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PANEL DISCUSSION

FUTURE OF HEALTH CARE AND HEALTH CARE INSURANCE

The achievements of modern medicine, of the health care complex, and of health care insurance are widely recognized. Yet significant shortcomings in relation to their potential development are frequently alleged and the forces of change are actively at work. What is in store for health care and health care insurance during the next five years? during the next fifteen years?

CHAIRMAN J. HENRY SMITH: The field of health care in this nation is of such significance and importance—it is so ramified, so fractionated, so kaleidoscopic in its alterations and colorations, altogether so bewildering—that it demands attention at every turn. If we are to make sense out of it for the future, it surely requires the concerted attention and action of the best brains the nation can mobilize. These days, we must be relevant—I believe that is the word.

Whatever may be the outcome of next Tuesday's balloting, the fact is that we are in the midst of great changes and great challenges in the field of health. We in insurance must be prepared to deal with them; indeed, we must be prepared to help shape the future of health care. The actuary particularly must play a significant and increasingly vital role in this process of re-examination and reshaping.

DR. VICTOR R. FUCHS:* We live in a time of intensive re-examination. All our major institutions—government, church, business—are being subjected to very close scrutiny.

And so it is with health and medical care. Indeed, this area seems to be getting rather more than its share of attention. I think it is readily understandable. Not only is health of vital importance to every one of us as individuals, but the organization, the production, and the delivery of medical care have become increasingly important from an economic point of view.

I might mention—although I am not going to give you a lot of statistics this morning—that expenditures for medical care in the United States have been rising at an average rate of 8 per cent per annum ever

* Dr. Fuchs is Vice-President of Research, National Bureau of Economic Research, Inc., and Professor of Economics and of Community Medicine at the City University of New York.

since the end of World War II. I certainly do not have to tell this audience what the implications are of compounding 8 per cent per annum over several decades.

All these things have given rise to a series of concerns. I tend to think of these concerns about health and medical care as falling into three major categories.

First, there are concerns about the effectiveness of our health care system. This is very evident when we look at some of the standard indexes of health performance in this country in comparison with those for other industrialized nations. We have, unfortunately, a very high infant mortality rate. We have, as you gentlemen well know, lower life expectancy than many other nations. Our age-specific death rates are very high for some ages, most notably at middle age for males, where we have rates, for example, that are almost double those of Sweden and some other countries. So we are very concerned about how effective a health care system we have.

In addition, there is a series of concerns about the efficiency of our system. We have a very costly system. We also have concerns about the equity of our system. How fairly and justly is medical care distributed among all the people of the United States?

These concerns lead to re-examination, to the asking of questions. We ask questions about what we are doing in the health care field. Are we, for example, giving too much emphasis to medical care as such? I, for one, think that we are. Are we neglecting other important factors that also affect health, such as health education, environmental programs of one kind or another, individual responsibility for health?

The question of what must be done if we want to have a healthier country is a very important one, and we need to give it a lot of attention. We must also re-examine the way in which we produce medical care. How do we organize production? How do we decide on the most efficient ways, if we do decide on the most efficient ways, of providing hospital services, medical services, drugs, and other things that go into the medical care package?

I believe that there are some very important inefficiencies in our present system. Consider hospitals, for example, which, for the most part, are reimbursed on a cost basis. The hospital incurs certain costs and expects to be reimbursed for them. Can you imagine any system less designed to produce efficiency, less designed to have incentives for efficient operation, than a system which reimburses strictly on a cost basis?

Or think of the ownership and the management of our hospitals, largely rooted in the tradition of single-unit operations—each little hospi-

tal with its own board, with its own manager. Contrast this with the way other parts of the economy are run, where the more able managers are given an opportunity to exert their influence and leadership over an ever increasing array of resources.

Then think of the doctors and the way medical practice is organized; the extent to which solo practice may have become outdated and inefficient as a way of delivering medical care.

Think of the questions about utilizing new advances in technology and the questions concerning the introduction of more paramedical personnel into the delivery of primary care and secondary care.

