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FILLING THE GAPS IN U.S. HEALTH INSURANCE

*Moderator: PETER M. THEXTON. Panelists: GORDON R. TRAPNELL, H. MICHAEL SHIFFER**

1. Identification of the uninsured and under-insured elements of the population.

   Employed

   Aged

   Unemployed

   Near Poor

   Poor

2. Comparison of NHI proposals now active, including HIAA's new Building Blocks approach

3. How is the cost to be shared among:

   Insured persons, and their employers, for their own coverage

   Insured persons, and their employers, for the coverage of others (Conversions and unisurable pools)

   Taxpayers

DR. JUDITH LAVE: One of the gaps in health insurance has been the uninsured and there are various estimates in the literature about how large and how important a problem this actually is. The other group in the population, about whom there is also considerable concern, are underinsureds. We know less about the underinsureds than we do about the uninsureds, not only with respect to who they are and how many they are, but also what is meant by underinsured. If a person selects a health policy to satisfy his own needs, is that person underinsured because it doesn't have certain characteristics that other people believe makes up a better health insurance policy? Though the underinsureds are clearly a critical and major problem, we will talk primarily about the uninsureds.

The definition of uninsured is also hazy. Is it a person who was never insured over the course of the year? Is it somebody who over the course of the year might become uninsured, or is it the average number of people that are uninsured over the year? The range in estimates that one looks at taking just these definitions can be fairly wide and probably ranges from approximately nine million to 35 million people, depending upon what it is that we are counting. It is traditional to count those who are

*Dr Lave, not a member of the Society, is Director of Economic Analysis in the Office of the Deputy Assistant Secretary for Planning & Evlauation at HEW.

uninsured in terms of the average number of people who are uninsured at a particular point in time. One method used to count uninsureds is by the unemployment count since people lose employment related insurance when they become unemployed. But since they may not return to insured status immediately upon being reemployed or may become unemployed again before reaching eligibility for insurance, I think the unemployment concept for continuing uninsureds is confusing. Partly, it becomes difficult because survey instruments are not designed to allow us to pick up the niceties of the questions. Survey instruments are often taken at one point in time and so we get the count of the uninsured at one point in time. A particular instrument being processed at HEW now is the National Medical Consumer Expenditure Survey. It will provide much better data than ever before on the insured and the movement in and out of the status of coverage by health insurance.

We should address the question of what it means to have health insurance. Some of the answers are fairly easy: a person who is on Aid to Families with Dependent Children (AFDC) has automatic access to Medicaid; an elderly person who is on Social Security is automatically eligible for Medicare; and a person who has a private insurance plan that has not expired is covered by health insurance.

But what do we do about people who might be eligible for insurance--are they insured or not insured? Medicaid has a step down policy in a number of states--if you pay a certain amount of money out on medical care expenditures, then you become eligible for Medicaid. If somebody who is potentially eligible for Medicaid after he spends a certain amount of money and does not have an insurance policy in his hand, is that person insured? Does it make any difference if he has to spend down $100? How about $1,000? What about $10,000? When is it that we define that person as being "covered" by Medicaid?

What about a Veteran who is eligible for VA services? Is that person covered by medical insurance? Suppose he lives out in Montana, is poor, and there is no veteran's hospital near him. If that person were to get sick and go to a city with a veteran's hospital, he would receive his care in a veteran's institution. Is that person insured or is that person not insured? Now this may sound as if we are playing "how many angels dance along the head of a pin," but it turns out that when one starts to define the uninsured population, one is forced to make decisions about how to count people who do not have an insurance policy but who might have access to care in some public settings. The Veteran's Administration poses one difficult problem. Consider another one: What if somebody uses a public health department, is that person counted insured? How about a neighborhood health center? A VD clinic? When does a person count as insured? This issue was brought to a head last summer at HEW. We had to sit down and think very carefully about what it means to be insured. Reviewing the literature on this subject, you will find out that people have made different decisions with regard to these situations.

The major survey instrument that the Department of Health, Education and Welfare uses to count the uninsureds is also the major survey instrument that was used by the Congressional Budget Office (CBO). The CBO study has been published; we have not yet published ours. There was a Survey of Income and Education (SIE), that was added to the Current Population Survey, interviewing people in the second quarter of 1976. People were asked a large number of questions including whether they have health insurance and what kind of health insurance they have--group insurance or individual insurance; who pays for the insurance, that is, whether it was paid for by the employer or by themselves; whether they were covered under somebody else's insurance such as a spouse. We then looked at that survey and counted up the number of people who said, "I do not have health insurance." The number of people from that survey who responded for themselves and for their families that they did not have health insurance was 25.7 million people. Everybody who has taken the SIE has gotten the same number because it is a simple count of do you have health insurance, yes or no, and is your family insured, yes or no.

