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PANEL DISCUSSION

SOCIAL AND ECONOMIC ASPECTS OF HEALTH INSURANCE IN THE UNITED STATES AND CANADA

Panel Members:

C. MANTON EDDY, Chairman
W. DOUGLAS BELL, Managing Director, Canadian Health Association
MORTON D. MILLER
H. LEWIS RIETZ

C. MANTON EDDY:

With me on the panel are Douglas Bell, Managing Director of the Canadian Health Association, Morton Miller, a former chairman of the Health Insurance Council, and Lewis Rietz, currently Vice President of the Health Insurance Association of America. We intend to focus our panel comments on what is happening today in Canada and the United States and on particular issues in the United States.

The issue of health needs of the nation is very much before the United States. The aspects are not only economic and social but very much political. The great growth of health insurance in United States and Canada in the past decade is a matter of record and needs no documentation here. Some of the earlier criticism of inadequacies and limitations of benefits is now changing to the complaint of rising cost of care. The expansion of benefits among the working population and their families has been so great that it has practically removed the older pressures in the United States for a national health insurance program but the acute problem of the aged still remains very much before us and we have to be conscious of the possibility that if action is taken with respect to this group it may later be extended to other age groups.

Very vividly and impressively before the United States is the question and decision as to which road it will take in the immediate future, the extent of government involvement and which level of government will be involved. The United States is a big country, big in geography and in area and great in the numbers of people. Racially we are not homogeneous; we have many races within our boundaries. We are urban and rural in our living; we are industrial and agricultural. To a great extent our states are sovereign political entities. All of this raises the question of whether broad nationwide solutions might be best or whether we should have a great deal of local autonomy and community decisions in the road we use.

Our neighbor to the north has already made some of these decisions. Mr. Bell will outline to you what has been happening in his country.

W. DOUGLAS BELL:

The Extent of Government Health Insurance in Canada

The federal government currently maintains a medical inspection service for immigrants, provides medical care for merchant seamen and fishermen, Indians, Eskimos, members of the Armed Services and certain veterans.

At the provincial level, six of our ten provinces have formal province-wide plans under which broad medical services are available to individuals receiving public assistance payments from local governments, with the medical profession paid for such services from tax funds. Various provincial agencies provide complete care in certain provinces for particular diseases such as mental illness, tuberculosis, cancer, poliomyelitis, arthritis, and others.

Other more localized plans, such as the municipal doctor plans in Saskatchewan and Manitoba and the so-called "Swift Current" plan in Saskatchewan are in operation with financial participation by local or provincial governments.

In the area of hospital care, provincial-municipal hospital plans were first inaugurated locally in the rural areas in Western Canada following World War I. By 1949, several of our Western provinces had full scale government plans in effect. In 1956, our federal government made its offer to assist the provinces financially if they established provincial plans for standard hospital care and for laboratory and radiological diagnostic services. Since that time, with the exception of Quebec, all of our provinces and the Northwest and Yukon Territories have brought hospital plans into effect. Further, it is expected that the Province of Quebec will commence a comparable plan this coming January.

While there are differences in these plans from province to province, generally they provide full standard ward care and almost all special services. Except for Ontario and Prince Edward Island, all residents are covered; and while the Ontario and P.E.I. plans are not completely compulsory, the great bulk of the population is covered. In all these cases both the federal and provincial governments are applying tax funds collected from the general public toward the cost of these plans.

In Ontario, Manitoba, Prince Edward Island and the Northwest and Yukon Territories, the government has assumed exclusive occupancy of the basic hospital insurance field. Accordingly, it has been provided either

by law or regulation that no hospital insurance may be written or retained in force by private insurers which would duplicate the benefits provided under the government plans. Currently, the Province of Alberta is considering comparable legislation and it is our understanding that the Quebec plan will follow this same pattern when it is introduced.

Two other more recent developments are noteworthy. So far, the only government in Canada which has taken steps to extend its activities beyond the public ward hospital level into the area of medical-surgical coverage is the Province of Saskatchewan. In an election held there this year, the CCF or Socialist Party made a promise to inaugurate a complete province-wide medical care plan if re-elected. In spite of strong opposition by the Saskatchewan medical profession and other interested parties, the CCF government was re-elected, although with only approximately 41% of the popular vote, which was a reduced percentage from their last successful election. Accordingly, it appears that a complete government medical care plan will be introduced in Saskatchewan, probably sometime in 1962.

