

# Proposals for National Health Insurance in the USA: Origins and Evolution, and Some Perceptions for the Future

I. S. FALK

## I. Origins

What we now debate in the U.S.A. as the needed development of national health insurance had its roots in centuries past—back at least to the Middle Ages and before, in Europe and elsewhere. In earlier times, responsibility for providing care for the sick and injured rested on the family, the neighbors, on the church, often on the king for his people, on the master for his servants, on the employer for his employees. With the beginning of the industrial revolution in Europe, first the journeymen's guilds and then the labor unions and the emerging socialist political parties assumed roles to provide for their members. Most governments only supplemented those provisions through public authority and funds.

While in many countries the provisions continued to rest on voluntary activities, the inadequacies of private systems led in some countries to increasing government intervention, including compulsory provisions for the group payment of the costs. On a national scale this happened first in Germany in 1883 as a political move by Prince Bismarck to check the growth of socialist parties, and many other countries followed suit. In recent years, nearly all developed countries (and many under-developed, also) that had been relying on private and voluntary provisions found them inadequate and moved to public and compulsory systems—in the patterns of social insurance or of national health services. This trend accelerated as earlier concern with the assurance of personal health services had to become, increasingly, at first inter-related and then commingled with community health services for societal protections and for prevention of disease and disability (Int. Labour Office, 1927; Frankel and Dawson, 1910; Rubinow, 1913; Falk, 1936; Shryock, 1947).

### *Early USA developments*

In the USA we had from our Colonial years governmental provisions for protection of society against common risks (as for epidemic disease), and as an inheritance from the Elizabethan “poor laws,” the provision by local government for the essential needs of the poor and destitute. In addition we had the supports provided by religious and other charitable agencies and by early labor unions, and the self-help assurances of fraternal societies, lodges, and clubs organized here by immigrant groups from Europe (Int. Labour Office, 1927). Thus, we have a long history of both governmental and private protections against the risks and costs of illness and disability, including reliance on prepayment plans among both urban dwellers and people in geographically isolated industries, for example, mining, lumbering, and so on (Williams, 1932).

The first major involvement of our *national* government in the provision of medical care for civilians arose out of a specific need of emerging national importance, almost immediately after our birth as a nation, for the health and safety of our merchant seamen. It began with the Marine Hospital Service Act in 1798, to provide for the temporary relief and maintenance of sick or disabled seamen and was financed by a charge of 20 cents per month on all seamen, mainly to pay for care in marine hospitals, and managed by the Treasury Department. It was in effect a compulsory contributory national health insurance program for a particular category of employed persons. The capitation payment was increased to 40 cents per month in 1870 and outpatient services were added; the head tax was replaced by a tonnage tax on the shipowners in 1884, and then by federal appropriations beginning in 1905. By 1902, the Marine Hospital Service had become the Public Health and Marine Hospital Service, and in 1912 it became the Public Health Service (PHS). By then it was charged with much broader functions in international and interstate quarantine, and in preventive medicine, health research, and other activities (Straus, 1950). The Public Health Service remained in the Treasury Department until 1939, when it was transferred to the newly created Federal Security Agency. In 1953 it was absorbed into the new Department of Health, Education, and Welfare.

With one exception that I will mention shortly, the PHS stood aloof from national needs with respect to personal health services

except when special and delimited problems, missions, and services for special groups demanded its involvement. It concentrated instead mainly on community-wide health services and the laboratory fields—until change began to come in the 1930s and 1940s.

### *The first USA proposal for health insurance*

The first major campaign in the USA for enactment of government-sponsored health insurance was waged from 1912 to 1920. It was intended to develop programs state-by-state and was led by John B. Andrews and his associates in the American Association for Labor Legislation (AALL). The campaign seemed a logical next step for them after a successful campaign for the enactment of workmen's compensation laws to clarify employer liabilities and to provide protection for workers in cases of work-connected accidents and injuries. Health insurance, patterned largely on the British National Health Insurance of 1911, was to provide corresponding protection against *non-work* connected risks, services, and costs. The campaign ended in disaster in the years of World War I, after the American Medical Association, business groups, insurance companies, and labor organizations retracted their early support for the movement and blocked affirmative action in the legislatures of sixteen states that considered legislation (Williams, 1932; Anderson, 1968).

During that campaign of 1912 to 1920, PHS Surgeon General Rupert Blue was apparently friendly to enactment of health insurance, and Surgeon B.S. Warren and Public Health Statistician Edgar Sydenstricker published in 1916 what was probably the best affirmative brief for a proposal. What they wrote is especially notable because it focused on the importance of preventive medicine and the desirability of moving toward the development of a public health program—to emphasize progress from “sickness insurance” toward “health insurance” (Warren and Sydenstricker, 1916).

### *Major change in U.S. medical education and practices*

The course of subsequent events was greatly influenced by developments which came not from social, political, or cultural movements but from the world of science and technology. The scientific revolution of the decades 1870 to 1900 had laid newer foundations for

medicine and medical care to rest on the emerging knowledge and technology of bacteriology, pathology, physiology, medical diagnosis, anesthesia, aseptic surgery, and radiology; but in the USA it had not led—except in a few places—to modernization of medical education and training. Most of our medical schools were commercialized institutions, supported by tuition from inadequately educated students, taught by local preceptorial practitioners most of whom were themselves ill-prepared to practice the improving arts of medicine. Many of our medical schools were merely diploma mills.

This antiquated system was demolished by the findings from a survey supported by the Council on (Medical) Education of the American Medical Association (Burrow, 1963) and published in the Flexner Report of 1910 by the Carnegie Foundation for the Advancement of Teaching (Flexner, 1910). Reform and modernization of medical education and training then came very rapidly, with momentous consequences for medical care services. Most of the proprietary medical schools closed down (Rayack, 1967; Bureau of the Census, 1960); many of the surviving and some newer schools reorganized toward becoming academic institutions; education requirements for student admissions were raised; and the number of full-time faculty members increased annually. Reorganization was largely along the lines of the Johns Hopkins Medical School (which had been established in 1893) and was based on the newer developments in science, the teaching hospital, the laboratory, and basic and clinical research.

As the exploding mass of new knowledge and of medical art and technology was thus incorporated into medical education and training, specialization in education, training, and medical practice became inevitable. Specialization resulted quickly in fractionation of medical care, increasing complexity of personal health services, rising costs, and the out-moding of the general practitioner and family doctor. Thus, along with improvement in the potential quality of medical care came growing difficulty for millions of people in knowing how to be served by the medical care system or to afford its rapidly rising and increasingly uneven costs. All this happened very quickly—first between 1912 and World War I (1918–20), and then again at an accelerating pace immediately after the war. With the newer wonders of the then modern medicine becoming widely known and the nation relatively prosperous, there emerged expanding public expectation of the capacity of medicine

to prevent and to heal. This led to rapidly growing demand for medical care and, at the same time, to widespread and increasing frustration about deficiencies in what, today, we call the “delivery” of medical care and about the threat of reduction in the availability and actual receipt of personal health services.