These are questions of efficiency; they are questions of concern to economists; I think that they are also questions of concern to actuaries and to life insurance companies. They should be questions of concern to the entire country.

Then there is the drug industry. A great deal could be said in connection with the drug industry about the many inefficiencies that have been built into it and the many wasteful practices that have developed because of the particular way in which drugs are produced, distributed, and prescribed for in this country.

We must also, I think, re-examine the financing of medical care. This comes down to the question of the equity of our medical care system. It is probably a question that is of primary concern to the insurance companies. There is a growing feeling in this country that we need new approaches to financing. You have heard all kinds of plans being discussed, and, indeed, you have seen certain programs introduced over the past couple of years—Medicare, Medicaid, and so on. I have developed my own approach to a national system of financing medical care. It is an approach rather than a detailed plan for several reasons. First, I think that it is a great mistake to try to impose a single, detailed plan on such a complex, heterogeneous, and large country as the United States. Also, I personally feel that the devising of a plan or plans is the responsibility of many people with many different skills, including hospital administrators, actuaries, other insurance executives, and the like.

All that I can offer is an approach, a set of principles or guidelines that I think would be useful in attempting to deal with the problem of a national system for financing medical care. With your permission I would like to present this plan or program to you, and I would be very happy to get your reaction to it. There are four principles or guidelines in my approach.

The first is that there should be universal coverage under some plan or group that at least meets nationally established minimum standards for

health and hospital care—in short, universal coverage. That, of course, involves some element of compulsion, just as, for example, universal coverage under auto liability insurance involves some element of compulsion. Compulsion is not something that I personally enter into very readily. I feel, however, that we have reached a point in the United States where considerations of equity and considerations of efficiency require some kind of universal coverage under some kind of plan or group that meets minimum standards.

My second principle is that the premiums for these plans or groups should be paid for by the consumer directly or by the employer or the employee, or some combination of employer and employee; the role of the federal government should be limited to subsidizing the premiums for the low-income portion of the population.

It is quite clear that there are considerable numbers of people in this country who do not earn enough money to pay for even a minimum level of health and hospital care. On the other hand, it is equally clear that the great majority of the country can and, indeed, must pay for their own care under any kind of system that is devised. It is simply impossible to have a system in which the average person is not going to be paying for the average amount of care, whether it is done through taxes, through premiums, or through something else.

My third principle is that there should be free choice of plan or group wherever that is practicable, including the right to buy more than whatever the minimum level is at any particular time.

My fourth principle is that these plans and groups should be consumer-oriented. They should approach the problem from the point of view of their participants—their members, the people who pay the bills. They should also employ knowledgeable people—professionals and experts in the health and hospital field who would negotiate with the producers, that is, the hospitals, the physicians, and other producers of medical care, for the delivery of services to their members.

Medical care, as you well know, is not something that the consumer himself can be well informed about. It is not something that he can simply go out into the market and buy in a knowledgeable fashion in the way he might buy clothing or food or an automobile or a refrigerator. Therefore, I see a need for someone who represents the consumer, who can supply a kind of informed competition into the medical care market in negotiation with the producers.

Let me mention several reasons why I choose this particular approach to financing. With respect to the universal coverage, first of all, I believe

that where children are involved—and, certainly, millions and millions of children are involved—if we mean anything by our commitment to equality of opportunity, we must include in that some kind of opportunity to get health and medical care. Also, there are certain elements of health that have significant externality, that is, the ill health in one person can affect the rest of society. Here too I believe society has the right to protect itself through requiring a certain amount of coverage for health and medical care. Finally, from my own point of view, there is a very significant point of equity in requiring people who *can* afford health and hospital care to pay for their own. Too often we find a situation of a person who, when he is well, can afford but does not take out the necessary coverage; then, when he gets sick, responsibility for his care falls upon the rest of society. That, it seems to me, is something that society has a right to protect itself against.