However, if one compares the answers from the SIE to what is known about Federal program data, one quickly finds a discrepancy: On the survey instrument 21.8 million people said they had Medicare. The program total for Medicare is approximately 24 million people. Approximately 11.8 million people said they had Medicaid. The monthly total count for the Medicaid population is nine million and the unduplicated count is 25 million. The number of people who are on VA disability is 1.7 million and the number of people who said they have private insurance is 162.5 million people. So we know that there are people who are eligible for programs but they are not telling and the question is, what does one do about it? HEW, CBO and most others decided that they would count as a Medicare recipient both Social Security recipients and their spouses, if the spouses were eligible according to the criteria. For Medicaid, they counted anybody who said that they were on AFDC plus their spouses and children. After that particular point the inferences about the Medicaid population are inadequate. As a result, CBO got a total of 22 million people on the Medicaid population, while HEW got close to 16 million people.

With respect to the Veteran's Assistance Program, CBO calls anybody who said they were on VA as uninsured; we also decided this group should not be called insured, but we called them "potentially eligible" for VA benefits and kept them identified as a separate count. What you have is a process of inferring data to impute whether people have coverage or do not have coverage under Medicare, Medicaid and the VA.

The other major problem is what to do about people with private insurance who deny coverage? The Department of HEW and a number of other people think that the HIAA has a certain amount of duplication in the count of those with private insurance. So there is some question as to whether the HIAA count of the number of people with private insurance should be considered a good control total. The second problem has to do with the bias of underreporting. The underreporting issue is a complicated one and there really are two sets of data that lead one to go in opposite directions about whether or not the reporting is likely to be under or over. If one goes from a person count to a record count, one finds that people underreport. When one goes from a record count back to people, one finds that they have overreported their extent of health insurance.

You will find out that people will say that they do not have health insurance who do have health insurance and people will claim to have health insurance who in fact, do not have health insurance.

We did our own survey at HEW on this particular point and tried to find out if our people thought there would be an underreporitng or overreporting of private health insurance. We decided that since health insurance is considered to be a primary benefit of being employed, that more people would think they had it rather than not. CBO did the same exercise among their people and came to a different conclusion. The survey on Income and Education reported that 25.7 million people are uninsured. HEW's estimate first got it down to 22 million people and then we brought it down to 19 million people by taking into consideration people we called potentially eligible--that is, they really did not know, but they looked like they would fall into an eligible population, i.e., Medicare and Medicaid. CBO's estimate is approximately 11 million people to 19 million people uninsured. We don't as yet have a very good count.

Characteristically, the uninsured tend to be poor. If one takes the SIE report with adjustments, 20 percent of people earning less than $5,000 do not have health insurance. The uninsured tend to be young, often in the age groups between 19 and 24 and they tend to be unemployed. Approximately 30 percent of people in an unemployed status and in families of unemployed people tend not to be insured. The uninsured tend to be black or in another minority group. However, some of them are actually wealthy. Depending upon how you want to count or how you want to define things, the uninsured number is anywhere between 11 million and 22 million.

MR. JOHN K. KITTREDGE: The second segment of this session is a comparison of NHI proposals now active, including HIAA's new Building Blocks approach. In trying to prepare for this, it became fairly clear that it is difficult to actually make an item-by-item comparison of the various proposals. What I have decided is to give you a few of the principal features of what appear to be the national health insurance proposals that are most likely to be talked about in the next year or two. These are not by any means all of those which are currently in bill form. I do not have a current count but at any one time there is usually a fairly sizeable number in Congress.

Most of the current activity seems to be taking place in the Senate. Senator Long has introduced three bills involving catastrophic insurance, two of which are essentially the same. Those two bills are similar to the bills that Senator Long has been introducing over the past several years to provide catastrophic insurance and they emphasize an employment base for the catastrophic coverage. They have a deductible which with respect to the hospital coverage is 60 days of hospital confinement and for the other expenses is $2,000 of other medical expenses. The coverage under the current bill must be provided by employers either through private carriers, Blue Cross/Blue Shield organizations, HMOs, or insurance companies or alternatively can be provided through an arm of HEW or the Health Care

Financing Administration (HCFA). The coverage is financed by a one percent payroll tax but with offsets for those employers who provide the coverage privately. The bill also contains some farily significant changes to Medicaid, including a provision which permits the near poor who are currenlty not eligible for Medicaid in most states to become eligible for Medicaid through a spend down provision such as that which was described earlier.