### *Birth of the CCMC*

In the early 1920s there were growing apprehensions that the changes in the medical care system were rich in potential promise for improvement of national health but also were not without serious shortcomings and prospective dangers. By the mid-1920s, leaders in medicine, public health, economics, and sociology began to sense an urgency to assess the trends and the outlook, and to consider what might need to be done and what could be done from such assessment and through leadership guidance of the medical care system (Committee on the Cost of Medical Care, 1928). This was the genesis of the Committee on the Costs of Medical Care (CCMC) in 1927.

## II. Evolution

### *The CCMC Program*

The CCMC was a self-created and private organization of about fifty leaders from the interested fields,<sup>1</sup> committed to a comprehensive five-year program “to study the economic aspects of the care and prevention of illness.” It was supported by contributions from eight foundations and by collateral studies of professional and other organizations and by official agencies (PHS, state and local health departments, and so on).

Over its five-year span, the CCMC conducted extensive

<sup>1</sup>From medicine, dentistry, nursing, pharmacy, public health, hospitals and other institutions, the social sciences, business, banking and insurance, labor, civic affairs, and so on, with Ray Lyman Wilbur, M.D., as Chairman of the Committee (formerly President of the American Medical Association, President of Leland Stanford University, and subsequently U.S. Secretary of the Interior, 1929–32), and C.-E.A. Winslow, DR.P.H., as Chairman of the Executive Committee (Professor of Public Health, Yale University) throughout the CCMC's five years.

studies: on resources for health and medical care; actual availability and receipt of care by families in many communities; costs, expenditures, and their impacts; standards for the measurement of adequacies and applications for evaluations; the resources and need for improvement of organization to assure ready and effective service; the need for better coordination of services, within the personal and community-wide services and between them; and so on. The staff prepared twenty-six reports and many miscellaneous papers, and summarized the studies and the related literature of the day in a final staff volume (Falk et al., 1933) and the Committee produced its own final report with recommendations addressed primarily to the communities of the country, inviting them to assess their own circumstances and to attack their own problem "of providing adequate medical care for all persons at costs within their means" (Committee on the Costs of Medical Care, 1932). The Committee had no authority to compel any action, and its appeal was to reason, responsibility, and the public interest. Thus, from its beginning in 1927 to its end in 1932, CCMC was an undertaking to achieve social progress through voluntarism.

### *The CCMC Final Report and controversy*

The Committee's Report presented five main recommendations, each based upon large volumes of supporting data:

1. for better organization of personal health services, especially through comprehensive group practice;
2. for strengthening of the public health services;
3. for group payment of the costs, whether through non-profit insurance, taxation, or combinations;
4. for more effective coordination of the services;
5. for improvement of professional education, with increasing emphasis on the teaching of health and the prevention of disease.

In the aggregate, the recommendations constituted a first formulation of a national health program in a pattern reflecting the circumstances, the needs, and the perspectives of the times, with implementation to rest mainly on voluntary actions.

The Committee members were not all of one mind. A (principal) Minority Report voiced strong objection to some of the majority recommendations—especially to the two that recommended

voluntary development and reliance on group practice and group payment. This minority advised instead continuing reliance on solo practice, fee-for-service payment, and the leadership and guidance of the professions, and it objected to community, governmental, or other intrusions into the field of medical care.

The (principal) Minority Report was formally endorsed by the American Medical Association whose *Journal* Editor consigned the Committee's Report to "innocuous desuetude" (Burrow, 1963; AMA, 1932, 1933; Davis, 1955). Since there was no substantial countervailing force in our society at the time, the Committee's proposals appeared for a while to hold little promise of serving as a basis for useful action. This sealed the death of a massive experiment to deal through voluntarism with the health and medical problems that were ahead.

The course of history was to show that the medical leadership of the time took the wrong path at the fork in the road and led the nation into a morass from which, even now, more than four decades later, it has not yet found a way out.

### *From CCMC to the Social Security Act, 1932–1935*

The downward turn in the national economy changed the fate of the Committee's Final Report and preserved it from "innocuous desuetude." The Committee had begun its work in 1927 when our economy was climbing toward a high level of prosperity; but it completed its work at the end of 1932 when the nation was already in severe economic depression, with needs far beyond the resources or capacities of private charity, voluntary agencies, and state and local governments. Efforts to deal with national needs—including the needs for welfare, health, and medical care—now moved to Washington in March 1933 when President Roosevelt was inaugurated and major undertakings were begun for dealing with critical national distress (Falk, 1970).

The first measures to deal with national economic depression were emergency programs, including programs to finance medical care costs. In mid-1934, however, President Roosevelt appointed the (cabinet) Committee on Economic Security to devise more orderly, more efficient and permanent programs for protection of society against common causes of insecurity, including the risks of wage loss and costs of health care arising out of illness. The Com-

mittee's staff (Edgar Sydenstricker and I, and some of our adjunct staff associates) recommended separation of income protection (through temporary and permanent disability insurances) from group payment of medical care costs, and proposed a broad national health program embracing both personal and community-wide health services, all of which was generally acceptable to the Committee. But the medical profession, the insurance industry, and others sent storms of protest to the White House and the Congress. Some within the Committee feared that controversy about government-sponsored health insurance might delay or even block passage of the entire economic security program. Thus only a preliminary report of the broad health program "for study" was made to the Congress. Since there was no organized popular demand for federal grants to support state-by-state proposals for health insurance and for medical care of the poor and near-poor, these proposals were filed away. Nevertheless, we did achieve in the Social Security Act of August 1935<sup>2</sup> federal grants-in-aid to the states for maternal and child health and for crippled children's health services (Title V),<sup>3</sup> and the first permanent authorization to the Public Health Service for grants to the states for public health work and authorization of funds for PHS "investigation of disease and problems of sanitation."

### *Proposals after the SS Act, 1936–1950*

The years immediately after enactment of the Social Security Act of 1935 were replete with continuing efforts to deal with the problems of medical care services, costs, and burdens, with continuing defeats of program proposals, and with steadily worsening situations. In 1936 an Interdepartmental Committee (to coordinate health and welfare programs) initiated the next chapter through a Technical

<sup>2</sup>In addition to old age insurance (national) and unemployment compensation (federal-state), and federal grants to the states for public assistance programs for the aged and for aid to dependent children and the blind.

<sup>3</sup>It is of interest to note that the U.S. Children's Bureau had since 1913 assiduously developed and nurtured a national supporting constituency identified with need for strong protections of child health and welfare. This played an important role in the enactment of Title V.



Committee<sup>4</sup> which developed a new formulation of a national health program, and this was used as an agenda of a National Health Conference in 1938. On January 23, 1939, a report and recommendations on national health by the Interdepartmental Committee, and a report on a national health program by its Technical Committee were transmitted to Congress by the President in a "Health Security" Message. The essential elements of the reports were incorporated in Senator Wagner's bill, the National Health Act of 1939. That bill received extensive hearings in the Senate (U.S. Congress, 1939a) but, owing to intense conflict among contending groups, persisting coolness in the White House, and increasing preoccupation with the impending World War II, the result was only a Committee Report and a promise of further pursuit (U.S. Congress, 1939b).