At the same time, I want to limit the role of the federal government. I want to limit, first of all, the financial burden that it places on the federal budget, and I want to limit the administrative burden that it places on the federal government. Medical care is something that must be produced and distributed locally. Therefore, you will get it done more efficiently if it is supervised, controlled, directed, bought, and negotiated for on a local basis.

I want to preserve as much as possible the opportunity for decentralized decision-making, for the bringing into play of the energies and the imagination of thousands and thousands of people all over the country, operating in different capacities and to some extent in competition with one another. If someone has an idea and wants to try it out, it can be tried out. If it is successful, other people will see its success and adopt it as well.

In addition, I have a strong commitment to freedom. That is my reason for wanting a system which provides as much freedom of choice for consumers and for producers as possible.

This plan that I am suggesting will not solve all our medical and health problems—not by a long shot. It will take a long time to change things in this country—to change doctors, to change the way they practice and the way they approach the problem of health. It will take a long time for people to change the way in which they approach doctors and the way in which they approach the problem of health. I do think that such an approach to financing, which provides a floor for everyone but puts a ceiling on no one, will create an environment in which further progress for health and medical care will be possible.

MR. IRVING J. LEWIS:* I understand that it was Voltaire who said that the art of medicine consists of amusing the patient while nature cures the disease. This may be true—as are many other witticisms about medical care, such as the report of the London physician who commented, "We got to him just in time—another two days and he would have recovered without us."

The truth is, however, that despite our healthy skepticism about physicians the subject of health care and health care insurance is serious business. The so-called health industry accounts for about $50 billion of our gross national product and employs about three million people. It is one of our major growth industries.

We tend to affirm with a certain solemnity congressional and presidential phrases that every American has the right to high-quality health care, easily accessible and readily available. I regard it as somewhat idle to debate whether it is a right or a privilege. The point is that the federal government spends $16 billion of the $50 billion and is a crucial supporter of the entire health care system. If we meant business in the enactment of some fifty major health bills in the past few years, then we have to face up to our responsibilities to secure this right.

I think it is equally clear that a major weapon in the arsenal of government to secure this right is insurance. When the Congress enacted Medicare and then added Medicaid, with its sleeper provision requiring fulfillment of the right by 1975, it ended the period of raging controversy about the federal role in respect to health care and insurance.

One brooding fact hovers over all deliberations regarding health care—ever rising costs. I would only bore you with the statistics, but we can all be certain that the next official government reports will reflect further increases. The impact of insurance premiums, availability of care, quality of care, and so on, is obvious to this group.

For those interested in health care the problem of rising costs is, in the last analysis, deeply political. It involves decisions that are political in the broad sense of the word, because health care is in constant competition with other national goals, such as education, employment, abolition of poverty, rebuilding of our cities, national security, and many others. Increasingly, as these demands generate greater pressure on our total resources, government attempts to relate differing levels of public investment to benefits and effectiveness by planned and rational choices. Medical price inflation is not a rational or an acceptable choice.

* Mr. Lewis is Acting Administrator, Health Services and Mental Health Administration, United States Department of Health, Education, and Welfare.

Therefore, the first generalization that I would make is that we had better start developing some quantitative goals by which health status can be measured and progress shown, in terms that can be related to the $16 billion the federal government spends and the $50 billion the nation spends for health. Surely, we can learn from the widespread disapproval of our public welfare system that eventually effectiveness and benefits must be related to costs. In every decision they make, the physician, the insurance company, and the government must be able to relate additional costs to additional benefits.

Another imperative for the future involves recognizing and using the known interaction between health insurance and the health care system. For example, we know that Blue Cross and other plans, by their exclusion of outpatient services, have unnecessarily raised the demand for hospitalization.

It is very clear that we should use the insurance method in such a way as to move patients in the direction of comprehensive health care, regardless of the facility. In addition we need to be aware that the extension of major payment mechanisms to new groups—whether government-sponsored or not—can bring about an effective demand that the total system is unable to support because of lack of manpower and other resources.

