 1st Sess. § 2009 (1971).

192 Id. § 2008.

193 Id. § 2010(a)(1).

194 Id. § 2010(a)(2).

195 Id. § 2010(a)(3).

196 Id. § 2010(b).

197 Id. §§ 2003, 2007.

198 Id. §§ 2004(a)(1), (a)(2).

199 Id. § 2004(f).

If the holder of the policy has an income tax liability of $1 to $10, then he is allowed, according to a graduated scale, a tax credit of 99 percent of his premium payment or a certificate of entitlement of equal value. If his tax liability is from $491 to $500, then the credit or certificate is 50 percent. Significantly, if the tax liability is $891 or any sum above that, the credit or value of the certificate is 10 percent.

ity of $891, the bill would impose a clear inequity upon moderate income families and individuals.[200] Prescinding from the question of tax inequity and possible claims of enforced subsidization of commercial carriers, the potential beneficiaries of both the Administration proposal and Medicredit could foreseeably be unwilling to accept partial coverage and limited benefits as the fulfillment of a reformed system of health care.

### B. *Administration and Structure Under S. 3*

The Health Security Act would be administered by a full-time Health Security Board,[201] its five members to be appointed by the President with the advice and consent of the Senate, and to serve under the Secretary of Health, Education and Welfare. The Board would be assisted in the development and evaluation of policy, standards and regulations by a Health Security Advisory Council[202] composed of twenty-one members, a majority of whom must be consumers of health services. Decentralization of administration would be effected through the existing regional offices of HEW, subregional health service areas and local health security offices.[203] Advisory community participation in administration would be promoted through appointment of consumer-dominated regional or local councils.[204] Professional and technical advice regarding services, payments and evaluations would derive from appointment of standing committees of experts from the health professions, medical educational institutions, providers of services and other sources of technological counsel.[205]

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[200] See Int. Rev. Code of 1954, § 1, as amended, Pub. L. 91-172, § 803(a) (1969).

Effective for taxable years beginning after December 31, 1970, married individuals filing joint returns showing taxable income of more than $4,000, but not in excess of $8,000, will pay a tax of $620 plus 19 percent of excess over $4,000. Heads of households claiming taxable income of more than $4,000, but not more than $6,000, will pay a tax of $660 plus 19 percent of excess over $4,000. Unmarried individuals claiming taxable income of more than $4,000, but less than $6,000, will pay a tax of $690 plus 21 percent in excess of $4,000.

Accordingly, the beneficiary whose taxable income is in the $7,000-$9,000 range would be allowed the same credit as the beneficiary whose taxable income is in the $70,000 or $700,000 range.

[201] Health Security Act § 121. No more than three of the five Board members may belong to the same political party.

[202] Health Security Act § 125. In its advisory capacity of recommending administrative or statutory changes, the Advisory Council would be required to submit to the Board annual reports of its recommendations and performance of its functions. The Board would then transmit this report to Congress with its own explanatory report on unimplemented administrative recommendations.

[203] Health Security Act § 124. At present there are 10 regional offices of HEW. Each health service area would comprise a state, part of a state, or an interstate area if the latter were more administratively expeditious or if the concentration of population so required.

The primary function of local offices would be to receive and investigate beneficiary and provider complaints regarding administration.

[204] Health Security Act § 126.

[205] Health Security Act § 127.

Participation in the program by all health care providers would be contingent upon adherence to standards established by the Board and upon agreement to provide services without discrimination, to charge no fees to patients for covered services, and to disclose data for utilization review, statistical studies and payment verification.[206] Once participating, all providers of services would still retain their private or community status. There would be no federal ownership of facilities or employment of personnel, a situation that has been erroneously cited as a component of national health insurance, but whose actuality would be rightfully disturbing.

Professional practitioners who were state-licensed after the program began would be required to meet national standards promulgated by the Board.[207] Participating hospitals would also be obligated to fulfill requirements established by the Board.[208] Nursing homes would be required to have a transfer agreement with at least one participating hospital or comprehensive health service organization and an affiliation

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[206] Health Security Act § 41.

[207] Health Security Act § 42. Physicians and other professional practitioners state-licensed before the effective date of enactment would be qualified providers of services in their respective states. They would be required to meet national standards if they located their practice in another state after enactment.