During World War II and in the post-war years, the Congressional discussions and national debates were focused mainly on a series of annual bills identified mainly with Senators Wagner (New York) and Murray (Montana) and Representative Dingell (Michigan)—the W-M-D bills. The successive proposals went through an evolutionary process that presaged the present scene. The bills started with a national health program based mainly on federal assumption of responsibilities through grants-in-aid to the states, with wide latitudes as to permissible implementations (as in the Wagner 1939 bill). But two kinds of developments dictated change in the pattern of the health and medical proposals: (1) the relative mildness of the proposals had not reduced the opposition to them but it had reduced the support of groups that wanted stronger programs; and (2) anyone could see that the federal-state government programs of the Social Security Act (especially for the public assistances and for unemployment compensation) were in fiscal and administrative confusion while the completely national old age and survivors social insurance was progressing smoothly. Beginning in 1945, the W-M-D bills therefore incorporated proposals for national health insurance in the pattern of the national social insurance instead of the earlier design of federal grants-in-aid to states for multiple and variable state-by-state programs. The design of an implementing program

<sup>4</sup>Dr. Martha M. Eliot of the Children's Bureau, Chairman, three officers of the PHS—Dr. Joseph W. Mountin, Dr. Clifford E. Waller, and Mr. George St.J. Perrott—and I.S. Falk from the Social Security Board.

had been developed in the Social Security Board and made available to the Senate Committee considering the proposed legislation (Falk and staff, 1946). These bills generated extensive national debates with even intensified organized opposition in the Congressional committees, and there were no enactments.

President Roosevelt had permitted the Social Security Board to continue to propose national health program developments during the World War II years,<sup>5</sup> and he had even included a modest program for hospital insurance in his 1942 Budget Message. However, he was responsive to counterpressures from the AMA and others and he did not urge enactment. When President Truman came to the White House in April 1945, he inherited a Roosevelt intention to go forward in this field, and he acted on his own strongly held views (along the lines of the then current W-M-D bill) which he expressed in his Health Message of November 19, 1945, to Congress. He followed this with two other messages in 1947 and in 1949, but he could not overcome the opposition nor could he become enthusiastic about the compromised recommendations which he received from the Magnuson Commission on the Health Needs of the Nation (Magnuson, 1952). There was continuing legislative stalemate.

Meanwhile, despite only moderate escalations of prices and costs generally, and with relatively insignificant inflation nationally, medical care costs had been increasing at unprecedented rates. The medical care system was steadily becoming more and more complex for providers and more and more frustrating to both urban and rural consumers. Demands for medical care and for quality assurances were intensifying while maldistributions of resources for care were becoming more pervasive and more inhibiting to receipt of care. The gap between the potential of medicine and its performance was widening. The reasons for these developments were diverse:

- (a) Continuing rapid increase in medical knowledge and in the complexity and costs of its technology;
- (b) Substantially untrammelled dominance of the medical care system by the providers themselves—for professional performance, for quality assessment and control, and for pricing;

<sup>5</sup>See, for example, the Board's 8th Annual Report, Fiscal Year 1942–43, and the *Social Security Bulletin*, January 1944.

- (c) Assurances of medical care financing mainly through a burgeoning private insurance industry that was providing open-ended financing of the providers by holding the public and their purses hostage to expectations and demands for medical care.

Nobody had planned these developments this way. They had emerged from the forces in our society and in our economy that had kept medical care in the marketplace and subject to its dynamics long after it had become clear that medical care does not—and cannot—function soundly and equitably amid the pulls and pushes and the *laissez-faire* and *caveat emptor* of that environment.

The American Medical Association and other professional organizations and institutions persisted in their opposition. They blocked development of orderly and regionally patterned group practice, its support by non-profit group payment, and the urgently needed expansion of public health measures. For many years they opposed governmental supports of professional education, and public and consumer sharing in equitable distribution of resources for care and in quality protections, and thus sowed the seeds of shortages, excesses, and dissatisfactions. And when they succeeded in keeping the fiscal controls in professional hands, they opened the door wide to self-serving increases of charges and expenditures and to almost unrestrained inflation of health and medical care costs.

In the final CCMC days (1929–32), we had been spending as a nation \$3.7 billion for all health services, about \$29 per capita per year (Falk et al., 1933)—about 3.6 percent of the gross national product (GNP) of about \$100 billion. By 1950 the expenditures were up to \$12.0 billion—about \$78 per capita—about 4.6% of the GNP of \$263 billion (Mueller and Gibson, 1976a, 1976b). Nor was there end in sight for the escalation, since it was being fed by private insurance and prepayment practices that were in effect so patterned as to guarantee physicians substantially whatever they charged and hospitals substantially whatever costs they incurred for most of the insured population. And federal and state governments were almost totally powerless to intervene or to effect moderations or controls.

### *Compromise, and Medicare and Medicaid, 1949–1965*

Except for the 1946 enactment of the Hill-Burton program to support hospital construction, inaction persisted while needs were growing and intensifying. In 1950 I suggested a tactical retreat from

the specifications of the W-M-D bills as a way of breaking the stalemate (Corning, 1969: 72–73). My recommendation was for a national health insurance coverage for the aged and survivor *beneficiaries* of the national social insurance system, instead of for the eligible covered population of the system. This would provide paid-up health insurance for those who needed it most, who generally had meager resources for health care or private insurance, who were not fiscally important to physicians, and who were a severe burden in costs to the insurance carriers.

This retreat served its purpose, although it took more than a decade to have its full effect. The achievement depended mainly upon two developments. First, the need for remedial action grew, as it became even more difficult for many people to obtain good medical care and to pay for it. Second, a new element emerged in the political process for federal health legislation—large-scale public support for national health programs. Previously, since CCMC days, there had been no organized or politically potent constituency *for* national health programs (with the possible exception of that developed by the Children’s Bureau), but only well organized groups *against* such programs, principally “organized medicine” and the insurance industry. From the mid-1950s to the early 1960s, however, “organized labor”—finally convinced of the futility of achieving its health goals through collectively bargained health insurance—committed itself to active involvement in national health legislation. Labor’s multi-million membership and diverse multi-million non-labor citizen supports—and funds—for the first time provided broadly based demands for the proposals advanced by Administration and Congressional leaders.

Thus, except for the brief interlude of the temporizing and ill-fated Kerr-Mills medical care assistance program of 1960–65, the tactical retreat and thirteen years of further intense debate, conflict, and compromises ended, and Medicare, Medicaid, and broadened maternal and child health programs were enacted on July 30, 1965 (Corning, 1969: 113–115).

### *From post-Medicare crisis to national elections, 1966–1976*

Within a few years it became evident that the Medicare enactment was making large contributions on a prepayment basis to the medical care of millions of older persons (Myers, 1970) and the Medicaid

enactment was augmenting medical care for the means-tested poor and medically indigent (Stevens and Stevens, 1974). It also became evident that the dominating compromises with the *status quo* that had been built into those newer public programs had brought about the very difficulties they had been intended to avoid—flagrant and steepened price and cost escalations, inadequate services and cost protections for the populations served, with large inequalities for people in the several states, exploitative and even fraudulent charges by personal and institutional providers, and pervasive corrosion of the medical care system generally. By July 1969, even a conservative President was constrained to say that America's medical care system faced "a massive crisis."

