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MANAGING HEALTH CARE

Moderator: RICHARD H. HOFFMAN. Panelists: WILLIAM C. HSIAO, DIANE B. McCARTHY, WALTER McCLURE, RICHARD J. MELLMAN

MR. RICHARD H. HOFFMAN: We are going to participate in what I believe will be a very stimulating and considered review of a complex, elusive but extremely vital subject, managing health care. How well health care is managed in the United States will affect what future proportion of the United States gross national product will be devoted to health care and perhaps even the future health of its citizens.

Currently in the United States, there exists little management in the delivery of health care services. The health care field has been described variously as a "cottage" industry, a "non-system," and in other similar ways. What these terms connote is that the industry is essentially unstructured and unmanaged. Rarely can the responsibility or accountability for the health care services delivered to any specific population group be assigned. Of course, the attending physician and the hospital are responsible for the treatment which each provides to its patients. However, what is missing is a designation of responsibility or accountability for the total outcome of all care rendered. Many believe that this is the root cause of multitudes of problems facing the health care industry.

Although these problems are relatively easy to identify, their solutions are very much harder, perhaps even impossible, to come by. Nevertheless, many measures are being tried, ranging from full-scale complex legislative programs to relatively simple voluntary steps. Some hold great promise. However, I think we should keep in mind, that in reality, these measures are attempts to introduce some form of management or control into the health care system.

REPRESENTATIVE DIANE B. McCARTHY: I feel this morning much like Red Adair, the famous Texan who caps runaway oil wells. I know the problem, I think I know the answer. But I am not really sure I know how to cap the damn gusher!

I must warn you at the outset, there are no simple solutions. There are only many intelligent choices. As an elected official, let me give you my perception of the problem. And I might state right now, we have a rather unique reputation nationwide: we are the only state without Medicaid.

*The Honorable Diane B. McCarthy, not a member of the Society, is a Representative in the Arizona State Legislature where she is chairman of the House Health Committee; she is also a member of the AMA commission on the cost of health care.

*Dr. Walter McClure, not a member of the Society, is Director of Interstudy, a non-partisan, non-profit foundation for research, consulting, and policy analysis in the field of health services.

Since 1965, Medicaid and Medicare have released billions of dollars into the health care system. In only ten years, 1965-1975, per capita federal health care spending increased by 813.6 percent. The actual total dollar increase was from 7 billion to 40.9 billion dollars annually. Even to a layman like myself, the inflationary effect is obvious. Take hospitals as just a single example: since 1965, Medicare and Medicaid have grown until they now account for 55 percent of hospital revenues nationwide. The private insurance industry in answer to the demands, especially from large groups, also grew, until today, 90 percent of all hospital costs are paid for by someone other than the person actually occupying the bed.

What is the result of this? The consumer thinks the care is free. At least he is not, as a general rule, required to reach into his back pocket before he can leave the hospital room, or the doctor's office. But he forgets something crucial to the basic understanding of the entire health care mess we find ourselves in. Somewhere, somebody has to pay that bill. We all know there is no such thing as a free lunch.

One of the most pernicious aggravations produced by the federal method of reimbursing health providers is the cost system. In the simplest terms, this means that all an administrator needs to do to generate more money is to spend more money on increased modern equipment to supply the finest care, or on wage increases for hospital personnel, without the normal market restraints on such expenditures.

And what is the government's current answer to this insidious spiral? An artificial wage and price control on hospitals. To me, this is the most unrealistic approach imaginable to a very complex problem. The United States Government can't even run the Post Office at a profit.

First, hospitals are not the cause of the problem, they are simply the most outstanding symptom. Second, a system of wage and price controls in one segment of the economy, without the same constraints on the rest of the economy, is certainly not going to control the costs. It will merely shift them to the unregulated segment. Government regulation is not the answer. We are only forcing hospitals to contain costs by rationing care. I suggest to you that this is immoral. That's right, immoral. What part does morality have in this debate, you may ask. I say that it plays a large part: if you say, I know how to save your life, but you are number six, and I have only enough money to save the first five, that, I submit, is immoral.

I also contend that limiting technology as a method of cost containment is immoral. Let me put it this way: is it more moral to not know and deny than to know and deny?

From beginning to end, the current health care shambles is a creation of the government. Unless the health care professionals act on this fact, there will be no hope for remedy.

So much for my perception of the background and the problem. What are the answers? You notice I use the plural. As a stated in my opening remark, there are no simple solutions. However, I believe there are intelligent choices.

Now, let us take a look at the participants in the delivery system and at the choices. The patient by and large thinks his care is free. But I tell you that until he has to reach into his pocket, to pay a portion of that medical bill, he will not limit his use of the system. By severely limiting or eliminating first dollar coverage in the care portion of the delivery system, you create a choice not requiring government legislation. This would be a positive incentive to provide care at a level which would meet everyone's minimum, basic needs - a compact car model variety if you will. If the patient wants a deluxe sedan, he may have it, but he must pay for it himself. The patient can no longer be a passive participant.

Now, let us consider labor and management as participants. We all heard that General Motors in 1976 spent more in health care for its employees than it did for steel. Specifically, the cost of employee health care was 735 million dollars. Translated into a cost per car off the General Motors assembly line, employee health care amounted to 700 dollars per car. I submit to you that the time is quickly approaching when management will not be able to afford the luxury of high quality care and over-utilization of the system without any thought of the cost. At that point, labor will be faced with some tough decisions.

Both sides have overlooked completely the alternative of less expensive care. Out-patient operating rooms, or home health care for recuperation purposes are just two examples. Choices in this area are euphemistically called compromises. But I suggest that as labor union agreements go, so goes the rest of the private insurance industry.

Why can't union contracts be written so an individual could make his choice of medical providers on the basis of value? He could go to a provider or a hospital that would offer the best value without sacrificing quality. At that point, and again, without government regulations, competition would re-enter a game in which it has long been on the bench.

Now, let us consider the insurance industry. Often it is pictured as an innocent victim caught between the demands of the consumer and the appetites of the providers. However, the insurance companies have used the symptoms as a reason to keep escalating their rates and have suggested solutions which deal only with the other participants, not themselves. They have <u>not</u> insisted on peer review or utilization review on all of their claims. Nor have they denied payments to any significant degree. They have not suggested additional payments to alternative care, rather than expensive acute care. I suggest the insurance industry pay for care in an ambulatory care facility or a storefront facility, instead of paying for care in an emergency room. That would introduce our old friends competition again, and it doesn't require government regulations. Please keep in mind that I am not trying to cover every choice which could be made. The time constraints are too severe for that.

Now, let us consider hospitals. These are the largest and most painful of the cost escalation systems and the least capable -- or willing -- to respond. The hospital is really the Catch-22 in this whole problem. They are the bad guys, the cause, the blame and yet they are not capable of making necessary changes. Why?