I should add that, in an election held in the Province of British Columbia just this month, the CCF Party campaigned on a similar plank. However, while they did increase their number of seats and percentage of the popular vote, and are the major opposition party, they were not successful in forming a government in that Province.

Another noteworthy and recent development is a new voluntary contributory group surgical-medical insurance plan for members of the public service of Canada and their dependents and for dependents of members of the Armed Forces and the Royal Canadian Mounted Police. This plan came into effect on July 1 of this year on a basis whereby the federal government contributes approximately half the over-all cost. Twenty-three insurance companies doing business in Canada are sharing this case which may ultimately involve over 200,000 participating employees and a premium of possibly $20 million. I mention this particular development specifically to point up a recent instance in which the federal government of Canada has looked to the voluntary insurance mechanism to provide coverage for its own employees.

Effect of Government Activity on Voluntary Insurance Plans

I hope this summary will give you some idea as to the extent of government participation in the matter of providing or financing health services in Canada. The next logical question would seem to be that of the effect of this government activity on insurance companies and other nongovernment voluntary agencies.

First, let us look at the premium figures for insured plans—and these figures pertain only to federally registered insurance companies, and do not include premiums paid to other voluntary agencies in the health insurance field. In 1937, total Canadian premium for personal accident and sickness insurance was just over $7 million. By 1959, total premium income exceeded $165 million for an increase to more than 23 times the premium in 1937. Clearly, these figures illustrate the fact that there has been a remarkable growth in accident and sickness insurance in Canada during a period and in an area where all levels of government have been particularly active.

Looking at the more immediate effect of the recent introduction of the provincial hospital plans, there has, of course, been a drastic reduction in premium income on basic hospital business. That this loss has been considerably offset by increased activity in related health insurance lines is clearly indicated by the fact that total figures for federally registered companies came to $158 million in 1957, $171 million in 1958 and $165 million in 1959. Thus, while 1959 totals are down slightly from the previous year, they are larger than the 1957 figures.

In the area of the number of persons with hospital, surgical and medical insurance furnished by insurance companies and the other nongovernment voluntary agencies, the Canadian Health Insurance Association has just this month released the results of a ten-year study. These figures clearly indicate that there has been a substantial increase in the number of persons with surgical and medical insurance during 1959. As compared to 1958, there was a 9.4% increase in the number insured for surgical expense. Over 8 million Canadians were so insured at the end of 1959 as compared to only 2,000,000 ten years ago. For medical expense, there was a 14.5% increase during 1959 in the number insured, with more than 1 million persons becoming new purchasers of medical insurance during that year. About 7½ million Canadians were so insured at the end of 1959 as compared to only 1,689,000 just ten years ago.

The study of comprehensive or major medical expense insurance indicates an even higher rate of increase, with the estimated number of persons insured increasing to 1,179,000 in 1959 as compared to 234,000 at the end of 1956.

As for hospital benefits, in spite of the provincial plans an estimated 6,236,000 persons remained insured by the voluntary agencies, either for basic hospital insurance or for benefits supplementing the provincial plans.

These figures certainly suggest increased public interest in supplemental medical-surgical coverage as well as major medical, comprehensive

and income protection benefits. They also form a basis for the suggestion that, if government activity in the field of health insurance can be limited to present levels, the insurance business will rapidly overtake the more recent setbacks and continue to grow in the future.

Effect of the Government Plans on the Canadian Public

Let us look now for a moment at the effect of all of this on the Canadian public. Obviously, the cost of the government activity to date must be paid for by someone and, just as obviously, that someone is John Q. Public. Experience so far is limited, but certain facts and figures are emerging.

On the hospital plans no uniform pattern for financing has evolved other than the fact that the contribution by the federal government towards the cost of the provincial plans is roughly 50%. The provinces are financing their share in varying ways, involving a combination of taxes and premiums in some cases, and sales tax or general taxes in others. Saskatchewan and Manitoba have just announced substantial increases in the amount of premium they charge and a similar increase is being rumored in Ontario. New Brunswick has already changed from a premium to a tax basis and indications are that the Quebec plan will be financed directly from taxation.