All practitioners would have to fulfill requirements for continuing education. The voluntary National Board of Medical Examiners has been instrumental in producing consistency in these state examinations, so that such national standards would not be an attempt at federal licensure, but rather would seem to go to establishing minimum standards, if only for the promotion of health personnel mobility among the states. What is really at issue here is the duration of licensure. Given rapid advances in medical science, it would seem that some form of continuing education is necessary for professional practitioners to maintain a quality of care consistent with these advances, and thus to merit their licensure.

Not later than two years after the date of enactment, the Health Security Board would establish requirements for continuing education, after discretionary consultation with professional organizations. A practitioner failing to meet a requirement after notice and a reasonable opportunity to correct the deficiency would cease to be a qualified provider.

Similarly, a physician would not be qualified to perform major surgery as a covered service or to provide specialized services unless he were a board-certified or board-eligible physician, or unless the circumstances were of an emergency nature. However, a physician could be found qualified to furnish specialized services as covered if he performed these as a specialist or if they constituted a substantial part of his practice. Moreover, he would have to meet standards established by the Board and be recommended by a participating hospital where appropriate.

[208] Health Security Act §§ 43, 44. Presently, hospitals are evaluated and accredited by the provider-oriented Joint Commission on Accreditation of Hospitals, a condition that has given rise to charges of conflict of interest. See Hearings on S. 2898 Before the Subcomm. on Executive Reorganization and Government Research of the Senate Comm. on Government Operations, 91st Cong., 2d Sess., 9 (1970) (statement of Dr. Breslow).

Conditions of participation for hospitals would include a requirement that every patient be under the care of a physician, that the institution provide twenty-four hour registered nursing services and that it establish a pharmacy and drug therapeutics committee for supervision of therapy. Id.

Psychiatric hospitals would have to meet the standards for hospitals and also provide active, noncustodial treatment for its patients.

agreement within two years.[209] Such conditions of participation presumably would produce a continuity of care and a scrutiny of such facilities that would terminate exploitation of the elderly.[210] Participation by home health agencies would be limited to public or nonproprietary private agencies,[211] but within two years after the date health benefits commence they would be required to form an affiliation agreement with a participating hospital or comprehensive health service agency.[212] Pursuant to agreement with the Board, miscellaneous health organizations, such as hospital-affiliated satellite centers, public or private nonprofit mental health agencies, nonprofit health prepayment or insurance organizations, and state or local public health agencies, could also qualify.[213] The Act especially encourages[214] under a diversity of organizational forms[215] participation by the prototypal structure for the delivery of ambulatory care, the comprehensive health service organization.[216] One benefit of participation inuring both to professional practitioners who satisfy state and national standards and to the comprehensive health care center would be the authorization of medical personnel to furnish their services in any state.[217]

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[209] Health Security Act §§ 45, 52(a), (b). Conditions for the participation of nursing homes would include a requirement that the health care of every patient be under the supervision of a physician, that they provide twenty-four hour nursing services with at least one full-time registered nurse and that they conform to the fire safety code of the state or the National Fire Protection Association.

A transfer agreement would provide for the transfer of patients and medical data between institutions.

An affiliation agreement would provide for the furnishing and assumption of responsibility for professional services in the nursing home.

[210] See text accompanying notes 156-57 supra.

[211] Health Security Act § 46.

[212] Health Security Act § 52(b).

[213] Health Security Act § 49(a).

[214] For the incentives provided by the Act for the planning and construction of these facilities, see text accompanying notes 273-76 infra.

[215] Health Security Act § 47. The comprehensive health service organization seeks to provide an enrolled population with preventive and diagnostic health services through prepaid group practice. Accordingly, in order to improve methods of delivery, the bill assumes a posture of receptivity to experimentation with new plans and to expansion of more familiar ones. Existing prepaid group practice plans like Kaiser-Permante, professional foundations sponsored by city, county or state medical or dental societies, community health centers, satellite health centers of a hospital, public or nonprofit mental health centers, state or municipal public health agencies, nonprofit health prepayment or insurance organizations, and private medical or dental group practices would come within the scope of the Act. Even a nonrural practice, i.e., a mobile health services van adaptable for rural areas, could conceivably fall within the intent and purpose of the Act.

For an exhaustive analysis of the organizational forms of prepaid group practice plans, their respective merits and how national health insurance could expedite them, see Comment, 84 Harv. L. Rev. 887 (1971).

