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In a special appeal to Congress on April 22nd of this year, the President requested the enactment of legislation to set up a system of so-called compulsory insurance to meet the cost of medical, surgical, dental and hospital care for an estimated 85 percent of the people of this country. Bills incorporating President Truman's request were introduced in both the Senate and House on April 25th. The Senate bill (S. 1679) was sponsored by Senators Thomas, Murray, Wagner, Pepper, Chavez, Taylor, McGrath and Humphrey. The House bills (H.R. 4312 and 4313) were introduced by Representatives Dingell and Biemiller, respectively. In this article, reference will be made to the Senate bill, and only Title VII thereof, the most controversial part of the bill, will be discussed.

Whatever may be said for or against legislation of this pattern, I believe there is rather general agreement that it is revolutionary in its theory as applied to the United States and is extremely far-reaching in its consequences. Such legislation deserves, and indeed demands, the most careful thought of the members of the legal profession, not only because of its probable impact upon them as citizens and as members of a profession, but because of their real or potential role as leaders of public opinion, particularly in matters calling for determination on the basis of fact and not fancy, of reason and not emotion.

S. 1679 has many facets, but it presents at least three questions on which we as members of the bar should be reasonably informed and have crystallized opinions, viz; What are its provisions? What is the need for such legislation? What will be its probable effects?

What Is The Bill?

Unfortunately, space does not permit a comprehensive digest of the provisions of the bill, which has had predecessors in Congress with substantially the same purpose and design. It is 163 pages long and consists of seven titles. The first six relate respectively to education of health personnel, medical research, hospital surveys and construction, special aid to rural and other areas which are short of medical personnel and facilities, and grants to states for basic state and local health organizations and for health services not provided for by Title VII. Title VII sets up the system of compulsory health insurance.

The administration of the system is to be delegated at the national level to a National Health Insurance Board, to be created in the Federal Security Agency. This board will have five full-time members, three of whom will be appointed by the President by and with the advice of the Senate. The other two will be the Surgeon General of the United States Public Health Service and the Commissioner of Social Security. The President will designate

one of the appointed members as chairman. Provision is made for a National Advisory Medical Council which is to advise the board concerning matters of general policy and administration arising in connection with the making of regulations, the establishing of professional standards and the performance of its other duties. The chairman of the board will be chairman of the council and sixteen members are to be appointed by the Federal Security Administrator, certain representations on the council being prescribed.

At the state level, an approvable state plan must designate a single state administrative agency. A state advisory committee must be created; membership on this committee shall consist of persons familiar with personal health needs in urban and rural health areas (a majority of whom must be representative of the interest of persons eligible for benefits), and of persons representative of the professions, hospitals and other organizations that will furnish the benefits. The state agency must make reports to the Federal board.

A state plan must also divide the state into local health areas and for each such area there must be a local administrative committee or administrative officer, and in addition a local advisory committee to consist of not less than eight nor more than sixteen members, a majority of whom must be representative of the interest of persons eligible for benefits. Local professional committees are to be appointed in accordance with the state plan.

If prior to July 1, 1950, a state has not an approved plan of operations, the National Health Insurance Board will itself administer the program in that state, beginning July 1, 1951, and will continue such administration until one year after the submission and approval of a state plan of operations.

The Complicated Financial Provisions

To finance the compulsory health insurance program, the bill would create on the books of the Treasury of the United States a separate account to be known as the "Personal Health Services Account". While the statement has frequently been made that the funds to be placed in this account will come, in the main, from a three percent payroll tax, split between employers and employees in covered occupations, on wages up to and including $4,800 a year, there is no such specific provision in the bill. Nor is there any definite statement concerning a tax to be imposed on the self-employed. Title VII, on the contrary, provides that there will be appropriated to the account for the fiscal year ending June 30, 1952, and for each fiscal year thereafter, sums equal to three percent of all wages estimated to be received during such fiscal year. There will also be appropriated to the account (1) sums equal to the estimated cost of furnishing dental and home nursing services during each such fiscal year and (2) any further sums required to meet the expenditures to carry out Title VII, with a proviso that the aggregate appropriations made pursuant to (1) and (2) for any fiscal year from 1952 to 1954, inclusive, may not exceed one-half percent, and for any fiscal year from 1955 to 1957, inclusive, one percent of the estimated annual

average of all wages, as defined in the title, received during the three fiscal years preceding such fiscal year.

There will be appropriated to the account, too, for the fiscal year 1951, a sum equal to one per cent of all wages estimated to be received during such fiscal year, to constitute a reserve fund for special allotments to the states for use in case an emergency arises, such as for example an epidemic or a disaster.

From the general funds in the account, allotments will be made to the states that have submitted approvable plans to the federal administrative agency providing for the supplying of the contemplated health benefits.

