Emily Anne Staples Tuttle papers.

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Version 3
August 20, 2018

San Antonio - 7/13/77

Dr. Douglas -

$30,000 per resident per yr. for family practice specialists now funded by state of Texas. No payback mechanism Dependent on selection.
McAllen, Tex. - 4 residents per year being graduated as a response to geographic mal distribution of providers
less expensive than building med. school.
70% of residents remain in practice within 70 mi. of where they took Residencies.
105 hosp. in Texas with over 200 beds which can be used for training.
Robert B. Green - 53 clinics 3,500 families being cared for (15,000 people) 86% kept appt. rate.
Those not eligible for medicade are because they are working poor. - Those are on sliding scale - one billing only
Serious work on educating.
About 18% of med students are Mex-American - but don't serve their own populace.
? Payment for supervisory personnel
No eligibility requirement for Bexar Cty. residents

Mary Ann Vara

Rural Health Initiative - legislative is to establish a health care system - using all resources.
? State supported hospital - residency requirements
Have fee for service referral

Mr. Lopez - Health - man power needs only until 2 yrs. ago then expanded to WIC - 11,000 participants
2/3 board members are migrants
1/4 of all farm workers are under 16
? Child labor laws - picking season
$8,000 annual income per family
20,000 migrants in Bexar County - 1 mil. in U.S.
2. Reimbursement for services by nurse practitioners - State. practice

[redacted] registered patients
[redacted]ors - 1 per 6,000 6 nurse midwives.
[redacted] payment system? lack of coordination
Pre paid contract?

Samuel Lopez -
Dr. David Ey

Most medical care is episodic ∴ hospitalization rate is higher.
Nutrition counseling is very difficult. = cost - diet
Prevention care - hard. These are "now" oriented people - not future oriented.

Continuity of care -
Para medical use -
Catigorization of care

Jack Corman - National Rural Center
Policy Research - Rural areas
25% of pop. but 40% of poor - 60% of substandard housing
Interagency task force - looking at Rural communications policy.
60% less - fees paid for medicare service in rural areas
medicaide - serves single parent family - most rural poor are not single parent
Suggestions: Rural development fund
Flexible reembursement system
Include transportation costs
Prevention + promotion - keep healthy!
Wyoming, Montana, West Virginia - as planning area
very difficult to get together!
Discrimination - race and cultural

Tom Triplett

Look at Nursing Practices Act for Nurs - expanded definition

Look at federal-state relationships - NCSL

Nurse midwife program

Professional liability insurance re p.a's

look at area of malpractice insurance!

Medicaide - Medicare - misuse is by doctors - not users!

Look at 1st $ gate

long term care - cost effectiveness - how best to do it?

Check on what kinds of procedures doctors can do at various hospitals - can only specialists do some procedures?

? How are claims processed - HEW coordination

? Under Medicaide in Minn. is there a maximum no. of hospital days per occurrance

Are clinic visits reimbursed?

? Coverage of preventive services - is there any education component?

Recheck EPSDT legislation

Wilbur Cohen - start with prenatal and early childhood care as part of a phase-in program

Look at whole area of physician extenders - nurse practitioners

look at utilization figures - both over + under!

Look at HSA - 93-641 - Health Planning.

? Number of doctors who will not accept Medicare - Medicaide participants.

? Reimbursement for hospitals

What are we doing for medically poor?

EPSDT - Fed. grant to state Welfare Dept contract w/Health.

One state Medical licensing board for all?

Dr. Sam Nixon

1.2 mil people in Texas are rural.

Prevention
Education!
Immunization (School shots)
Nutrition
Dental health
Accidents
farm + motor
Sexuality
School boards

Manpower
Double med. schools.
1980 - 1,000 drs. per yr. graduating

facilities
keep family near. Don't interfere w/ small community hospital.
Emergency med. services are vol.
Funding + control of funds should stay close to home.
Paperwork!
1st dollar cost - poor way to do things
60% of Medicaide $'s spent in last year of life.

funds.

no responsibility on part of the individual!

Hospital is small (65 beds?) but couldn't do it w/o contributions of Sisters of Divine Charity.

Dr. Maria Ramirez - Star County - Roba

Dr. Adela Navarro - 10 years to get a degree. Rural resident of Bexar County. Health care is a right - not a privledge.
Medicaide - 3-6 mos to become certified as permanently and totally disabled.

Incentives to consumers to remain well.
Rewards for education. - prevention.
Disincentives for crisis orientation!

Need for rural migrant tracking system.

LBJ Library - 7/14/77

Dr. Connett Grief - urging that each states problems be considered individually, formulating regs. State should control mandated services

Medicare-Medicade

Commissioner Raymond Bowe?

State Medical assistance dirt.

12 regional units.

Review of Hospitals -

Monitoring - program by program as well as overall

Criteria by region

Strong medical advisory committee

Cost study done before any new rule is promulgated.

NIMS system

? Lack of uniformity in functioning of PSRO's.

Allow state to do it?

Administrative costs low - would be hard to duplicate in a fed. program.

DHEW removes States initiative to be effective

Bill Fullerton cost sharing - 2X. of benefits goes to ~~patient~~ consumers

Medicare - contracts with separate organizations & with states - Federally regulated

(A + B Hosp Phy deduct. Coins +)

Medicade - Federal - state partnership.

States in trying to contain costs have done certain things.

~~Philosophical difference~~

Medicare - a right

Medicare - part of welfare

Dr. Grief

Recipient education program

2% of recipient used 12% of ~~program funds~~ services

Screen out possible over users. (Sarcas) for special counseling.

at the moment reimbursement is only fee for service

Dr John Smith -

254 counties in Texas
1 State acute general disease hosp - Galveston
"Hospital district law"
In 1975 Texas leg. licensed HMO's for Texas

Must Review committees established to review competency of physicians - (health)
Strong advocate of states rights
1931 - 2.2 visits per yr per patient average
1937 - 6 visits per yr " "
Portable medical insurance which always goes with

1981 - 110,0 medical school graduates
1976 - 7000 " " "

Former pending oversupply

Sen Joe Bernal

Monopolies of health care - U.S Senate testamony before Sen. Hart
You must be a welfare recipient in Texas in order to qualify for medicade. What happens to the "medically poor"?
EPSDT - contractual arrangement with Metro.
Health Dist is for screening only -
Need - program of national health insurance - delivered nationally w/ quality control monitored by the govt - not peer review.
No competition for medical care.

Certification + licesure - Supply of physicians
Now national board certification - 15 states have relicensure requirements.
P.L. 94-484 - foreign graduates - prevention of allowing to practice in U.S. Swatts
"Corporate practice of medicine" is illegal in Texas
Prepaid group practice can only be extended by physicians

Charles Greenfield? - San Antonio - Bexar Co. Dir of Health Services.

Karen Leerner - Study of agencies and their relationships.

EL CARMEN CLINIC

Visit's Purpose

The clinic is a representative example of the limited health delivery system in rural areas. Even with these limitations, the clinic exceeds what exist in many rural areas of this country.

The purpose of the visit is to offer the Committee an opportunity to see a rural health clinic in operation, listen to problems experienced by its staff and provide appropriate time to interface with the professionals who deliver the services.

Clinic Background

The El Carmen Clinic operates under the direction of the Daughters of Charity of St. Vincent de Paul. It is part of the El Carmen Mission which was established in 1817 as a memorial to the neglected dead of the Battle of the Medina River.

The Daughters of Charity of St. Vincent de Paul own and operate the clinic. They came to El Carmen Mission in 1958 at the request of the pastor, Father Raymond O'Brien. It was his desire that the Sisters establish a clinic to minister to the medical needs of the people of the area.

In 1959 the establishment of the clinic almost became a reality. A two room house was bought and moved to El Carmen. After being renovated into five rooms, donations of medical supplies and equipment arrived from the Daughters of Charity Hospitals. The clinic, however, did not open at this time.

Home nursing courses, care of the sick and injured and mother and baby care were implemented at the clinic in cooperation with the American Red Cross. There was difficulty in persuading doctors to volunteer their services.

In 1964 four doctors agreed to volunteer their services at the clinic: an obstetrician, a dermatologist, a medical-surgical doctor, and a pediatrician. These doctors treated patients in a new clinic which was built through the generosity of Mr. Warren Crane. Also in 1964, a Daughter of Charity, who was a nurse-midwife, began serving at the clinic. She provided prenatal care and delivered babies until 1969.

In 1968 the clinic was again confronted with the problem of insufficient medical doctors. At this time another site was selected. This was the beginning of the De Paul Family Center on Somerset Road. This site services the emergency needs of the people of the area.

Again in 1971 a doctor volunteered his services so that once more the people at El Carmen would have medical services. Presently, medical services are limited to a Sister nurse who provides emergency medical services and counsels the patients to seek further medical attention if needed.

Southwest Migrant Association
San Antonio, Texas

The Southwest Migrant Association, originally known as Bexar County Migrant and Seasonal Farm Workers Association, was established in 1968. The Association primarily serves the Bexar County migrant and seasonal worker population, but also provides more limited services to similar populations in surrounding counties within a 100 mile radius. The target populations are primarily Spanish-speaking.

Southwest Migrant Association is presently responsible for three Federally supported health programs, as follows: (a) Migrant Health Project ($275,000) which serves about 10,000 persons per year; (b) Women, Infants and Children ($5,000-USDA) which serves about 11,000 persons per year; and (c) Rural Health Initiative program in nearby Atascosa County.

Other kinds of services are provided to about 5,000 persons each year. In all, it is estimated that 18,000 individuals receive some type of service annually. In addition, a migrant and seasonal farm worker manpower program is operated in 11 counties in conjunction with the Governor's Office of Migrant Affairs ($5,000,000).

The Board of Directors consists of 14 members elected annually. The Board then selects seven other members who need not be members of the Association.

The Association also works with local school districts as consultants and resource people for migrant and seasonal farm worker related problems. The same services are provided to local junior colleges, colleges, and universities. The Association sponsors about 50 young people each year for college training or similar self-improvement programs. Technical assistance of various kinds are made available without cost to local communities or other groups in surrounding counties.

Southwest Migrant Association owns, or is purchasing, its own quarters. In addition, the Association built a new building for a health clinic from their own funds. There is now pending a $300,000 HUD grant to construct a Migrant Service Center at their headquarters site. This building is to be used for general purpose services to migrants and seasonal farm workers.

The Southwest Migrant Association provides weekly public service programs on local television, radio stations and other local media to discuss their programs and services. This service has been underway for several years.

BIOGRAPHICAL MATERIAL
ON SPEAKERS

HERSCHEL DOUGLAS, M.D. - Professor and Chairman of the Department of Family Practice, University of Texas School of Medicine at San Antonio, Texas. He also serves as Director of the Medical and Dental Staff, Bexar County Hospital District, and Chief of the Family Practice Service, Bexar County Hospital. Dr. Douglas is a recognized consultant in the field of ambulatory health care delivery and training by the Veterans Administration and the Southern Medical Association. He is also project director of a PHS-funded Family Practice Residency Training Program that will train 21 residents during the 1977-78 period. Residents receive instruction and provide primary health care in both rural and urban ambulatory training settings.

JOAQUIN MARRON, M.D. - Currently a private physician. He is a former volunteer physician for the El Carmen Clinic for several years. He is a member of the Texas Medical Association, American Medical Association, the Association of American Physicians and Surgeons, and the Bexar County Medical Society.

RUTH STEWART, R.N. - Associate Professor in Community Health Nursing, University of Texas at San Antonio (1969 - Present). Formerly instructor in Public Health Nursing at University of Florida (1967-69) and University of Wyoming (1961-63). Previous experience has included public, private, and foreign duty nursing. She is currently the President of the Texas Nursing Association (TNA) and is the TNA Coordinator for passage of the Nursing Practice Act. She has made numerous presentations on the use of Nurse Practioners.

DANIEL HAWKINS - Executive Director of Su Clinica Familiar, Harlingen, Texas. Su Clinica Familiar began as a Migrant Health Clinic in 1971 and became a Rural Health Initiative Clinic in 1975. They have two clinics--one in Harlingen and one in Raymondville. The clinics serve 27,000 patients, most from indigent families. Seventy percent of the patients are migrant, seasonal farm workers. Mr. Hawkins is Past-President of the Rio Grande Federation of Health Centers and current Treasurer of the National Association of Neighborhood Health Centers, Inc. He has testified before numerous Congressional Committees regarding migrant health problems.

MANUEL LOPEZ - Executive Director of the Church and Society Commission of the Catholic Diocese of Brownsville. He is a board member of Su Clinica Familiar. When the clinic opened in 1971, Mr. Lopez served as interim administrator and was also the interim administrator of the Delta Rural Medical Center. He is a member of the National Advisory Council on Migrant Health and has served on various health planning groups. Mr. Lopez is also associated with the South Texas Health Consumers Association and is currently in charge of staff development at the Center for the Management of Innovation in Multi-Cultural Education (MIME). MIME responds to the needs of students with limited English-speaking ability.

DAVID ENZ, M.D. - Formerly a physician with Su Clinica Familiar for three years. He has been studying pediatrics at the University of Texas School of Medicine in Houston for the past year and plans to return to the Rio Grande Valley to practice upon completion of studies.

JACK CORNMAN - President of National Rural Center since June 3, 1977 and was previously the Executive Director since March 1975. The National Rural Center is an independent non-profit organization which develops policy alternatives and provides public information to help rural people and communities achieve their full potentials. Mr. Cornman has professional experience in a variety of capacities on various Senatorial and Congressional staffs.