[216] For an analysis of the development of these organizations and the health maintenance role they can assume, see Kissick, Health-Policy Directions for the 1970's, 282 New Eng. J. of Med. 1343 (1970).

[217] The Health Security Act of 1971 § 56, S. 3, 92d Cong., 1st Sess. (1971) [here-

Presumably, such authorization would preempt state laws that restrict health personnel mobility or inhibit the establishment of group practices.[218]

Unlike the Administration plan and the Medicredit bill, which substantially predicate their proposals for health insurance upon the existing system of erratically regulated delivery[219] and private insurance,[220] the Health Security Act contains several provisions that promote quality of care and efficient utilization of resources. Of critical importance in such quality control of health care is not only the formulation of national standards for both institutions[221] and independent providers,[222] but also the proposed establishment of periodic utilization reviews by the hospitals themselves.[223] Furthermore, in view of the

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inafter cited as Health Security Act]. Similar authority would be granted to nurses and ancillary health personnel. Id. § 56(a) (1)-(3).

The Health Security Board would thus be enabled to allow professional practitioners in participating hospitals and comprehensive health service organizations to employ paraprofessionals under their supervision and responsibility. If there were general acceptance by patients of physicians' assistants, the family physician would be freed from routine testing to devote more time to those medical procedures, judgments and personal relationships which only he can offer.

[218] For precedents of congressional preemption through the Supremacy Clause, U.S. Const. art. 6, cl. 2, see Ivanhoe Irrigation District v. McCracken, 357 U.S. 275, 295 (1958); King v. Smith, 392 U.S. 309, 333 n.34 (1968).

[219] Medicredit does propose the establishment of an 11-member Health Insurance Advisory Board to prescribe regulations, and to formulate minimum federal standards for the use of state insurance commissions in determining what constitutes a qualified health insurance plan. The Board would also consult with carriers, providers of services and consumers to

> plan and develop programs whose purposes are to provide for maintaining the quality of medical care, and the effective utilization of available financial resources, health manpower, and facilities, through utilization review, peer review, and other means which provide for the participation of the insurance carriers and the providers of services . . . .

H.R. 4960, 92d Cong., 1st Sess. §§ 2020-21 (1971).

Given this inclusion of commercial insurance carriers, whose interest could ultimately be grounded in net profits, there is a substantial question as to whether utilization review under such a system would be vitiated.

[220] The Administration plan posits the necessity of the health insurance "industry" and alleges that its virtual elimination "would deny people the right to choose how they will pay for their care." H.R. Exec. Doc. No. 49, 92d Cong., 1st Sess., at 18.

This assertion would appear to beg the questions of whether people believe quality health care can and should be insured privately, and whether they are willing to subordinate an arguable right to health care to the right to choice in payment of that care.

[221] Health Security Act §§ 43-44.

[222] Health Security Act § 42.

[223] Health Security Act § 51. Uniformity of utilization review, already common in many hospitals, would presumably derive from this provision. A review plan would be sufficient for a hospital if it provided for the periodic review of admissions, their duration and professional services furnished, thereby evidencing their medical necessity and the efficient use of resources and facilities. Such review would be submitted periodically to the institution, its medical staff and to the Health Security Board when requested. Since the prospect of any centralized federal inspection would generate substantial suspicion on the part of hospitals and their staff, the form of utilization review of records most acceptable would probably be one conducted jointly by institutional representatives and

suspicion that there is excessive surgery being performed in the United States,[224] national regulations would exclude from covered services "specified procedures, when not required by life-threatening or other acute emergencies, which have not been preceded by consultation with, and recommendation of surgery by, such appropriately qualified specialists as may be required by the regulations."[225] Services of a professional practitioner would be excluded from coverage if furnished in a nonparticipating hospital.[226] This exclusionary provision would presumably have the dual purpose of inducing hospitals to participate and comply with national standards,[227] and of discouraging physicians from admitting patients to such hospitals. In formulating national standards the Health Security Board would take into consideration standards of professional associations, and could "require the revision of a provider's staffing patterns, or its standards for the selection or retention of professional or other personnel, which fail to meet standards or criteria established or recommended by such an association or organization."[228] The Health Security Board would also contract with state health agencies to allow them to determine whether providers of services comply with standards[229] and whether there exists co-ordinated availability of services in a given area.[230]

