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Comprehensive Health Insurance: The Reality

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In his article, Dr. O'Keeffe outlines the major proposals (both generic and specific) in the area of national health insurance. He then describes in depth the proposed Warren County Plan and the Foundation Concept in relation to three fundamental concepts: availability, utilization and financing of medical care.

Comprehensive Health Insurance: The Reality

Daniel O'Keeffe, M.D.

There is absolutely no question in anyone's mind that Comprehensive Health Insurance in the United States of America will be a reality within a very few years. "The enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or social conditions". This statement is taken from the World Health Organization. To this end the drums are beating on all fronts, the natives are restless and rightly so.

The decade of the 60's just past was a turbulent period in our nation's history marked by rioting, burning, violence and clamoring for civil rights. Two key words were "activism" and "relevance". They were shouted at us by the young from the campuses and by the politicians from the streets: *and yes, by members of the scientific and medical communities.*

And though it be obvious that one may not condone the violence, it is easy to see the changes have been

wrought in attitudes because some have spoken out. In many instances these changes regarding the health of people have been for the better. I am referring specifically to a move away from the "ivory tower" approach to medical care which seems to have been initiated in this new decade of the 70's. Historically, 1970 will be the year of new health proposals by numerous advocates.

Looking at the broad picture there are three generic proposals: (1) a completely socialized medicine which is defined as the *governmental ownership* of all medical facilities with all medical personnel being government employees. (2) *A national health insurance plan,* as represented by Universal Health Insurance and Comprehensive Health Insurance. (3) The system which has prevailed the past hundred of years, viz, strictly private medicine with little or no government control.

In looking at this big picture, particularly with emphasis on health care delivery, there are three fundamental concepts which cannot be overlooked. These are as follows: (1) *The availability of medical services.* What good is it to promise the public that we will render medical health care if we do not have the availability of medical services to carry out this program? (2) *The utilization of medical services.* It is this concept which will determine ultimately the success or failure of any program. Over utilization of medical services, on the part of medical personnel, or on the part of the individual receiving the

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Dr. O'Keeffe, a dedicated obstetrician and gynecologist and a strong and uncompromising friend of the Church, became interested in the matter under discussion while serving as President of the Warren County (New York) Medical Society. Largely through his initiative, a Foundation Plan is close to becoming a reality for a large part of northeastern New York.

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medical care will destroy the effectiveness of quality medical care. (3) *Financing of medical care.* There has been a great deal written about this subject, and as we all are aware there are extremely diversified and complicated solutions offered to solve the financial problem. Some of the practical aspects involved in attacking this important problem include the rights and privileges of the physician, the rights and privileges of the patient, third-party payers, employer-employee relations and utilization by both the physician and the patient to mention just a few tormenting subjects.

Let me be a bit more specific about financing. For nearly three decades the cost of health care in the United States has been increasing in an unprecedented and unremitting rate. From the 4 billion in 1940, the amount spent for the nation's health has doubled and redoubled reaching 27 billion in 1960. This year it has doubled again to over 54 billion. The amount spent per individual climbed from $84 in 1950 to about $275 this year. It is no surprise to everyone that the cost of medical care has increased at such a rapid rate that not only the needy and the low income groups are being priced out of the care they need, but more and more citizens in the moderate and middle income groups find it difficult to pay for their medical care. This is especially true of hospital services. It has been noted that the average cost per patient today in New York state is $75.38. The average cost per hospital stay is $783.95. These figures as of December 1, 1968 are taken from the Health Insurance Institute.

Major Congressional Bills

On the national front we are all aware of the four major bills in Congress on National Health Insurance. Briefly they are as follows:

(1) *The AMA's Medicredit Bill—The Fulton-Broyhill Bill et al HR-18567.* This is a three part program providing basic health insurance protection for all individuals under 65, as well as Peer Review Organizations (PRO) for quality and cost control. Part "C" of Medicredit would establish a Peer Review Organization. The Secretary of HEW would contact the State Medical Societies for the operations of a PRO in each state. Under the program, there would be first local and then state-wide review of MD's and DO's, reports and allegations of improprieties bearing on reasonableness of charge, need for services rendered or quality of service rendered by the provider. A finding against a provider could result in his suspension or exclusion from participation in the Federal Government Health Program.

(2) *The AFL-CIO's Griffiths HR-15779.* This is another organized labor plan introduced into the House of Representatives by Martha Griffiths of Michigan. This Bill would

provide comprehensive health care protection for all citizens and for those non-citizens who have resided in the United States for at least one year. In other words, everyone would be covered, "cradle to grave". The estimated cost would be from $44 to $77 billion per year. The taxpayer would pay through the Federal Government. Like the Kennedy Bill the cost would be financed half from general revenues and half from social security payrolls.

The Government would operate the entire program through a Health Security Board which would set the standard charges and prepay the bills. Again, this type of Bill would stimulate group practice arrangements versus solo practice to furnish comprehensive health medical care.