All of this indicates that, even though health costs may climb, they will demand less and less on a direct basis from individual Canadians in need of health care, and more and more from the entire community who must foot the dazzling bill through premiums and taxes.

Long range, or even short range, estimates as to cost are difficult to make. A reputable publication in Canada, the *Financial Post*, estimates that Canadians' health and Canada's defense cost about the same to the nation—some $1 billion 750 million per year. This same publication estimates that, in today's money and as an average for the next five years, the major tangible items on the annual bill for the provincial hospital schemes will be $500 million for the basic plans, $200 million for general hospital construction, and $75 million for grants and subsidies to specialized rest homes, mental institutions and homes for the aged and chronically ill.

These figures clearly indicate that Canada's so-called "free" hospitalization program is hardly that. Nonetheless, there has been a loss in the direct relationship of the citizen's payment for hospital care to the amount of care he needs. Payment has been assessed, instead, on the basis of regular payments to be made by everyone, or almost everyone, every year.

Not so remote as the question of cost, but related to it, is the matter of utilization. There is evidence to suggest that the Canadian public now regard hospitalization as a matter of right and are insisting on getting hospital accommodation when they feel they need it. This means crowded hospitals. Long waiting lists have become common in many Canadian cities, creating further pressure for additional hospital construction. For example, in the 1959–60 session of Parliament, alarmed by the evidence heard of hospital crowding and the difficulty of finding beds in some hospitals for seriously ill patients, the Commons Estimates Committee called for a national survey to determine the extent of the need. In a report tabled by the Chairman of the Committee, an immediate effort to deal with the problem of chronic bed care, with the aim of providing more hospital space for seriously ill patients, was recommended.

In spite of problems of this type, there have been no apparent disasters in the federal-provincial hospital plans so far, even though there has been much controversy. While there have been substantial premium increases already, none of the plans has had to be reorganized or radically altered for financial or political reasons. And, whatever your view may be as to whether these steps by government have been "good" or "bad," it appears that government hospital insurance in Canada is here to stay.

Possible Future Trends

On the background I have outlined, what may we reasonably expect in the way of further developments in the Canadian health insurance picture?

I have already attempted to comment on some of the known effects of government activity in the health care field on the public, on insurance companies, and on costs. Certainly it would be presumptuous and foolhardy for me to attempt specific and final conclusions in these areas where our experience so far is relatively brief and far from conclusive.

Of one thing, however, I believe we can be sure. As witnessed by the recent developments in Saskatchewan, we can expect further efforts will be made to extend government activity into other areas of health insurance, particularly the area of medical coverage.

Currently, considerable debate is being carried on in the press and other media in Canada as to the pros and cons of such possible extensions. There are those political leaders, social planners and others who seem to feel strongly that the problem of providing and financing adequate medical care for the Canadian public cannot be solved under the free enterprise system. Others argue that costs of a complete government plan would be difficult, if not impossible, to control, as opposed to the built-in

controls in voluntary plans due to their competitive nature and the fact that the individual retains a personal financial responsibility in the choice and operation of the plan. This argument contends that costs would be higher under a government plan than under a voluntary free enterprise approach to the problem, with government participating only in those areas where the individual is unable to make provision for his own care.

It is further argued that standards of care would deteriorate under a complete government plan and that the basic defect in the governmental approach to the highly personal matter of health care is based on social rather than economic implications. On that basis it is contended that a government medical care plan could not be established without eventually leading to complete control of the type of care to be received by the public from a medical corps serving as salaried state employees under the supervision of a government agency. This view holds that Canadians should not be forced to cede their freedom of choice to a governmental body which must necessarily look to the problems of the masses to the exclusion of the rights of the individual.

The Canadian Health Insurance Association which I represent is strongly in support of the views I have been expressing. It is our sincere belief that further extensions of government activity in the health insurance field to those now able to provide for the financing of their own health care would not be in the public interest, from either an economic or a social point of view.

C. MANTON EDDY:

Our next two speakers come from different parts of the United States. It is my hope that by having them address themselves to situations in their own areas, we may have a clearer picture of our problems than perhaps we get when we try to think in terms of the great area which comprises the United States.