An important safeguard in the Act intended to protect against the Board's arbitrary or capricious exercise of discretion in making determinations is the right to seek administrative and judicial appeal. Pursuant to regulations, the Board would determine those entitled to benefits, those who may participate as providers, the composition of covered services, and the amount of compensation due providers.[231] However, provision is made for aggrieved providers and other persons to pursue an administrative remedy. If a participating professional practitioner in a substantial number of cases performed services medically unwarranted and for which payment was claimed; furnished services whose quality was inferior to recognized standards of care;

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local federal health representatives. The review proposed by the bill would be made by a staff committee of the hospital composed of two or more physicians, or composed of a group established by the hospitals and the local medical society. Id. §§ 51(a), (b).

Review of skilled nursing home care would also be made by a group so constituted, or by a state or local public health agency under contract with the Health Security Board.

224 See notes 130-31 and accompanying text supra.

225 Health Security Act § 28(h).

226 Health Security Act § 28(g).

227 The existence of national standards would perhaps preclude litigation against hospitals. See text at notes 48-67 supra.

228 Health Security Act § 54.

229 Health Security Act § 128(b).

230 Health Security Act § 128(c). In the areas of environmental health, licensure and inspection, and health education, the Health Security Board is required to consult with state health agencies for coordination of their activity and the administration of the Act. Id. § 218(a).

231 Health Security Act § 132(a).

neglected to furnish necessary services to eligible persons; or breached any of the provisions, regulations or agreements, the Board would submit such evidence to an "appropriate professional organization" for recommended action.[232] If the Board determined that the health of eligible persons were endangered, it could elect to terminate or suspend the provider's participation, effective immediately.[233] A fair hearing could then be requested before a hearing officer or panel of the Board, whose determination could be appealed to a Board-established national tribunal or to an intermediate regional tribunal.[234] Of significance to professional providers is the provision that a substantive issue of professional practice or procedure would be heard and adjudicated in the presence of one or more members of an appropriate health profession.[235] Such peer review by one professional is obviously better than none. However, it is submitted that greater equity would inhere in the practice of adjudicating issues of professional conduct before a tribunal composed of several professional peers, whose unanimous decision would carry greater weight than that of one man. The concluding procedural safeguard subsequent to a final decision of the Board would be judicial review, exclusive of issues of professional practice or conduct, and obtainable in any federal district court.[236]

In order to facilitate optional utilization of services in a given area, to provide services where they are deficient, and to consolidate them where they are duplicative, the Health Security Board would be authorized to issue directives requiring institutions to discontinue for purposes of payment one or more services.[237] It could also initiate one or more services presently unavailable in a given area and enter into agreements with other providers for the transfer of patients and medical records, the exchange of data and skills, and the co-ordination of services in the best interests of the health area.[238] Of crucial importance for decentralized but integrated health services planning is the statutory mandate that no such directive could be issued "except on the recommendation of, or after consultation with, the State health planning agency . . ."[239] and until notice of the proposed directive and its rationale have been published in the health service area.[240] Issuance of the directive could be appealed by the provider, by a health planning agency, by professional practitioners, or by residents at a public hearing convened by the Board, at which evidence would be presented

[232] Health Security Act §§ 132(b), (c).
[233] Health Security Act § 132(e).
[234] Health Security Act § 133(a).
[235] Health Security Act § 133(b).
[236] Health Security Act § 133(c)(1).
[237] Health Security Act § 134(a)(1).
[238] Health Security Act §§ 134(a)(2), (4).
[239] Health Security Act § 134(c).
[240] Health Security Act § 134(d)(1).

and argument heard by both parties.[241] The determination of the panel which heard institutional providers would also be subject to judicial review.[242] Through such co-ordinated review by the Board and the local health planning agency, wasteful and unreasonable costs could be reduced, inefficient practices and replication of facilities eliminated, and local monitoring of services effected in each health delivery area.