Qualifying As A Beneficiary and Benefits

A potential beneficiary must qualify for services by meeting certain requirements spelled out in detail in the bill. He must, for example, have received a specified amount as compensation during a given period preceding the beginning of the benefit year. Non-insured persons, such as those who are in the indigent class and who may be entitled to be furnished medical care by either the state or by one of its political subdivisions, may become entitled to the benefits promised by the bill if equitable reimbursements are made on their behalf to the federal account by public agencies of the United States, the several states or their political subdivisions.

The personal health services that are to be made available as benefits are medical, dental, home nursing and hospital services and certain auxiliary benefits, such as laboratory and therapy services, prescribed drugs, special appliances and eyeglasses. Medical services, which may be rendered at office, home or hospital, will consist of (1) general medical services such as can be rendered by a general practitioner, including preventive, diagnostic and therapeutic care and (2) specialist's services by a physician rated as a specialist by the federal board. Payments for hospital services will be based on the least expensive multiple bed accommodations available in the hospital unless the patient's condition necessitates use of private accommodation. Hospital services will not include hospitalization in a mental or tuberculosis hospital.

Physicians, dentists, nurses, hospitals and others may qualify to render services to beneficiaries if they wish to do so. Physicians and dentists and other who decide not to participate in this program will be forced to limit their practice to the estimated fifteen percent of the noncovered population or possibly to covered individuals who are willing privately to contract and pay for the services they need. Apparently the state agency may make agreements with any organized group of individuals or consumer cooperative, any hospital or any hospital and its staff, or any organization operating a voluntary health-service plan to provide the services to be made available by this title.

An eligible beneficiary is promised the right to select the physician, dentist, nurse, medical group or hospital of his choice, provided the selectee has agreed to participate in the program and consents to furnish services to the beneficiary. This promise is subject to a further limitation. Maximum

limits on the number of eligible individuals for whom any person may undertake to render services may be fixed by the local administration committee or officer on the basis of a recommendation of the professional committee in that area that such limitation is necessary.

Other provisions of the bill will be referred to in the course of this article. Necessarily, this outline of the bill is brief and incomplete.

What Is The Need For This Legislation?

Need is of course a relative term. What might be regarded as a necessity at a given cost, no longer seems so indispensable if the price is greater. The question as to the need for a federal health insurance program is therefore closely related to the question of cost.

Good health, and the financial availability to everyone of medical and hospital care to maintain or restore good health, are objectives with which no one can quarrel. The question is, how may these objectives be best realized? If they are not now being attained, can they or should they be realized through a program of compulsory health insurance?

Advocates of this legislation would have us believe that the state of the nation's health is so critical and that the standards of public health and medical care are so low that the Government must interecede. No impartial survey of the facts has yet been made which warrants such a conclusion.

In a recent statement before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, Mr. Ray D. Murphy, vice president and actuary of The Equitable Life Assurance Society, gave the following as "some of the highlights of the record of achievement with respect to health conditions in the United States in recent years:

"1. The overall death rate in the United States has been reduced by more than 40 per cent since 1900. If allowance is made for the higher proportion of older people in the population now than 50 years ago, then the death rate has been cut almost in half since the turn of the century. To put these figures in another way, we are now saving one and one-quarter million lives a year due to our progress since 1900!

"2. The average life span has nearly doubled since the Republic was founded and has increased by more than a third in the last half century alone. Currently, the average expectancy of life is around 67 years as against little over 49 years at the turn of the century and only 35 years at the beginning of the nation.

"3. Of the record crop of nearly 4,000,000 babies born in 1947, more than half will be alive at the age of 72 based on present mortality conditions. If mortality conditions prevailing at the beginning of the century were continued in effect, only one-half would be alive at the age of 58.

"4. The rate for infant mortality has been reduced more than one-half and the rate for maternal mortality has been reduced four-fifths in the last twenty years.

"5. The following diseases, once potent scourges, either have been virtually wiped out or mortality from them has been reduced by 80% or more since 1900: scarlet fever, whooping cough, diphtheria, measles, pneumonia, influenza, diarrhea, enteritis, tuberculosis, malaria, typhoid fever and smallpox."

He concludes: "This is not the stuff from which a health crisis can be made."

The Brookings Report on Medical Care

In 1947, the chairman of the above mentioned Senate committee invited the Brookings Institution to prepare a report on medical care for the individual. Its report was released last year. The conclusions of the Brookings study are in substance the following with respect to the present state of the nation's health:

1. Probably no great nation in the world has among its white population, better health than prevails in the United States.
2. The United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country.
3. The non-whites in the United States have materially poorer health than the whites, but the evidence does not indicate that this condition is primarily or even mainly due to inadequacy of medical care.
4. The advances in health in the United States in the past four decades do not suggest basic defects in the American system.
5. Although the so-called draft statistics have been widely used to show bad health among the American people, they are unreliable as a measure of the health of the nation.