This is because physicians control 100 percent of the hospital income, and 80 percent of the expense and the quality of the product. They must no longer be excused from the obligation of ownership. They must also retain the right to participate in all institutional and/or system-wide policies over which they have such a profound influence. However, today we have the wrong people working on the wrong things. Doctors are acting like politicians trying to change the government, and politicians are acting like doctors, trying to control the health system. Politicians should be involved as legislative overseers, not as regulators at the "request" of the government decision makers. Sometimes the so-called "request" resembles the Sword of Damocles. In short, it is a threat, but the legislative alternative is far more abhorrent than the requested change, so the change occurs.

Generally, legislative involvement, particularly in shaping public opinion, is an asset rather than a liability. I suggest to you that we have not made use of that asset. In fact, we have not done a very good job of shaping public opinion. Much time and effort has been spent in the health care system and the management of things. Internally, hospitals have dealt with managing and consolidating such aspects as administration, audit procedures, and laundries. Externally, legislators have attempted through certificate of need and rate review legislation to manage the costs of capital expenditure and services. We have found that both the internal and external efforts have failed to bring the costs down. May I suggest that instead of managing things, we should manage care.

And finally, is there a public interest? Who should be responsible for it? In a word, doctors. It has been suggested that the reorganization of health care is too important to be left to doctors. I suggest that this is like saying flying is too important to be left to pilots. Doctors are the key to the entire exercise.

And now I find myself back to opening remarks. I am sitting on top of a gusher, but how do you cap it? What incentives do we use on doctors to force them to make the changes? I honestly do not know! I do know we have a variety of choices which make sense.

Specifically, what about health education? Knowing how to take better care of ourselves has to be the responsibility of doctors. Why don't we have "Life Savers" - teams of doctors or hospital volunteers in our schools teaching us preventive care? Another specific presentation of alternatives to government proposals: why don't we have a Health Service Corp., an arm of the country, state and national medical association responsible for funding experiments to find new ways to manage health care? I have a particular hang-up as far as most MD's are concerned. They feel that because they have MD after their name they can stand there and say "no," and that is the end of their responsibility. I have never seen positive alternatives suggested by the medical association.

Another specific that we should consider is health care management. Why don't we have some kind of consortium that deals with managing care, not managing things.

There are only three choices. The final solution must also include an acceptable level of risk on the one hand, and on the other, a sufficiently high but basic standard of care. Economics should not be a sole judge of quality. Another ingredient has to be competition, for a long time the lost chord in this entire structure.

The skeleton of cost containment or management of health care will grow flesh and blood only when joint planning for and management of health care is funded on a basis other than efficiency for efficiency's sake. I refuse to sacrifice the future for the expediency of present political gain.

MR. RICHARD J. MELLMAN: Let me explain, first of all, that the health insurance industry, through the HIAA, our trade association, supports a form of national health insurance which will essentially build on the present system. The idea is that comprehensive, high limit coverage should be made available to everybody who can afford to pay the premium, or whose employer pays it for them. Taxes should be used only for those who cannot afford it: the elderly, the poor and the near poor. Because we think this will best serve the country's needs, we are working very hard to try to ensure that this is the form of national health insurance that comes.

One of the biggest concerns is the rapid escalation of medical costs. It is well known, as Representative McCarthy has pointed out, that medical costs are rising very much more rapidly in the United States than the general CPI. Indeed, this situation is not unique to the United States. It is true in Canada, and in all the developed nations in Europe and elsewhere which have national health insurance programs. So the problem is much the same regardless of whether you do or do not have national health insurance in place.

In the United States for the fiscal year ending September 30, 1976, we will have spent 155 billion dollars on medical care, which comes to over 700 dollars per capita. The most rapidly rising component of that is hospital care, which represents about 40 percent of the total and which last year rose at a rate of 22 percent. If you remember your compound interest tables, you will know that if you could invest money at 22 percent it would double in three and a half years. That rate of escalation is basically what President Carter's hospital cap is intended to moderate.

Medical costs in the United States have risen, not only as a result of the price increases, but also as a result of increasing intensity of care; that is, high technology, and also increasing utilization. Medical care is readily available to most people, though there are some areas which are underserviced.

Representative McCarthy has explained why medical costs rise so rapidly and I need not go over that. Basically, we do not have an economic market. Doctors are trained in medical school according to the oath of Hippocrates to do what is best for the patient regardless of cost. People do not pay the cost directly out of their pockets and consequently, do not shop for medical care. Therefore, we have a system which is essentially very expansionist and inflationary.

Representative McCarthy spoke about villains. I am not sure, with the exception of some of the fraud and abuse, that there are many conscious villains. I think the important factor is the system itself, of which we are a part. Long run success in containing medical care costs will require changing this system around. This is very important to those of us in the insurance business because, if we don't, the balloon will burst and such drastic measures will be required that our business would probably not survive. So it is important for us to work with all the other segments of society to try to bring some rational controls to the system.

Now the economists tell us that there are four ways in which this can be done:

1. We could restore an economic market by getting back into more meaningful deductibles and cost sharing and so forth, pay a larger percentage of the cost of alternative, less expensive forms of care, and perhaps impose much bigger deductibles and co-insurance on the more expensive things like hospitalization. The theory is that by reducing the scope of third-party payments, we would motivate people to shop for medical treatment.

   This would have been a great idea if somebody had thought of it in the early 1930's when the business was in its infancy. However, it is now 1977, 45 years later, and practically everybody in this country already has the other form of coverage. It is difficult to take benefits away from people as the automobile industry found out in its most recent round of bargaining.

2. We can regulate the existing system. This appears to be the main direction in which our national health policy has been heading in recent years, though much more is needed. Under the National Health Planning and Resources Development Act of 1974, P.L. 93-641, we now have regulation of capital investment in health care by broad-based groups of local citizens representing a mix of consumers and providers. The Professional Standards Review Organization Act of 1972, P.L. 92-603, establishes utilization review by panels of physicians for certain hospital confinements. Many states are enacting programs of prospective budget review to control hospital costs.

3. We can develop innovative, alternative forms for the organization and management of health care delivery that are more efficient. The Health Maintanance Organization (HMO) is an example of that.

4. We can nationalize the whole system, that is, make the hospitals public utilities, and, in effect, make all the doctors civil servants.

   I am pleased that we are primarily moving along routes two and three.

What are the insurance companies doing? I have here a booklet recently published by the HIAA. It is entitled "A Program to Contain the Costs and Assure the Quality of Health Care." Copies are available in your companies. If not, you can get it by writing to the Health Insurance Institute or the HIAA. It is essentially a laundry list of all the things that the industry is presently doing and that we are committed to working for. Some are things insurance companies can do now. Others are things for which we need government legislation or regulation, so that the private sector and the public sector, together, can work on them.