SAM NIXON, M.D. - Member of Board of Directors of the Camino Real Health Systems Agency, Inc, which is a health planning development organization. He is Chairman of the State Rural Medical Education Board and is a speaker to the Congress of the American Academy of Family Physicians. Dr. Nixon has been involved in the practice of family health in rural Texas for the past 23 years.

MARIO RAMIREZ, M.D. - County Health Officer for Starr County in South Texas. He is the only physician in a county of 17,000 residents. Instrumental in the establishment of a 48-bed hospital in the county in 1975. Chairman of South Texas Medical Steering Committee whose goal is the improvement of the delivery of health care services in a 40-county area of more than two million persons. Dr. Ramirez has been the County Judge of Starr County since 1970 and is a member of Board of Directors of Blue Cross-Blue Shield. He is a member of the HEW National Advisory Health Council and Chairman of Committee on Health Care of the Poor, Texas Medical Association, as well as Vice-Chairman of the Committee on Health Care of the Poor, American Medical Association.

ADELA NAVARRO - Supervises outreach work at the Barrio Comprehensive Child Care Center and is a social worker for the clinic. She is a member of the Health Action Council, Food Stamp Task Force, Subcommittee for Child and Maternal Care at Camino Real Health Systems Agency, Inc. and is on the board of the Visiting Nurses Association. She has spoken before the Texas Legislature on health care in Texas (lack of), Senator McGovern's Nutrition Committee, Medicaid hearings, and the World Hunger Conference.

EMMETT GREIF, M.D. - Deputy Commissioner for Medical Programs, Texas State Department of Public Welfare. He has been in general practice for twelve years and is a practicing anesthesiologist. He came to the Department of Public Welfare in September 1974. He is a member of the County and State Medical Associations and a member of the Society of Anesthesiologists.

BILL FULLERTON - Deputy Administrator for Health Care Financing Administration as of Friday, July 8. He was formerly Special Consultant to the Secretary of HEW and was the Washington representative for the American Association of Foundations for Medical Care in 1976-77. Mr. Fullerton was also the Washington representative for the American Association of Professional Standards Review Organization from 1970-76.He was a Professional Staff Assistant for the House Ways and Means Committee from 1967-69 and was a specialist in social legislation at the Library of Congress from 1965-66. First Executive Secretary of Health Benefits Advisory Council.

JOHN M. SMITH, JR., M.D. - Current President of the Texas Medical Association (TMA). Instrumental in the establishment of the University of Texas Health Science Center and the South Texas Medical Center in San Antonio. He is a former member of the TMA Council of Medical Jurisprudence (1954-66) and the Texas State Board of Health (1963-75). Past President of Bexar County Medical Society (1967) and Past Chairman of the TMA Board of Trustees (1970-76). Former member of the American Hospital Association Committee on Physicians (1974-76) and American Medical Association Political Action Committee Board of Trustees (1974-77). In 1973 he became a Fellow of the American Academy of Family Physicians. He has served on the Texas Medical Foundation Board of Directors from 1973-76. Current members of the Board of Directors of the Texas Political Action Committee.

JOE BERNAL - Former State Senator. While in the State Legislature he sponsored a constitutional change extending Old Age Assistance to non-citizens who had been in the United States for over 25 years. Mr. Bernal also authored legislation for the University of Texas at San Antonio dental and nursing schools. He is also a board member of the Texas United Community Services Center. From 1964-1968 Mr. Bernal

JOE BERNAL - Continued
worked as a social worker at the Inman Christian Social Center in San Antonio. He was executive director of the Guadalupe Community Center in San Antonio from 1968-69. Mr. Bernal served as executive director of the Commission for Mexican American Affairs from 1970-74.

MICKEY LELAND - Representative Leland is a graduate pharmacist, thus his interest in health and medical legislation. Rep. Leland has and is sponsoring progressive health care legislation. He sponsored enabling HMO legislation first in 1973 and continued his support of the HMO Act until it was finally passed in 1975. As a member of the House Appropriations Committee, Rep. Leland has been instrumental in the funding of various health care facilities. He has also introduced various bills dealing with catastrophic illnesses. Rep. Leland was instrumental in the funding of the Rural Medical Education Program. Generic drug substitution legislation is also introduced by Rep. Leland during each session of the legislature. He has also encouraged more sensitive appointments to the various state regulatory agencies dealing with health and health related fields.

NATIONAL HEALTH INSURANCE COMPANY

Austin, Texas 78757

Exchange Park
7800 Shoal Creek Blvd.
(512) 458-5111

THE MEN AND WOMEN OF THE NATIONAL HEALTH INSURANCE

COMPANY WELCOME YOU TO AUSTIN

National Health Insurance Company (NHIC), a wholly owned subsidiary of E.D.S. Federal Corporation (EDSF) and its parent corporation, Electronic Data Systems Corporation (EDS), was chartered as a Chapter III corporation to conduct life, health, and accident insurance business in the State of Texas on October 5, 1976.

Fewer than 120 days were required to organize and staff NHIC, and to acquire and equip its physical facilities. Underwriting and administrative services for the Texas Medical Assistance Program began January 1, 1977. In the first six months of operation, NHIC has processed approximately 1.5 million claims for services provided to Medicaid recipients.

NHIC's base of business is oriented toward government programs and specifically its contract for the Texas Medicaid Program. The NHIC system is designed to ensure the optimal combination of clerical staffs, professional staffs, and the latest computer technology for effective control of administrative costs and benefit dollar expenditures. This is possible due to the experience EDS had gained in its approach to health care facilities management over the past 11 years. It is much wider in scope than the traditional data processing role of providing only system maintenance and operation. EDS traditionally has been involved with its customers in such activities as design of clerical procedures and workflows, development of clerical production standards, interpretation of regulatory statutes, development of provider education programs, defining performance goals, conducting marketing and acturial studies, and drafting of payment determination policy. As a result of this approach to facilities management, it was necessary for EDS employees to have a thorough knowledge of the health insurance business as well as computer technology. As early as 1966 EDS has been involved with the Medicare and Medicaid programs. This involvement has been nationwide and specifically in the following states:

Texas	Washington	Louisiana
California	Minnesota	Florida
Massachusetts	Arkansas	North Carolina
Indiana	Ohio	Idaho
West Virginia	Alabama	Wisconsin
Iowa	Tennessee	New Mexico
Pennsylvania	New York	Kansas
Puerto Rico		

In total, EDS systems currently process over 164 million health insurance claims annually. This represents approximately 45 million Medicare Part B claims, over 88 million Medicaid claims, 2 million CHAMPUS claims, and 29 million claims for non-government group contracts. Millions of dollars and thousands of man years of effort have been invested in the data processing systems, designed and programmed by EDS, that handle these large claim volumes. Of the 164 million claims, EDS has total responsibility for the administration of over eighteen percent (18%) of this volume (30 million) as an underwriter and/or fiscal agent.

EDS has made a reality of the often discussed concepts of national model systems, regional computer centers, remote on-line processing of data, and elimination of costly duplicate efforts. These operational computer systems are reliable, highly efficient and help produce tangible results for the nation's health care delivery system.

We trust your visit to our facilities will assist in formulating your ideas and recommendations.

AGENDA

ADVISORY COMMITTEE MEETING

Hartford/New Haven, Connecticut

September 22-24, 1977

September 22

evening	- Arrive in Hartford; accomodations at Hartford Hilton Hotel, 10 Ford Street, Hartford, Connecticut (203) 249-5611.
8:00 p.m.	- short briefing

September 23

8:15 a.m.	- leave by bus for The Aetna Life and Casualty, 151 Farmington Avenue, Hartford, Connecticut
8:30 - 10:15 a.m.	- tour of above facility
10:30 - 12:15 p.m.	- convene public meeting at the Aetna Company topic: Role of Private Insurance Companies Under NHI
12:30 - 1:30 p.m.	- lunch
1:30 - 3:00 p.m.	- reconvene public meeting at Aetna Company topic: Non-physician reimbursement
3:15 - 5:30 p.m.	- general audience participation and committee business meeting.
evening	- dinner in Hartford at The Brownstone

September 24

8:00 a.m.	- leave by bus for Yale-New Haven Hospital, 780 Howard Avenue, New Haven, Connecticut
9:00 - 10:30 a.m.	- tour of above facility
10:45 - 12:30 p.m.	- convene public meeting at Yale-New Haven Hospital topic: Hospital Reimbursement
12:30 - 1:30 p.m.	- lunch

1:30 - 3:00 p.m.	- reconvene public meeting at Yale-New Haven Hospital topic: Mental Health Benefits under NHI
3:15 - 3:45 p.m.	- general audience participation
evening	- leave New Haven by charter plane for Reston, Virginia

September 25

10:00 - 11:45 a.m.	- meeting with international group on national health insurance
11:45 - 12:45 p.m.	- lunch
1:00 - 3:00 p.m.	- reconvene meeting

VANDERBILT UNIVERSITY

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August 29, 1977

Ms. Susanne Stoiber
Project Coordinator
Advisory Committee on National
Health Insurance
Department of Health, Education,
and Welfare
Office of the Secretary
Washington, D. C.

Dear Susanne:

This material was sent to me with the request that it be transmitted to you and to the members of the Committee.

Thank you very much for taking care of this matter.

Sincerely yours,

Ingeborg

Ingeborg G. Mauksch, Ph. D., F.A.A.N.
Professor and Family Nurse Clinician

lly

enclosure

UNIVERSITY OF WISCONSIN–MADISON
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August 8, 1977

Ingeborg G. Mauksch, Ph.D., F.A.A.N.
Secretary's Advisory Committee on
National Health Insurance
Senior Project Consultant
The Robert Wood Johnson Nurse Faculty
Fellowship Program
School of Nursing
Vanderbilt University
Nashville, Tennessee 37240

Dear Dr. Mauksch:

I did not know, until after I arrived at the Advisory Committee meeting (Wisconsin Center, Madison, Saturday, July 30, 1977), that members of the public would really be offered an opportunity to speak. If I had known, I would have prepared a statement that more clearly presented my concerns.

I ask now that you forward to the Chair my written comments.

Mr. Chairman; Members of the Committee:

Thank you for the opportunity to speak. I have several concerns. Perhaps the most serious pertains to the composition of the Advisory Committee. Since women make up more than 50 percent of the work force in the health care industry (providers), are reported to use the industry's services more than twice as often as do men (consumers), and women make up at least 50 percent of the population of the country (tax payers), I do not see how the five women members of the Advisory Committee can be expected to represent women's interests in health insurance. Further, the total number of nurses is vastly greater than the total number of physicians; yet, one nurse only has been appointed. This comment is not intended to reflect on the quality and competence of the women and men of the committee. The committee composition, however, does reflect a lack of sensitivity and commitment to equal representation of women in all aspects of this administration's appointments.

My second concern relates to the comments made previously by the health planners. I heard mainly discussions about hospital costs, nursing homes, and cost containment. The planners either do not know about, or if they know, do not care about, the hundreds of home health care agencies in this country which provide care to

persons in their own homes. Additionally, the economic value of health/sickness services provided in the home by wives, mothers, and other relatives needs attention for reimbursement consideration (See Eugenie Carpenter's research, University of Michigan). Further, no attention has been given to the costs of maintaining and the services provided by the mini-hospitals in such industries as Dole, General Motors, or Ford Motors. Planners and economists attend to the health or fringe benefit package in union contracts. This package, I believe, excludes the costs of maintenance of an in-plant/on-site primary and acute care facility. These facilities, to my knowledge, have never been included in a community inventory of health service sites. Nor do I believe that any of the present bills in Congress address the payment for services rendered in these sites. The costs of these sites are reimbursed by the purchaser of cars, steel, pineapple and other products.

My third concern relates to the fact that all bills are presently titled health insurance, when in fact, they are bills intended to pay the costs of sickness; they are sickness insurance bills. The design of the bill is constructed on a sickness/medical model, not a wellness/non-medical model. My last reading of the bills led me to conclude that there is little in any of the proposed legislation that will address the serious issues of redistribution of services and personnel. Present proposals seem designed to protect the status quo, maintain medical domination of decision-making, propose reimbursement mechanisms whereby physicians can increase their income with the employment of non-physician health providers. If cost containment and quality assurance are truly factors, then whatever form national legislation takes, it must include separate reimbursement mechanisms for certified nurse-practitioners/nurse-midwives. Incentives to states to change their nurse practice, medical practice, and pharmacy acts in order to enable legal practice and thus reimbursement, must be written into the legislation.

One final concern relates to the present proposals which offer no reimbursement for care provided by alternative care systems. For example, a couple desiring birth at home, attended by either a physician or a certified nurse-midwife, would not have child bearing costs covered. If that birth occurred in the hospital, however, the costs would be covered. Whatever form the legislation is to take, it needs to provide a way to cover the costs of childbearing, preventive health services such as breast examinations, cytology tests for both women and men for early detection of pathology, and, of course, contraception/conception control drugs and services. Anti-immune globulin (Rho-Gam) costs approximately $5 to $10 in Canada; it costs between $50 to $100 in this

country. Do the present bills cover the costs of these preventive services? I think not (See D. Lewis, Guttmacher Institute). The present bills will ensure hospitals and physicians of income; they will do little toward altering the system. The precedent was set with Sheppard-Towner, it continues in the present proposals.