### C. *Cost and Financing*

It has been estimated that in fiscal 1970 $41 billion, or seventy percent of all personal health care expenditures in the United States, was expended for health care benefits that would have been covered by the Health Security Act had it been in effect.[243] Private health insurance payments and private out-of-pocket payments contributed $30 billion, expenditures by the government for personal health care totalled $8 billion, and state and local governments contributed $3 billion.[244] This Health Security cost estimate for 1970 would therefore have represented no new additional expenditures, but rather a theoretical redistribution of these payments for health coverage which would have provided comprehensive care to all persons. One incident of this redistribution, beneficial to fiscally troubled municipalities[245] and states, would have been the relief provided by federal absorption of $3 billion expended by state and local governments—the cost of Medicaid, public assistance and local medical programs.

Through no fault of its own, however, the Health Security Act does not submit to accurate cost analysis and projection. Since the program will have inherited a system of health care formed by patterns of inefficiency and disorganization, delays in implementation will probably increase its initial costs.[246] The universality of coverage, the emphasis on primary care, and the early diagnosis and treatment of sickness that would have been ignored or tolerated by the patient in the absence of such insurance could also contribute to considerable initial costs. Obversely, this preventive care and early diagnosis would soon begin to decrease the incidence and cost of acute illness. The restructuring of the methods of delivery would also eliminate costly inefficiency and replication of services. Although these factors may combine to prevent precise cost projections, at least in the first years of Health Security the cost of comprehensive health care would probably not exceed the cost of the partial coverage and incomplete benefits available under the present inflationary system. Beyond this

241 Health Security Act § 134(d)(2).

242 Health Security Act § 134(d)(2).

243 117 Cong. Rec. 91-92 (daily ed. Jan. 25, 1971) (remarks of Senator Kennedy).

244 Id. at 92.

245 See text at notes 48-54 supra.

246 See note 13 and accompanying text supra for projections of national health expenditures in 1975 and 1980.

analysis the more fundamental question will most likely not concern costcontrol, because quality health care will continue to be justifiably expensive even when inefficiency is reduced. Rather, the issue will be the amount of resources and manpower the electorate and its government are willing to transfer from other areas to commit to the advancement of medical technology[247] and to a comprehensive program of universal health care.

Under the Act the cost of Health Security would be financed through the establishment of a trust fund[248] similar to the Federal Hospital Insurance Trust Fund of the Social Security Act, which S. 3 would amend.[249] The fund itself would be generated from the following sources:

1. a tax[250] on individual income equal to one percent of wages not exceeding a wage contribution base of $15,000;[251]
2. a tax[252] on the payroll of every employer equal to three and one-half percent of paid wages;
3. a tax of two and one-half percent on self-employment income;[253]
4. a tax of one percent on unearned income exceeding $400;[254] and
5. general tax revenues.[255]

Of the total funding, fifty percent would be derived from federal tax revenues, thirty-six percent from employer payrolls, twelve percent from employee wages and unearned income, and two percent from self-employment income.[256] The use of payroll taxes for financing the trust fund raises numerous substantive issues of tax equity not within the scope of this comment.[257] In brief, however, it is submitted that

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247 See M. Crichton, note 2 and accompanying text supra, and cancer research discussion, notes 117-26 supra.

248 Health Security Act § 61.

249 42 U.S.C. § 401 (1964).

250 Health Security Act § 201(a), amending Int. Rev. Code of 1954, § 3101(b) (hospital insurance tax on employees).

251 Health Security Act § 201(c), amending Int. Rev. Code of 1954, § 3121 (definitions applicable to Social Security payroll taxes).

252 Health Security Act § 201(b), amending Int. Rev. Code of 1954, § 3111(b) (hospital insurance tax on employers).

253 Health Security Act § 211(a), amending Int. Rev. Code of 1954, § 1401(b) (hospital insurance tax on the self-employed).

254 Health Security Act § 212, superseding Int. Rev. Code of 1954, § 1403, to be redesignated as § 1404.

255 Health Security Act § 61(a).

256 117 Cong. Rec. 91 (daily ed. Jan. 25, 1971) (remarks of Senator Kennedy).

257 For an analysis of the merits of direct federal expenditures as opposed to use of the tax system, see Surrey, Tax Incentives As a Device for Implementing Government Policy: A Comparison With Direct Government Expenditures, 83 Harv. L. Rev. 705 (1970); McDaniel, Alternatives to Utilization of the Federal Income Tax System to Meet Social Problems, 11 B.C. Ind. & Com. L. Rev. 867 (1970).

For a criticism of payroll taxes and how they affect the social security programs of

total funding from general tax revenues would obviate problems of inequity, but this method of financing appears unlikely until other national preoccupations are resolved.