Senator Long also introduced another bill which relies premarily upon private insurers for the provision of catastrophic insurance except for the provisions for the aged and the poor. This bill was one which we understand to have been rather hastily drafted and was introduced by Senator Long with the recognition that it would lead to a number of comments. He hoped that the technical suggestions for change would be forthcoming and that this could then be used as a basis for forming still another bill following the same principles. There is another catastrophic bill in the Senate which is sometimes known as the Three D bill sponsored by three Republican senators: Senators Dole, Danforth, and Domenici. The features of this bill are to improve Medicare and to provide for catastrophic insurance through the private sector. The coverage is to be mandatory on employers and individuals would be free to purchase catastrophic plans from insurers with a Federal subsidy being provided for the near poor.

The next bill that I would like to discuss has not yet been introduced. Senator Kennedy is the principal sponsor, and Congressman Waxman who is Chairman of the Health Subcommittee of the House Committee on Commerce and the Environment has indicated that he will also introduce this bill in the House. Senator Kennedy and his staff have released a fairly lengthy document which describes many of the principles of this bill. At least some of us who have read the document are still confused as to how some of the features of the plan will work because there are some conflicts as to who is going to do what and when. The principal features of this bill are to provide a form of comprehensive coverage with no coinsurance or deductibles; coverage is to be available to each individual through one of four consortia. The first consortium would be composed of all of the Blue Cross and Blue Shield organizations in the country; the second would be private insurers; the third would be the prepaid group practice plan type of HMO; and the fourth would be the individual practice association.

The Kennedy bill will provide for premium rates to be community rated with certain exceptions. There are certain categories, for example, the AFDC recipients, who will be separately experience rated and for whom the premiums will be charged at a different level than the community rates that will apply to the bulk of the population. From reading the document, it is not completely clear to me the degree to which the community rate is specified as being the same for all four consortia. It is more likely that the intent would be to have different community rates based upon the anticipated experience of the four different consortia. I think this is something which will take the bill itself to determine positively. Employers will be required to furnish the coverage to employees; each consortium will pay benefits on behalf of all its members.

The plan overall is to be overseen by a national board and a set of state boards. The national board would have the responsibility of establishing a national budget for health care expenditures for each forthcoming year and would then allocate this by geographical area and among providers. Setting of premium rates and so forth would then work out to a process involving the state boards. In effect, the bill does provide for a maximum on national health care expenditures which is one promulgated by the Federal government or on an arm of the Federal government. The national board, incidentally, would report directly to the President.

One way of characterizing the net result of the Kennedy plan is that it represents a tax which would be collected by the private sector for insurance designed in such a way that it is quasi-social insurance. However, the method of cost collection is outside of the Federal budget.

In the meantime, the Health Insurance Association is developing a revised proposal for national health insurance and this is colloquially referred to as "Building Blocks." I suspect that by the time it is developed and introduced, it may well have a different name. This will replace the Burleson-McIntyre bill as the bill to be supported by the Health Insurance Association and its members. It became evident that it was time to consider a replacement for Burleson-McIntyre for a number of reasons, not primarily because neither Burleson nor McIntyre happen to be in Congress anymore but rather because there has been a much greater spread of health insurance throughout the country since the time that the Burleson-McIntyre bill was originally conceived and drafted. In addition, in today's climate we believe that the Burleson-McIntyre approach of replacing Medicare and Medicaid with privately insured coverage paid for by the government is probably unrealistic. The general mood of Congress and the country is one of concern about Federal and state governmental expenditures and it became farily obvious that any workable form of national insurance plan must be phased in gradually as Congress and the country are ready to pay the necessary bills.

One basic concept of the Building Blocks approach would be that of providing coverage through employers. One possible way of starting the plan is through the initial adoption of a form of catastrophic coverage. Employers would be provided a strong tax incentive to purchase the minimum plan which would be specified in the bill. Individuals also would be urged to purchase the coverage and would also be provided strong tax incentives to do so.

What does Building Blocks do? At this point, Building Blocks is not in bill form; there are still lots of important details to be worked out. The basic concept of Building Blocks is to strengthen the present coverage where it is necessary and to fill in the gaps. As we have heard, defining or quantifying the gaps is very difficult. However, trying to define the major areas where gaps exist is less difficult.