The State of New York is well known for many things. One of them is that it has been somewhat in the forefront in social legislation. Regardless of whether it is considered good or not, there has been a great deal of activity. Mr. Miller will discuss the picture in his own state.

MORTON D. MILLER:

Our Chairman has assigned to me the task of describing certain aspects of health insurance in the state of New York, where this subject has received more than its share of study and consideration in the last few years. Major differences from the situation as it exists in other parts of the country may be revealed thereby and emphasis placed on the diver-

sity of the many problems associated with the provision of health care and health insurance which concern all of us so much today.

I would like first to draw a capsule profile of the state as a backdrop for our discussion. New York is the largest state in the union (Texas to the contrary notwithstanding) with a population of 16,600,000—incidentally, almost as great as the whole of Canada. About 9% are over age 65, the same proportion as countrywide. It is a highly industrialized state with a relatively small agricultural population. Per capita income was $2,736 in 1959. This ranks New York fifth in the United States, behind Delaware, the District of Columbia, Connecticut and Nevada, in that order.

Our citizens are well supplied with health insurance. Over 15 million persons in the state, or 9 out of 10, have some form of hospital and medical expense protection. This is considerably more than the countrywide average of 70% and makes New York first in the nation in this respect. The coverage has increased rapidly in scope, with all but a small number of these having both hospital and surgical benefits. Another measure is the fact that some $4\frac{1}{4}$ million New Yorkers already have broad plans covering an extensive range of medical services with substantial maximum benefits and thus reaching into the area of catastrophic or major medical expense situations. In this last count I have included both the major medical expense plans underwritten by insurance companies and the plans of a comprehensive variety offered by the Blue Cross–Blue Shield and similar type organizations in the state. The proportion with such broad coverage is over a quarter of the entire population and almost double the national average.

The workers of New York are well protected too in the area of wage loss replacement, since New York is one of the four states with a compulsory cash sickness law. Our law was enacted in 1950 during the tenure of Governor Dewey. With recent amendments, it covers the employees in establishments with two or more workers and provides benefits, after a seven-day waiting period, for a maximum duration of 26 weeks of disability and in a weekly maximum amount of $50. Benefits are provided through insurance company policies, self-insurance and the state insurance fund. The law affords a substantial degree of flexibility in meeting its requirements and has operated satisfactorily with a minimum of interference with established plans or agencies.

New Yorkers are served by 119 insurance companies, life and casualty, that are licensed to write health insurance in the state, besides the state insurance fund which operates like an insurance company for disability benefits. In addition, there are the service type organizations established

under a separate section of the law. These include eight hospital service corporations, nine Blue Shield type plans and two dental expense indemnity plans. Among them are the largest Blue Cross and Blue Shield plans in the country, and two plans specializing in broad programs of doctor services, one of them operating through group practice centers.

It is against this backdrop that the other matters I am about to describe should be viewed. First, there is the considerable activity of the Joint Legislative Committee on Health Insurance under the chairmanship of Republican State Senator Metcalf. Prompted by a desire to develop and stimulate the growth of health insurance among the aged, this Committee examined extensively the marketing of health insurance. In connection with individual insurance, they became concerned about the termination of policies after issue, either through expiration at a specified age, or by the unilateral action of the carrier. They attempted to legislate, as being in the public interest, the requirement that all individual policies be of the lifetime guaranteed renewable variety. While the Committee did not succeed in their endeavor, they did see to it that, in the future, the right of nonrenewal of an individual health insurance policy by the carrier would be limited, after it had been in force two years, to reasons other than the deterioration of the health of the individual insured subsequent to the issuance of the policy and, further, that the expiry age would be specified in the policy, if there was to be one.

In connection with group health insurance, the Committee sought to require that the right of conversion to an individual health insurance policy be available to all individuals on termination of their group coverage, and that to make the individual policy attractive to terminating employees the premium rate for the policy be fixed at a level below that needed to support the benefits to be provided. The deficiency in cost was to be borne by the group policyholders. Again the Committee did not prevail, but they did legislate the requirement that every insurance company make available a rider which the employer could add at his option to the master group policy and through which terminating employees were given the right to convert to an individual policy.