As you read through this list, it is easy to see how many of these things fall into category two -- regulation -- for example, prospective budget review and supporting the Health Systems Agencies (HSA's). Many of them also fall into category three -- innovative alternative forms of health care delivery and financing. There are a number of others which perhaps do not fall into any of these four categories in that they are not motivational things to replace an economic market, but are simply good cost benefit-effective ideas that should be explored and developed. Some examples would be second

surgical opinion, preadmission testing, trying to get hospitals to work seven days a week, rather than to put people in the hospital on Friday night and then have nothing happen until Monday morning. (Studies show that a very large percentage of people do go into the hospital on Friday night or Saturday morning and, that on the average, those people are in the hospital three to four days longer than people who enter the hospital on Monday through Thursday.) So, while there are difficulties in staffing a hospital with nurses and attendants over the weekend, tremendous economies are possible. We all know in our own companies, that when we buy an electric typewriter, we do not necessarily hire three shifts of typists to keep it busy around the clock, but when we get an IBM computer system, we have the people who operate it work several shifts to keep the machine busy. Similar accomplishments must be brought about in the hospital field, where we are getting into very expensive high technology equipment and it is simply not satisfactory to work that equipment only 35 hours a week.

What are some of the practical difficulties in bringing about these improvements? First, in our tradition of free private enterprise, a lot of education is required before the mass of the American public appreciates that these things are the most desirable (or the least undesirable) of the alternatives which are available to us. I am sure that doctors and hospitals do not want more regulation, but on the other hand, what else is there?

So, we must somehow educate and persuade people who are on boards of hospitals, involved in organized medicine, or hospital associations, that regulation is is in their own best long range interest.

Many people in the health care delivery system understand this; unfortunately, there are more who do not. If you talk with a typical business executive who is a hospital board member, you are likely to find that he feels that his board is running a very tight shop with little waste. But I submit that if hospitals can be persuaded to regionalize, share expensive services, and not have their own CAT scanner across the street from the next nearest one, tremendous economies are possible.

Secondly, we have to get the business community more involved. HSA boards are at least 50 percent but no more than 60 percent consumers (a consumer is any one who is not a provider). And it is very difficult to get employers involved on these boards, because basically they do not like to be involved in the regulation of another industry. The average business executive would much rather be on a hospital board where he can work on the fund raising committee than be on an HSA where he might be called upon to turn down a hospital's application for expansion. Many of the larger employers understand this and are doing real missionary work in getting the word out through such organizations as the Washington Business Group on Health, or the National Association of Manufacturers. Goodyear, Alcoa, Ford, and General Motors, for example, understand this very well.

I would like to close on this note: if you have the authority, I am talking to you personally, and if not, I hope you will take this message back to your shops. There are three things that we in the private health insurance industry can do to keep the momentum moving forward in this whole area. The National Health Insurance bill that the HIAA supports is the Burleson-McIntyre Bill. I will not go into its specifics here. Basically, any proposal which builds on the present health insurance system rather than tearing down the present system and then starting from scratch with a federal takeover, is the

type of approach we favor. This bill contains three principles which we should be putting into place right now under our current voluntary system.

1. As a start, we should be selling broad comprehensive, high limit major medical coverage under individual policies. While such coverage is generally available on a group insurance basis today, relatively few companies are selling it on an individual policy basis. I would urge you not to withdraw from the individual health insurance market but rather to write broad high limit individual major medical coverage.

2. Preventive medicine coverage. The Burleson - McIntyre Bill contains provisions for certain types of preventive medicine, such as immunization of children, and well-baby care. Although coverage for these might not meet the theoretical textbook definition of insurable risk, it is a political necessity. I am sure we would agree that if we advocate a certain kind of bill, we should be willing to write that same kind of coverage under our current private health insurance. So I urge you to work towards developing that sort of preventive medicine coverage which can be added and included as a part of the health insurance coverage packages that you offer.

3. Insuring Medicaid feature. The third feature is that the Burleson - McIntyre Bill makes it possible for a state to insure its Medicaid program through private carriers as an alternative to doing it itself or retaining a private carrier on a no-risk basis as a fiscal intermediary, as is customary today. So again, if interest develops in one or more states in insuring Medicaid, I would hope that when they ask carriers to bid on it, there will be a good number of companies who will say "Yes, we are interested in making a proposal on that basis," although again, it departs somewhat from the classic textbook insurable risk.

DR. WALTER McCLURE: The big problems that worry us, at the national level, are that 5-10 percent of the people in this country have no coverage and perhaps another 10-15 percent have coverage that most of us would consider inadequate. How are we going to get those people covered? Most of these people are also the working poor and cannot afford this coverage directly.

Secondly, we have a problem of maldistribution of health care services, particularly in rural areas, and to some extent, in inner city areas. There is also a maldistribution in resources, skewed towards the specialized high technology end and away from the primary care.

The third problem is that the quality as assessed by outcomes is highly variable in this country. At its best, it is the best in the world. However, there are a lot of places where it is not at its best. We do not know what we are buying for our money.

The fourth problem is cost escalation. It is consistently rising from 50 to 100 percent faster than the rest of the economy. And, really, it is this last issue that is driving everything else. All the good things we want to do on extending coverage and improving access to medical care are now being pushed into abeyance because of the cost problem. We are afraid to spend another dollar on this industry, because every time we spend a dollar it comes back wanting two more. Until we get some handle on the cost problem, all these other things are being pushed aside. Looking at it globally, those four problems are, in essence, what we are worried about.

Now, what do we know about this problem? First of all, we know that it is not a financing problem. In fact, "financing only" solutions have tended to aggravate these problems, not solve them. It is a delivery system problem. We will not solve this problem until we take on our delivery system. It is really a delivery plus financing problem. For example, by passing Medicare or Medicaid, we vastly escalated the costs, and by applying cost control on pieces of our financing, as in Medicare and Medicaid, we just squeeze the old and the poor. We have not squeezed the system.

We understand also the basic cause of the problem. And the basic cause of the problem of the delivery system is the absence of market forces.

If your problem is an absence of market forces, then you have basically two large choices to make. One, you either restructure your delivery and financing to restore market forces, or you substitute regulation as an alternative to market forces. Now you really can do one or the other or try to do some consistent combination of both. Those are your choices.

What are the effective market solutions available and what are the effective regulatory solutions available, and where might we want to be down the road? There is a great deal of difference between a regulated system and a market system. What kind of future medical system do we want? Then let us do the things that lead us in that direction. Our big problem is that all the effective solutions, both the market and the regulatory solutions, are extremely painful. They all involve a lot of change and they all gore a lot of cherished oxen. And there is presently no understanding or support for any of them. Consequently, our public policy at this point is in what I call the omnibus tinkering state. Like a rocking chair, it looks like motion but it does not go anywhere. You pass all kinds of legislation, but it doesn't add up to what future medical system do you want and that is the basic problem we have to address.

My basic strategy is that we first of all have to build public understanding of the problem and, hopefully, of the alternatives that are available to us. You, as insurers, certainly have access to the public and to providers and to government leadership, to raise that kind of awareness.