One very sizeable gap is the so-called temporarily uninsured people who were covered under employee based coverage and who are now between jobs. The Building Blocks plan would address these people by requiring the qualified plans carried by employers to continue such individuals for up to six months of coverage with the cost sharing between the employer and the employee being on the same basis as for actively employed individuals.

There is a group of individuals who are uninsurable, but who can afford the cost of insurance. The cost of the availability of coverage for those individuals would be handled through the establishment of state pools by insurers, including the Blue Cross/Blue Shield organizations and with the cost participated in by the self-insured plans. The cost charged to uninsurable individuals would be considerably less than the actual cost of the coverage to them and the excess cost would then be allocated among the privately insured companies and passed on to the public through an element within their premium rates.

The problem of the uncovered poor would be addressed by extending Medicaid ultimately to all of those individuals with incomes below the poverty level. In terms of total cost and the total impact on the Federal budget, this is probably the largest element. The near poor would be treated in a somewhat similar way by placing a maximum on the amounts which they would pay for their insurance and, at least at this point, the Building Blocks proposal limits the payments to 10 percent of the excess of an individual's income over the poverty level. There are a number of other gaps which are also addressed and specifically considered by the Building Blocks plan. This simply explains the basic concept of Building Blocks, namely, to fill in the gaps and strengthen our present system.

The Carter Administration and HEW have been working for some period of time in gradually developing and honing down to a specific proposal. We don't know specifically at this point what that proposal will be, although there was an article in the newspaper yesterday which said that the proposal will be introduced very shortly. There's an implication in the article that the Administration plan will be a catastrophic plan with a $2,500 deductible and that in addition to that, the Administration proposal will also call for essentially full payment, not only for the poor but for everyone, of prenatal and natal care. According to the article, this bill will be introduced in the House of Representatives by Representative Rangle, who is the Chairman of the Health Subcommittee of the House Ways and Means Committee. He is quoted in the article as having hoped that the plan would also include some decree of postnatal care, but this apparently has been dropped from the proposal in the interest of cost.

That's a quick glimpse of the various proposals that are currently before Congress and are likely to attract attention this year and of several proposals which are currently being worked on.

MR. PETER M. THEXTON: The next question in the program relates to the sharing of these various insurance costs among different groups of people, insured persons and taxpayers. Of course, individuals ultimately pay all of the cost of medical care and of medical care insurance by whatever name it's called. We tend to hide a certain portion of it in, for instance, lower wages and higher prices by employers and in higher taxes for payment by government for its specified groups. In turn this results in higher prices or in a need for higher wages in order to pay personal taxes.

In discussing national health policy, the political decision makers are generally looking for cost calculations on an aggregate dollar basis and primarily they are interested in the amount which must be covered by taxes. We in industry usually try to emphasize to Congress the private sector costs: indirect increases through employer premium increases, and indirectly increased prices and wages to pay the taxes. You've heard about the various proposals in terms of benefit plans and arrangements and about several Federal agencies' struggles and conclusions in trying to determine who needs more coverage, how much they need and how many there are. The HIAA also has trouble with these same questions. We, in fact, do not want to quarrel about the answers but rather want to come to some broad consensus on the general order of magnitude, particularly, about the magnitude of the costs which result from these counts.

Here are a few numbers that the HIAA has put together that may be of interest to you. For a catastrophic plan which is to provide a limit on out-of-pocket expenses of $2,500 (the plan the government would sponsor), the new claim cost that would have to be borne by individuals or by employers or out of taxes, is estimated at about $8 billion. Of this, the private share, which is borne directly by employers and individuals, would be about $3 billion. The tax claim cost would be about $5 billion.

In my view, these numbers are really plus or minus about 50 percent of themselves. For instance, if someone proposes a tax cost between $2½ and $7½ billion for the same or closely similar plan where I had estimated $5 billion, I'd say we had the same number, because there are uncertainties in the number of persons involved, and in determining the values of the benefits in excess of these limits. As a percentage of earnings or incomes or taxes, these numbers are relatively small, although some individuals and groups may not think so. For instance, a middle-aged person with no current coverage might find that a $2,500 deductible, the amount for a person who has no coverage, could cost $250 a year or more in 1979. If the deductible is not indexed for inflation so that in 1980 it is still $2,500, then the cost increase may be twice the rate of inflation because the deductible value erodes as the cost of everything increases. Twice the rate of inflation is coincidental and approximate. It depends on the shape of the curve of the coutinuance of expenses in this particular range.