Medical care for the pauper and the medically indigent classes present, it is true, one of our greatest problems. But is the proposed legislation the answer? In the past, provision has been made for them through philanthropy or public assistance at the local or state level. In accordance with sound American tradition there is where the responsibility should rest. If the local or state agencies have made full effort to meet the needs, and, because of the general economic condition of the state, fail, it may be necessary to resort to federal assistance in the form of stand-by financial support of the state program. Certainly, however, the medically indigent problem does not justify a grant of power to the federal government to impose a single system of medical care for all states and all people or of the right to control the administration of medical aid plans at the local level. Moreover, in the present bill, provision for payment of benefits to this segment of the public is only conditionally made.

In this connection, it should also be borne in mind, as pointed out by the

Brookings study, that "the large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditures. The issue is not whether they can afford medical care, but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority."

Voluntary Prepaid Insurance A Better Answer

There is no doubt, of course, that there is a large group above the medically indigent level who find the cost of a seious illness a grave financial problem. Illness, however, is only one of the contingencies that might occur to them with disastrous economic consequences. Their home might be destroyed by fire and the life savings which they had invested in it would be gone. In driving their car, a momentary lapse might subject them to a legal liability which would bankrupt them. Against these contingencies they have voluntarily provided a hedge for themselves in the form of insurance. In its essentials the contingency of loss through medical and hospital expense presents no different problem, and these costs can be and should be provided for on a prepaid insurance basis. In fact, apparently building on this philosophy, Title VII of the bill has been headed "Prepaid Personal Insurance Benefits", but the system set up by its elaborate provisions is definitely not insurance. It utterly disregards insurance principles and should be more aptly termed a "Health Taxation System".

There is nothing the Government can do in the field of health insurance, however, that the individual cannot better do for himself and at far less cost. This is not merely theory because the last two decades have seen amazing progress in that direction. Though the Blue Cross and Blue Shield organizations, commercial companies, labor unions and other plans, coverages for hospital and medical costs are being provided. Through these voluntary plans, it is estimated that a total of 61,000,000 Americans are now insured against the cost of hospital care, about 34,000,000 against the cost of surgical care and some 13,000,000 against the cost of general medical care not involving hospitalization or surgery. It must be recognized, of course, that there is need for expansion of these voluntary efforts, both in the scope of coverage and in the number of people covered. That such expansion can be achieved in an orderly evolution of these existing insurance devices, there can be no doubt; and it can be done without compulsion or regimentation and without sacrifice of the attributes of personal responsibility, foresight and thrift which have made this country what it is.

The philosophy of S. 1697 is not American. It is a product imported from abroad, with the naive point of view that the proven failures of the system wherever it has been tried can through the wisdom and astuteness of our planners be avoided here. Before launching this nation on the experimental course of government medicine, from which there can be no turning back, as experience in other countries has shown, it is submitted that the proof of

need should be clear and convincing. In any event, does not prudence dictate a deferment until the gains and losses of the British experiment can be more fully ascertained and evaluated.

What Will Be The Cost?

What the cost of the proposed legislation will be in terms of dollars and cents, no one can say. Estimates vary from six billion dollars a year to more than double that amount. To quote again from Mr. Murphy's statement:

> "The cost is very uncertain. It depends on a large number of factors, not the least of which is the amount of unnecessary medical care which would be demanded as a matter of right.
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> "Experience abroad indicates the difficulty of accurate prediction with respect to the cost of health services under government control paid for by taxes. In Great Britain, for example, it is a matter of record that the cost of the British program was underestimated by fully 40 per cent for the first nine months of its operation which started in July last year. The official figures for New Zealand show that the cost of its health benefits have increased at a marked rate year after year and rose nearly 50 per cent in the last five years alone. The New Zealand experience is of particular interest since compulsory health insurance has been in effect there for 10 years; and it might thus be expected that the cost of the medical and health care benefits would have become stabilized after the first few years. Instead, the costs climbed.
>
> "Thus all the evidence indicates that the financial burden of a compulsory health insurance system would be very great on the American people and on the economy. Can the nation afford any new burden of such dimensions, and such potentially far-reaching consequences, when the over-all cost of Government in the nation is already so high—well over 25 cents of every dollar of national income, according to the latest figures? When the Federal Government itself is again running a deficit in its budget? When the public debt stands at $252 billions, equivalent to $1,700 for every man, woman and child in the country? And when the nation is committed to such future obligations as the Old Age and Survivors' Insurance program which, on the liberalized basis now being considered by Congress, will alone cost anywhere from $13 to $20 billions a year, according to official estimates, in the lifetime of the majority of today's children?"