In conclusion, I support Dr. Ris' plea for attention to the needs of adolescents. I would urge considerable attention to reimbursement incentives for home health care agencies, to consideration of the differences between sickness and wellness and the costs of treating the one and promoting the other, and finally, an examination of the model on which all present bills are built.

These hearings are a part of a long American health policy history. I am pleased to have had an opportunity to contribute to that history.

Thank you.

For what it is worth, Dr. Mauksch, I wrote my preliminary examination as an "Essay in Defense of a National System of Licensure for Nurses and Physicians" and my dissertation on "Federal Policy Affecting Child-Bearing Women 1912-1913." We have spent a mint since 1919 on hearings pertaining to federal policies for payment of medical/health care services to the American people. I am not optimistic that much will change. Profits and incomes are too good to share or alter.

Sincerely,

Joan E. Mulligan

DR.

Joan E. Mulligan, Ph.D., C.N.M.
Associate Professor
Graduate Division

sds

cc: Mr. Manuel Soliz, Executive Director
Rio Grande Federation of Health Centers, Inc.

REIMBURSEMENT FOR MID-LEVEL HEALTH PROFESSIONALS

Introduction

This paper describes the roles, reimbursement options and current government policies for non-physician health personnel with emphasis upon nurses, nurse practitioners (NPs) and physician assistants (PAs). First, the various types and numbers of non-physician health professionals are discussed in the context of the supply of physicians, the increased specialization engendered by the rapid implementation of sophisticated medical technologies and state licensure laws. Second, government policies that subsidize the training of non-physician health personnel are discussed. Third, existing and alternative reimbursement practices are analyzed.

Allied Health Personnel

There are more than 150 different categories of allied health professionals, numbering 3.5 million, who account for 74% of the employment in the health sector. These groups vary widely with respect to their roles in the provision of health services as well as to their education and training. The largest groups are nurses (registered and practical), nursing aides and orderlies, and clinical laboratory technologists and technicians, which account for 38%, 27%, and 4.8%, respectively, of all allied health professionals. The number of these personnel is striking compared to that of the 350,000 practicing physicians. The number of non-physician health workers is expected to increase from 4.5 to 5.7 million, an increase of 27%, over the next 10 years.

The particular tasks performed by virtually all health professionals are in a continuous state of change and are dependent upon historical institutional

roles, the number, location and practice modalities of physicians, the rapid implementation of sophisticated medical technologies, new health care delivery modalities, state licensure practices and the reimbursement practices of public health programs and private insurors. Historically, the physician has been the dominant decision-maker in the health industry, providing services to patients, directing other health professionals, advising hospital administrators on capital equipment purchases, and so on. The physician alone has been viewed as the sole professional with sufficient training to make decisions regarding the diagnosis and treatment of patients. More recently, however, nurses and new categories of health personnel, such as physician assistants, have claimed the expertise to assume some of these functions.

Physician Supply and Availability

While the physician-population ratio remained stable at approximately 150 physicians per 100,000 population for the first six decades of this century, that ratio has since risen to 176 per 100,000 in 1975. Current projections are that the physician-population ratio will increase by 35 percent to 237 per 100,000 by 1990. This growth in the proportionate number of practicing physicians has been accompanied by increasing specialization and geographic concentration of physicians. Consequently, access to primary care services has not necessarily increased concommitant with the increase in number of physicians. In some areas, supply has actually decreased, creating shortages of medical care.

The increasing technological complexity of medical care, the specialty practice of physicians, and the geographic maldistribution of primary care physicians has resulted in increased demand for allied health professionals

both to perform specialized, technical services and, ironically, to provide primary care services which physicians are not available to provide.

Mid-Level Primary Care Practitioners

While the bulk of jobs for allied health personnel are in hospitals, the focus of this discussion is nurses, nurse practitioners, and physician assistants, many of whom are providing primary health care services in ambulatory settings. These services range from history taking and patient education and counselling to performing physical examinations and diagnosis and treatment of common patient complaints and illnesses.

In considering the services of these mid-level, primary care practitioners, and the alternative methods of paying for them, it is useful to classify these services as either complementary to physician services or substitutes for them. Traditionally nurses have provided patient care services which complement those provided by physicians. Within the past decade, however, nurses have sought expanded roles which have been formalized by post graduate nurse practitioner training. Many of the services which nurse practitioners and physician assistants have been trained to provide go beyond those services which are incidental to or complementary to physician services; they substitute for them. Thus the services provided by nurses, NPs and PAs can be classified as of two types --the monitoring services which nurses have traditionally performed in institutional settings and certain diagnostic and treatment services traditionally considered to be physician services, which NPs and PAs are beginning to perform under the supervision of physicians. In actual practice, it is not known to what

extent mid-level practitioners working in primary care settings do provide substitute services as opposed to supplementing physician services to patients.

Licensure and Medical Practice

An important distinction between the legal status of nurses and nurse practitioners on the one hand, and physician assistants on the other, is that nurses have licenses and are subject to State nurse practice acts, whereas physician assistants practice under the general delegatory authority of State medical practice laws or, in the majority of States, under the regulatory authority of boards of medical examiners. An area of ambiguity is whether nurse practitioners, in the performance of medical services rather than nursing services, are practicing under the authority of nurse practice acts or under the delegatory authority of physicians. The nursing license permits considerable independence of functioning in the provision of traditional nursing services. The gray area lies in the performance of services which have traditionally been considered medical in nature. Licensure requirements and the requisite degree of physician supervision of these mid-level practitioners vary from State to State.

Amendment of State nurse practice acts specifically to allow for the performance of diagnostic and treatment services by nurses began in 1971. State legislation permitting the supervised practice of physician assistants was first enacted in 1970. Since these recent developments approximately 8000 persons graduated from nurse practitioner training programs and 5000 from physician assistant training programs. It should be noted that these training

programs are not standardized in content or in length of study. The DHEW agency making grants to these program does set criteria for funding purposes.

Federal Support

The Federal government has supported training programs to prepare nurses for new and expanded roles, including nurse practitioner training, since 1971. In fiscal year 1977 project grants and contracts to support these advanced nurse training programs totalled $18 million. Physician assistant training programs have received DHEW grant support since 1972. In FY 1976 DHEW awarded grants to 35 training programs totalling $6.3 million. Training funding has also been available from agencies such as the Department of Defense.

A Profile of NP and PA Practice

Forty-five percent of the NP graduates practice in community-based clinics or physician practices and another 25% in hospital-based clinics. Sixty-six percent of physician assistants practice in primary care settings. Mid-level practitioners are more likely than physicians to practice in rural areas* -- 21% of NPs, and 25% of PAs, compared to 7.5% of patient care physicians.

Reimbursement Practices and Alternatives

Traditionally most allied health personnel, including nurses, NPs, and PAs, have been employed on a salaried basis by institutions or by solo and group physician practices. Only limited third-party reimbursement is available for non-institutionally based nursing services, or for the services of ancillary health personnel such as physical and occupational therapists. Payment for hospital-based nursing services is included in the cost-related reimbursement to these institutions from third-party payors.

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*Nonmetropolitan counties of less than 50,000 population

NPs and PAs functioning as dependent providers of essentially medical services have for the most part remained salaried employees of physician practices, ambulatory care clinics, and hospitals. The issue of reimbursement for the services of these professionals is quite complex. While they may perform some of the same services which physicians provide, by statute they must function under some degree of supervision. While it would be theoretically possible for NPs and PAs to "buy" necessary supervisory time from physicians and maintain their own fee-for-service practices, this is unlikely for three reasons. First, physicians are not likely to sell their services to potential competitors. Second, some State practice laws are too restrictive regarding physician supervision to allow for an economical arrangement (e.g., the physician would have to be on the premises with the NP or PA at all times.) Third, most third party payors are reluctant to extend fee-for-service reimbursement to mid-level practitioners because of concerns for quality of care, because fee levels and the services to be provided by these practitioners would be difficult to determine, and because this would increase total reimbursements. Given the present organization of NP and PA practice, fee-for-service reimbursement directly to these dependent practitioners would set a precedent for reimbursement of other allied health professions with potentially inflationary consequences. The alternative of salaried employment of NPs and PAs presumes their continued presence in organized settings.

The Health Care Financing Administration is conducting an experiment in Medicare reimbursement of NPs and PAs working in primary care practices. Medicare payments are made to the practices (not to the individual practitioners) for services provided to beneficiaries by PAs and NPs according

to one of four methods. These are periodic payments related to the costs of providing services to Medicare beneficiaries, and three reasonable charge methodologies: the practitioner's reasonable charge (1) equals that of the supervising physician, (2) is set at 80 percent of the physician's reasonable charge, and (3) is set at a rate related to average cost. The evaluation of study data will consider the effects of the reimbursement method applied, the effects of the presence of mid-level professionals within practices, the quality of services provided and the levels of expenditures for care both from the Medicare program and from beneficiaries.

Congress is considering legislation which would allow the Medicare program to pay for the services of NPs and PAs practicing under general physician supervision in primary care clinics in nonurbanized, medically underserved communities. The clinic would receive cost-related reimbursement for all covered services provided to beneficiaries by both physicians and mid-level health professionals. An amendment to this bill would require State Medicaid programs to pay for services in the State plan to Medicaid beneficiaries when provided in clinics which are eligible for the Medicare payments described above. Currently Medicare Part B covers only those services provided by non-physicians which are an incident to physician services and the payment for these services is then included in the physician's charge.

Conclusion

There are three basic approaches to payment for the services of mid-level pratitioners. First, these services may be included as overhead in the institution's charges or cost-related payments, as is the case now with

hospital-based services and with billing under Medicare Part B for physician services and those "incidental" to them. Second, fee-for-service payments for these services may be made to the practice, clinic, or hospital with which the mid-level practitioner is associated. The practitioner could have a variety of employment arrangements with the practice. Third, the practitioner could receive fee-for-service payments directly. Determination of the basis on which payment will be made for such services under NHI will depend as much on what the nature of the service is considered to be, and on the legal status of the practitioner, as it will depend on efficiency considerations.

Our experience with alternative reimbursement methods for mid-level practitioners is extremely limited. Current reimbursement practices regarding hospitals and physicians are being evaluated and reconsidered even as this new group of health care providers is emerging. The numbers of mid-level practitioners can be expected to grow quite rapidly, as are the numbers of other allied health professionals. Establishing separate fee-for-service reimbursements for any of these professions would set a precedent for extension to other professions which would be politically difficult to resist. Given the current problem of health care costs, and the general inflationary consequences of fee-for-service reimbursements, many policy makers are reluctant to propose extensions of the fee-for-service system at this time.

NON-PHYSICIAN REIMBURSEMENT UNDER NATIONAL HEALTH INSURANCE: THE PHYSICIAN'S ASSISTANT*

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Health Care in the United States

The United States Congress and the Administration have attempted to address in a pragmatic and economical fashion the inequities and injustices in the American health care system. American medicine has improved the quantity and quality of medical care since the publication of a classic report on medical education by Abraham Flexner in 1910. However, challenges continue to face the American health care system, inclusive of, but not limited to, changes in population size and composition, a maldistribution of income, general economic inflation with an inflationary rise in medical care costs, limited "access" to primary care, and a high mortality and morbidity rate for an industrial nation. Evidence to support these claims is visible through: an extremely mobile population base; a significant physician manpower pool which is, unfortunately, maldistributed; the state of our economy; and comparisons of age-specific death rates and life expectancies. Accessible medical care of an acceptable quality is not a reality for many Americans. "Access" is a problem which can be directly related to cost and a maldistribution of consumers and primary care physicians. Victor Fuchs in his book entitled, "Who Shall Live?" believes "the most important

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*Presented to the National Health Insurance Advisory Committee, regional hearing, Hartford, Connecticut, September 23, 1977.

reasons for current complaints about access...is the growth of specialty practice within medicine...and...finding a physician who will take continuing responsibility for the patient...."[1]

It seems generally agreed there is an imbalance of valuable health resources in the United States and the present fragmented system for financing health services is in itself a major handicap. Annual expenditures in the United States for health purposes have reached significant proportions: $139.3 billion in 1976 which represented 8.6% of the gross national product and an annual per capita expenditure of $638 for every man, woman, and child in the country. Since 1967, with the implementation of Medicare and Medicaid Programs, the trend has been toward increased public financing of health care. Subsequently, the cost of health care has risen rapidly and the governments' (federal, state, and local) share of the nation's health bill is currently more than 42% compared with 25% in 1966.[2]

Private health insurance has expanded over the last decade with increased consumer participation in various programs. However, many Americans have limited protection and in 1974 paid $28.4 billion in premiums and subscription charges. In 1974, 78% of the population had insurance for hospital care and only 60% were insured for physician outpatient care. An estimated 22 million people or 12% of the American population have no health insurance protection under either public or private programs.[3]

We have not utilized our health resources well in terms of capital plants (hospitals) and manpower (physician, nurse practitioners, and physician's assistants). The issues surrounding the nation's current supply of health manpower focus on: (1) a geographic maldistribution of primary care and "specialty" physicians; (2) the increasing reliance on graduates of foreign medical schools; and (3) the underutilization of mid-level health practitioners termed physician's

assistants and nurse practitioners. The national average is 130 physicians per 100,000 population, but in South Dakota we have 71 physicians per 100,000 and in New York 195 physicians per 100,000 population. Many of the nation's physicians are concentrated in densely populated metropolitan areas with only 7.3% of physicians located in non-metropolitan areas to serve the needs of 17% of the population. The nation continues to depend on foreign medical school graduates (FMG's) which represented 6% of all physicians in the United States in 1959, compared with 20% of that population in 1973. Nurse practitioners and physician's assistants have been trained in increasing numbers, but economic disincentives for their employment by clinics and physicians persist because of a lack of Medicare and Medicaid reimbursement for their services. Finally, the nation's 7,156 domestic hospitals represent a major capital component of our health resources, yet many have been ill planned and mismanaged. In 1975, they employed three million full time equivalent employees with a total payroll of more than $27.1 billion and handled 36 million admissions and nearly 255 million outpatient visits. However, due to ill planning (and reduced lengths of stay and declining occupancy rates) there exists a significant idle-bed capacity which represents an expensive waste of capital outlay.