A third consideration for the future is that one of government's primary health objectives must be to improve the quality, effectiveness, and accessibility of health services for the urban and rural poor. These are the groups with the highest infant and maternal mortality rates, the highest incidence of disease, the greatest number of disability days per year. At the same time these people, who need care the most, are those who obtain it least. High-quality care is often all but inaccessible to them.

Although the poor constitute a primary target group, candor compels me to admit that we need to develop a coherent strategy for reaching them. True, there is a glittering collection of programs—Medicaid, child health projects, migrant health grants, various categorical disease project and formula grants, OEO centers, mental retardation and mental health centers, and so on. Each program holds promise, but they need to be pulled together in a grand strategy.

As a base for this strategy, I would suggest that we affirm a reliance on Medicare, Medicaid, and other insurance programs as primary mechanisms to pay for health care and that we clearly place PHS, OEO, and other service programs in the category of organization and delivery mechanisms. As our model cities program for restoring the social and physical fabric of our inner cities grows, it is important that we rely on

this strategy rather than create new ones to provide and pay for health care.

My fourth major point is precautionary. As we emphasize improving the health care system for the poor, we should be careful not to saddle the poor with a separate subsystem. We cannot afford a split-level health care system. The neighborhood health center idea is attractive in its outreach characteristic. But it carries within it the danger of creating a system rooted in the ghetto, apart from and duplicating the health care system of the community as a whole. Centers should be fully tied into this system, and we should try to see whether accessibility and availability of health care can also be achieved by alternative methods that diminish this danger.

Actually, it seems to me that the enormous weight of government insurance—perhaps private as well—is tending to blur the difference between the public and private sectors, the poor man's and the rich man's medicine. The old modes of public institutional care based on charity and the Elizabethan Poor Laws are being rejected by the medically indigent and the aged. The expansion of insurance and other payment mechanisms will compel state and local government to re-examine the role of the public facility. Conversely, we may well ask how private and voluntary any hospital is whose financial survival depends upon government insurance programs. The outline of the shore may be only dimly seen, but we are surely moving to a period where traditional public and private labels will have lost their meaning as new relationships are formed.

Encouraging new relationships is an important part of the "quest for order" in the health system, on which the federal government is now embarked. Increasingly we are using the incentive of federal dollars to help such relationships develop. One example is the growth of co-operative arrangements among physicians, medical schools, hospital centers, health departments, and medical societies in the new regional medical programs. In fifty-four regions these arrangements are attempting to move the frontiers of science into the practice of medicine. At the same time, we are undertaking a new and still uncertain course of federal-state-local-private relations under the Partnership for Health Act. The comprehensive health-planning mechanisms of this act are intended to stress the logistics of the health care system and the various social, political, and economic factors which shape the system. Both programs will materially affect how future health care is delivered.

Washington, state capitals, and academia are in a ferment about health planning. Like so much of our effort to rearrange our institutions to meet human resources needs, health planning has its partisans and its

opponents, as well as a fair abundance of confusion. Especially relevant is the issue of whether planning shall be oriented to "action" or "process." In brief, should there be "teeth in planning"?

This brings me to a fifth observation about the future of today's subject. We are in need of some new sophistication in dealing with the intricate relationships among planning, capital financing, and reimbursement through third parties—especially federal reimbursement. There is no doubt in my mind that the need to control health care costs, coupled with the need to bring sense and order to capital financing, will compel us to bring together these areas of concern. Obviously, there are no sharper teeth in planning than those which chew on the capital-financing elements in reimbursement formulas.

To the extent the tie-in is accomplished under the Partnership for Health Act, it will raise some novel questions about the respective roles—and capabilities—of the public and private sectors and the differing levels of government in our federal system. In this complex issue we in the federal government will have to weigh our choices carefully with regard to both the character of any proposals and the nature of planning agencies.

For—and I would conclude on this thought—in health as in so many other fields of social action we are witnessing a dramatic unfolding of new governmental relations. The old shibboleths of states' rights, designed for simpler issues in a simpler day, no longer apply. Instead, we grapple with ideas of shared revenues and block grants, new problems of resource allocations. With increasing discomfort we face the fact that our organizations and institutions at all levels of government are simply not up to the task of delivering to the neighborhood the services which are demanded by the people and, in large measure, approved in Washington.