If reasonable coverage as currently sold or qualified by a national health policy is purchased and if the limit on out-of-pocket principle as opposed to deductible principle is maintained, the catastrophic cost is drastically reduced. We estimated that it is about $25 or less. Our own data indicate that a little less than half of the insured population has coverage which is better than the $2,500 limit on out of pocket. There are gradations between those policies that have $1,000 limits on out of pocket and those that have no limit at all, maybe even basic coverage only. The inflation problem applied; $25 will increase rapidly if inflation continues and the $2,500 limit is not indexed. For persons over 65, our estimate of the cost of a $2,500 limit is about $175 per person or about $4 billion total out of the $5 billion of tax costs I mentioned earlier.

I'd like to mention more assumptions. For Medicaid, we divided the population using the CBO study because that's published (as Dr. Lave said, her work is not published). From the CBO study, which indicated

an estimate of 11 to 18 million people with no insurance, we picked the middle number, 14½. Then from all the other counts you can balance out to the total population figure of 218 million. It ended up with 160 million with private insurance. Considering Medicare as one separate count, Medicaid as another count (AFDC eligibles are categorically Medicaid eligibles), you arrive at the number that I mentioned--14½ or 15 million totally uninsured.

There is a fairly large portion of the population who have public insurance in the form of military insurance, and Federal employees are teamed with private. There are also a couple of other categories that are smaller. We considered the non-institutional and tried to limit it to that because it's almost impossible to tell what's going on with the institutions.

We make no specific caluclations with respect to the two classes that were mentioned in the program, people with conversions and the uninsurables. The excess morbidity for these two groups will have to be added to the cost of those who are insured on a standard basis, slightly increasing their costs.

In our calculations we felt that as regular group and individual insurance continues to expand and fill the gaps for the currently underinsured and noninsured, the pool of those who are less healthy and who are not fully insured will become smaller and the relative portion should shrink probably to something substantially less than five percent of private premiums. That seems a manageable number if the self-funded plans carry their share.

As to what individuals will pay for insurance under a catastrophic proposal, all those who have some insurance now probably will have very little change in their own share of their medical care costs. This $2,500 is, after all, a fairly substantial number. Very few people actually get to that area. I don't have a very good frequency number for that, I'm sorry to say. We can estimate what the broad range of the cost would be but not the details of it. Most people are going to be in the same position after a catastrophic proposal as they are now.

I didn't come prepared to speak about costs for the Building Blocks proposal at this time since we haven't gone over our calculations on it.

DR. LAVE: Can I make a statement before the questions begin. The 22 million number that I mentioned is a 1976 number. The Department's number is now down to about 20 million, so its really the same as the high end of CBO.

MR. THEXTON: The survey is of 1976 and we're trying to do our calculations as of 1979. What has been the change? Our own survey for 1977 is just about to be published and 1978 is just being processed.

MR. DANIEL PETTENGILL: Are the costs mentioned earlier based upon a $2,500 out-of-pocket figure, per individual?

MR. THEXTON: You're absolutely correct, and it's a very good point. I was working with the cost per individual. The cost estimates that came to me indicated that they should be increased by something on the order of seven percent if the limit was made to per family as opposed to per individual. Two people agreed on that number and the other people who were working on it did not make any estimate. We will have further estimates on this.

MR. WARD MILLER: You didn't indicate in what order these Building Blocks might be phased in. Has that been studied at all?

MR. KITTREDGE: It has been studied. My understanding of the current stages of the development is that the work is being done and that the Technical Advisory Committee of the Association has a tentative proposal which would start with a form of catastrophic coverage. In additon, it's obvious that the two most pressing needs are those of broadening Medicare, which is, at least by some standards, considered to be less than completely adequate, and then addressing the problems of the poor and near poor who are not now covered by Medicaid.

MR. MILLER: Does the $3 billion figure that was quoted include anything for Medicare or Medicaid?

MR. THEXTON: It includes nothing for Medicaid because I considered only the categorically eligible for Medicaid. All the rest are balanced somehow into all the other figures and, presumably, if you're too poor to pay your first dollar of medical expense, the government is already paying the catastrophic and there can't be any increase. For Medicare, it does include an estiamte and half of that $8 billion is for the catastrophic for Medicare.