D. *Budgetary Allocations, Provider Compensation and Incentives*

In order to impose some measure of cost control and to preclude cost escalation caused by continual fund-tapping, the budget available for a given fiscal year would be predetermined. Accordingly, the maximum amount to be obligated in a given year could not exceed the net receipts from the imposed taxes augmented by equal funding from the general revenue; and it could not exceed the aggregate obligations incurred during the fiscal year when the determination is made.[258] Regional allocations would be similarly predetermined, the amounts to equal the estimated aggregate expenditures for covered services in the most recent twelve month period.[259] The Health Security Board would take notice of regional differences in population, the incidence of morbidity and morality, and the availability of personnel and facilities in modifying allocations. Disparate per capita expenditures could then be equalized not only in these regions[260] but also in health service areas[261] and among categories of covered services.[262] In this manner the financing mechanism, instead of perpetuating regional disparity of expenditures through indiscriminate funding, could be used to stimulate an increase, over a period of time, in the availability and utilization of services and facilities in rural or inner-city areas where the average per capita cost is lower than the national average.

Compensation under the Health Security Act would be made directly to the individual provider, but the independent professional practitioner would still retain freedom to elect his preferred method of payment. He could request compensation by fee-for-service, the payment for each covered service to be determined by relative value

old-age, survivors, disability and hospital insurance (OASDHI), see J. Pechman, Federal Tax Policy 173 (1971).

> The impact of this payroll tax is especially significant for low income persons: In 1971, the federal payroll tax for OASDHI purposes will be the highest tax paid by at least half of the nation's income recipients (assuming backward shifting of the employer tax), and $1.5 billion will be paid by persons officially classified as living below poverty levels.

Id. at 175. See also Brazer, The Federal Income Tax and the Poor: Where Do We Go From Here?, 57 Calif. L. Rev. 422 (1969).

258 Health Security Act § 62. The amount available for obligations may be modified if the Secretary of the Treasury finds that expected tax receipts will differ by one percent or more from the estimate; or if the cost of administration will differ from the estimate by five percent or more; or if a disaster, epidemic or other contingency compels higher expenditures. Id. § 62(c). See 117 Cong. Rec. 111-12 (daily ed. Jan. 25, 1971) (remarks of Senator Kennedy).

259 Health Security Act § 64(a).

260 Health Security Act § 64(b).

261 Health Security Act § 66(b).

262 Health Security Act § 65(a).

scales prescribed by the Board after consultation with the respective health professions.[263] The physician who is an independent practitioner engaged in general or family medicine would be entitled to an annual capitation payment for each health area resident served if he furnished complete primary services, maintained arrangements for specialist or institutional referral, and kept records of services provided.[264] Through operation of the capitation payment method those family physicians not in group practice presumably would be encouraged to move beyond fee-for-service practices and to provide nonepisodic, continuing care to their patients if they were not in fact already doing so. If new methods of provider reimbursement were to be proposed, the Health Security Board could enter into agreements with a state or local professional society, representative of independent practitioners, to substitute these alternate modes of compensation on an experimental or demonstration basis.[265]

Participating institutional providers would be paid their approved operating budgets, determined in advance through consultation with their representatives in health service areas and through local health services planning. Such planning could then co-ordinate services in a health area and provide for institution of deficient services and needed expansion of facilities.[266] Comprehensive health service organizations would be compensated for covered services on the basis of a capitation amount multiplied by the number of eligible persons enrolled.[267] From a regional allocation, funds would then be categorized for payment of institutional providers and practitioners receiving stipends, and the balance would be apportioned to determine per capita expenditure for each covered service. For example, if the per capita expenditure for covered services of a physician were $65 in a community of 100,000 persons, one-fourth of whom were enrolled in comprehensive health organizations, the latter providers would receive $1,625,000 ($65 × 25,000) for physician services. If the remaining 75,000 persons opted for the services of solo, fee-for-service physicians, then these providers would receive compensation from a fund of $4,875,000 (65 × 75,000).[268]

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[263] Health Security Act §§ 82(a), (g). The Board could also delegate that fee-for-service payments and per session amounts be paid to a professional society or to an agency designated by representatives of a profession in the area.

[264] Health Security Act §§ 84(b), (d).