Many rural Americans are without adequate access to primary care and this country's ability to provide sound health programs is limited by cost and health manpower constraints. A total of 133 counties in the United States (with more than 500,000 residents) are without a physician engaged in patient care. Physician manpower supplies have been increased with a resultant modest increase in access to physicians since 1958. However, in addition to the availability of health providers, principle determinants include the patients' attitudes toward and the ability to pay for health care. Personal life-styles, biological makeup

and the environment in which Americans live and work are major determinants of health. Consumers seem to risk long-term "health" for short-term hazards such as smoking, lack of exercise, alcohol and poor compliance with medical therapy. Low income consumers face the additional hazards of poor housing, malnutrition, and inadequate sanitation. Obesity, physical indolence, smoking, and substance abuse are largely self-determined behavioral choices -- choices which have major consequences for the health care system. Sound preventive health programs and an improvement in patient compliance (through patient education) seem to be sound long-term investments. With real concerns relative to cost, I concur with Fuchs who believes "...demand for access can not be met for the total population by personnel now known as physicians (such personnel are too expensive)...and...an efficient effective solution to the access problem requires the deployment of properly trained, properly supervised... physician's assistants."[4] It would seem reasonable to train more physician's assistants whose cost of education is substantially less than that of the physician, and whose role and function in primary care would be a valuable asset in both the provision of preventive care as well as acute and chronic care intervention.

Medical Care and the Physician's Assistant

In an attempt to improve patient access to and the quality of medical care, the United States Congress and organized medicine have been responsible for the training and deployment of physician's assistants (P.A.'s). In 1970, the American Medical Association defined the physician's assistant as, "...a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible

for the performance of that assistant."[5] Since 1971, the American Medical Association in collaboration with medical specialty societies has accredited more than fifty programs. Since 1973, the National Board of Medical Examiners has administered a national certifying examination and continues to do so in collaboration with the National Commission on Certification of Physician's Assistants. Currently, forty-three states have enacted legislation recognizing and regulating the practice of physician's assistants.[6] The development of this profession over the past decade has been carefully planned by individuals on the cutting edge of medical education and health care delivery.

Physician's Assistant Impact

Economics of Care: Educational cost data from the National Center for Health Services Research on physician's assistants show the educational costs to be $15,100 per year.[7] The cost of producing a physician's assistant is less than 25% of the cost of preparing a graduate physician.[8] Wert's[9] data reveals production cost savings (physician's assistant:physician) with a P.A. able to provide 2.6 years of physician-equivalent services before a physician, who simultaneously began his medical education, can begin practice. Moreover, Record[10] estimates a savings of $20,000 per physician's assistant per year in a health maintenance organization setting. Peterson[11] and his colleagues have shown significant reductions in hospitalizations through the utilization of physician's assistants in the delivery of chronic care in ambulatory clinics. This data has been substantiated by Runyan[12] and in a study done by the Mitre Corporation for the Appalachian Regional Commission.[13]

Access of Care: Scheffler[14] and Light[15] report wide distribution of physician's assistants throughout all fifty states with a majority in primary

care settings. Dr. Light surveyed 4,963 physician's assistants in 1976, had a response rate of approximately 80% and found 82.7% of the population providing primary care in both rural and urban settings and in private as well as institutional practices. Various physician's assistant programs report: in Oklahoma 62.2% and in Utah 72% of program graduates are practicing in communities of less than 25,000; and in Washington 57.7% are in communities of less than 20,000.

Quality of Care: Numerous studies: Nelson,[16] Pondy,[17] and Henry[18] have shown patient acceptance as a function of perceived quality of care is highly favorable. For example, Nelson found that more than 85% of patients rated P.A.'s as highly competent and professional, and 71% reported an improvement in the quality of care. Task analysis studies find P.A.'s performing complete history and physical examinations, diagnosing acute and chronic disease, performing complex diagnostic and therapeutic procedures, and in the management of disease, (in collaboration with and under the supervision of licensed physicians), providing much more preventive medicine and counseling services to the patient and the family. Continuity of care has been much improved with the deployment of P.A.'s in hospitals, nursing homes and extended care facilities. Record reports no significant differences in morbidities or "outcomes" in primary care services delivered by physician's assistants and physicians.[19] Most importantly, B. J. Anderson, J.D. (A.M.A. Legal Counsel) stated that as a result of decreased patient waiting time and increased continuity of professional care, it appeared that the inclusion of a physician's assistant in a practice was an excellent deterrent to the ever-present threat of malpractice.[20]

In sum, a review of available research seems to show that the physician's assistant concept has been successful in addressing the three major issues confronting the nation's system for health care by inducing: (1) a reduction in

cost, (2) an improvement in accessibility, and (3) the delivery of high quality care.

The Case for National Health Insurance

The literature is replete with articles on national health insurance and its potential for application in the United States. The British National Health Service has been well dissected.[21] Peter Fisher in his book, "Prescription for National Health Insurance" proposes a plan based on the Canadian experience, specifically that of the British Columbia system.[22] Wilbur Cohen, the former Secretary of D.H.E.W., has long been an advocate of national health insurance.[23] Karen Davis, of the Carter Administration, has promoted a comprehensive plan with universal coverage.[24] Likewise, Congressional support seems strong with more than a dozen national health insurance bills introduced before the 94th Congress and many already re-introduced in the current Congress. Now more recently, in an article in Medical Economics Cohen stated, "Today organized medicine accepts the concept of national health insurance...."[25] Despite all of this, I sense considerable apprehension regarding national health insurance proposals (if not near-violent non-support) by "rank and file" practicing physicians throughout the country. This, in view of the fact that physician's assistants are dependent upon physician supervision, has significant implications for the physician's assistant profession. On the other hand, and I think importantly, the physician's assistant profession has seen the need for national health insurance and more social programs and support their careful implementation over the next decade.

Physician's Assistants Under National Health Insurance

If the goal of national health insurance is to improve accessibility to

health care and at the same time attempt to constrain increasing costs, physician's assistants should play a valuable role in the delivery of health care. Under national health insurance, as with the Medicare and Medicaid Programs, two-thirds of the cost incurred in the delivery of primary health care will be attributable to labor costs. The utilization of physician's assistants will impact directly on national health insurance costs because: (1) production costs in comparison to physician manpower are significantly lower, (2) opportunity costs to society are recouped with better physician "survival rates" in rural areas for example, and (3) delivery costs will be reduced by substituting physician's assistant for physician manpower when appropriate. In addition, physician's assistants are capable of performing in a broad range of environs (offices and clinics, patient homes, hospitals, and nursing homes for example) and can provide a broad range of health services (preventive maintenance, acute and chronic care, and emergency care for example).

Do we perpetuate the present system of health care adding on to the Medicare and Medicaid Programs, or do we scrap endeavors of the past for new comprehensive programs in the future? A perpetuation of the present system might continue the flow of "first dollar" medical care, promote the training of "sickness-oriented" physicians, bring on the hue-and-cry of existing personnel who "want to do what they've been trained to do," and downplay preventive care. The current American "red, white and blue" free enterprise system has shielded physicians from true competition and allowed for the preferential treatment of some third-party payers. Under the Medicare fee-for-service system, we have seen a continual rise in the cost of physician services. And under Medicaid, we have begun to see a decrease in the provision of services at the state level and an increase in fraud and abuse by providers. At the very least, if Medicare and Medicaid Programs are

to remain intact, it would seem advisable to initiate some fundamental reforms in the current system. Medicaid should probably be absorbed under the national insurance program, but if it remains must allow for the inclusion of more individuals in lower income groups and face more stringent federal regulation. Medicare must develop economic incentives rather than economic barriers if shifts in physician manpower distribution and appropriate physician's assistant utilization are to be realized. Physicians have been provided incentives to specialize and to practice in urban communities where they receive higher rates of reimbursement under the Supplemental Medical Insurance Program. The outcome, in New York City for example, is an oversupply of surgeons with increasing costs and "too much" surgery. The public will soon learn that the increased training of family physicians, for example, does not necessarily mean more primary care in rural areas. Organized medicine has begun to respond to the need to constrain the training of different types of medical manpower. At the very least, it would seem the federal government could develop a consistent reimbursement policy whereby physicians are reimbursed for a given service at the same cost-related (not inflated fee-for-service) rate. At the very most, discriminating reimbursement differentials could improve the redistribution of physician manpower.

An alternative system, given appropriate licensure/certification of personnel and a quality peer review mechanism, could allow for reimbursement no matter who the qualified provider. In this system reimbursement could be provided for services with rate regulation, no matter who the provider: psychologist or psychiatrist; L.P.N., R.N., or nurse practitioner; or physician's assistant or physician. This system would encourage the delegation of responsibility to the least trained yet competent provider. It would release competent providers with extensive training to handle complex cases. This alternative would reduce the cost of health care delivery.

Any one system of national health insurance will not cure all the ills confronting our country but will allow the government to use the power of the purse to control costs. It would seem appropriate to use as a cornerstone some of the programs which are now operational. It would seem reasonable to allow the private insurance industry to play a significant role, equal to if not greater than state government. After all, private enterprise now plays a major role in the provision of health insurance and I think it is at times more cost-conscious (with a profit-oriented base) than state governments. In addition, it should be appreciated that other social programs should be implemented and/or expanded to deal with such problems as substance abuse, nutrition, and the need for better housing and sanitation. In my opinion, it would seem appropriate for a national health insurance program to include:

1. participation by the consumer (as taxpayer and patient) in the formation of policy and in the administration of the system;
2. administration by the federal government in collaboration with state and private organizations;
3. the provision for universal coverage of all United States residents;
4. the utilization of physician's assistants in the provision of primary, secondary, and tertiary care;
5. incentives for the development and continued operation of health maintenance organizations and the allowance of voluntary HMO participation in the program;
6. an incremental approach to the provision of comprehensive benefits over a period of ten years in the following priority:
   (a) inpatient and outpatient services for catastrophic illnesses with caps on the costs incurred by consumers;

(b) preventive services for children inclusive of well-child examinations, immunizations, and routine dental care; and sexual education and counseling services for adolescents;

(c) inpatient and outpatient services for the elderly inclusive of dental prostethic services;

(d) maternity and family planning services;

(e) inpatient health care for all age groups;

(f) ambulatory services for all age groups inclusive of care provided by community health centers;

(g) limited mental health benefits (with limits on care because of the difficulty in defining illness and its appropriate length of treatment);

(h) prescriptive drugs.

7. utilization of a "broad-based" financing mechanism as suggested by Mitchell and Schwartz.[26] This approach might include:

(a) patient prepayment (premiums);

(b) patient co-insurance (deductible) to stifle unnecessary over-utilization;

(c) employer contribution;

(d) payroll tax to provide general revenue;

(e) a health (sales) tax of significant proportion on alcohol, tobacco, refined sugar, salt (within limits), and any product deemed potentially hazardous to one's health as identified by the Food and Drug Administration (products containing carcinogens for example); and

(f) increased contribution by the government from general revenues.

National health insurance offers great potential to the United States. NHI will increase the demand for care and, unfortunately, there is no satisfactory method of estimating the exact cost of the program. The lesson to be learned from the Medicare and Medicaid Programs is that any program that seeks to increase entitlement to health care benefits must from its inception be linked carefully and thoughtfully to a concept of cost control. We have the technology to define what providers do and at what cost services can be rendered. In addition, we learned under the Economic Stabilization Program (1971-1973) that an inflationary rise in medical care costs can be curbed. A most important link to cost control will be the appropriate utilization of mid-level health practitioners. Physician's assistants have improved access to health care and hold the potential for reducing the cost of health care under national health insurance. The President, the Congress, and the people of the United States as they design a national health insurance program should provide incentives for the appropriate utilization of physician's assistants. In the ensuing debates the positions of organized medicine and nursing should be weighed carefully in view of the physician's assistant's unique history in the delivery of health care as a non-physician. Physician's assistants support the need for and should play a valuable role under this country's program of national health insurance.

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STATEMENT ON REIMBURSEMENT ISSUE

BEFORE THE

ADVISORY COMMITTEE ON NATIONAL HEALTH INSURANCE

BY

ANNE ZIMMERMAN

PRESIDENT, AMERICAN NURSES' ASSOCIATION

SEPTEMBER 23, 1977

HARTFORD, CONNECTICUT

I am Anne Zimmerman, President of the American Nurses' Association. I take pleasure in having the opportunity to meet with you today to discuss reimbursement of providers of health care services. The issue is complex. It involves both differing values and the difficult decisions of entitlement, priorities, and financing.