The most evident reason for crisis in medical care was persistence in rising costs. By 1969 national expenditures for health services were up to \$61 billion per annum, \$295 per capita, 6.7% of a GNP of \$899 billion, and increasing at a rate 50–100% higher than for other necessities of life (Mueller and Gibson, 1976b). Medical care was pricing itself beyond the reach of tens of millions of people and was becoming one of the most common causes of economic insecurity, burden, or even family fiscal catastrophe. But cost was not the only reason for crisis: the system was no longer self-regulating, national shortages and maldistribution of resources were increasing, and quality assurances were becoming increasingly unsure. *A broad consensus was emerging that resolution of the problems required not only better financing but also improvement of the system itself, and that effort to achieve either would be futile without the other. This meant a return to the perspectives and recommendations of the CCMC, but now with elements of compulsion they had eschewed.*

The United Auto Workers, with their considerable interest in health care in collective bargaining, were sensitive to these issues. They decided in 1965 that the enactment of Medicare was helpful, but that it probably could not solve the health care problems of either the elderly or of the whole population. They therefore set up an informal working group of about twenty of which I was a member, charged with exploring whether these problems could be addressed by a comprehensive plan for the whole population. The group was asked to formulate a plan which would include the use of the private insurance industry as an integral part of national health insurance. After over a year's effort, the group reported that they could not meet the charge, mainly because inclusion of the private

insurance industry thwarted all efforts to deal with several of the key problems.

With this perspective, a Committee for National Health Insurance (CNHI), originally organized in November 1968 under the leadership of the late Walter P. Reuther (President of the United Auto Workers), undertook to develop a comprehensive proposal for medical care for everybody (Reuther, 1969, 1970). Its major objectives were to make medical care available to everybody through the *private* resources for care but with national *public* financing, with the total funding to be determined by national policy and with annual cost escalations to be restricted to those of the economy as a whole. Since Reuther's death in an aeroplane accident, the Committee has been led by his successor at UAW, Leonard Woodcock.

The development of CNHI was initiated by a major labor union, but from the beginning it included not only other national labor union leaders but also participants from all the major health professions, from civic, religious, and farm organizations, spokesmen for the civil rights movement, youth groups and others, and influential members of the Congress.

As a "Health Security" bill began to emerge from the Committee's studies (Kennedy, 1969) and as it was first introduced in Congress in 1970 and 1971 (U.S. Congress, 1970a,b; 1971a,b), a veritable flood of alternative proposals began to appear (Falk, 1970): some to preserve the *status quo* by merely pumping more money into medical care channels; some to protect the vested interests of this group or that; some to substitute more limited undertakings in order to minimize system changes; some to serve only narrow groups in the population or limited categories of medical care costs; some to minimize the intrusion of government into the system or the role of public funds in the financing; and so on.<sup>6</sup> This flood of legislative proposals led to the use of the cliché that this legislation was "an idea whose time had come"—even if only "with all deliberate speed" after nearly half a century of public discussion.

As the national elections of 1976 approached, polar positions appeared in the platforms of the two major national political parties. The Republican expressed opposition to compulsory national health insurance, and support for an extension of catastrophic illness protection mainly through private insurance. The Democrat

<sup>6</sup>For a recent compilation of proposals submitted to Congress see Waldman (1976).

advocated a comprehensive national health insurance system with universal and mandatory coverage, financed mainly by a combination of employer-employee shared payroll taxes and general tax revenues.

In the course of the presidential campaign, candidate Carter frequently expressed his commitment to mandatory national health insurance of broad scope. We are now waiting for his decisions as President as to what he will recommend to Congress and how this will be related to fiscal and other elements in his legislative program. He has sent a first Health Care message to Congress (April 25, 1977), transmitting a proposed "Hospital Cost Containment Act of 1977" (H.R. 6575 and S. 1391), as a preliminary to phasing in "a workable program of national health insurance," and a "Child Assessment Program (CHAP)" (H.R. 6706 and S. 1392), and, at this writing, congressional hearings are under way. Also, HEW Secretary Califano has appointed an Advisory Committee on National Health Insurance Issues, and it is holding public hearings in various parts of the country. The Secretary would be obligated (under the cost containment bill) to report to the Congress by March 1, 1978, on permanent reforms in the delivery and financing of health care.

### III. Some Perceptions for the Future

#### *Cost escalations*

If, as many are now saying, we have a general national health insurance in our future in the U.S.A., it is not so much because it is "an idea whose time has come" as because the costs of health services and medical care have already risen to nearly intolerable levels, because they are still escalating at unacceptable rates, and because there is no sign of moderation of this steep upward climb. If this is anomalous by the canons of economic principles, rules, or dogmas that perceive restraints dictated by price, it merely confirms what is known even to the tyro in *medical* economics. This field functions not within the dynamics of the *common* economic marketplace, but within the greatly different *medical* economic marketplace—where the *provider* largely determines need, kind, and volume of services and goods as well as the value and price (Falk, 1972).

Health care expenditures reached \$139 billion in fiscal year 1976, they will surely exceed \$150 billion in 1977, approaching 9 percent of a GNP of over \$1,700 billion, and they are proceeding toward \$200–\$250 billion or more a few years hence (U.S., Congress, 1976) *with little if any reference to what will be happening to the GNP!* This outlook compels undertakings that—in the face of largely uncontrolled utilizations and continuing rises in price and cost (Klarman et al., 1970; Rice and Wilson, 1976)—will bring the costs within manageable bounds. Since “rollback” of costs and expenditures may not be feasible, decision is urgent because the longer the delay the more heroic and drastic the action will have to be. But costs and expenditures do not prevail without reference to other characteristics of the medical care “system.” It is therefore necessary to reassess resources for care, for their availability and actual accessibility, and for their efficient organization, as well as for their necessary, sufficient, and assured financing. Any program with reasonable promise of success must achieve *both* cost controls *and* system improvements, since neither one can be effected without the other. Less than a comprehensive attack on the causes of the current crisis would be an invitation to repetition of past failures.

### *Improvement of the system*

My reference to system improvement extends to a long list of deficiencies and insufficiencies—weaknesses from solo practice and fee-for-service payments; largely unrestricted practice of surgery and other specialties; excessive fragmentation of services due to specialization gone rampant and resulting in insufficiencies in primary and coordinated care; inadequate support for better organization and excessive use of inpatient hospital care; geographical maldistributions; the professionals’ self-serving resistances against effective control over quality and ethical performance; and professional control of price and expenditure levels.

Further, “system improvement” is not limited to the elements of medical care delivery *within* a system but extends to the systems (plural) themselves. Ten years of complacency with one system for the poor and medically indigent, fostered by public assistance and Medicaid, and another system for the rich and those with an adequate income, preserved largely by private insurance and an attitude of *laissez-faire*, has bred near-disaster for both. Proposals that would engender more multiplicity—even five systems—for



Medicaid, Medicare, the employed, the self-employed, and the non-employed—would assuredly render impotent all efforts to effect real improvements. The need for both cost control *and* system improvement compels, I believe, one system serving everybody. And this in turn dictates most of the major specifications for the design of a national health insurance that has promise of meeting the national need by resting on national resources.