Secondly, it seems to me, we ought to pursue the market approach and the regulatory approach in mutually consistent ways, so they are not constantly fighting each other. The regulation we adopt tends to inhibit the market. And the market solution people seem to forget about the corners which might best be handled by regulation. We need to be doing both in mutually consistent ways and that is difficult.

Let me note that the medical care system, like any system of people, behaves the way it is structured and rewarded to behave. And it is now behaving exactly the way that society has structured it and rewarded it to behave. There is no mystery in its behavior overall. I am sure that rigorous economists like Mr. Hsiao will have a lot of questions about detailed behavior, but I think we understand enough about the general behavior to make some important decisions.

Basically, there is an absence of market forces and you can see that in three factors. First of all, you can always escalate the quality, style and expenditures for medical care. There is a Parkinson's law that operates. Medical costs will expand to absorb the dollars available. And you can easily see why that is so. Why do 50 dollars worth of tests to be 90 percent sure of your diagnosis, if you can do 250 dollars worth of tests and be 93 percent sure of your diagnosis? That is not bad care; that is good care. You can always spend more to try to save a hopeless case, even if the odds are very small. Why not, if someone will pay? That is not bad care; that is good care. You can always look for more and more rare diseases. That is not bad care; that is good care. It costs a lot of money. So we can always escalate the dollars. The problem is, of course, that at our present high levels of medical service, it takes an inordinate amount of additional medical dollars to make even a miniscule improvement.

Secondly, the incentives in this system are all geared toward high costs and high technology. We pay doctors fee for service, we pay hospitals by cost. The more complex and expensive the services you do, the more income you make.

Now there are a lot of other incentives beside that financial one, but that is probably the most important.

Another one to look at is professional prestige and interest. Remember that prestige and reputation always go to the specialized guy who is playing with the blinking lights, not to the one who is handling the general practice patients out in the plains of rural Arizona.

Third, we have the insurance mechanism which essentially lowers the price to the consumer, so he has no incentive to be cost conscious. And it gives a blank check to the provider, so he has no incentive to be cost conscious. In fact, it is quite the reverse. When somebody else pays, we all want the very best, and that includes carpet on the floor and T.V. in the rooms and some more. And, of course, our providers want to give it to us. So who is surprised the costs are escalating? Who is surprised that doctors like to go into very specialized work and treat half a dozen dialysis patients in a nice place like San Francisco and instead of treating 5,000 primary care patients in Nebraska or rural Minnesota? There is no mystery in all that.

The question is, what do we do about it? There are really three things we know to do about it. They can be listed so as to put the emphasis on the consumers, on the providers or on the government. If you want to put it on the consumers, you do what Representative McCarthy suggested, or what Mr. Mellman suggested and that is you really raise the "co-insurance" and "deductibles" for the middle class, not for the poor. It should be "income related" so the poor are financed 100 percent, and then decreasingly to zero for the middle class. If we all paid the first thousand dollars of medical care out of our pocket, I think we would be much more effective buyers. We would look twice before we jumped into the hospital if there were an ambulatory alternative available to us. And our health would not be affected as far as I can see. As far as I can see, that alternative would work.

But I think that Mr. Mellman is right; if we had a chance 40 years ago, there is no way we can take away front-end benefits now. Can you imagine the politician or labor leader who comes back to his constituents and says, "I have this great national health insurance plan for you: it takes away all your front end coverage." This will not sell. So, we can hold the line, that is

option number one. This means much more increased consumer cost sharing and at the front end, not the back end. We still want to give them good insurance protection.

As a second option, if you are going to have comprehensive insurance, then what you can do is try to create competition between providers over the premium and the benefits. Now, how do you do that? You do it by breaking up the health care industry into competing and identifiable groupings. You divide the doctors and hospitals into groupings who compete with each other for consumers on the basis of premiums. In other words, you experience rate the providers, not the consumers. Now these groupings can range all the way from a group practice HMO, which is very highly organized, to what we are now calling a health care alliance, which is a very loose organization. Now, when we originally tried to sell the HMO idea to Congress, and the administration, our HMO idea embraced all these options; but that idea was virtually destroyed at the hands of Congress. Now, we have to invent new names to try to bring back the old concept because it is just as true as ever.

What is the health care alliance? The health care alliance is no more than an insurance plan in which every doctor in town cannot participate. At most, say 50 percent of the doctors in town are allowed to participate in one health care alliance, and half the hospitals. A special problem exists in some rural areas where you don't have enough doctors or hospitals to create the competition. However, where it is possible to divide doctors into competing groups, how would you do it? An insurance company might come into town and say,we are going to start the Gold Cross Plan. It is going to compete with Aetna and Blue Cross and so on. The Gold Cross plan will consist of the most efficient doctors that we can identify in town. We will sign them up as participating in our Gold Cross plan and consumers who want to join us will agree to go to them. They practice just the way they always have: solo or group practice fee for service, medicine, independent cost reimbursed hospitals. But the premium reflects their costs. If they are more efficient, their premium will be lower and they will attract consumers.

Now a consumer can buy these health care alliances, buy HMO's, or buy anything in between. I can imagine intermediate arrangements; or primary care doctors could form a grouping and buy specialized care from independent specialists on a fee for service basis within a prepaid amount of dollars. So there are a whole range of alternatives from these tightly organized groups of HMO's to these health care alliances, which allow you to divide providers into competing groupings amongst whom consumers choose on the basis of the premiums and the benefits.

That means we also have to change the bargaining arrangement. We have to change the way that benefits are given to people. We need arrangements where the employer puts in a fixed amount of money and the employee puts in the differences between that fixed amount and the actual cost of the plan that he chooses, somewhat like the federal employees health benefits programs. We need more of those arrangements in the private sector as well as the public sector so that consumers are motivated to choose an efficient grouping. That way we reward providers by getting more consumers, we reward consumers by giving them lower rates, more benefits, better service. Now that kind of competitive system, it seems to me, will work in a comprehensively insured world.

The third alternative we have is the government. The government has to regulate the system. If we are not going to use the market, if everyone is going to be comprehensively insured at government expense, then the government better regulate the system. And we only really know one way, so far, to regulate the system and that is to put a lid on it like England does. We don't have to take over the system, but we put a lid on it; we decide this is how much it is going to spend. There is no more and we will allocate it out by some means. That is the reverse of what we do now, where the medical care system does whatever it wants to do and we run after it, shovelling the money. We do that in the United States, they do it in Canada even though they have a completely public reimbursement system. So it is not the fact that it is public or private, it is whether you reimburse open-endedly or reallocate from within a fixed lid. If you are going to do a public utility system, it might work if you use a lid.

Now, those three options, more consumer cost sharing, competitive delivery systems, and a public utility lid, seem to me the three options that we know now. It seems to me some mix of them is where we should be headed.