(3) *The Committee of a Hundred Health Security Program.* This is the Kennedy et al bill. This bill is comparable to the other organized labor bill introduced into the House by Rep. Griffiths. The program would be financed by three sources: 40% from general revenues: 35% from employer payroll tax: 25% from individual payroll tax. These monies would be paid to a Health Security Trust Fund. Allotments would be made to local regions for physicians' payments. Priority would be given to salaried physicians *in institutions,* to those in comprehensive practice prepayment organizations, to others who agree to accept capitation payments. The remainder in the local fund would be used for payment of fee for service bills, i.e., private physicians and private practice. If the fund is low these payments would be pro-rated. It is extremely important to notice the method of payment.

(4) *Medicare-for-all — Javits Bill — S-3711.* This bill entitled *National Health Insurance and Health Services Improvement Act of 1970,* would provide a system of national health insurance to be implemented by expanding the present Medicare Program to include all individuals.

Additionally, two other proposals are under consideration:

(1) *Nixon's Administration Plan* —This has two parts: a health insurance standard's plan and a family health insurance plan. The estimated cost is roughly 5.5 billion dollars. The National Health Insurance Standard's Plan is an insurance program financed by premiums charged employers and their workers. Private Insurance Companies and non-profit organizations such as Blue Cross-Blue Shield would run the program under Government regulations. Stress would be on providing service through group practice plans that offer comprehensive medical care at a prepaid fixed fee, the so-called health maintenance organizations (HMO).

(2) There is another plan which is referred to also as the *Ameriplan* put out by the American Hospital Association. This plan would offer three packages of insurance: (1) One would provide standard benefits resembling those of Medicare

with added coverage for such things as maternity and child care. (2) Another would provide health maintenance care including annual physical checkups, complete examinations if ordered by a doctor, immunization shots and dental services for children. (3) The last would protect against cost of a catastrophic illness.

In the past, organized medicine for some unknown reason has taken the negative attitude toward any changes in health care delivery, or when faced with imminent defeat has proposed too little, too late. Witness: Medicare and Medicaid. With this in mind, the Warren County Medical Society of New York State set up an Ad Hoc Committee on Universal Health Insurance for the express purpose of developing a health plan with which all the components and segments of health care could live and function to the medical and economic benefit of all.

Our tentative proposal was set forth because we were concerned with providing quality medical care for all in the communities which we serve. We believe firmly that there should be no second-class citizens under any circumstances much less with respect to the medical care received. It was our feeling that to effectively attain such goals, the economics of providing medical care should be established on a more organized and equitable basis than may now be found in certain areas. We felt that such an approach would tend to minimize and could even control the publicized increases in the cost of medical care. In so doing, we wish to consider the taxpayer on the one side and still not jeopardize the patient on the other end of the scale.

The plan set forth must be comprehensive to include every person under 65. It would be administered by private insurance carriers, thereby enhancing private enterprise in our country as well as in our state.

Classification of Financial Categories

There were three classifications of financial categories: (a) those who can pay their own insurance premiums, (b) those who obtain their insurance at their jobs, and, (c) those who are medically indigent. The proposal was for a basic health insurance plan. We do not propose an unlimited program of medical services. This is again, a basic pattern of medical services with adequate room for individual enterprise and collective bargaining to provide for arrangements which are as elaborate as the individual prefers, or the group may negotiate.

The suggestion was made that the premium paid by the individuals and employers or employees should continue to be tax deductible. The plan would be administered on a basis similar to that of the disability and Workmen's Compensation Board in New York State. There would be built-in safeguards and controls to include consumer receipt, verification of multiple hospital visits and a professional review

committee. Fees would be established on a usual and prevailing fee basis. The plan also incorporates a co-insurance and deductible feature. To this was to be added a catastrophic insurance rider and lastly, free choice of physician and hospital.

It was an inherent part of our program to use the insurance payment system for all: the employed, the self-employed and the needy. Thus a large step toward eliminating the concept of the second-class medical citizen.

Along the very same order as we have proposed above, the Foundation Concept of Medicine has been functioning apparently very successfully for several years on the West Coast. This plan employs and embodies many of the concepts which we felt were essential to a good health plan.

The Foundation—A Definition

What is a Foundation? Is it something you build a house on? Is it part of the Ford Motor Company? Is it a garment to squeeze a lady into shape? It is none of these. It is a program noble in purpose, and unlike prohibition has been successful. A Foundation is an organization of doctors of medicine sponsored by a local County Medical Society. It is a separate and autonomous corporation with its own Board of Directors. The Foundation for medical care is concerned with the development and delivery of medical services and the reasonable cost of health care, whether publicly or privately financed. It also believes in the American tradition of free choice of personal physician and hospital by the patient, the fee for service concept and the local judgment of the problems concerning over-utilization and under-utilization thru peer review.