*Phasing, staging, incrementalism, and so on*

At the moment it is popular in some quarters to argue that a national health insurance should be developed in steps and not all at once. This counsel goes by various names—phasing, staging, incrementalism, gradualism, and so on. To the extent that the reasons given are alleged lack of resources for service (as for comprehensive dental care for everybody) and the need for time to create the necessary resources, this may be an unavoidable policy.

To the extent that it refers to the magnitude and complexity of a non-phased comprehensive program, and thus argues for step-by-step additions of “categories” (whether of categories of services to be included or of categories of population groups to become eligible for the proposed services) (Cohen, 1976), it reflects a basic disregard of both the lessons of history and the objectives of a good program.

In the more than three decades between CCMC and the Medicare-Medicaid enactments of 1965, we were developing health services by categories, usually small, limited, and underfinanced, and always they have had to conform to the existing medical care system. Similarly, we were providing for categories of population groups and with the same restraint. And both approaches have operated to preserve the inherited system, bulwarking the *status quo* and breeding our current difficulties. Categorical developments could not provide leverage to improve the system, to work toward good care which, to be good, has had to be comprehensive and has had to attack simultaneously the various related causes of distress. Nor has much improvement been effected by the succession of a score of categorical programs enacted since Medicare and Medicaid in 1965 (U.S. Dept. HEW, 1976). The gains from some of the newer public laws and programs have been largely offset by newer complexities and confusions they have precipitated.

Nor is the decade of experience with Medicare itself without bearing on this subject. A broad (though not fully comprehensive)

spectrum of covered benefits under Title XVIII of the Social Security Act (Public Law 89-97) actually came into being nationally on a single “effective date” (July 1, 1966) *without phasing, staging, and so on*, though surely requiring a large and skillful effort. It made services available to nearly all of its 20 million eligibles on “the appointed day.” The difficulties that have developed in the program have resulted *not* from that *non*-incremental initiation but mainly from three political compromises and one failure of design in the legislated program.

Among the compromises were:

- (a) uncontrolled allowance to physicians, hospitals, and so on, to “adjust” their economic and practice “profiles” in the year or two before the effective date might bring fiscal restraints on them;
- (b) lack of provision for adequate and continuing quality and fiscal controls to moderate the guarantees of payments—for self-determined fees, prices, and reimbursable costs—which in effect gave signed blank checks on the Trust Funds to about 250,000 physicians and about 6,000 hospitals;
- (c) statutory negativism in the very first section of Title XVIII prescribing that the Act conferred no authority to change the medical care system.

The basic failure of design was to develop this as primarily a system to pay bills for services obtained by the eligibles on their own, but with little concern for the availability of the right kinds of services of good quality needed by the aged. Thus there are valuable lessons from Medicare, but they do not support incrementalism (Ball, 1975; Fein, 1976).

When phasing, staging, incrementalism, gradualism, and so on, are advocated on *fiscal*—not administrative or service—grounds, we are confronted with totally different questions, especially if a national health insurance is to be in the Health Security pattern and, although relying on the private sector for services, is to be financed through public funds. I will return to this subject later.

### *Alleged excessive demand*

It is also popular in some quarters to argue against an initially comprehensive national health insurance system by alleging that

eligibility for services solely because they are needed and *without* insurance contributions and without ties to some particular employer, or deductibles and copayments, or income or means tests, and so on would precipitate massive overloading of provider resources. And by judicious selection of data from limited experiences and observations, some writers support this view as an inevitable consequence of open-end eligibilities—as for the neglected poor, the emotionally disturbed, “the worried well,” the “induced services” envisioned by some actuaries, and so on. It is as though with health and medical services suddenly made price-free, millions of people will rush to the doctors’ offices or demand inpatient surgery. This is patent nonsense, witness that the imagined dash for service does not happen where services are made available without financial barrier—whether in private charitable provisions or in the public assistance programs. Witness also that group practice prepayment plans, with open-end availabilities for primary care services and for specialty services by referral from primary care physicians, function with substantially the same medical attendance rates as for the population generally *and with about one-half* the inpatient hospitalization rates for the population under 65—even if with higher rates for readily feasible and much less expensive supporting ambulatory technical services. With system improvements, especially to emphasize ambulatory care and to control excessive surgery and the “dumping” of patients into hospital beds, such plans demonstrate fiscal achievements without a substantial overloading of resources.<sup>7</sup> But, admittedly, these observations merely support what I have said earlier—that the financing of a comprehensive national health insurance must be coupled with fiscal controls and with supports for system improvements.

In this connection I am ignoring quantitative speculations about increased service demands, utilizations, costs, and stresses on the medical care system that may be expected from broadened insured coverages when those engaged in such speculations do not assume provisions to invite improvements in organization of services or to impose controls on costs and expenditures (Newhouse et al., 1974; N. Eng. J. Med., 1974). Such speculations merely reinforce

<sup>7</sup>A possible exception to this remark is large demand for frequent health examinations, reflecting decades of health education which encouraged it. Since it heavily burdens clinical staff schedules and is of doubtful productivity, it calls for design of a more effective substitute.

the idea that a national health insurance *within such a framework* could be an invitation to disaster from which the nation could not be protected by any acceptable levels of deductibles and/or co-payments levied as barrier payments on patients.

Also, in passing, I would invite those who advocate restraints on services through phasing or through barrier payments or "cost sharing" in the form of deductibles and co-payments to inspect the Canadian experience with its national program largely without such "gimmicks" for over 20 million persons. They will derive no comfort from that record (Andreopoulos, 1975).

### *"Catastrophic insurance"*

An alleged alternative to comprehensive national health insurance is the proposal for "catastrophic insurance"—to provide protection in cases of very high-cost medical care (U.S. Congress, 1975). In my opinion, this would be no alternative at all, since in providing the intended protection for those who now lack it because of present inadequacies in public programs or under private insurance, it would leave unaffected the other major needs to be served by a more comprehensive program. Further, despite its good intention, a "catastrophic insurance" program would quite surely lead to increase and intensification of much that already ails the medical-care system.

Advocates of this approach seem not to realize that, by having to require very large deductibles or prior expenditures as a precondition for eligibility to benefits,<sup>8</sup> their design inevitably biases the program toward those who can afford or already have broad basic insurance or toward those of considerable means who can afford relatively large personal expenditures, thus greatly limiting the potential reach of the program (Stoiber, 1977). Such advocates seem to be unaware of—or indifferent to—the undesirable effects such proposals can be expected to have on medical care and its costs—first by *inviting* expensive surgical, hospital, and other services at least up to the qualifying deductible levels and then by *inviting* further extremes of high-cost specialism. Also, this form of

<sup>8</sup>For example, the "catastrophic" insurance benefits (like those in Medicare) in the program sponsored by Senators Long, Ribicoff, Talmadge, and others would be available to those who have already incurred medical expenses of at least \$2,000 or have been hospitalized for at least 60 days, or satisfy both of these requirements.

action would certainly contribute nothing to improving the system and would even strengthen resistance to the need for more adequate provisions (Falk, 1977).