The history of the attention given to the public's health in this country has been and continues to be fraught with jurisdictional disputes. These disputes include not only those between private enterprise and government control but also disputes among the local, state, and federal levels of government as well as disputes among providers, among consumers and planners, and indeed among the environmentalists, the nutritionists and the welfare reformists. Is there some way to reach accord or reconciliation over a matter as important as health - the services required, the payment system, the mechanism(s) to assure quality and equity of services, the full and appropriate utilization of provider resources, the elimination of fraud and abuse in the delivery system?

Answers must be found and nursing must participate in that whole process; nursing wants to participate and is ready to do so. The American Nurses' Association has a long and steady record of supporting reforms in the health care delivery system of this country. The Association - the voice of professional nursing in this country - has, through the commitment of its members, worked to improve the standards of nursing practice, developed models for quality assurance control, promulgated standards for organized nursing services and for education and continuing education in nursing, and has implemented certification mechanisms for practitioners.

For over two decades ANA has advocated that health care is a basic right of all people and that government has the responsibility for assuring, through appropriate legislation (and implementation), the accomplishment of this goal.

As we have examined the health care delivery system and its financial structure, all available evidence suggests that the traditional health care reimbursement system fails to provide incentives for providers and consumers to seek out and use less expensive, alternative sources of health care services. The continued domination of the industry by those whose view of health care is almost exclusively from the perspective of acute care and an illness orientation has resulted in an abnormally expensive system, and the public is denied access to wellness-oriented health care, such as health education and health maintenance.

For over two decades ANA has worked toward a national health policy which would restructure the present delivery system and would improve utilization of nursing resources in the delivery of health care. ANA has consistently advocated the inclusion of coverage for the services of nurses in all prepaid health insurance plans available from private and public third party payors.

In advocating legislation for a national program of health care insurance, ANA is vitally concerned with the provision of cost-effective health care services. We urge that attention be given to providing that insurance programs clearly spell out the covered health care services and allow the consumer to choose and have access to services of nurses. We urge consideration of language for the reimbursement of services of nurses in all national health insurance legislative proposals. Nurse providers,

whether they be self-employed or employees of an institution or agency, can authorize appropriate nursing services. Insurance programs should not require the payment of a fee to a physician for signing a claims form for reimbursement of services which are provided by nurses with nursing authority.

No longer can "medical care" be synonymous with or equal to "health care". Medical care is a vital and necessary component of health care, and there is growing recognition that nursing care is also an essential component of such care.

We can grant you assurance today that professional nurses are being prepared to provide comprehensive health care services as primary care providers, and that these practitioners are working in a variety of health care settings in a collaborative manner with other health professionals and, indeed, in some settings are providing essential health care services where there are no other providers. These practitioners contribute to health maintenance, provide primary assessment of developing illness, and arrange for prompt intervention by other professional colleagues when appropriate.

The inclusion within insurance plans of the reimbursement of nurse practitioners is a slow process - but is emerging. In the state of Washington, the indemnity insurance act was amended to require any insurance policy - group or individual - written by a commercial insurance company to provide for reimbursement of any covered service performed by a nurse. The law excludes any requirement that the service must be provided under the supervision of a physician. The State Board of Nursing determines who is qualified to provide the service. The

"Blues" are not covered by that act but efforts in this state and others seek the inclusion of these provisions on a broader basis.

An example of the successful implementation of the reimbursement mechanism for a nursing clinic by Blue Croos/Blue Shield is found in Vermont. The project at the Grand Island Clinic is an example of experimental efforts in the private sector to give attention to appropriate utilization of nursing resources for a community and attention to the logic of a pre-payment plan designed to include as benefits the services of professional nurses in primary care. The plan does not require the supervision or signature of a physician.

The practice of making the availability of the benefits of nursing care services contingent upon the signature or supervision of a physician is restrictive as well as illogical. Nurses do not deem to authorize or supervise reimbursable medical services, and physicians should not be required to determine or sign for reimbursable nursing services.

The nursing profession is committed to the establishment of peer review systems whereby providers of nursing care services can be held accountable by consumers and third party payors for the effective and appropriate utilization of nursing services of high quality.

Legislation for rural health clinics has been introduced which would expand access to health care through altering Medicare/Medicaid reimbursement provisions to cover the services of non-physician primary care providers, including nurses. This legislation would enhance and maintain these essential services to the people of rural communities. ANA supports this

legislation as a significant step toward national health insurance, but has urged that the legislation accurately reflect the full professional status of the nurse. This means recognition of the fact that the nurse is legally responsible for her/his practice and works in collaboration with other health care professionals including physicians, but not under their supervision.

As national health insurance legislation is developed by this administration the benefits of the services of nurses should be given equal and adequate treatment for the beneficiaries of such insurance, just as the benefits of medical care services are presently identified in both public and private health insurance plans.

In principle, we believe, insurance programs should define the covered health care services. Insurance programs should not, however, identify or define who or which professionals can provide the services, although it is appropriate that the programs require that providers be licensed or authorized by the state to so act.

The responsibility of defining who can do what or what education or other credentials are required in order to provide health care services to the public is the prerogative of the public and is enunciated in legal statutes in each state which govern the licensure of nurses, physicians, and other health care practitioners. Compliance with the statutes governing nursing practice rests with boards of nursing within the states, and thus nurses are accountable for their practice to the public.

In addition to licensure, the nursing

profession provides credentialing mechanisms for accreditation of educational programs and certification of practitioners.

To allow third party payors (public or private) to make determinations as to what health care services may be provided by what health care practitioners violates the public trust invested in the health professions. Such a system also hinders progress in health care delivery and increases the costs to the public by restricting access to health care services and by requiring that needs for all such services be channelled through the medical care provider system in order to be covered as benefits of health insurance programs. Such provisions deny consumers access to the services of nurses without first going through physicians. For example, it has been estimated that in rural and urban health clinics, 70 - 80 percent of the health services required are and can be competently handled by nurse practitioners, yet in order to be reimbursed for such services the clinics must provide authorization of the services by physicians.

The nursing profession is ready and willing to participate in working toward a national health insurance program for this country. We believe a national health policy should be developed which makes possible the goals of improved health status for all Americans; equity in access to needed health care services which encompass health maintenance, preventive services, and alternatives to institutional care; and an insurance program which seeks to alter the financial structure of the health care delivery system by appropriate reimbursement mechanisms which encourage cost-effective delivery of high quality health care services.

VMP:mc
9/20/77

CITIZENS' HEARING ON "HEALTH CARE: THE UNDERSERVED AND OVERCHARGED"

June 16, 1977

A PLAN OF ACTION

A Special Report

This report is made pursuant to Contract #282-77-0116-JK. The amount charged to the Department of Health, Education and Welfare for the work resulting in this report (inclusive of the amounts so charged for any prior reports submitted under this contract) is $19,000. The names of the persons employed or retained by the Contractor, with managerial or professional responsibility for such work, or for the content of the report are as follows:

Max W. Fine
Edwin A. Beller
Deborah K. Wood

COMMITTEE FOR NATIONAL HEALTH INSURANCE

A PLAN OF ACTION

The Citizens' Hearing on "Health Care: The Underserved and Overcharged" heard testimony on programs that are successfully serving a variety of disadvantaged populations--but unanimous agreement from all those representing these programs that their life-span, their scope, their replicability, and their capacity to deliver services are severely limited or rendered impossible by the current patchwork of health care financing and delivery in the United States.

The success of these programs, insofar as they are successes, is clearly a tribute to the massive efforts and heroic ingenuity of those who somehow piece together various sources of funding and payment and thus keep them in operation for various periods of time. Their managers and participants, however, made it clear that they would far rather have the stability conferred by a universal, comprehensive national health insurance program than the kudos for their ingenious ability to keep them alive and functioning, somehow, in the absence of that program.

In this report, we will describe briefly some of the programs about which the Citizens' Hearing was told, programs serving disadvantaged populations, and proceed then to describe a plan of action in terms of principles for a national health insurance program that would eliminate the burdens under which they labor and permit them to flourish and extend their capacity for service.

One of those whose testimony was quite explicit about the limited nature of the success achieved, the methods by which it was brought about, and the clear necessity for a better system if it is to survive and flourish was Stephen Tang, president of the South Cove Community Health Center in Boston.

Mr. Tang said:

"I don't know if you know it but one out of 4000 Americans is Chinese, and I'm glad to be overrepresented here today. I come from the Boston Chinese-American community, and our experience has been with the working poor population in one Chinatown in this United States, and I will be speaking from this experience.

"Our population is facing many barriers. One is the language and one is the culture. 80 percent of our adults don't speak English. And the cultural acceptance of Western medicine really isn't there. In addition, we are working poor. Over 99 percent of our folks work, but only 10 percent are eligible for any form of public or third-party reimbursement. So we are that in-between front that can't really afford the medical care, just as in the rural population.

"Now, up until this past year the situation was that the health system did not serve these folks. Basically it isolated them except at three points--one at birth, one at death, and one during crises. There was no coordination of the care. There was no access point for these folks. And finally, the health system that did service them really was a sort of health system that was paid to see patients and not to make them well.

"Ten years of planning in our community, scheming, some lucky breaks, a little bit of federal money and so forth has allowed us to piece together an ambulatory care center that provides a comprehensive package of physical and mental health, and very important, support services that will allow the population to begin to learn how to help themselves.

"As we have done this, we realized that we can't do it without a backup for the specialty and tertiary care. So we gently coerced and we now have the full cooperation of the New England Medical Center as our partner. They give

us lots of money and lots of support.

"And further, this morning I heard of the lack of sensitiveness. They (the professionals) can be trained, but sensitiveness is another thing. We have embarked on a joint planning for training that makes sense within community settings, and we're moving in this direction.

"Now, have we been successful? Well, we looked over 10 years of planning and we have an ongoing clinic; we've got a lot of good things going; we have an excellent staff. And you can say that's successful.

"But in reality, the way we have been funded, the way we have been supported, it's a Chinese jigsaw puzzle, and it's not a way to go about delivering health care. We need a long-term commitment to the residents of this community and any other community that has special needs. And I believe firmly that something like a national health insurance policy that can underpin in a financial sense the sort of special programs that each community develops for their own folks is really the only way that we are going to guarantee the continuity and the good health care that each of these folks need.

"Now, I think the last thing I want to say is that universal entitlements, which is what some folks are thinking national health insurance is, is an absolute guarantee we have health care we need. And that isn't so. I think sensitive, comprehensive planning that's been talked about this morning will be the only thing that guarantees the sort of care that answers the needs of each of the different communities that we have here today."

Testimony on a church-sponsored free clinic was provided by Rev. James N. Holmes, minister of St. John's Presbyterian Church, in Tampa, Florida. He said:

"Some four years ago, we began to look at the community as a church and to see where we would be able to best serve in our local community. We began to look at the area of health care and the inadequacy of the health care in

Hillsborough County. We began to see that if you were a person living on $200 or more per month, you qualified for no medical assistance in Hillsborough County, not even for a vaccination in our health department.

"So we began to organize a free medical clinic. And we got one doctor and one nurse and one examining table and we put it in a Sunday school room, and we began. That was some four years ago. And today, we now have 75 physicians on our staff, we have 35 dentists, we have podiatrists, speech pathology and audiology. We have feeding programs, we have nutrition, we have home visitations. We have 400 lay volunteers to backup our medical personnel.

"This has been an interesting experience for us to be able to provide this kind of service. We do try to provide medical care for persons who becasue of their economic situation cannot obtain sufficient medical care.

"We accept no government money. All of the support comes from the community. We recently sent an individual to Zurich, Switzerland for an operation because it was cheaper for us to send him there and pay the plane fare than it was to have it done in America.

"We are concerned with delivery of medical care to all persons. And it seems to me that we have in some way been successful. I recall that when we first opened our medical clinic, the AMA in their local magazine editorialized against us and warned physicians not to practice in church basements because we did not need primitive village-type medicine in Hillsborough County. But we needed uptown medical care.

"So hopefully, we still have a little bit of the primitiveness in us and that we will eventually move uptown.

"Perhaps the greatest day of my life will be when we can close the door of our free medical clinic because it will no longer be needed in America.

"I do not believe that medical care should be contingent upon a gratuity from another person.

"I believe that medical care is a right. I think that the church has a role in providing medical care for those who do not have it today. I hope that we will be able to get out of that and to go into something else. And I look forward to the great day when everyone will be treated with justice and equality in our health delivery system."

A rather different perspective on success and failure of existing programs, this time with respect to the totality of the Health Maintenance Organization sector of the health care delivery system, was provided by James Doherty, of the Group Health Association of America.

His presentation focussed on the political and administrative background to the problems and prospects of HMO's and the need for a more uniform national system as an underpinning for the growth of that sector.

Mr. Doherty said that he told the Executive Director of the Committee for National Health Insurance some time ago that "I think about the only thing worse than not having your bill passed is to get your bill passed under the Nixon Administration." He continued, "Because that is what happened to us.

"We were sincerely interested in the Health Maintenance Organization Act of 1973, which was signed in December that year on a slow news day in San Clemente, California. Part of that time in 1972, arrangement was made with the Doctor's Committee to Reelect the President of the AMA, and with the White House to stultify, if not kill, the HMO legislation. Unfortunately, the legislation in the previous Congress had gone too far and had taken on too much of the legislative base. So that the President was left with no choice, but to sign it.

"Ever since then, the Administration of the law has been terrible--no policy, no subsidies from the direct areas, no structure for what are good HMO's and bad HMO's.

"We are extremely grateful that Secretary Califano has indicated that they will try to make the HMO program viable. So that it is in the context of

that potential viability that I speak.