Now I think that our agenda should be to find complementary ways to pursue each of these three approaches in ways that do not rule out the others. And I will present this one last idea to you. I think the essence of this is for us to decide what are our goals in costs. We can also have other goals, but let us start with cost. If you state your cost goal to be that per capita health care expenditures shall rise less than x percent a year, x might be 10 percent in high cost areas and 15 percent in low cost areas, for example. Then let us say that if the private sector can achieve per capita expenditure rises of less than x percent, we will leave it alone. It will have met our goal and it is exempt from cost control regulation. On the other hand, if it exceeds x percent per year, then we will regulate it with increasing severity on the basis of how far it exceeds that goal. Now this means that if the private sector can organize itself and set up these groupings or however it does it, the government will not regulate; on the other hand, if it is going up faster than x percent, then we will start to put in the rate squeeze, the caps that HEW is proposing and all the rest of the garbage that the government can dump on the health care system.

Now, I do not believe that any of these regulations will be very effective. There is no history of our being very effective regulators in any industry, let alone health care. But I do believe it will be onerous, and therefore the regulation itself will become an incentive for providers to make these market systems work in order to escape the onerousness of the regulation.

MR. HOFFMAN: I might add that another variation in connection with your second alternative, the health alliances - HMO alternative, is one under which carriers were able to themselves exercise strong cost controls with respect to the services which their insureds use.

MR. WILLIAM C. HSIAO: Most Americans view national health insurance in a very simplistic way. They look at it simply as a mechanism from which their health services would be paid for. Most of the American public believe that it would give them greater financial access to comprehensive health care and that would improve their health in general. They also believe that it would protect individuals and families from potential ruinous medical costs.

There is very little perception that a national health insurance program should manage health care. I do not think most people believe or understand that national health insurance would have a very important role in managing the health care delivery system. But, in fact, if we did not restructure the health care system at the same time, our national health insurance program would not really improve the health of the people. Moreover, I think it would further escalate the cost of medical services. In addition, for the first few years there would be longer queues for primary care services because the increase in demand would exceed the supplies available.

Everybody has pointed out time and time again that financing health care does not significantly affect the distribution of doctors or the availability of services so I am not going to bore you with going through the same litany again. But let me just articulate what I believe to be some of the primary goals that a well planned national health insurance must try to achieve.

First, I believe that a national health insurance program would have to be able to provide all the people with reasonable access to health care. This means financial access as well as availability of care. And this means a national health insurance program has to be concerned about the supply of services.

The second objective that a national health insurance program would have to achieve is to be able to constrain the portion of our nation's resources being siphoned into the medical services. It was pointed out earlier that roughly 8.6 percent of our gross national product is being spent for medical care. Some people believe that is the top limit that should be spent for medical services.

Thirdly, I believe a national health insurance program would have to be able to maintain flexibility for the continuous adoption and diffusion of medical technology. I think all of us want advancement in medical technology. We want to have new drugs; we want to have new medical procedures; we want to have new cures. On the other hand, we want to make sure these new methods are really effective before we use them, instead of just spending money without additional payoff.

Fourthly, I think most people would want to make sure the money we spend would be spent for reasonably good quality care. Therefore, there might be regulations: they might follow the present path of using PSRO's and that kind of method to insure a reasonable standard in the quality of care.

And lastly, if the health care were being paid for with public funds, the revenue would have to be raised in a way that would be according to the people's ability to pay. In other words, the tax rate should have at least some element of graduated tax rate in it so people who are in a better position to pay would pay a larger share of the cost. I am not suggesting that national health insurance today would necessarily be financed from the public funds. I am just saying that if it were paid for from the federal treasury, it would probably be paid for in proportion to people's ability to pay. If we do not care or worry about the amount of money that goes into medical services, it is very easy to achieve the objective of providing care for the people. The problem and conflict arise because we want to do this job without further escalating the cost and also without devoting a still larger portion of our total national resources for medical services.

This concern has been particularly heightened in the business communities in the past few years. Mr. Murphy, president of General Motors, recently testified that the largest supplier of General Motors is not the steel industry, nor the rubber industry, nor the glass industry; rather, it is the health insurance industry. Today, the average American employee works one day out of eight to pay for his medical services. There is also a growing concern that already we are diverting too large a portion of our total resources to medical care. The sad thing is that we are not getting much positive return from this investment. As a matter of fact, there is some scattered evidence to show we might be getting a negative return from this over-investment in medical care. For example, we have spent billions of dollars financing the training of doctors during the past decade. A recent study conducted by the American College of Surgeons shows that the majority of our surgeons today are not doing enough surgical cases to maintain their technical competence. There are just not enough surgical patients around on whom they can practice their surgical skills. This surplus of surgeons may have resulted in some possibly unnecessary surgeries. According to studies conducted by Drs. John Bunker and Wennberg and others, there are perhaps an average of 10,000 to 20,000 excessive mortalities each year due to these unnecessary surgeries.

Hence, pumping more money into the medical care system does not necessarily give us better health, or even a neutral result, but actually can be harmful to us. And as Representative McCarthy said, perhaps we are not doing enough in some areas, such as preventive medicine; instead we are really spending too much money on some of the acute care or high technology care, like surgery. The vexing problem confronting the national health insurance program is how to provide adequate medical services with reasonable cost.

Now, Dr. McClure has suggested a number of ways and let me just comment on some of them. The first method some people advocate is to reduce and restore some of the market discipline by reintroducing the financial incentives to the patients through cost share provisions. And as pointed out, we might be 40 years too late because people are accustomed to first dollar coverage. But a more important question to me is whether the medical decisions are really made by the patients or by the doctors. That would determine the effectiveness of cost sharing. I have an insurance policy which has a deductible and co-insurance. When I go to my doctor he never asks me, "What is your deductible and co-insurance?" He orders the most expensive medical care that is available, assuming that my insurance will pay for it. If there is any cost share provision, my doctor assumes I have the financial ability to pay. He does not ask me to make the choice; he is making the choice for me. I seriously question how much market discipline can be restored by cost sharing provisions for health services.

Secondly, Dr. McClure mentioned promoting competition through HMO's or by foundation plans. I would like to raise the question with him as to how effectively these kinds of competition have been able to restrain the cost of inflation? We have plenty of experience from some HMO's which were established long ago; for instance, in the San Francisco area, the Portland area and the Seattle area. We have had HMO's in those places for two or three decades. Have those communities had a lower rate of inflation and more effective use of our health dollar than other areas in the country? These are the questions we should ask, because those ideas might be conceptually good, but do they really work?

Thirdly, of course, we talk about regulation; various kinds of regulation have been mentioned. One kind is to put a cap on the total amount we will spend. Another type is to put a limit on each type of medical service, and another type is to provide incentives to providers to make more effective use of the dollar. If there are savings, the providers share part of these savings. An example is the prospective budgeting system.