[265] Health Security Act § 82(h).

[266] Health Security Act §§ 83(a), (d). Physicians and other professional medical personnel whose services are provided through a hospital or institution would receive compensation from the allocated budget, thereby foreclosing independent billing by physicians. Health Security Act § 83(c).

[267] Health Security Act §§ 87(a), (b).

[268] 117 Cong. Rec. 112 (daily ed. Jan. 25, 1971) (remarks of Senator Kennedy). The fund for fee-for-service would be further increased if nonresidents were furnished services on a fee basis, and to the extent that some capitation payments would be lower because covering only primary services. Appropriate adjustment would also be made for age distribution and other relevant factors. Health Security Act §§ 82(g)(2), (3).

The incentive of guaranteed capitation payments to general practitioners not disposed to participate in group practice or unable to join one is a first step away from fee-for-service or symptomatic treatment and toward preventive care. However, it alone could probably not move the present health system to organized patterns of comprehensive care. Unless the development and growth of group practice, with its co-ordinated battery of primary and specialist physicians, diagnostic equipment and laboratory services, is stimulated, an organized system of comprehensive care will be difficult to achieve. Since private groups have often been discouraged from attempting to operate prepaid group practice plans due to the problems of attracting physicians and acquiring sufficient capital from the private sector, the Health Security Act would employ its financing mechanism as a stimulus to encourage the growth of these comprehensive health care structures.

Collaborating with state comprehensive health planning agencies[269] and with other regional health planning programs, the Secretary of HEW could direct that funds from a Health Resources Account[270] be used to assist in the development and expansion of comprehensive health service organizations and in the recruitment of professional and ancillary health personnel to staff them,[271] particularly in those rural and urban areas where critical shortages and maldistribution exist.[272] Incentives would be offered to public and private nonprofit health organizations in the form of grants not exceeding ninety percent of planning costs for new organizations[273] and eighty percent for the expansion of existing ones.[274] Low-interest loans to defray ninety percent of new construction costs and eighty percent of expansion costs would also be offered.[275] The underwriting of all or part of any reasonable operating deficit for the first five years[276] should encourage the

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[269] Health Security Act §§ 102(a), (b). This section would amend the Public Health Service Act to extend authorized appropriations for state and local planning until 1978. By strengthening the role of the states in coordinating health planning efforts in a given area, the Health Security Act recognizes that this responsibility should rest with the states rather than with the federal government.

[270] Health Security Act § 63(b). During the fiscal year following enactment this account would represent two percent of the general account and would increase to five percent six years thereafter.

[271] Health Security Act § 103(a).

[272] It has been estimated that if 2,000 new group practice programs could be developed in the next five years with an average staff of twenty physicians assisted by paraprofessionals, sixty million persons could be served. The same 40,000 physicians in solo practice could serve only half that population. Why Health Security, Committee for National Health Insurance, Washington, D.C. at 12 (1970).

[273] Under present funding and planning arrangements, one model community health center required nearly 3 years of planning. Interview with Dr. John P. Connelly, Executive Director, Bunker Hill Health Center of the Massachusetts General Hospital, in Boston, Massachusetts, May 4, 1971.

[274] Health Security Act §§ 104(a), (b).

[275] Health Security Act § 104(c).

[276] Health Security Act § 104(d).

expansion of these organizations, since such deficits have frequently discouraged their growth. Given the substantial planning, construction and operating costs, these incentives would have to be considerably greater than the $23 million in planning grants and the $300 million in construction and deficit loan guarantees offered by the Administration bill[277] if these organizations are to increase in number.

The Health Resources Account would also be used to support programs for the recruitment, education and training of health personnel, thereby avoiding the congressional system of unpredictable appropriations and the sometimes surgical review by the Bureau of the Budget. The Board could provide stipends, either directly to individuals or to educational institutions under contract, for the training of physicians and medical students in family practice or for any other medical specialty where a shortage of practitioners exists.[278] Education and training for other classes of needed professional and paraprofessional health personnel, including new categories such as community health liaisons between area residents and health organizations, would also be provided, especially if other federal assistance were unavailable or insufficient.[279] For those persons disadvantaged by poverty or race, stipends would be available, either directly or to institutions, for health training as well as for remedial and supplementary education preparatory to or concurrent with that training.[280] As recognition of the necessity of sound hospital administration, the Board could also undertake to recruit and train physicians to serve as hospital medical directors.[281]