And the neighborhoods, representing their own variegated patterns of citizens and consumer groups, know the inadequacies of things as they are. They are asking new questions of the professional, be he physician or administrator. The day of the professional, in health as elsewhere, has not set. But he must move over and share his views with and listen to the consumer, especially the poor consumer.

MR. DANIEL W. PETTENGILL: In the eyes of John Ruskin my remarks this morning are going to be most unscientific, because I have no facts to substitute for appearances. Indeed, the topic is so immense and so complex that all I can offer you are my impressions. If they stimulate you to positive action, I shall be well rewarded.

With respect to health care itself, my impressions are as follows. First, the body of scientific knowledge in the field of medicine is growing at a

more rapid rate than ever before. Second, this body of knowledge is more than any one doctor can both learn and transmit into actual practice. Third, there are not enough doctors to administer all the care that could be given. Fourth, the cost of treating certain conditions, such as a defunct kidney, is more than most people can afford. Fifth, the average person now knows enough about medical care, or at least thinks he does, that he is very critical of the care he receives, even to the point of instigating a law suit. Incidentally, this attitude on the part of the patient not only raises the cost of malpractice insurance but often forces the doctor to make tests and render care that would have been thought unnecessary a few years ago.

Couple all the foregoing with the fact that many of the poor now realize that they have never received adequate medical care, and I think the future of health care can best be captioned by the word CHANGE. Most of us resist change instinctively. However, when change is inevitable, it is better to attempt to direct the course than to stand idly by bemoaning the results. Accordingly, the health insurance business is trying to be part of the action. I shall now outline some of its efforts.

First let us consider peer review. This is a collective term for medical society review committees, hospital utilization review committees, and any other committee of doctors that reviews the work and the fees of their fellow doctors, for education rather than disciplinary purposes. The first medical society review committees were established a decade ago at the request of the Health Insurance Council. This request arose from the need of companies writing major medical insurance for a source of information as to what is "necessary" medical treatment and what is a "usual and customary" fee. The medical profession's initial reaction to the request was quite negative. Some doctors said, "Why should we pull the insurance companies' chestnuts out of the fire?" Others said, "We do have grievance committees, so get your claimants to file formal complaints that the doctor concerned has broken our code of ethics." It took a long time for the HIC to convince the profession that peer review was needed for much broader purposes than punishing flagrant violations of professional conduct and that such review should be conducted in the quiet tradition of research rather than the explosive atmosphere of a potential law suit.

Today the concept of peer review is endorsed by the American Medical Association and has been made almost obligatory by Medicare. More importantly, however, the concept is beginning to be recognized not as a crutch for health insurance companies but as an effective means whereby the medical profession can demonstrate to government and to the public

that it is keeping its own house in order and that the vast majority of care being rendered is good.

I use the term beginning because there are still many county medical societies that do not have review committees, and some of those that do have them do not have effective ones. Thus the Health Insurance Council still has a major project on its hands. This is especially true when one realizes that good review committees are not formed overnight. It takes years of patient training by skilled insurance claim adjusters to develop a review committee that will not only render advice to insurers but will see to it that the advice is brought to the attention of the entire medical profession and generally heeded thereafter.

May I take this occasion to remind you that the Health Insurance Council has a paid staff of fewer than twenty men and women and that the real work is carried on by volunteers from the insurance business who are members of the state committees of the Council? I would urge each of you to check into the status of peer review in your home town. If it is nonexistent or weak, then help the HIC State Committee to develop or perfect it. Those of you who work in the field of health insurance can be particularly helpful by furnishing the doctors with statistics that will help them to factually bolster their professional opinions. Hospital utilization committees in particular often need to be educated as to what constitutes a statistically significant sample and how to select such a sample. Otherwise, such committees may be completely ineffectual by reason of attempting the impossible task of reviewing all cases.