There are elements of costs to be considered other than the money required to pay for the benefits and to maintain the host of additional government employees needed in the administration of the plan. For example, will the cost of financing the system be done at the expense of other factors that contribute to good health, such as good housing, wholesome food, recreation and travel? Most important of all, however, what will the cost be in terms of the quality of our medical care?

One certain effect of compulsory health schemes is that the *quantity* of medical care will be increased. This very quantitative increase, the over-utilization inherent in the plan, will inevitably lower the quality of medical care because the time and energy of those rendering the care can go only so far. The deterioration of medical care is definitely one of the costs that must be counted in an appraisal of the merits of the bill. Apropos of this point, some additional provisions of the bill cannot be dismissed from consideration.

The Government Medicine Man

The proponents of compulsory health insurance self-righteously disclaim advocacy of socialized medicine, with its evil connotations. They say their proposed system does not contemplate that the government will own or operate hospitals or that doctors will be converted into government employees, and that the plan will not substantially change the status of those rendering hospital and medical care. Whether these assertions, if factual, would sustain the disclaimer of socialization of medicine depends upon how the term is defined. But is the disclaimer based on facts; and if so, shall we be so naive as to believe that the Administration's present proposal is the ultimate, rather than merely the initial stage of a nationalization program which, like any malignant condition, if once started will uncontrollably grow.

One cannot impartially review the comprehensive scope of the administrative power delegated by S. 1679, however, and escape the conviction that this proposal takes a long step towards the socialization of medicine.

The National Health Insurance Board which the bill establishes shall perform "such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title", and such other regulations not inconsistent with the title as may be necessary. With these regulations the doctor must comply if he enters into an agreement for the furnishing of services. To the lawyer, familiar as he is with existing administrative regulations touching much simpler matters, I am sure it will seem a plausible forecast that such regulations will assume prodigious bulk and complexity. The bill goes further, however, and provides that all functions of the board shall be administered "under the direction and supervision of the Federal Security Administrator," thus vesting in one man immeasurable power. Among the functions of the national board is that of establishing "standards as to the special skills and experience required to qualify an individual to render each such class of specialist services as benefits under this title" and prescribing, by regulation, maximum rates for hospitalization furnished as benefits. The Federal Security Administrator, through such units of the Federal Security Agency as he may determine, shall upon his own initiative or upon application of any individual make determination as to the eligibility of individuals for benefits.

Agreements are to be made with doctors and dentists for the furnishing

of medical and dental services (other than specialist services) and these agreements shall provide "for payment (1) on the basis of fees for services rendered as benefits according to a fee schedule; (2) on a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list; (3) on a salary basis, whole time or part time; or (4) on such combinations or modifications of these bases including separate provisions for travel and related expenses, as may be approved by the State Agency". The method of compensation is to be determined for a health service area by the majority of practitioners under agreement to furnish services in that area. In arriving at the amount of fees the practitioner is to receive, the bill provides that regard must be had for the annual income which the payment will provide, to the degree of specialization, and to the skill, experience and responsibility involved in rendering the services; but these fees, the bill says, must be adequate to provide professional and financial incentives to practitioners to advance and to practice where needed and to encourage high standards in quality of services. This provision for adequacy of fees, not found in predecessor bills, apparently assumes that the science of medicine may be advanced, and the high standard in quality of medical service may be maintained, merely by waving the magic wand of money.

In concluding the discussion of this point, the following quotation from a recent address of Dr. A. Lawrence Abel of London is enlightening: "First of all, about the effect on the public, there is no doubt that there is a certain portion of the public which favors socialized medicine with the thoughtlessness and greed which characterizes the man or woman not astute enough to realize that because they are paying nothing at the time, they are actually not getting anything free. There are certain people who delight in thinking they are getting something for nothing, especially if it comes out of the government. This situation has to be seen to be believed The most serious aspect, I believe, sir, from the public's angle, is that the material benefits which they get at exorbitant cost cloak the real loss of true medicine."

One of my prefatory remarks was to the effect that lawyers had a concern in this legislation because of its probable impact upon them as members of a profession. In that vein, I conclude with the thought which is sufficiently expressed in the following quotation from the 1949 Report of the Standing Committee on Legal Aid Work of the American Bar Association:

> "During the coming summer, it is expected that the British Parliament will enact legal aid legislation providing government funds to cover legal assistance for indigent persons and also for a large segment of the population in the lower income brackets. Although it is argued that since the handling of the funds will be under the direction of The Law Society, the bar remains independent, the scheme can conceivably be a long step toward socialization of the legal profession. Its operation in this country would have consequences most lawyers would not like to envisage."