One incentive merits special attention, if only because what it hopes to produce is probably beyond monetary attraction. In order to remedy the maldistribution of physicians caused by a disproportionate concentration in metropolitan and suburban areas, the Health Security Board would attempt to recruit and train professional practitioners who would agree to move to medically deprived rural and urban areas and practice in comprehensive health organizations or community health centers.[282] A physician who agreed to so practice for at least five years, and who initiated his practice before the effective date of health coverage, would be paid until that date a stipend supplementing his normal income.[283] Thereafter, compensation could continue in the form of a "full-time or part-time stipend in lieu of or as a supple-

[277] Message of the President of the United States Relative to Building a National Health Strategy, H.R. Exec. Doc. No. 49, 92d Cong., 1st Sess. 6 (1971).

[278] Health Security Act §§ 105(b), (e). A physician could also be reimbursed for special costs of required, continuing education. Health Security Act § 82(c).

[279] Health Security Act §§ 105(c), (d). If other assistance were available but inadequate for such education, the Health Security Board, with the approval of the Secretary of HEW, could provide for such education pending action by Congress on a recommendation to increase appropriations.

[280] Health Security Act § 105(h).

[281] Health Security Act § 105(g).

[282] Health Security Act § 105(f).

[283] Health Security Act § 105(f).

ment"[284] to the normal methods of compensation. Just how many physicians in established practices in areas of concentration would be so enticed to move elsewhere, even temporarily, is conjectural. Such an incentive would seem more likely to attract young medical graduates for whom mobility poses no problem. But since they also could commence upon a practice that would be well-salaried without the income provided by this incentive, it is problematical whether their motivation to practice in such deprived areas would be monetarily grounded. Ultimately, this provision appears to be not an incentive at all, but rather an appeal to altruism, a quality whose essence is not amenable to legislative lure, but whose presence is indispensable to universal quality health care.

## CONCLUSION

The American health care crisis is a complexity of escalating expenditures for services, a shortage and maldistribution of physicians, episodes of marginal care, inadequate insurance coverage and unbridled premium costs, and a federal response devoid of effective organization or objective. If the inverse phenomenon of rising costs and diminishing services is becoming more acute, its increasing visibility is at least compelling a re-evaluation of both what the substance of health care should be and what form it should assume in a technological society exceeding 200 million persons.

In such a re-evaluation any new proposed system of financing must serve not only to fund health services but also to promote a co-ordinated system of delivery of primary and acute care. Otherwise, escalating costs will only imperil an already precarious health care structure by imposing upon it an increasing demand for expanded patient services that it is unable to supply. If this financing mechanism is so crucial to the reorganization of the health care system, it is doubtful that a multiplicity of commercial insurance carriers should be entrusted with its operation, prescinding from their history of offering partial health insurance coverage, encouraging hospitalization, disparaging ambulatory care, and incurring substantial administrative costs. It is equally dubious that the alternative should be an operational assumption of the financial mechanism by the federal government that would convert health care into a bureaucracy and its professional personnel into civil sevants.

The submission of this comment has been that, of all the legislative health care proposals, only the Health Security Act, by providing universal and comprehensive coverage of primary and acute care simultaneous with modifications in the health system, can avert the foregoing dilemma. Through regional health planning, utilization review and standards of participation for all providers, a nationally coherent but decentralized health care policy could emerge, integrating in an orderly process presently fragmented programs and inefficient

[284] Health Security Act § 82(c).

services. One particularly compelling provision of the Act is the incentive for the development and expansion of the comprehensive health services organization, the prototypal instrumentality for making health maintenance optimally accessible. Projected costs of Health Security do not lend themselves to easy analysis, but it is submitted that the delivery of superior comprehensive health care will not be inexpensive. Eventually, more of its funding will have to derive from the general revenue, a phenomenon that seems doubtful until the nation's priorities are reordered.

Given the vagaries of the legislative process, ultimate enactment of the Health Security Act may unfortunately be conditioned by partisan compromise. It can only be hoped that the health of the people, posited and protected in the Act, would transcend any such political maneuvering. But whatever the precise form the legislation may assume, it is imperative that it create a system of universal and comprehensive health care that would remain dynamic, experimental and responsive to all the people it serves.

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