I do not have any answers as to which regulatory approach is best; I only have some principles I believe to be very important in designing a national health insurance program. We want to provide adequate health care at a reasonable cost. I believe that if we go the regulatory route, the regulatory agencies must have the incentive to regulate. Today in America, we have fragmented regulatory agencies. The bills are being paid by Medicare programs or Medicaid programs, or the Child and Maternity Health Programs. But they do not regulate. The regulations come from health system agencies who do not have to pay the bill. They come from rate setting commissions who do not have to pay the bill. What incentives will you have as a regulator to hold the line by not giving in to political pressure or community pressure when you do not have to pay the bill?

We have designed the worst possible administrative structure today, in my opinion, to regulate health care. Unless we can unify these regulatory agencies, and make sure the regulatory agencies have the economic incentive to regulate, we are bound to fail.

I think the second principle is that the people and institutions who are being regulated must be given incentives to modify their behavior in the direction that is best for the nation. There are limits as to how far we can pressure and coerce a free man or a free institution. As Dr. McClure pointed out earlier and Representative McCarthy said as well, throughout the history of America, regulation has largely been a failure. And I think most economists here today agree with that conclusion. We realize that it is not possible to dictate people's actions. You have to use either economic incentives or other social factors to induce people to modify their behavior. And I think any kind of regulation which comes from the national health insurance program must embrace these two basic principles; that is, give the incentives to the regulatory agency to have the incentive to regulate, and the people who are being regulated must have the incentive to modify their behavior.

Now, Dr. McClure has said that we have been tinkering with the system and he is very critical of that approach. But he also made a very strong statement to say that we know how the system works. I confess that I, for one, do not know how the system works. We do not know what kinds of incentives hospitals or doctors respond to.

In the late 60's, we thought that the one way to induce the doctors to give more patient care was by offering higher prices. That is common sense. For example, if you are earning 20 dollars per hour today and your employer doubles that wage to 40 dollars an hour and asks you to work five more hours per week, you will probably say "Yes, I will be willing to do that." And this was the principle used with the physicians which determined the reimbursement policy for the Medicare program.

What actually happened? We observed that the prices went up and the number of patient care hours went down. This experience just shows a person like myself that we really do not know how the system works.

We can have perverse incentives and regulations which will make the problem worse rather than better. Because of our limited knowledge of the medical care system, I believe that there have to be some interim measures. And I believe one form of interim measure which can be effective is putting a cap on the total amount of resources we spend for medical care. If we tell the American medical community today that we are only going to spend 8.6 percent of our gross national product for medical services, and you have to provide the health care to the people within those limits, I think it will force the doctors, the hospital administrators, and the nurses to make sensible choices and really improve efficiency.

As long as we give an open, blank checkbook to the providers, there is never any incentive to be efficient, to make hard choices, and to make sure we are doing the right thing.

Therefore, I believe we should put a cap on the total amount of resources we are willing to spend for medical services, and then allow the decision makers in the system to make the decision as to how and what kinds of services should be provided.

MR. HOFFMAN: Thank you for giving us that fine discussion of the problems from the legislative and regulatory point of view. I think you will agree that the panel has covered just about all of the alternatives for putting that cap on the gusher. On the other hand, neither the panel nor apparently anyone else is able to say unreservedly which solution ought to be adopted. This situation is not unlike most of the other key issues facing the United States. I believe the major reason for this is that we do not seem to be able to obtain agreement from all those affected in choosing one or another of the various alternatives, or some combination.

MR. WILLIAM A. HALVORSON: What programs does Arizona have for the poor?

REPRESENTATIVE McCARTHY: We do have a Medicare program that is covering the elderly. We have been in Medicare for a long time. In terms of Medicaid, the counties have accepted the responsibility of taking care of not only the categorically indigent, those people who are receiving aid under aid to dependent children or supplemental security, but also what we call the medically indigent, the working poor, if you will, the people who are paying taxes, but are not making enough to actually afford adequate health care for their families. Counties have accepted this responsibility and are currently spending around 60 million dollars a year in public tax money to take care of those people. The main reason that Arizona does not participate in the Medicaid system is this problem with the medically indigent. Originally, and we have always been the 50th state, we did have Medicaid on the books. We just never funded it. It is a fine technical problem. We do have it, but obviously there is no money for it. We were assured by the federal government when we got into Medicaid four years ago, that the government would reimburse us for the cost of care, not only to the categorically, but also to the medically indigent. After the legislation was passed, the government came back and said, "Gee, we're really sorry folks; we've made a small technical error and we can only reimburse you for the cost of the care to the categorically needy;

we cannot pick up that portion that would be due to those we classify as the medically indigent." We are talking about 75,000 people in that category in the state of Arizona and therefore the counties would still have the responsibility of paying for those people in addition to paying for and being reimbursed by the government for the categorically needy. In effect, in five counties you would be raising the amount they would have to now spend to cover those people, and that is the main reason we have stayed out of Medicaid.

MR. RICHARD A. BURROWS: Representative McCarthy, you mentioned that the hospitals are really in the control of the doctors. Could a scheme be designed whereby the privilege to practice was predicated on doctors' participating in hospitals so that half their fees had to be turned over to the hospitals and then come back to the doctors out of hospital profits; is that viable?

REPRESENTATIVE McCARTHY: I think it definitely is. I think there are a lot of things that we have not tried to any great degree as far as hospitals are concerned that would provide an incentive for them to be more efficient. I think what I said is that the doctors control the hospital usage completely. And they do. Who else is making all the decisions about putting the people in there? Mr. Mellman mentioned operating the hospital on a seven day week basis, obviously having surgery open 24 hours a day. You know, 1:30 on Saturday afternoon is not the doctor's favorite time to operate. He would rather be at the golf course. But he has to be more effective and efficient in the system. Preadmission testing is something that we have never really talked about and/or tried to get involved in hospitals to a great degree. Alexander McMahon, the president of the hospital association estimates that we would save 100 million dollars a year nationwide, if we allowed pre-admission testing in the hospital. That is a significant amount of money in terms of the health care delivery system.

Another thing we are trying in two hospitals, just on a test basis, which we started the first of the year, and for which we are finding some significant kinds of results, is that the doctors are told the costs of every single test they give and prescribe and the cost of all the medications in the hospital. It is posted. Now they have never ever before understood how much a blood gas test costs, and as a result, were ordering four of them in a 24 hour period. Or they did not realize what the cost of an aspirin was in the hospital. They were absolutely appalled when they found out it was costing a dollar and ten cents per aspirin per prescription in the hospital, when you can buy a bottle for a dollar and ten cents in the drug store. They were willing to bring them in, as a matter of fact, from a local drug store.

These are the kinds of things that doctors really have never known about this system, because as Dr. McClure says, there has never really been the incentive for them to know.

And they are always doing bigger and better things. If you bring them down to reality and show them what it is costing the folks, I think at that point you are going to be able to provide them these incentives. Yes, I think your idea is viable. Sure it is, but you have to hit them in the pockets with it as well as everybody else in the system.