A second and more recent effort by the HIC to influence the changing course of health care is its HiCHAP program. The full name is Health Insurance Community Health Action Planning. The purpose of this program is to persuade and assist insurance people to participate in both the Governor's advisory councils and the area-wide planning agencies that are being established under Public Law 89-749, which is better known as the Partnership for Health Act. Under this Act the federal government has offered to the states the opportunity to assume responsibility for comprehensive health planning of facilities, manpower, and services. Each state must set up a state agency to co-ordinate all future health planning. The work of these agencies is subject to the guidance and review of a voluntary advisory council, a majority of whose members must be consumer representatives. Insurance men should be and are representatives of the consumer. Thanks to HiCHAP, thirty-one of the thirty-nine advisory councils thus far appointed have insurance representation.

In most states, the planning work will be done on a regional basis within the state. Here again are opportunities for insurance men to serve

effectively. Planning is more an art than a science. There are many judgments to be made and few facts on which to base such judgments. The plans must be practical and flexible, and continuously revised to take into account medical techniques yet unthought of.

The same Congress that enacted the Partnership for Health Act also enacted Public Law 89-239, which establishes regional medical programs for heart, cancer, stroke, and related diseases. It also left the Hill-Burton program essentially intact. Our distinguished panelist, Irving Lewis, has the difficult job of co-ordinating and administering these programs. Actually, he can only succeed to the extent that there is harmony and co-operation at the regional level. We in the insurance business have a vital interest in assuring his success. Planning is not a panacea, but good planning is essential if we are to optimize the health care we receive for the dollars we are willing to spend.

One reason why health planning in the United States is so difficult is that we do not have any semblance of a health care system. Most doctors are solo practitioners and as such are private entrepreneurs who generally decide what and where they will practice without regard for the needs of the public. Each voluntary hospital is an empire unto itself. It may add beds and equipment to enhance its own reputation without any thought as to whether such action may result in a surplus of facilities. To the extent that hospitals are privately financed and serve only self-insured patients, such freedom is proper. However, most hospitals are financed with substantial amounts of public funds, and most of their patients are not self-insured but insured with insurance companies and service plans. This is one of the reasons why there should be area-wide planning agencies with which hospitals could check to insure that their own plans were reasonably in the public interest.

There are many people, however, who feel that planning cannot really be effective unless all elements of health care are first integrated into a unified system. These people include Wilbur Cohen, present secretary of HEW, and Bert Seidman, head of the social security department of the AFL-CIO labor organization. In 1967 both of these gentlemen arranged conferences at which insurance executives and others were told that prepaid group practice is a workable system that appears to offer optimum health care for the dollar outlay involved. The attendees were urged to finance and promote prepaid group practice plans.

It is important to realize that, in the field of health care, the term "group practice" has a wide variety of meanings. For example, if three pediatricians were to contract together to practice pediatrics as a single entity in order to assure themselves of getting certain weekends off plus

regular vacations, they would be said to be practicing pediatrics on a group basis. Two-thirds of the group practice plans in existence today are of this limited, single medical specialty type. However, this is not what Messrs. Cohen and Seidman have in mind. They are thinking of the Kaiser type of group practice, in which a number of doctors representing at least all of the primary medical specialties practice together in a clinic on a co-ordinated basis and preferably also run their own hospital and extended-care facility. Under such a system of integrated health care, an individual may receive every type of care, from a simple flu shot or a routine physical examination all the way to a complex abdominal operation.

Not only are there marked differences in the degree of comprehensiveness of the health care offered by group practice plans, but there are also differences in the manner in which such plans charge for the services they render. The typical group practice plan charges a fee for each service rendered, the same as would most solo practitioners. Here again, this is not what Messrs. Cohen and Seidman have in mind. They are thinking of the plan that combines the group practice of medicine with a prepayment mechanism for financing whatever covered services may be rendered. For such a plan to be viable, there has to be a group of reasonably healthy individuals who are willing and able to pay the group practice plan a uniform premium in advance in return for which they will receive all of the covered health care services that the plan believes they need.