All this should be strikingly clear now when there is an increasing clamor, even from professional sources, about excess and excessively costly resources: *as to hospitals*, too many hospital beds in many areas with too many persons in those beds, too many expensive in-hospital specialty services, and too much very expensive equipment; *and as to physicians*, an outlook that alleged shortage in numbers has been reversed and is giving way toward an excess, and already with too many specialists, too much surgery, sometimes by unqualified surgeons, too few primary care practitioners, and too little relatively inexpensive ambulatory care. A national "catastrophic insurance" could invert promising trends to rationalize the outlook and could be disastrous for the medical care system, both from the point of view of the program *per se* and from the resulting delay of more comprehensive action.

To support and defend "catastrophic insurance," some argue that it would cost much less than comprehensive insurance and would deal with an urgent need to provide protection against catastrophic costs for individuals and families (U.S. Congress, 1975). The "cost" argument rests on too narrow a perception, especially as it ignores the overall cost history, its trends, and its outlook. The "protection" argument ignores the system and overall cost effects, especially since a comprehensive program would provide the desired protection without potentially disastrous consequences for the system, for quality of care, for needed controls of excessive specialty care—and for costs.

### *A role for private insurance*

One of the most contentious subjects in the national health insurance debates concerns the place of the insurance industry in any new program. A national health insurance program adequately financed by budgeted national funding would abolish the fiscal "risks" that are the usual basis for private insurance or re-insurance. Whether there is or is not a place in such a program for the insurance industry—to serve certainly not as a carrier of risk but perhaps as claims-takers or fiscal intermediaries—is not a question of logic or necessity but of political feasibility. Massive national ex-

perience shows that the insurance industry adds billions of dollars in cost and distorts sensible patterns of service and expenditure, while contributing little in administration and even less in quality and cost control. This could be done at least as well and probably better and at lesser cost by public administration.

### *Rationale about costs*

The prospective costs of national health insurance and its financing involve many kinds of consideration, opening the door to endless discussion and dispute. The premises should therefore be as clear as may be possible.

At the outset, it is important to keep in mind that the various proposals for some kind of a national health insurance have large differences in comprehensiveness of services and/or of populations to be covered, and thus large differences in the costs that would be incurred as charges on the program or that would be excluded and met from other sources. These differences are compounded by important differences in how the program costs are to be financed. Fair cost comparisons have therefore to consider not only how much may be expected to be program cost, the source(s) of the funds and the outlook for future trends in those costs, but also how much is *not* to be program cost, is expected to be left to others to pay, and the outlook for escalation in the excluded as well as in the included costs (Falk, 1971).

Thus, a program with a limited service or population coverage may itself incur relatively small private costs or demands on the federal treasury; but such a program may still leave the nation with a frightening outlook for national expenditures and for burdens from costs outside the program. On the other hand, if a program of comprehensive service and population coverage would incur a much larger cost and may even require a relatively large governmental outlay, it may still mean only a transfer of expenditures from fiscal flows in the private sector to flows in the public sector. Also, if a comprehensive program uses the leverage of its relatively large expenditures to dampen the prospective escalation of national expenditures, it can be the more conservative undertaking for the future of medical care and of the national economy than the smaller expenditure of a more limited program that cannot exert such influence.

---

I am not unaware that transfer of medical care financing from the private to the public sector invites disputes because it affects large private vested interests in the insurance industry and among private personal providers of services and goods, and because it raises a major issue of public policy. I would point out, however, that such transfer has actually been in process for decades, witness the steady increase in the amount and the share of personal health care expenditures financed annually from public funds—from \$0.3 billion in 1929 (9 percent of the total) to \$40 billion in 1975 and about \$52 billion in 1976 (42 percent), though proceeding by incrementalism instead of by formal national policy (Mueller and Gibson, 1976a, b). The issue can be avoided only at the price of a continuing and worsening system.

From these perspectives on costs, their financing and potential impacts, I would first touch on three points here:

- (a) all substantial studies show that the diverse proposals for a broad or comprehensive program would be associated—in the short run—with *national* expenditures only a little different from what is to be expected with no new program (U.S. Dept. HEW, 1974; Davis, 1975; Trapnell, 1976);
- (b) the national interest demands that one new program or another shall not permit or invite—in *the longer run*—continuing escalation of medical care prices, costs, and expenditures at a higher rate than for the economy as a whole; and
- (c) an acceptable program should propose financing and fiscal controls compatible with the dual objectives of national availability of good medical care and national fiscal feasibility and acceptability.

In my opinion, political debate but not national interest is served by pointing to the relatively low demand *on the federal treasury* for a particular proposal while ignoring what fiscal burdens that proposal would leave on state and local government or on employers, employees, the self-employed, the non-employed, the medically indigent, the needy poor, etc. Also, I think the national interest is not served by criticizing a program that would rely mainly on public financing without referring to the corresponding reductions it would bring to state and local governments and to private financing, within the global national costs for medical care. Nor are actuaries' estimates the better if they use *plus* signs generously for

increased utilizations, prices, and costs from so-called "induced" services to be expected for a program but use *minus* signs ungenerously for reductions that may be reasonably expected from cost controls built into a program proposal. This obviously leads to a relative cost overestimate for a program that makes provision for cost controls in comparisons with programs that do not.

Because costs have been rising rapidly in recent years, cost estimates for program proposals soon become outdated. Also, since earnings and income levels have not progressed on expected courses during the current economic recession, the relationship between prospective program costs and tax-base levels to finance those costs has changed and now is uncertain for the years ahead. The details of program financing therefore need re-examination with new focus on the years when the program is expected to be enacted and put into operation.

An unusually troublesome fiscal problem at the moment is the question of demand on the general revenues of the federal treasury for the financing of a truly comprehensive national health insurance. How much would be required? And how much can the federal government afford for this purpose in a period when the federal budget is in grave deficit and is expected to need at least several years to overcome the effects of recession while moving toward a balanced state? The amount that would be required will be much less than is often alleged if it is estimated *net* of (a) federal expenditures already committed for existing programs that would be absorbed by the proposed new program, (b) tax expenditures (tax subsidies) that would be automatically eliminated (and others that could be), and (c) income from taxes earmarked for national health insurance. *Whatever the demand on the federal treasury, however, it will continue to be under pressure to grow larger the longer the delay in undertaking even a program with substantial cost controls, and the longer medical care costs escalate at rates two or three times as high as in the general economy.*

This is the current dilemma—how can the objectives of a comprehensive program be preserved while minimizing program demand on the federal treasury?

One approach to this problem is to reduce prospective program costs through extensive cost-sharing by the persons served—as through extensive deductibles and/or co-payments; but this requires great care in ensuring (a) that the cost-sharing does not keep



patients from receiving care, especially families of modest or small means, and thus to defeat a program objective, and (b) that such fiscal devices can be readily eliminated when no longer needed.