MR. MELLMAN: One of the simplest, most promising things I think we could do is to develop the concept of open staff privileges in hospitals. Today, each hospital competes with the other hospitals in town by trying to line up the best doctors for its own staff. One very elementary example of how this can be wasteful and expensive: birth rates today are much lower than they used

to be, and yet we have maternity wards that are staffed to meet the old frequency of babies. Doctor Berke, a very distinguished hospital administrator in San Francisco who died a few years ago, tried to close down a number of maternity and obstetrical wards in San Francisco hospitals because they found that three out of seven would be adequate. The proposal failed because most of the obstetricians had only privileges at one hospital, and you were depriving 4/7 of the obstetricians of a living. You must have open staff privileges to achieve these economies.

In New Jersey, our health commissioner has recently issued a regulation (and I believe she is being taken to court on it) that said that no maternity ward should continue to operate unless it delivers 1000 babies a year. She said we are going to close down those that are delivering less than 1000 provided there is another hospital within 20 minutes motor distance. So these things are going to force open staff privileges. In addition, it would make possible a great deal more regionalization of specialized care.

Representative McCarthy mentioned as well that two of the large hospitals in Arizona are now posting charges for the ancillary services. This is a very promising idea. Now that computers are available, you can easily turn out a run which would indicate which doctors are ordering how many tests. As long as the funds are unlimited, there is no incentive to reduce the number of tests; but if there were some sort of budget, it would be easier to pinpoint those doctors who are running above average for a particular service and put pressure on them to reduce their utilization, if there is not some mitigating circumstance.

MR. HOFFMAN: These are fine ideas but there are other equally fine ideas, and they should all be tried. But, let us not feel that there is only one way to do it, because the danger is that an idea will be rigidly introduced into national health insurance and then we are stuck with that one approach, whereas maybe there are other approaches that might be superior. More to the point, what is right for one community may not, probably will not, be right for another community.

I have been very hopeful about HMO's and I do not know whether that has really been an empty hope. Dr. McClure, can you respond to Mr. Hsaio's question about the effect of HMO competition on health care costs on the west coast?

DR. McCLURE: The evidence is that in the HMO's, both the absolute amount and the rate of increase are changing at a rate lower than in the fee for service system. It used to be, for example, that, in our town, we had an HMO start in General Mills, and the HMO had a very comprehensive program which was more expensive than the alternative program which General Mills offered to its employees. But the rates of increase are such that those programs have crossed over; now the HMO is the cheaper plan and the alternative plan is becoming the more expensive plan even though the benefits are less expensive. We are trying to convince General Mills, "Okay, now make sure you use the HMO as your base rate, and if employees want to join the traditional insurance plan, they have to put the extra dollars in." No one has done that. That has not been the pattern in traditionally bargained arrangements. Generally, the HMO adds extra benefits and matches whatever premium the Blue Cross plan or the commercial plan is offering. So one ingredient we need to strengthen is bargaining arrangements or benefit arrangements where the employee is rewarded for his choice. And I think that the only way that has been done before

is benefits. I do not think benefits are nearly as visible to consumers as dollars.

Secondly, in the past, business has tried to stay out of medical care. If business becomes interested and wants to push options to employees, if labor becomes interested, and wants to push options to employees, a lot could happen. I give you an example of the power of labor: we were having a problem with the labor organized plan which we were consulting on,a dental plan. People were not showing up to keep their appointments. We documented this and we went to the labor union leader and we said, "Look, your members are not showing up for these appointments. Maybe we should have some educational programs about why they should show up." He said, "If they don't show up, then we will kick them out of the plan." The next month the number of broken appointments fell to .2 percent. Now, that is what I call clout. When they are interested, that can make a big difference.

As another example, in Rochester, when Kodak pitched the two choices, there was really no interest by Kodak in those choices so the penetration of the HMO plan was very small. In the same town at General Motors, they began having a high interest in HMO's through other activities that we were engaging in, and they made sure the employees did know about those choices and what they were and what the advantages of each was. The market penetration of the HMO in the General Motors crowd was 30 percent, which was unheard of in traditional prepaid group practice.

In Minneapolis, and I happen to think that Minneapolis is the hottest town in competitive delivery systems right now in the country, we are having penetration of 50 percent in competing alternative delivery plans, and we have a variety of them. We have the traditional co-op type group health plan. Now we have multi-specialty fee for service groups offering plans, and we have hospitals offering plans. And we have a medical society plan. I do not like monopolies, no matter whom they are run by. What I would like to see that medical foundation plan do is split in two and compete with itself and the rest of the plans in town. That would be our health care alliance idea. We would have all these plans competing and I think we would start to see a moderation in cost trends.

One of the reasons that you have not had a competitive effect is that HMO's have always remained a small portion of the market. Mr. Hsiao would argue that that means the consumers do not want it. I do not think that is what it means at all. I think what it means is that there has been a lot of anticompetitive behavior by physicians to discourage their members from participating in HMO's and so the competition has never been allowed to get off the ground. The second is that there has never been real interest from the real consumers, and the real consumers are business and labor. If business and labor and medicine get behind these ideas, as an alternative to being regulated to pieces by the federal government, which is the way we are going now, then we will see a real difference in the competitive effect. Remember there has never been a foundation plan which was not preceded by an HMO. Thus, the medical societies' fee for service system does react to competition from groups if you can get it going. And it is beautiful to have the competition emerging from different places, for example, from fee for service multi-specialty groups who do not trust traditional HMO. If you are going to have competition preserved in an industry where you have only a few producers and it is expensive to get in, then it is good that these outfits do not trust each other because they will not collude, and you can preserve the kind of competition that is going on.

The key factors are legitimizing change to medicine and to business and labor. Tell them it is all right to do these kinds of things. It is good for medicine. Once business and labor are telling you, as insurers, what to do, then you can have a lot more clout than you had. In fact, they do not know what to do; what you should do is tell them what to tell you to do. Then you can go ahead and do it.

MR. HOFFMAN: I am not sure it is entirely proper to measure the impact of an HMO in a community on the basis of the effect on the inflationary factor only, particularly in areas like Seattle and California where HMO's have been present for many years. There is probably a permanent reduction in costs for those who have become members of HMO's, although the inflation may be just as bad or almost as bad as it is for non-HMO service. I do not know any system that can eliminate inflation.

MR. HSIAO: My challenge is not only on the rate of inflation at these communities I mentioned -- San Francisco, Seattle and Portland -- where HMO's have a very large, very deep market penetration already. But also on the absolute level of cost, I think the evaluation studies done (and I give you a reference by Cliff Gaus) show the performances of HMO's to be uneven when you take into account the patients who go outside the plan for care. Some HMO plans do better than fee for service, but others do worse.

DR. McCLURE: That out-of-plan use in Medicare is well known now and documented. In Group Health Co-op, the Medicare population uses 20 percent out-of-plan hospital services. We know that, and yet even with that 20 percent out-of-plan hospital service, they are still 30 percent less expensive. The reason out of plan use occurs is that there is no lock-in provision in Medicare; that is, patients can go outside the plan. If you cannot control the utilization of the people, then how are you expecting them to control utilization?