The Foundation for medical care establishes minimum standards for health care as practiced in the community which it serves. It offers broad coverage within reasonable cost level. It accepts the service principle of insurance, thereby making certain that coverage is available to all consumer groups. The quality of care is emphasized through utlization review technique and includes examination of both over-utilization and under-utilization by either the physician or the patient.

Basically then it is a system of medical insurance which is geared to operate within the normal framework of established practices in the insurance field and with a free choice of carrier and a free choice of doctor. It involves the prepayment of health care concept, it is neither a group practice type of plan nor is it a closed panel as opposed to the Kaiser-Permonetti Plan type of health care delivery. Neither is the Foundation in the insurance business nor does it act as a broker, agent, trustee, or administrator for the groups. The Foundation does the following: (1) Sets minimum standards for coverage. (2) Sets maximum fees in the area.

(3) Approves doctor membership. (4) Appoints medical review committees. (5) Hires needed administrative clerical help. (6) Processes and pays claims in behalf of carriers. (7) Receives a determined allowance from the carrier for claims payment. (8) Studies local medical-economic problems.

We are dealing with some philosophical concepts which are extremely important to the doctor, but equally to the patient. Such philosophical concepts include medical care for all regardless of the ability to pay, which is the sine quo non of our Warren County Medical Society's conceptulization of a plan in which there shall be no second class citizens. These concepts also include equating medical care to prepayment, broader coverage under prepayment program, a service concept, certainty of coverage, abuse control and free choice of prepayment plan by consumer groups.

The Foundation Plan utilizes private enterprise as a fiscal intermediary. The foundation is not a union, it is not a local Blue Cross-Blue Shield Plan, it is not publicly paid medical care. The greatest failure of publicly paid medical care is its inability to curb its own excessive expansion. It is all too vulnerable to political demagogues who promise even greater benefits for more people, and to the bureaucratic bungling which occurs in administration of medical programming and therefore pushes the administrative fee of any federally or state administered program into the exorbitant range.

A contributive health insurance plan is most in keeping with the needs and wishes of most Americans today. It has many advantages: (1) Beneficiaries have a direct stake in the prudent management of the system since their own premiums support it. (2) It encourages self-reliance thus enhancing individual dignity. (3) It avoids the stigma of public assistance that prevents some people from seeking medical care from government programs even when they are eligible for it. (4) It fosters the customary doctor-patient relationship and it builds upon the existing and well developed system of private and non-profit health insurance companies.

Health Care for All— Moral Obligation

We, as physicians, have a moral obligation to render quality health care to everyone, but we also have a moral obligation not to fiscally bankrupt the public or the taxpayer in rendering quality health care delivery. There cannot be any prevailing personal motivations, be they political, medical or financial in the design of any health care delivery plan. It has been emphasized throughout this essay that in both the Warren County Plan and the Foundation Concept there are no second-class citizens, medically. The dignity of the patient is ex-

tremely important. Under these plans the doctor has a moral obligation to treat all patients in the same manner. In the past, the physician frequently rendered service without expecting or receiving any remuneration other than a very pleasant "thank you, Doctor" which was very adequate and well appreciated. Suddenly, like a "bolt out of the blue", the legislators in their benevolent wisdom insisted that everyone must have medical care with a total disregard of the practical problems even whether there were available physicians to render this care.

Secondly, but equally important was the problem of who shall pay for this health care system which they innovated. The Medicaid program as originally legislated was tantamount to fiscal bankruptcy in New York state. Lacking a sound background in medicine and failing to listen, the legislators blundered into deep water and nearly drowned. With all due respect and credit to their intentions and motives, which were undoubtedly good, the modus operandi was poorly thought out, poorly implemented, and poorly executed.

The plan that most closely relates to Christian justice will be the one that renders first-class quality medical care to all citizens in any community and at the same time does not produce or foster fiscal irresponsibility. On the other hand, from time in memorium it has been the coveted code of a physician to treat all patients regardless of color, race or creed, or financial status. (It has been as sacred as the Hippocratic Oath, although one wonders how sacred this Oath is today, especially in the State of New York where abortions are being fostered by permissive legislation.) The Christian physician blessed with special talents has a moral obligation to fullfil this duty. It is because of this dedicated duty that he, the physician, has a privilege also to deal directly with his patient, and not through a bureaucratic organization. This has been referred to in the past as doctor-patient relationship which, in my opinion, is the most vital part of the practice of medicine. This relationship has, at many times, equalled or exceeded the relationship between priest and parishioner and to destroy this relationship by interjecting a bureaucratic monster would be to destroy the keystone of medicine.

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Editor's Note:

Throughout his essay Dr. O'Keeffe infers that his Foundation Plan provides medical care for the medically indigent but does not explicitly mention in what fashion. Having followed the development of this program, I am in a position to know that the plan does call for payment of the health insurance premiums of the indigent by social agencies. Thus, payment in whole or in part will be made by county welfare or social organizations which organizations will be responsible as well for determining the eligibility of the applicants. (VHP)