Another approach being advocated seeks resolution through phasing the introduction of the program, starting with delimited categories of covered services or of covered populations, thus holding down the program costs and the needed federal sharing, and proceeding toward a comprehensive system through scheduled successive categorical additions. Obviously, this would be compatible with the program objectives only if there were, from the beginning, firm and substantially irrevocable commitments to the continuation of the step-by-step process, and only if the measures for cost control and system improvement were initiated at the outset. Lacking such provisions, the sponsors of such a phased program would be confronted with the possibility of an exercise in futility. This course of action might well fail the program objectives, bulwark further deficiency in the medical care system, and fuel further medical care cost escalations. *A major fiscal result to be expected from a phased program—in which each of the phased steps would be without sufficient leverage to effect cost controls—is to increase instead of to decrease prospective demand on the federal treasury and thus to contribute additional difficulty in progress toward a balanced federal budget.*

In my opinion, neither of these approaches, or any variant or combination of them, should be adopted until adequate study has assured that the demand on the federal general revenues cannot be reduced to an acceptable level through other feasible allocations of program costs.

In this connection, I would emphasize—at the risk of redundancy—that while procrastinating debates about prospective costs and controls continue, medical care prices, costs, expenditures, and inadequacies escalate not merely on crisis levels but toward disaster levels that will invite more drastic proposals than are already before the Congress. Witness the proposal for a salaried public national health service recently espoused from within the American Public Health Association (APHA, 1977).

### *The “better life-style” alternative*

I would like to make only passing reference to a newer confusion

that has been recently introduced into discussions of national health insurance. Some people are proposing that what we need is less emphasis on medical care and more on so-called "better life style for health" and greater emphasis on "preventive services"—as though these are real alternatives. Surely we can be of one mind about advocating healthier living styles, controlling occupational and environmental hazards, and favoring wider applications of promising procedures (especially through more effective interlocking with the mainstream of the personal health services) for prevention of the infectious diseases, the onset or progress of chronic disease, accidents, etc. But we should not be expected to act as though we are uninformed of the continuing need for medical care in injuries, disease, or disability that cannot yet be prevented. These proposals come with singular bad grace when pressed by insurance industry leaders with a long record of being primarily salesmen, claims-takers, and bill-payers who have given only lip-service to prevention of morbidity, have avoided coverage of preventive services in the contracts they sell, and have been giving only self-serving explanations of why it has not been their function to be responsible for quality assurances.

### *In conclusion*

In the light of the views I have been expressing, it must be no surprise that I do not subscribe to the designs for national health insurance that have been proposed by former President Nixon, by former President Ford, or by leading spokesmen for the Department of Health, Education, and Welfare, or by the American Medical Association or the insurance industry. Their proposals start with commitment to private insurance and its current patterns that have contributed to the present difficulties. And it must come as no surprise that, instead, I advocate the Health Security program which I believe can serve us better—both in system organization and operation and in financing (U.S. Congress, 1977a, b). It proposes a partnership of the *private* sector for the providing of health and medical services by all who are qualified to participate, and of the *public* sector for the financing of those services, with augmented consumer participation in both. It would make all who need care eligible for the services they need—without contribution, income or means tests and without deductibles or co-payments, lest any of

these serve to impede receipt of needed care or to ration care by ability to pay. And it would support availability of services by funds earmarked for new needed resources, for organizational improvements, and for further development of quality assurances.

Finally, I can refer to the pride we all take in what is good in our medical care system, and to a determination we all can share to preserve and nurture what is good. But I would urge that we not ignore the inherited and developed weaknesses in that system, its outworn patterns that no longer serve the nation well, and its inadequacies that have become barriers to effective service.

The good in the present system is not all the good that is needed now and for the future. The Health Security program that many of us labored to design can help this system to serve us better. I hope the Health Security program will soon be enacted with whatever further improvements can be made in its design so that the good in the present system will not continue to be an enemy of a better system for the future.

## References

- American Medical Association. 1932. Editorial. *Journal of the American Medical Association* 99:1951.
- . 1933 (June). *Proceedings*, House of Delegates, 84th Annual Session (pp. 3, 58).
- American Public Health Association. 1977. Resolutions, October 20, 1976. Committee for a National Health Service and Establishment of a National Health Service. *American Journal of Public Health* 67:84, 86.
- Anderson, O.W. 1968. *The Uneasy Equilibrium: Private and Public Financing of Health Services in the United States, 1875–1965*. New Haven: College and University Press.
- Andreopoulos, S., editor. 1975. *National Health Insurance: Can We Learn from Canada?* New York: John Wiley & Sons, Inc.
- Ball, R.M. 1975. *Background of regulation of health care, Controls of Health Care*. Washington, D.C.: National Academy of Sciences, Institute of Medicine (pp. 3–22).
- Bureau of the Census. 1960. *Historical Statistics of the United States, Colonial times to 1957*. Washington, D.C.: Government Printing Office (p. 34).

- Burrow, J.G. 1963. *AMA: Voice of American Medicine*. Baltimore: Johns Hopkins Press (pp. 33–36).
- Cohen, W.J. 1976. Policy planning for national health insurance, *Health in America, 1776–1976*. Dept. HEW (HRA) No. 76-616. Washington, D.C.: Government Printing Office (pp. 175–191).
- Committee on the Cost of Medical Care. 1928. *The Five-Year Program*. Publication No. 1. Chicago: University of Chicago Press.
- Committee on the Costs of Medical Care. 1932. *Medical Care for the American People: The Final Report of the Committee on the Costs of Medical Care*. Chicago: University of Chicago Press. (Dept. HEW, 1970. Reprinted with a Foreword by J.W. Cashman and a Preface by I.S. Falk. Washington, D.C.: Government Printing Office.)
- Corning, P.A. 1969. *The Evolution of Medicare—from Idea to Law*. Office of Research and Statistics. Dept. HEW, SSA, Research Report No. 29. Washington, D.C.: Government Printing Office.
- Davis, K. 1975. *National Health Insurance, Benefits, Costs, and Consequences*. Washington, D.C.: Brookings Institution.
- Davis, M.M. 1955. *Medical Care for Tomorrow*. New York: Harper.
- Falk, I.S. 1936. *Security Against Sickness: A Study of Health Insurance*. New York: Doubleday-Doran.
- . 1970. *National health insurance: A review of policies and proposals*. Law and Contemporary Problems, Symposium on Health Care, Part II (pp. 669–696).
- . 1971. *The Costs of a National Health Security Program and Their Financing*. Washington, D.C.: Committee for National Health Insurance.
- . 1972. Financing for the reorganization of medical care services and their delivery. *Milbank Memorial Fund Quarterly* 50(2):191–221.
- . 1977. *Financing and cost controls in medical care, Medicine in a Changing Society*. 2nd ed. Edited by L. Corey, M. Epstein, and S.E. Saltman. St. Louis: C.V. Mosby, Co. (pp. 188–205).
- Falk, I.S.; Rorem, C.R.; and Ring, M.D. 1933. *The Costs of Medical Care: A Summary of Investigations on the Economic Aspects of the Prevention and Care of Illness*. Report No. 27. Chicago: University of Chicago Press.
- Falk, I.S., and staff. 1946. *Medical Care Insurance: A Social Insurance Program for Personal Health Services*. Report from the Bureau of Research and Statistics, Social Security Board, to the Committee on Education and Labor, United States Senate. Senate Committee Print No. 5 Committee on Education and Labor, 79th Cong. 2nd sess. Washington, D.C.: Government Printing Office.