Notice that when a physician is on salary or a per capita basis of reimbursement, he cannot augment his income by rendering more services. Thus, he will presumably not render unnecessary services, and this will keep the cost of medical care down. There is, of course, the danger that, if a doctor gets overworked under such an arrangement, he may reduce the number of services he renders below the level needed to provide top quality care and hence the patients may suffer. A study which the American Medical Association made several years ago indicated that, at that time at least, the prepaid group practice plans were being careful to avoid such underservicing and were presumably rendering care that was at least comparable to the care rendered by solo practitioners.

A second important feature of a prepaid group practice plan is that the patient does not receive any benefits for medical expenses which he voluntarily incurs outside the group practice plan. Specifically, if the group practice doctor says that a member does not need a given surgical procedure and the member nevertheless wants the procedure done and goes to an outside doctor for this purpose, the group practice plan pays nothing. There do not appear to be any reliable studies that indicate how

often this type of situation occurs. Thus we as actuaries are missing a very important piece of information in our efforts to evaluate prepaid group practice, namely, the amount of expense not covered by prepaid group practice plans but nevertheless incurred by their members.

The aforementioned two controls on utilization, the one applicable to the physicians and the other to the patients, undoubtedly account for the attractiveness of prepaid group practice plans to those responsible for endeavoring to do something about the rising costs of medical care.

In response to the mounting interest in prepaid group practice plans, the Medical Economics Committee of the Health Insurance Association of America has appointed a subcommittee to study and make recommendations as to the role insurance companies might play with respect to prepaid group practice plans. So far, this Committee's studies are proceeding along three lines.

First, it is having discussions with existing prepaid group practice plans to determine what role, if any, insurance companies might perform for them. The Health Insurance Plan of New York has already indicated that it is most willing to participate with insurance companies in offering dual-choice plans. This particular prepaid group practice plan is just beginning to acquire its own hospitals and therefore is, temporarily at least, interested in having the insurance carrier underwrite the hospital benefits on both sides of the dual choice.

A second area of investigation consists of discussions with the American Association of Medical Clinics in an effort to determine whether one or more of its members might consider switching from group practice on a fee-for-service basis to prepaid group practice if it received insurance company support in the marketing and underwriting of the revised plan.

The third area of study by the HIAA Group Practice Subcommittee consists of an experiment with one of the numerous medical schools that are establishing prepaid group practice plans for the purpose of teaching future generations of physicians how to practice medicine in a group setting. The initial experiment, which is intended as a prototype, will be made with the Harvard Medical School. It will be novel in at least two respects. First, the sales work will be done by insurance companies and the Blue Cross rather than by the group practice plan. Second, the group practice plan will use experience rating, even if only on a broad class basis.

This experiment is expected to commence in the summer of 1969. The HIAA will publish a bulletin containing the full details of the Harvard plan as soon as they have been finalized.

In closing, may I point out that each of you can play a role in the future of health care simply by taking good care of your own health.

CHAIRMAN SMITH: Each of us will carry away from this discussion his own particular interpretation of the trend of things in the future. But, thanks to the perceptive and mind-stretching discussion we have been privileged to hear from these three gentlemen this morning, I expect that we all are more aware than ever before that the shape and character of the place of insurance in the health field are changing and that we—especially actuaries—must play increasingly involved roles.

At the risk of oversimplification, may I suggest that a major task to which our profession and our industry might well address themselves—in co-operation with the health professions, the hospitals and other segments of the private sector, and with government—is the task of helping to develop and shape a *rational system* of health care. This is a task in which many are already engaged, but it needs all the help it can get. We seek for our society a health care system which takes into account individual, family, and community *needs* and *resources* and which assesses *priorities*—a system which achieves some reasonable cost/benefit ratio and also recognizes our widely acknowledged social commitment of health services for all. The achievement of a result even approximating this goal is no mean task. Through our skills and experience and those of our industry we have much of value to contribute, while at the same time ever revising and projecting our health insurance coverages.