MR. JAMES L. PURDY: How much would the estimate of those uninsured be reduced, if Medicaid were brought up nationally to the level of some of the better Medicaid programs around the country?

DR. LAVE: I can't really answer that question offhand. However, something like 20 percent of people with incomes of less than $5,000 don't have any health insurance at all. That's 13 percent of the population, so you're picking up a bunch of them.

MR. HARRY SUTTON: The Secretary of HEW characterizes health care as a non-system. Will any of these proposals result in change in the delivery system?

MR. KETTREDGE: None of these proposals makes major reforms in the system in terms of how physicians and patients relate or how hospitals fit into the system. As a matter of fact, none of the proposals actually make any sweeping changes in terms of the provider's interest in what health care costs. Indirectly, the proposals do address this to a varying degree, depending upon how they treat coverage under prepaid group practice HMOs and Individual Practice Associations, both of which are mechanisms to try to bring more discipline and more orderliness to the delivery of medical care and, in addition, to try to introduce to the provider some element of

responsibility for the financial costs of medical care. An HMO, for example, does this because of the fact that the HMO received a specified amount of premium income for which it agrees to provide all of the defined health care needs of a particular population. The interest of the provider, the physician who decides exactly what medical care will be given, is controlled through a number of forces, but probably the most important ones are peer pressure, review of how they are practicing medicine by those who are in a supervisory role with the HMO, and in many if not most HMOs, an out-and-out financial interest on the physician's part because a physician may be paid on a fixed salary basis but may receive a bonus or at least an element of additional compensation based upon the extent to which the premium funds have been utilized. So that the degree to which any of the approaches really changes the delivery system or non-system really is a function of the degree to which HMOs, IPAs, and perhaps similar kinds of mechanisms are encouraged. That's a long way of answering your question, but I think the answer is probably no.

MR. RICHARD JESSUP* It may be of some interest if I give you an indication of how New Zealand has overcome the problems of filling the gaps in health coverage.

The health coverage elements of our Social Security scheme were introduced in the late 1930s by a government committed to a philosophy which said that all citizens should be entitled to health and education services independent of their means. The cost of providing such services were expected to be outweighted by the benefits of having a healthy and well-educated work force. There was at that time very little in the way of health insurance. Medical and hospital services had a limited coverage.

A scheme finally introduced provided a platform of income for those unable to work because of ill health. The income benefit was subject to a means test. The services of medical attendants were to be free and in the final scheme this was brought about by a reimbursement of fees to a level which initially made the service free in most instances. Hospital services and drugs prescribed by a doctor were also intended to be free.

The system ran into a major problems at the outset because of opposition from the medical profession who felt that there was a danger of interference by the state in their relationship with their patients. This problem was solved in a manner which has proved acceptable to the doctors and the system has worked well.

In recent times the level of subsidy has not kept pace with the rate of increase in medical fees so that the costs of doctors' fees are now borne partly by the patient. The costs or providing free hospital services have escalated and the service is now not adequate to completely cover demand. In these circumstances private hospitals are now becoming more common as is health insurance. Efforts are being made to ration new equipment amongst public hospitals.

The benefits described above, together with a whole range of other Social Security benefits were initially financed by a special tax of 7½ percent of all wage and salary earnings. There were no elements of insurance and there

*Mr. Richard Jessup is not a member of the Society. He is a Fellow of the Institute of Actuaries of Australia and New Zealand.

was no relationship between the contribution paid and the benefits to which the citizen was entitled. Coverage is complete. There are no gaps. I beleive that the delivery of health services according to need rather than to means has had a beneficial effect on the health, productivity and wealth of the country. There is no way of measuring the value of these benefits but they must offset the costs to a considerable degree.

It would be overstating the case to say that there are not problems and on the broad front there are some who suggest that a system of welfare as all-prevailing as that in New Zealand has a bad effect on attitudes. The effect is a difficult one to measure.

Two particular difficulties which have arisen in recent times have been attempts to "improve" the system, particularly by the introduction on a no-fault system of Accident Compensation which is more insurance-like. Insurance benefits to accident victims are related to income and the disharmony with the sickness system is producing strains, particularly in the boundary areas where it is difficult to define whether the disability has arisen from an accident or sickness. A second more general problem is the rapid escalation of costs, particularly of drugs and of hospitals. These problems are being addressed and in some ways are easier to solve in a universal system than in a piecemeal one such as applies in many other countries.

The New Zealand system has many very staisfactory features and in particular, it delivers adequate health services to those people who fall in the gaps in other counrties.