- Fein, R. 1976. Part III in *Options, A Right to Health—The Problem of Access to Primary Medical Care*, by C.E. Lewis, R. Fein, and D. Mechanic. New York: John Wiley & Sons (pp. 249–286).
- Flexner, A. 1910. *Medical Education in the United States and Canada*. Bulletin No. 4. New York: Carnegie Foundation for the Advancement of Teaching.
- Frankel, L.K., and Dawson, M.M. (with the co-operation of L.I. Dublin). 1910. *Workingmen's Insurance in Europe*. New York: Russell Sage Foundation.
- International Labour Office, Geneva. 1927. *Compulsory Sickness Insurance*. Series M (Social Insurance), No. 6, pp. 1–12; *Voluntary Sickness Insurance*, Series M (Social Insurance), No. 7, pp. xix–xlvi.
- Kennedy, E.M. (Senator). Comprehensive National Health Insurance. Congressional Record Vol. 115, No. 173:S13166–13168, Oct. 28, 1969.
- Klarman, H.R.; Rice, D.P.; Cooper, B.S. et al. 1970. *Sources of Increase in Selected Medical Care Expenditures, 1929–1969*. Office of Research and Statistics. Dept. HEW, SSA Staff Paper No. 4. Washington, D.C.: Government Printing Office.
- Magnuson, P.B., Chairman. 1952. *Building America's Health: A Report to the President by the President's Commission on the Health Needs of the Nation*. Washington, D.C.: Government Printing Office.
- Mueller, M.S., and Gibson, R.M. 1976. National Health Expenditures, Fiscal Year 1975. *Social Security Bulletin* 39(2):3–21; *ibid*, Fiscal Year 1976, 40(4):3–22. Washington, D.C.: Government Printing Office.
- Myers, R.J. 1970. *Medicare*. Illinois: Richard D. Irwin, Inc.
- New England Journal of Medicine*. 1974. Letters to the Editor from Amasa B. Ford; George A. Silver; Arch B. Edwards and John M.M. Banham; Richard N. Podell; George D. LeMaitre; (reply by) Joseph P. Newhouse, Charles E. Phelps and William B. Schwartz. 291:628–630.
- Newhouse, J.P.; Phelps, C.E.; and Schwartz, W.B. 1974. Policy options and the impact of national health insurance. *New England Journal of Medicine* 290:1345–1359.
- Rayack, E. 1967. *Professional Power and American Medicine: The Economics of the American Medical Association*. Cleveland and New York: World Publishing Company (pp. 66–72).
- Reuther, W.P. 1969. Health Care in crisis. *American Journal of Public Health* 59(1):12–20.

- . 1970. The health care dilemma: new directions. *Journal of Medical Education* 45:96–103.
- Rice, D.P., and Wilson, D. 1976. The American medical economy, problems and perspectives. *Journal of Health Politics, Policy and Law* 1(2):151–172.
- Rubinow, I.M. 1913. *Social Insurance With Special Reference to American Conditions*. New York: Henry Holt.
- Shryock, R.H. 1947. *The Development of Modern Medicine*. New York: Harper.
- Stevens, R., and Stevens, R. 1974. *Welfare Medicine in America: A Case Study of Medicaid*. New York: Free Press.
- Stoiber, S.A. 1977. *Catastrophic Health Insurance: Budget Issue Paper*. Congressional Budget Office. Washington, D.C.: Government Printing Office.
- Straus, R. 1950. *Medical Care for Seamen: The Origin of Public Medical Service in the United States*. New Haven: Yale University Press.
- Trapnell, G.R., Associates. 1976. *A Comparison of the Costs of Major National Health Insurance Proposals*. Executive Summary prepared by Saul Waldman. Dept. of Health, Education, and Welfare. (Full report available: PB-259-153, 1976. NTIS, Springfield, Virginia)
- U.S., Congress, Budget Office. 1976 (March 15). *Budget Options for Fiscal Year 1977: A Report to the Senate and House Committees on the Budget*. Washington, D.C.: Government Printing Office (pp. 49–50, 151–167).
- U.S., Congress, House, “The Health Security Bill,” H.R. 19158, introduced by Representative Corman and others, 91st Cong., 2nd sess., September 14, 1970.
- U.S., Congress, House, “The Health Security Act,” H.R. 22, introduced by Representatives Griffiths, Corman and others, 92nd Congress, 1st sess., January 22, 1971.
- U.S., Congress, House, “The Health Security Act,” H.R. 21, 22 and 23, introduced by Representative Corman and others, 95th Cong., 1st sess., January 4, 1977.
- U.S., Congress, Senate, Subcommittee of the Committee on Education and Labor, *Hearings on S.1620, “National Health Act of 1939,”* introduced by Senator Wagner (NY), 76th Cong., 1st sess., April and May, 1939.
- U.S., Congress, Senate, Committee on Education and Labor, *Establishing a National Health Program: Report No. 1139*, by Senator Murray, Preliminary Report on S.1620, 76th Cong., 1st sess., August 4, 1939.

- U.S., Congress, Senate, "The Health Security Act," S. 4297, introduced by Senator Kennedy and others, 91st Cong., 2nd sess., August 27, 1970.
- U.S., Congress, Senate, "The Health Security Act," S.3, introduced by Senator Kennedy and others, 92nd Cong., 1st sess., January 25, 1971.
- U.S., Congress, Senate, 1975. Catastrophic Health Insurance: The Long-Ribicoff Bill, S.2470. Congressional Record, 94th Cong., 1st sess., Oct. 3, pp. S17449–17472.
- U.S., Congress, Senate, "The Health Security Act," S.3, introduced by Senator Kennedy, 95th Cong., 1st sess., January 11, 1977.
- U.S. Dept. of Health, Education, and Welfare. 1974. *Estimated Health Expenditures under Selected National Health Insurance Bills: A Report to Congress*.
- U.S. Dept. of Health, Education, and Welfare. 1976. *Health in America, 1776–1976 (including a chronology of major health legislation)*. Publication No. (HRA) 76-616. Washington, D.C.: Government Printing Office.
- Waldman, S. 1976. *National Health Insurance Proposals: Provisions of Bills Introduced in the 94th Congress as of February 1976*. Office of Research and Statistics. Dept. HEW, SSA, Publication No. 76-11920. Washington, D.C.: Government Printing Office.
- Warren, B.S., and Sydenstricker, E. 1916. *Health Insurance: Its Relation to the Public Health*. Public Health Bulletin No. 76, 2nd ed. Washington, D.C.: Government Printing Office.
- Williams, P. (assisted by I.C. Chamberlain). 1932. *The Purchase of Medical Care Through Fixed Periodic Payment*. New York: National Bureau of Economic Research.

An abbreviated version of this paper was presented at a session in the Health Resources Administration's 1976–77 Colloquium Series, Dept. HEW, December 3, 1976, at the Parklawn Building in Rockville, Maryland.

*Address reprint requests to:* I.S. Falk, Ph.D., Yale University School of Medicine, 150 Sargent Drive, New Haven, CT 06511