"Back in 1972, when the National Journal published an article relating the AMA deal with the White House to kill the HMO legislation, then Secretary of HEW Richardson called a group of us into his office to reassure us that he was dedicated toward the HMO legislation and HMO purpose. And we asked him whether or not this reflected the White House view. And he said he did not know.

"Then, he said that he wanted to make it very clear to us that no matter what the form of the HMO legislation, whether a person was rich or poor, that the benefit packages would be uniform and that every member of the HMO would be entitled to the same benefits. And he wanted to make that clear.

"On the other hand, he said that under no circumstances would this administration support a premium subsidy for the poor. So that is what we were faced with.

"Now, there are some advantages to HMO's. We don't proffer them as a panacea, but a choice for rich and poor alike, and that a well-structured HMO can offer comprehensive benefits which are accessible, no co-payments, no deductibles, which are continous with centrally oriented medical record systems. But this can only be done if there is a national health insurance system.

"We are gratified that the drafters of the Health Security Act do put within that Act incentives for providers to organize into a Health Maintenance Organization kind of configuration; that bonuses are paid by virtue of their hospital utilization savings to HMO. But we can only do that when there is a uniform national policy in this crazy health insurance system of ours. And we think that the HMO part of the national health insurance system will do more to organize health care in this country than any other."

The sometimes successful, though limited, efforts of young interns and residents to use their collective bargaining power to produce some changes

for the better within the existing system, and the frustrations attendant upon such efforts, were set forth by Dr. Daniel Asimus, president of the Physicians' National House Staff Association. He said:

"Representing practicing physicians, it is rather frightening to stand up here. I am glad we have all eaten lunch first.

"I feel very honored, though, to come before you today. And I can tell you for sure today that there are some physicians that are your friends in this country.

"I will be glad to also tell you these physicians are younger physicians, interns and residents, and they practice in our hospitals throughout the United States. We are the ones who greet you when you come in the door after the long wait. We are the ones that try to explain to you that X-rays have been lost. We are the ones that try to explain why the nurse hasn't come in and changed the bedpan, why the dressings aren't there.

"And this has been difficult being an intern and resident. And now some of us are starting to do something about it.

"I think we have some solutions, but obviuosly, we enjoy this opportunity to let you know that we need your help as you need ours. We have done some things.

"The physicians' National Housestaff Association was formed in 1972. We now have 10,000, interns and residents, across the United States.

"We work mostly in our public hospitals. And most of those hospitals are a disgrace. And we plan to do something about it.

"I can also assure you that we are not associated with the AMA.

"All physicians are not alike. Todays' physicians are changing. It is going to take a lot of your continuing effort to educate the physicians along with us.

"Back in 1972, there were a group of physicians who said we had had enough, we had remained quiet, we had been irresponsible and not spoken out about the deplorable conditions in our public hospitals. At that time, we had engaged in committees and collective bargaining and all the rest. We realized that the best thing for us was to get some legitimacy. And we did that through collective bargaining.

"We formed a national union for interns and residents that realized that would be one of the ways for us to officially address the management and not have them put us off any longer. We have been struggling along the lines of collective bargaining for these last several years. We have had some successes.

"In Los Angeles, we put our money where our mouth was and split our salary increase for the past two years, setting up a patient care fund worth $1 million per year of the interns' and residents' money to buy necessary equipment--fetal monitors, EKG machines and other vital equipment that the nurses and social workers and community indicated that they needed and we needed as a health care team.

"We testified along with you, the young physicians, in Congress, supporting Jimmy Carter. We were the only group of physicians nationally that had enough wisdom to endorse Carter-Mondale and work for their election. We are proud of that and are helping to design the new health care system with you and with him.

"We believe that we need to do it together. We have liaisons, and this one is a very important one, with the Committee for National Health Insurance. We also believe that health professionals must start working together, and you have our support. We belong to the coalition of American public employees which is made up of the nurses, and the social workers, the hospital workers, physicians, and National Education Association, and some other groups.

This is the way we must do it as a group. And this demonstration today has impressed me very much.

"Along with our efforts, we have reached some obstacles too. We feel like the underdog. We are not listened to. The AMA and American Hospital Association squelch us as they do you.

"With all of our successes in trying to increase the quality of care, keeping patients out of hallways, having a room to tell a family as a physician that one of their relatives has just died, having anesthesia coverage for gunshot wounds in the middle of the night, these are the items that are in our contract. Salary has not been a substantial issue at all.

"Last year, we were also given a blow. The National Labor Relations Board decided we were students, not professional employees, denying us the right from here on out to bargain professionally with management. We are fighting that. We have made an impact. I know that we can do it together.

"As far as we are concerned, there is a definite two-class health care system. The public hospitals are run and staffed much differently than the private hospitals in this country. I myself worked at Los Angeles County for four years, the largest public hospital in this country. And it was a disgrace what we had to go through. We fought, and now we are starting to have some changes made there.

"We believe, and our organization says, health care is a right; that health care for the poor shouldn't be the last chance; that they shouldn't be given the leftovers; that the interns and residents and nurses and social workers shouldn't have to work in those types of conditions because the morale among the employees as well as among the patients is deplorable and disgraceful for our type of country.

"Our group, the young physicians, believe also along with you, and we are now forging our final position on national health insurance, that the system,

though, should be universal, comprehensive, cost effective, mandatory with cost controls.

"We should also concern ourselves about malpractice because you, the consumers, pay for my premiums for malpracitce.

"And lastly, the financing must be an important issue, as Senator Kennedy has said. There is some work to do ahead of time. Physicians, there are not enough of in this country. Senator Kennedy has fought very hard for manpower legislation, and we supported him along the way. We see now more physicians entering primary care types of specialties, more pediatricians, family practitioners. And this is the way that we are going along with the legislators in order to overcome the maldistribution problems in our country today.

"More physicians are gaining social awareness of realizing we will work together and as employees rather than always fee-for-service private practitioners. We are accepting these tenets because we also feel that the present system does not work.

"We also believe that there should be considerations as Senator Kennedy also said for national licensure, for recertification. And you should insist I keep up on medical knowledge even though I might have to work 80 hours a week. We should ask for recertification.

"I have to leave right after this and go to Los Angeles to attend a second meeting of Secretary Califano's Advisory Committee on National Health Insurance Issues. I can say this was the greatest preparation for me, to be vocal and a strong proponent of a new system for health care in this country.

"I would just like to say that our organization, and like I said the young physicians today do feel a moral responsibility. We wish all of us luck, and I believe we can change this system so that all Americans can get high quality health care at a reasonable cost."

All of the foregoing makes it perfectly evident that it is precisely those who have the greatest experience at putting together the various pieces that are required to make any program for the disadvantaged successful under the conditions prevailing today are the most eloquent and forceful in demanding a better system, one which would permit them to concentrate on their roles as professionals, workers and administrators in the actual delivery of care to those who need it.

The plan of action that is needed to bring about such a state of affairs can be stated as a set of principles, principles upon which a new system for the delivery of health care to all Americans can be soundly based.

These principles are:

1. All persons resident in the United States should have available, as a matter of right, comprehensive personal health care services, with equal opportunity of access to the available services throughout the country.

2. Personal health care services should be provided under arrangements that, to the maximum extent practicable and within a framework of improved provisions for service, make full use of existing personnel and facilities and are acceptable to the people to be served and to those who provide the services.

3. The availability of personal health services should be assured through a national health insurance system.

4. Tha national health insurance program should be an integral part of the national social insurance system. The program should be financed by contributions from employers, employees, self-employed persons--preserving the present provisions which permit employer assumption of all or part of employee contributions--and from Federal general revenues.

5. The benefits of the program should extend to the entire range of services required for the maintenance of personal health, including services for the prevention and early detection of disease, for the care and treatment of illness, and for medical rehabilitation when needed.

6. Payments for the services provided as benefits of the program should assure full financial protection for the consumers and should be fair to the providers of

the services.

7. The national health insurance program should include provisions designed to contribute toward safeguarding the quantity, quality, effectiveness, continuity and economy of the family health care services it finances.

8. The administrative arrangements and the finances of the national health insurance program should be designed so as to encourage the organization of professional, technical and supporting personnel into health teams and groups capable of providing comprehensive health care for families and individuals efficiently and effectively, with compensation through comprehensive per capita payments as an alternative to the prevailing fee-for-service method of payment.

9. There should be public control of the basic policies governing the program, and full public accountability for its financial and operational activities.

10. There should be appropriate provisions for effective participation by consumers and providers both in the development of the national health insurance program and on the advisory councils assisting in its continuing public administration.

11. The national health insurance program should be so structured and have such inter-agency relationships as to enable it to influence substantially the accelerated development of needed health manpower and facilities and their availability, and to this end shall contribute substantial and assured continuing financial support toward the national development of adequate manpower, facilities and organization needed for the effective delivery of comprehensive personal health care services in all parts of the country.

continuing

12. Although primarily directed to the development and support of comprehensive personal health care services, the national health insurance program should also have concern for the development of effective community health and welfare programs at the national, state, regional and local levels through comprehensive community health planning.

13. The national health insurance program should provide for studies and demonstrations which give promise for continuing adjustment of the health services so as to serve the changing needs of people in the most effective manner consistent with sound professional goals and standards and so as to utilize expanding medical knowledge and skill.

14. The national health insurance program shall be designed

and developed in accordance with these principles and policies so that it shall function not merely to increase national expenditures for health services but also to contribute to the control and elimination of present wastes and extravagances and toward maximum practical effectiveness and efficiency in the delivery of and payment for comprehensive health services of good quality commensurate with our need and potential.

AGENDA

PROBLEMS OF THE URBAN POOR AND PUBLIC HOSPITALS

Los Angeles

June 16 - evening - arrive in Los Angeles; accomodations at Hyatt House Hotel at LA International Airport, 6225 West Century Boulevard, Tel. (213) 670-9000.

10:00 p.m. - short reception and briefing on schedule for the next two days

June 17 - 8:00 a.m. - leave by bus for Watts Health Foundation and East Los Angeles Child and Youth Clinic (1/2 of group at each place)

8:30 - 10:30 a.m. - tour of above facilities

11:00 a.m. - convene public meeting at the L.A. County-USC Medical Center, Room 1602, 1200 N. State Street, Los Angeles, California
topic: Public Hospitals
presenters: Arthur E. Hess - overview
Dr. Sol Bernstein
Dr. David Scott

12:30 p.m. - lunch - L.A. County - USC Medical Center - Doctor's Dining Room

1:30 - 2:30 p.m. - tour of L.A. County - USC Medical Center

3:00 - 4:30 p.m. - Reconvene public meeting
topic: Problems of the Urban Poor
presenters: Dr. Julius B. Richmond - overview
Ken Stein, Ph.D.
two representatives of the Human Services Coalition

4:30 - 5:30 p.m. - questions and comments from audience

6:00 p.m. - dinner on route to airport

8:30 p.m. - flight to Oakland (PSA #857) from Hollywood-Burbank Airport

9:25 p.m. - arrive in Oakland; transportation to Holiday Inn, 500 Hegenberger Road, (415) 562-5311

AGENDA

HEALTH MAINTENANCE ORGANIZATIONS, PREVENTIVE SERVICES
AND CONSUMER PARTICIPATION

Oakland

June 18 - 8:45 a.m. - bus to Kaiser integrated in-patient out-patient facility in Oakland, California

9:00 - 10:00 a.m. - tour of above facility

10:30 - 12:15 p.m. - convene public meeting at the Kaiser Building, Kaiser Center, 300 Lakeside Drive, Oakland, California
topic: Health Maintenance Organizations
presenters: Alain Enthoven, Ph.D. - overview
Dr. Joseph Dorsey
Hilda Birnbaum, Ph.D.
Thomas G. Moore, Jr.

John Custer
Bernard Rhodes - Hayward
James Kane - counsel

12:15 - 1:15 p.m. - lunch at Kaiser

2:00 - 3:15 p.m. - reconvene public meeting at the San Franciscan Hotel, 1231 Market Street, San Francisco, California
topic: Preventive Services
presenters: Dr. Robert S. Thompson - overview
Robert L. Johnson

3:30 - 4:45 p.m. - continue public meeting
topic: Consumer Participation
presenters: Alberta Parker - overview
Joseph Blackman, Ph.D. - pres. Mid Coast Health Services agency
Yori Wada
Adan Juarez ex dir. - Regional Rural Health Program - Dixon

4:45 - 5:30 p.m. - questions and comments from audience

Briefing Memo on HMOs

HISTORY

An HMO has been defined as an organization which "(a) makes a contract with consumers (or employers on their behalf) to assure the delivery of stated health services of measurable quality; (b) has an enrolled population; (c) offers a stated broad range of personal health service benefits, including at least physician services and hospital care; (d) is paid on an advance capitation basis."

There are many different types of organizations that fit within the broad concept of a health maintenance organization. HMOs have developed under the sponsorship and evolved from medical group practices, medical foundations, hospitals, community health centers, insurance plans, self-insured employer benefit plans, consumer co-operatives, unions, and private enterpreneurs. Organizational arrangements both vary and change over time. In its initial development an HMO often provides directly only some health services and contracts for all other services. The mix of services provided directly and the proportion of services provided directly vary greatly from HMO to HMO and change over time in a given HMO. The staffing patterns show the same variability including combinations of members of a group practice, associated independent practitioners, hospital-based medical staffs, and practitioner contracted for a specific number of health services.