If you want to get the savings in Medicare, then you have to include the lock-in provision; they join the plan, they cannot be reimbursed on the traditional basis outside the plan. On that basis, they can make their choice. Now, if I were in Medicare, I do not know why I would make such a choice since I can always join the regular Medicare plan and have it all paid for; but even with the 20 percent out-of-plan use, the costs in Group Health Co-op of Puget Sound were 30 percent below an age, sex, matched sample of Medicare enrollees. Now, that is a fact that we have measured. We have measured it twice. Ken McCaffrey replicated the study. I think that evidence is in. Even with the out-of-plan use, we have chapter and verse of studies which vary in rigor but they all point the same way: that when you match population and when you take into account the out-of-plan use, you still find HMO savings average from 10-30 percent. And those examples where you do see a higher cost of HMO than in the fee for service system, you have explanatory variables which could very likely account for it.

MR. HSAIO: I would like to clarify a few points. First of all, the study I cited is not on Medicare population. It is actually in the Medicaid population and they are locked in. Secondly, this study analyzed the experience of the 11 plans and showed the experience varied. Roughly, one half of the HMO's can do the job more efficiently than fee for service and roughly half of them do much worse jobs.

MR. FRANK E. FINKENBERG: Mr. Hsiao, your proposal for an interim cap on the resources allocated to health care concerns me somewhat. For one thing, if it were put into place and we did not have the desired response to the incentives, then we could get intó a situation which I believe Representative McCarthy would label as "immoral." Secondly, because all the resources do not flow through one or two channels of payment, you would have to set up a very strong regulatory system which, far from being interim, would be a first step toward nationalization. You would foreclose the other option.

MR. HSAIO: I agree with you. It is a somewhat subjective judgement to say we are spending enough resources for medical care already, and I think that kind of decision has to emerge through the political process, where the elected representatives in Congress have to decide whether or not we will put a cap on. And I wish the common people would make their voices heard, rather than only have the voices of the organized interest groups heard, namely the hospitals, the doctors. My own personal experience is that people find the cost of medical care a burden; on the other hand, I think if they become sick, they want everything possible done for them. However, they want to make sure there is a cap on it for the rest of the people.

On the other hand, if people are better educated about the total problem, I think they will be willing to make a decision, to say, "That is all we can afford to spend for medical care." Let me just give you another piece of evidence: Great Britain has a national health service. I am not suggesting that is the best kind of system. However, since they initiated that system, they have limited the total amount of their nation's resources for health care. And that limit is 4.8 percent. In 1948, the United States also was spending 4.8 percent of our GNP for medical care. Great Britain was also spending the same proportion. And Great Britain kept their proportion at that level, but we have almost doubled it. And for any measurable health outcome like mortality rate, disability base, morbidity rate, Great Britain is just as good if not better than the United States.

DR. McCLURE: This 8.6 figure is a pejorative kind of number because it enables people to say that we are working one month out of the year just to pay our medical bills. And, I think we are all concerned about how it has risen from 4.8 over the years, but I do not think anybody has said that 8.6 is too much. But we are concerned that the rate of increase is too much and that it is uncontrolled. The public, I believe, is telling us to slow it down, don't go to 10 percent or 15 percent of the GNP.

We have all talked about regulation, but I think your question, Mr. Finkenberg, pinpoints this a little bit and gives us an opportunity to bring out one thing: there is regulation and there is regulation. And, Mr. Hsaio spoke about a cap; of course a cap can be insensitive if it applies across the board, and if it penalizes the efficient provider and simply trims a little fat from the inefficient provider. I think it is possible for us to obtain some more sensitive limit that would give a budget to the people who are spending this money, but allocate it with a little more judgement and sensibility and appreciation of the variations.

The other thing is, who regulates? Many of the regulations that are now in place are fragmentary. They do not apply to all the patients. For example, PSRO's apply to just Medicare and Medicaid. Much of the prospective budgetary review applies just to them plus Blue Cross and leaves private insurance out. And, too often there is either a czar who is in charge of this regulation or else we give it to the common people, the average man, Mr. Hsaio said. The

HSA's, for example, are required to have board members that are representative of the socio-ethnic economic mix in the community. Unfortunately, while all of them want good health care, very few of them see the health bill directly. The essence of decision-making is that those who make the decisions should face the budget for those decisions, so that the results are weighed against the alternative use of resources. That is why it is so important that we get employers and insurers and labor involved, the people who are really paying the bills for the rising cost of medical care. Employers and labor unions must be educated to the fact. It really is a fact that it is to their interest to become involved in these things and not leave it to the others with little cost stake to fill up all the HSA board seats and vote in favor of more, more, more -- more costly medical resources with negligible benefit to health.

MS. SUZANNE J. SIMONELLI: It seems that one facet of the cost containment problem has been overlooked so far, and that is the malpractice insurance question. Mr. Mellman mentioned that at his hospital he questioned why on the average 50 tests were being made per patient visit. May we attribute the high utilization of tests and other health services to the fact that doctors are attempting to protect themselves in the event of a malpractice suit?

REPRESENTATIVE McCARTHY: That's one of my very favorite subjects and, as a matter of fact, I mentioned it in my remarks; we do have to talk about it as accepted level of risk, but I would point out again that malpractice is a specific area where the state has taken the leadership role in protecting the doctors, protecting the attorneys, and protecting the insurance companies in the states, rather than looking to the federal government for a solution at the federal level. Thirty-seven states in the last year and a half have adopted some kind of state laws regarding professional liability. We know that this is just the tip on the iceberg as far as the doctors are concerned. Lawyers are having much worse problems now finding liability insurance. Architects, engineers, municipal liability and products liability are all tremendous problems. But, it is not totally what is causing the problem as far as a lot of tests in the hospital are concerned. We found that we are eliminating a lot of testing in our hospitals because we limited the definition of standard care to the borders of Arizona. If there is a malpractice suit brought in Safford, which is a little town in southeastern Arizona, you cannot bring in a doctor from Chicago or New York now to testify against the doctor in Safford, because the standard of care is limited to the borders of the State of Arizona. I would suggest to you to take a look at what the malpractice legislation is in your various states, because most of it is aimed at making some kind of a protection available so that the risks are reduced and we can deal with the problem rather than having these outside problems coming in, such as malpractice.

MR. HOFFMAN: Although there isn't a great deal of agreement amongst our panel, one thing is clear: that these issues and their outcomes are extremely vital to all of us, as insurers, and as citizens as well.

MR. HALVORSON: I want to say Dick Hoffman has added to his illustrious career in bringing such a panel together. One of the serious problems we have in the health care field is getting this kind of information into the public hands, so they understand the issues. I would hope we could get adequate publicity for this panel which has brought real light, in an understandable way, to a very complex subject.