Health maintenance organizations are not a new phenomenon. Some prepaid plans began operations as early as the 1930's. However, until very recently, the number of prepaid plans, as well as the enrollment within plans had grown slowly due to a variety of factors. Most fundamental among these was the lack of investment resources, restrictive state laws, inadequate marketing opportunities, and resistence among the medical community and the general public.

In 1971, the climate for HMOs changed dramatically. The President issued a white paper on health that promoted prepaid health care providers as an alternative to traditional fee-for-service medicine and coined the phrase Health Maintenance Organizations. Limited federal funds were made available for the development of demonstration HMOs. The Social Security Amendments of 1972 authorized Medicare to reimburse HMOs but precluded reimbursement on the basis of prospective capitation rates.

In 1973, a Federal statute, the HMO Act of 1973, was enacted authorizing Federal funds for the planning and development of HMOs. In addition, this statue provided some relief against restrictive State laws, and required that HMOs determined by the Federal government to be "qualified" should be accorded access to markets currently held by private health insurance. To be determined qualified, an organization had to meet all the requirements under the strict statutary definition of a qualified health maintenance organization. In addition, a number of States began enacting laws specifically enabling HMOs to operate. State Medicaid agencies in some States initiated contracts with HMOs on a prepaid basis, and private sources of capital--largely insurance companies--began investing in HMOs.

A growing minority of the physician population changed their perception of the desirability of practice in HMO setting.

As a result of all this activity, the number of new HMO plans began to increase. Some of these new HMOs received Federal financial assistance, but many did not. Some of the new plans grew rapidly, while others expanded enrollment slowly. Some appeared to evidence substantial stability while others ceased operations shortly after their inception.

The HMO Amendments of 1976 extended through FY 1979 the authorizations for Federal grants and loans to developing HMOs and eased some of the statutory requirements for an HMO to be determined as "qualified". Several studies concluded that many HMOs could not meet the requirements in the original HMO Act and still compete with service insurance plans (i.e. Blue Cross-Blue Shield) or indemnity insurance plans. In addition, the HMO Amendments mandated that HMOs must meet PHS requirements to receive prepaid reimbursements from Medicare or Medicaid.

The number of prepaid health plans has grown from approximately 40 in 1971 to 175 in 1976. However over the last two years there has been a decline from 183 prepaid health plans in 1974. Clearly today the HMO program is developing very slowly. This growth pattern also reflects a pruning away of some very questionable prepaid plans, particularly the California plans that enrolled only Medicaid recipients. The number of entrollees has grown more steadily from 3.6 million in 1971 to 6.5 million in 1976.

The Federal involvement with HMOs has three major components:

- Development: feasibility grants, planning grants, initial development grants and loans, operating loans
- Regulation: initial qualification and continuing compliance
- Reimbursement: Medicare beneficiaries, Medicaid recipients, enrollees in Federal employee health benefits plans

As of January 1, 1977 the HMO development program has awarded 119 feasibility grants (for a total of $5.7 million), 79 planning grants ($9.6 million), 59 development grants ($30.2 million), and 23 loans ($36.9 million) to a total of 127 organizations ($45.5 million in grants and $36.9 million in loans). Over the same time Kaiser has invested approximately $200 million in capital expenditures for new HMOs and expansion. The enrollment in HMOs receiving federal grants and loans is about 250,000 people while Kaiser has expanded by approximately 500,000 more enrollees.

The Federal government regulates only those HMOs that apply to be determined as "qualified". Federal qualification improves access for the HMO to the market for group health insurance. Employers (with more than 25 employees

in the service area of a qualified HMO) must offer "dual choice" to their employees of at least one qualified HMO. To be determined qualified, an HMO must meet many requirements including a broad benefit package, financial viability, limited open enrollment, quality assurance and staffing arrangements. A qualified HMO is monitored thereafter to assure continuing compliance with all requirements. The number of qualified HMOs has grown from 5 as of September, 1975 to 31 as of May, 1977. The federal regulation of HMOs is performed by an organization within the Public Health Service that is separate from the division responsible for the development of HMOs.

The Federal government's involvement with HMOs includes the purchase of prepaid health services under Medicare, Medicaid and Federal Employees Health Benefit Plans as shown below:

Program	Number of Organizations	Enrollees	Payments
Medicare	39	379,000	$61 million
Medicaid	75	300,000	$105 million
Federal Employee Health Benefit	26	550,000	$110 million
Total		1,229,000	$276 million

The HMO Amendments of 1976 mandated that Medicare and Medicaid can only prepay health services to plans that meet the PHS requirements and are determined to be qualified. In the short run this will lead to a decline in federal purchase of HMO services.

The present status of HMO development including qualified HMOs, federal supported HMOs, and other prepaid health plans is shown in tabular form in Exhibit 1 and displayed in a map in Exhibit 2.

©Carissa Ward National Health Security for Srs.

Dr Robert Thompson - preventive medicine
primary - (IX immunization
secondary - (PAP.

Role of physician - disease specific approach
important role of health questionnaire
Read paper

* Robert L. Johnson Pres National Center for Health Education - S.F.
Public Health Education.
Health Education needs to be given for greater emphases.
* Financial incentives for preventive services
National Health Policy with clear cut goals.
Do not confuse Health Education w/ information only

Alberta Parker - pediatrician - ~~USC~~ Cal
Personal health care system - organized participation
Consumer participating model - WHO
Consumers - access - facilitation
Professionals - quality
Involvement - necessary ingredient for behavioral change.
8th floor experience - L.A. Middlesters.
What is the role of the consumer in health care reform?

Joseph Blackman -
treatment - technology - institutions - emphasis of goal
* get 93-641 - HSA - Health Service Agencies - use these as testing bodies for regional planning.

Gori Wada -
Consumers - monitoring and evaluation.
Consumers - providers = partnership.
Sensitivity to cultural + ethnic differences.

Adan Juarez -
Need to look at a system which is responsive
Rural America ~~care~~ dearth of mechanisims for payment
Payment mechanisms have not guaranteed access.

McGuire - entry into the system - trauma - accidents
unevenness of E.R. Care and treatment

ASSESSMENT OF EFFECTIVENESS

The theory behind HMOs is that they offer the following advantages:

- contain costs because the economic incentives of prepayment lead to 1) substitution of preventive and ambulatory services for institutional services and 2) greater efficiency such as less duplication of laboratory tests.

- improve access because a wide range of comprehensive benefits are available from the same organization.

- improve quality of care through greater interaction among peers and economic incentives for effective peer review.

- improve health status because of economic incentives to promote preventive health care.

While not all these advantages can be demonstrated with convincing empirical evidence, there is enough evidence to show that at least some models of HMOs definitely do work in that they contain costs and provide services of acceptable quality to have retained enrollees for long duration. For example, 25 HMOs with over 4 million enrollees have worked for over 10 years. There is ample evidence to demonstrate that HMOs generally can contain costs, substitute ambulatory care for institutional care, operate on fixed prospective budgets and provide quality health services. On the other hand, the limitations of HMOs have also become more clear since 1971 when HEW announced its goals for the HMO program. HMOs have not become a dominant force in the health service market, many prototype HMOs have failed, several models of HMOs are unproven, many settings appear inappropriate for HMO development, and some prepaid health plans, particularly in California, have been scathed by serious scandals.

Evaluating the cost effectiveness of HMOs is a difficult task because HMOs and insurance plans offer very different products. For example, both types of organizations impose limits on coverage to contain the price of premiums. Insurance plans tend to exclude routine and preventive services from the benefit package while HMOs tend to impose deductibles on acute services. Consequently the best measure of cost effectiveness is a comparison of total health expenditures but the definition of total health expenditures is often imprecise (i.e, should transportation costs be included and which drugs are really cosmetics) and the data is difficult to collect.

Nevertheless several studies have examined the total expenditures of employees, Medicaid recipients, Medicare recipietns and insured populations. These studies generally show that total expenditures for HMO enrollees are 10% to 40% less than other covered populations and are summarized in Exhibit 3.

not eligible for Medi Cal. - means precludes them.
Fear of two levels of health care. (3) very rich
middle - HMO
poor
In Contra Costa - stigma over Co. care is being overcome
Need to take principals of Kaiser for example and translate them to other programs
Change reimbursement system.
Dennycaulfield MD
Weissman -

Incentives

What will encourage a physician to join HMO? Is salary a factor? Not necessarily - team approach

Medicade - Outreach - in Boston - transportation built into capitation

? Legislature sends more under Medicaide - Washington ?
Lagging problem of who can become members of HMO's

EXHIBIT 3

Total Costs Under HMOs

1. Total annual family expenditures for California Public Employees, 1970-71

Kaiser-Permanente	Blue Cross/Blue Shield	California Western
$440 year	$560	$483

2. Total annual per capita costs in Southern California, 1968-69

(2) group practices	(2) service benefits	(2) indemnity plans
$126	$233	$177

3. Total annual costs per capita Medicaid recipients in Washington, D.C., 1971-74

	prepaid (1000 recipients)	fee for service (300,000 recipients)
1972	$282	$373
1973	$232	$435
1974	$282	$465

4. Ambulatory cost per person in Medicare group practice prepayment plan 1970

Prepaid:	$507	$431	$388	$331	$312	$225	$196
Fee-for-Service:	$489	$423	$414	$406	$398	$336	$295

The evidence on the impact of HMOs on hospital utilization is extensive and convincing. Riedel examined the records for over 55,000 Federal employees between 1969 and 1970 and found the HMO had 383 hospital days per 1,000 membership years as compared to 724 days per thousand for Blue Cross Blue Shield. Similar results were shown for the Marshfield HMO in Wisconsin, Health Insurance Plan of New York, Medical Care-Group of Washington University in St. Louis and HMOs in Rochester. Enrollees in qualified HMOs have substantially less hospital utilization as shown in Exhibit 4. This evidence is further substantiated by recent studies in Rochester that examine the hospitalization experience of several cohorts of Blue Cross subscribers, including those who join HMOs and those who maintain Blue Cross service coverage. The study indicates that the hospitalization rate for a cohort of Blue Cross subscribers is reduced by the HMO.

Secretary Joseph Califano -

In Kaiser - paying for a $30,000 bed - rest of Calif $90,000 bed

This issue moving to the forefront of the National agenda

Cornerstone for next yr.

Cong. Peter Stark

Alain Enthoven - Prepaid health care vs. Retrospective cost funding

Benefit cost analysis

fee for service - cost reimbursement - third party (gov. insurance) intermediary

Offer - quality + economy work together

Total cost 10% to 40% lower for HMO than for comparable plan.

Medical care - highly differentiated product

HMOs not all the same -

Individualized practice assn.

Encourage diversity

Not getting better health but pumping more money into the delivery system.

Fee for service has provided good living for providers.

What does Natl. Health Insurance have to do with HMO's?

It could kill them.

3rd party system not compatible w/ capitation system

No such thing as best - Jus market test.

Harvard Community Health Plan - Joseph Dorsey - M.D.

Hospital days

345 NCHP vs 850 Blues - per 1000 per yr.

Prepaid group have now rational means of determining needs

* Prospective rate setting critical

HMO requirements set on HMO member needs

Hilda Bernbaum - Puget Sound HMO - group health cooperative

Consumers want health care to be accessible. available - appropriate *

Consumer care. health education - access to records

learned from womens movement

Any legislation on health insurance should provide for bona fide consumer representation.

Jim Moore - php. (Prepaid group practice)

Venture capital - dreadful overhead.

No relationship between potential enrollees and providers.

HMO legislation designed to combat that

HMO's deserting the poor.

Measures of efficiency such as productivity are not very precise and not usually published. Some of the evidence of greater efficiency includes shorter lengths of stays in hospitals in part because the pre-operative laboratory work is performed before hospitalization. A more global measure of efficiency is that the Kaiser-Permanente Program has 1.5 staffed hospital beds per thousand members while the national average is over 4 beds per thousand persons.

There are several other dimension of effectiveness of HMOs that have not been documented by objective evaluations. The impact of HMOs on quality of health services and health status are difficult to measure because the general imprecision of measures and data on quality and health status and because of the complex interactions between the health delivery system, determinants beyond the control of the health care providers (i.e, smoking and other aspects of life style) and the impact of the attitudes of patients on measures of quality and health status. The absence of significant findings suggests that quality and health outcomes under HMOs are not dramatically better or worse than other plans. The other major impacts not yet documented are the secondary effects of an HMO on its community.

Dr Sender

330 bed licensed gen. hosp.
164,000 Oakland
1/2 mil. office visits
156 staff physicians

John Custer

6 independent Permanente medical groups
3.2 mil people in U.S. served - West. Gr. Calif. Hawaii Colorado. Ohio.

3,000 contracting physicians
Natl. Health Planning - Dev. Act of 1974
* K.P. contracts with Permanente Med Group + Kaiser Found Hospital - left over funds divided between med group + hosps.
Permanente Independent group
Capitation or Ext - provided regardless of service provided.
Since 1970 - 750,000 new members
1 of 70 in U.S. is member of K.P. health plan

Plan BB
1 - 25.14
2 - 50.28
3 + more 72.19

no experience rating
community rated

Bernard Lase

Principles 1) group practice 2) integrated facilities 3) prepayment 4) preventive health services + early detection 5) vol enrollment 6) physician responsibility.
Healthy member economic asset

Jim Lane Natl. Health
Free standing Catastrophic - Counseled against

Proposals for NHI 1) Pluralistic - w/ diversity + innovation
2) allow consumers equal choice
3) no disincentives for providers
4) adequate provisions for meeting Capital Requirements
Prepaid group practice.
1) fixed Amt. for all plans (per person)
2) average amt. for geographic area
3) mandate same charges for an area.

BRIEFING PAPER: HEALTH SERVICES AND THE UBRAN POOR

Poor city residents face unique problems with regard to health care services. Their health is worse and their access to medical care more limited than for most Americans. Environmental and economic factors adversely affect the health of poor urban residents to a greater extent than they do that of non-poor residents of metropolitan areas. Medical care services are less available to the poor in cities both because of a scarcity of practitioners and a lack of financial resources. The urban poor are more likely to receive medical care routinely from hospital emergency wards than are other Americans.

A more detailed discussion of these conditions follows. Past and current initiatives to improve health services to the urban poor are reviewed and the ways in which a program of national health insurance are likely to affect these health care problems are explored.

Demographic Characteristics of Central City Residents

National statistics are not generally available for the urban poor specifically. A conventional breakdown for metropolitan areas (cities and clusters of counties of 50,000 or more population) is between central city and non-central city residents. While central city residents are twice as poor as non-central city urban residents, central cities do contain many high income, well-educated residents whose characteristics are reflected in the demographic and health status data presented below. Figures for rural areas are not presented for reasons of brevity. While rural residents experience health and health services problems as severe as those of poor city residents, the problems are of a somewhat different nature and will not be addressed herein. The following table presents age, poverty, race, and education data from the 1970 census for central city, metropolitan urban other than central city, and total U. S. population.

			Age	
	% below poverty level	% black population	% under 18 yrs.	% 65 yrs and over
Central city	14.9	20.6	31.9	10.8
Urban, non-central city	7.3	4.7	35.5	8.0
United States Total	13.7	11.1	34.2	9.9

Health Status

The urban poor experience greater health problems than other urban residents. Poor nutrition, hazards in housing such as lead paint in old buildings, less prenatal care, and belated treatment of disabling conditions all contribute to their poorer health status. Infant mortality rates remain almost twice as high for non-whites as for whites, and non-whites comprise a much higher proportion of central city residents than they do any other geographic area. The following table illustrates some of the differences in health status and utilization of services.

	% of pop. with activity limitations*	Days of restricted activity per person 45 yrs and over*	Days of bed disability per person*	Hospital discharges per 1000 persons*	% of women having live births seeing a physician in first trimester**
Central City	14.4	29.2	7.7	136.2	76
Metropolitan other than central city	12.1	23.2	5.8	127.1	85
United States Total	13.8	27.2	6.5	140.5	85

* National Center for Health Statistics, 1973-74.

** R. Anderson, et. al., "National Trends and Variations in Health Service Use", U. Chicago, 1970.

Access to Health Services

While central city residents have rates of physician visits as high or higher than any other population group, the nature and place of the services poor city residents receive are different from those of the non-poor. Preventive and routine medical visits for children are fewer for poor children, and hospital outpatient or emergency wards are more likely to be the usual source of care for poor city residents. Access to private physician practices is limited for the urban poor both because of an actual scarcity of primary care providers and because of inadequate financial resources.

Over thirty percent of residents of medically underserved areas* live in urban areas. While metropolitan areas generally have a disproportionately high number of physicians, these physicians tend not to practice in poor central city locations. Many private practice physicians do not accept Medicaid patients or they strictly limit the number they do accept.

Financial access is often a greater barrier to care in urban areas than is the relative availability of physicians. Urban residents working in low wage industries often do not have private insurance through their employment, and do not seek medical care for non-critical conditions.

Medicaid physicians fee payment levels are low in many states, and delays in payment and paperwork requirements further discourage physicians from treating Medicaid patients. Nine million poor persons are not eligible for Medicaid. The near poor and poor who are not categorically eligible for Medicaid have the lowest utilization of health care services of any population group.

As a result of limited access to private practitioners, poor city residents use hospital outpatient facilities or other public clinics and health centers as their regular source of care. A 1973 General Accounting Office (GAO) report on 17 urban hospitals and 5 public health centers (4 of which were city or county facilities, one a federally funded center) found their patient load to be primarily the medically indigent, those who have no source of funds for medical services (48%), and Medicaid recipients (32%). Only recently have some hospital outpatient departments recognized their defacto role as primary care providers and become concerned with providing comprehensive, continuous care to a regular clientele.

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* As designated by DHEW.

Efforts to Improve Care to the Urban Poor

During the past decade there have been several federal programs and initiatives which have been attempting to improve health care services to the poor. The introduction of the Medicaid program in 1966 is an obvious example. It dramatically changed the frequency of physician contacts for the urban poor.

Neighborhood health centers, initially a demonstration project within OEO, provides comprehensive ambulatory care services to an estimated 1.3 million low income persons. This is only a small fraction (5%) of the entire population to which the program is targeted, however. Not only have neighborhood health centers been a source of free or low cost comprehensive care, they have maintained the physician supply in areas which were losing physicians practicing in other settings. The relatively high costs of establishing these centers and the very real problems the centers have in gaining third party reimbursements and achieving financial self sufficiency have limited further expansion of this program.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program was added to Medicaid in 1967 but not implemented until 1972. The impetus for this program was a belief that special efforts were needed to assure that poor (Medicaid eligible) children receive preventive health services and early treatment of potentially disabling diseases. Very little is known about the performance of this state-administered program. States with large, urbanized Medicaid populations have had difficulty in getting these services to a large segment of the eligible population. The Child Health Assessment Program (CHAP) is an administration proposal which would amend the EPSDT program to encourage enrollment of eligible children with comprehensive care providers. It would also extend eligibility for this program to poor, noncategorically eligible children.

Outreach activities and consumer education are recognized as having value in encouraging appropriate use of the medical care system by poor people. The federal government provides a higher matching rate for outreach services to State Medicaid programs that provide them.

The National Health Service Corp (NHSC) program, established in 1970, places physicians and other health professionals in communities with shortages of these professionals. While the program is in large part oriented towards rural areas, currently about 15% of NHSC personnel are placed in urban shortage areas.

HEW has also supported the training of nurse practitioners and physician assistants. These primary care practitioners can provide many of the services which physicians have provided traditionally. They reflect a lower resource cost than physicians and potentially could do much to alleviate shortages of primary care providers.

National Health Insurance (NHI) and the Problems of the Urban Poor

Even the most generous NHI program will not address many of the health problems of the poor, particularly those of nutrition and housing which have been inherent to poverty. Depending on the nature of a NHI program, however, several barriers to care could be removed and the quality of care provided to poor people improved.

First, a NHI program could reflect the social as well as personal value of certain preventive health services (e.g., immunizations) by including them in the benefit package. Many of these services are not covered by private insurance policies or by public financing programs. The poor have been discouraged from getting these services more than others by their cost.

A NHI program which worked the same way for poor and non-poor beneficiaries, one that made no distinction at the place of service by income or welfare status, would eliminate most opportunities for discriminatory treatment by providers.

With financing for health services for the poor raised to a level equivalent to that for the non-poor, more health professionals would be attracted to practice in underserved areas. Similarly, financing would remove the barrier to getting early treatment of non-critical problems which are potentially disabling.

A NHI program could actively encourage and support alternative delivery systems for health services -- community health centers, HMOs, practices employing non-physician primary care providers, etc. These innovative organizational forms are currently subject to conflicting public policies and uncertain or shrinking funding. Presumably health policy under NHI would be more consistent and financing somewhat more stable. These comprehensive services providers are promising structures for providing high quality care to the poor.

BRIEFING MEMO ON PREVENTION

"Prevention" refers broadly to a wide variety of measures which seek to intervene in the process of disease development. Some measures are community-based such as those aimed at environmental sanitation. Other measures involve the social patterning of behavior. Still others concentrate exclusively on biological factors at the level of the individual.

Societies influence the health-impacting behaviors of their members and support public health measures to decrease individual exposure to specific environmental hazards. However, since the introduction of effective immunization against certain disease, "prevention" has been thought of increasingly within the medical model, based on the interaction of a patient and practitioner. Even the generally accepted definitions within the field of preventive medicine

reflect its therapeutic orientation. To the "primary-prevention" measures that seek to intervene in the etiologic process to prevent disease occurrence, has been added "secondary prevention" or efforts aimed at early diagnosis, screening, and prompt treatment in order to limit the disability brought on by existent disease. Even rehabilitation has been included in the preventive umbrella as "tertiary prevention."

Despite these important advances, a significant body of opinion has recently urged Americans to think beyond the model of therapeutic medicine to encourage complementary approaches to the achievement of improved health levels. Of particular interest to many are opportunities for making better use of the growing body of knowledge regarding environmental influences, both sociocultural and environmental, and the role of certain behaviors in disease occurrence.

Within an even stricter definition of prevention which extends only to screening and early diagnosis are found in many of the most significant advances of modern medicine. Immunization against infectious diseases has spared vast numbers of Americans from the death and disability caused by many infectious diseases. Screening techniques for a broad variety of conditions from metabolic disorders to hypertension and neoplasms have enabled physicians to institute treatment in time to enhance the opportunity for successful intervention.

The charge to the Advisory Committee to consider the preventive aspects of National Health Insurance requires discussion of the relationship between somewhat disparate forces in current health policy discussions. Many proponents of increased attention to preventive opportunities stress the limits of the medical model in signficantly improving upon current health levels. Yet at the same time, the nation is poised for resolution of the question of equitable access to the medical system that has confounded health policy makers for over four decades. Many challenging questions surround identification of the preventive opportunities available through the institution of a National Health Insurance program.

Design of an effective system for assuring public access to the health care delivery system must consider only those preventive actions that are appropriate to the medical service delivery model. Immunization, screening and early diagnosis clearly fall within that model. Yet the types of interventions that can be undertaken within that model are not clearly established. Physicians have recently prescribed food for indigent children and fire alarms for patients living in deteriorated housing. Yet many would argue against any more extension of the medical model into social problems that impact health status.

Thus, the first question to be addressed is what preventive measures should appropriately be encouraged within the medical care delivery system.

Decisions regarding what services should be extended require resolution of complex questions regarding efficacy and risk/benefit calculations, societal notions about the appropriate role of government in influencing individual behavior, as well as cost considerations.

Determining what preventive measures meet a standard of efficacy that justifies encouragement under an insurance scheme is one of the most difficult questions to be addressed. Within the arena of traditional preventive measures are many services of unquestioned value. Virtual medical consensus affirms the utility of preventive service packages such as prenatal and well-baby services as well as many discrete interventions such as childhood immunizations. Yet even within preventive services developed in the medical model, many areas of disagreement persist. Polio vaccines cause a limited number of actual cases. The recent swine flu immunization program drew extensive scientific and public debate after the potential for rare but extremely serious side effects became known. Disputes over the risk/benefit tradeoffs involved the mammography in the early diagnosis of breast cancer still persist.

Preventive approaches to health, mostly based on behavior change, that have grown up outside the medical model face even more serious questions of efficacy. Long term analysis of nutritional regimens, a wide variety of stress reduction programs, and anti-smoking programs, to name just a few, have not yet been completed or in many cases, even undertaken. Furthermore, measures aimed at behavior change, whether they be coercive, merely informative, or somewhere in between, elicit widely varied reactions depending on one's notion of free will and the proper role of government in influencing personal behavior.

Extensive research into traditional and nonmedical preventive approaches is clearly required. While many services are of unquestioned value, some standard of efficacy must be set for those of equivocal value. Designers of benefit packages will, as always, be faced with decisions without the aid of adequate information to make truly rational judgments.

Still other questions concern the applicability of the insurance model for promoting access to such services. Many preventive approaches, such as product labeling for nutritional improvement and workplace stress reduction, while valid preventive health measures, are clearly beyond the capacity of the payment/service delivery model of National Health Insurance.

Within traditional preventive services lie equally complex questions regarding the appropriateness of the insurance model. Many traditional preventive services are delivered not only within the private health care delivery system, but also within special categorical programs such as Maternal and Child Health service programs and the Early and Periodic Screening, Diagnosis, and Treatment program for children. Many argue that entitlement does not assure adequate utilization and that special outreach programs will continue to be required particularly for those unconditioned to frequent use of preventive services. Even where entitlement to preventive services under National Health Insurance is deemed advisable, another range of options is presented regarding various incentive systems such as cost sharing waivers that could encourage utilization of these important services.

A final question regarding the choice of preventive measures to be covered under a National Health Insurance plan is the inevitable question of cost effectiveness. Despite the persuasive arguments of proponents of an enlarged preventive health strategy, patients with existent disease will always attract the first health dollar. Proponents of increased expenditures for preventive services must justify claims on marginal health dollars within a constrained Federal budget. Early cost benefit analyses have been encouraging, but much remains to be done.

Finally, designers of National Health Insurance plans must consider means of influencing the organization of the delivery system to promote the delivery of preventive services. Many believe that the primary care specialties are best able and disposed to render comprehensive preventive services and health education. Others place major emphasis on the incentives introduced by prepaid Health Maintenance Organizations to keep enrollees healthy as the best organizational approach to prevention. Still others would encourage greater use of mid-level practitioners and complementary specialists such as physician extenders, nurse practitioners, and nutritionists as best able to provide the detailed attention, counseling, and followup necessary to encourage constructive behavior change and health improvement.

Clearly not only decisions regarding what is covered under National Health Insurance, but also regarding what practitioners, in what settings are covered at what reimbursement levels, will have a decided impact on the preventive emphasis of our future health care delivery system.