More recently, these discussions went through a second phase. Governor Rockefeller, in his annual message last January, stated that he would recommend legislation requiring the conversion at fair rates of group health policies to individual policies at the time of retirement. He said later he did not intend to increase the cost of the coverage under the group policy. These turned out to be inconsistent objectives, since by fair rates he appeared to have in mind originally rates below prevailing levels. Without increasing the cost of the group coverage through charge-backs

of conversion policy losses, this is not possible. We are now struggling with the legislation that emerged, which makes the conversion right mandatory under group health insurance policies, and which gives to the insurance department the responsibility to establish a maximum premium level for conversion policies issued to those age 60 and over. Incidentally, this is, I believe, the first instance of the departmental determination of premium rates for health insurance underwritten by insurance companies.

The next item to which I would like to refer is the study of the Blue Cross service plans and the similar medical expense indemnity corporations of the state commissioned by the Health and Insurance Department in 1958. The study, paid for by these organizations, is being conducted by Dr. Ray E. Trussell and the Columbia University School of Public Health and Administrative Medicine. The report on the Blue Cross part of the study has just appeared. It includes a number of recommendations dealing with the operation of these plans, on such matters as the extent to which their Boards of Directors are adequately representative of the various segments of the community, the scope and the levels of benefits which the plans should be writing, the collection of statistics, performance standards for the plans and the basis of reimbursement of the hospitals.

Of the broadest significance, however, is the recommendation that there be set up a state hospital review and planning commission, supported by similar councils at the local level. The commission would deal with such matters as hospital costs, utilization, rate increases, extending enrollment, improvement of benefits, promotion of standards and community planning for health services. Related is a recommendation that the Blue Cross pay its benefits only where the patient is confined in a hospital which meets the standards established by the Joint Commission on Accreditation of the American Hospital Association and the American Medical Association. These recommendations deal with the very important area of the organization and planning of medical and hospital facilities and with the sensitive questions of the control of the quantity and quality of medical and hospital services.

Related is the formation following the passage of the necessary legislation this year of an interdepartmental health and hospital council within the state government consisting of the commissioners of health, social welfare, mental hygiene, education and insurance. Among other things, the executive order stated, this council is to consider new aspects of health problems facing the state and study such health areas as health service for the aging, standards of hospital facilities and service, and methods of financing hospital care.

Then, too, we have the recent deliberations by the Superintendent of Insurance with respect to Blue Cross. In our state the Superintendent not only has responsibility for the approval of Blue Cross premium rates, but also by law must satisfy himself that their rates of payment for hospital services are reasonable. The premium rates are, of course, a direct function of the formula the plans use to reimburse member hospitals, *i.e.*, those with which they have contracts, for the cost of the benefits for insured patients.

The Superintendent took the position that reimbursable hospital costs should leave out of consideration such items as loss of income from charity care, underpayments by New York City for welfare cases and out-patient department deficits, and that less weight should be given to the funds required for depreciation and replacement of equipment. This was contrary to the Trussell Report, which held that hospital reimbursement formulas should be more broadly based and greater recognition given to these items.

The effect of eliminating certain costs from the reimbursement formula is to make Blue Cross insured patients preferred customers of hospitals who do not pay their full freight. The entire cost of what Blue Cross should pay for but doesn't must then be obtained by the hospitals by increasing their charges to patients who are paying their own way, or who have insurance under a different mechanism. The inequity is apparent and the difficulty obvious when it is considered that Blue Cross patients in New York City comprise better than 60% of the total, leaving the burden of 100% to be shared by the remaining 40%. Actually, the Superintendent's final adjudication went further than earlier he had said it would go, and the resulting reimbursement formula is a substantial improvement over the previous one, although it still does not give the hospitals all they had sought.

Now let us turn to another area. Governor Rockefeller has a healthy interest in matters relating to health insurance and health care. Most of you will recall that he served with Secretary Hobby in the Department of Health, Education, and Welfare. At any rate, in his annual message to the Legislature in 1959 he expressed his concern over the impact of serious accident or illness and the accompanying bills for hospital and medical care upon the economic circumstances of an entire family. He indicated his intention of bringing together a group of experts to consider the practicability of extending the disability benefits law to encompass major medical expense type protection. This study was accomplished by a governmental task force assisted by an advisory committee on which there were representatives from industry, labor, the medical and hospital pro-

fessions and insurance. The report of the study should be forthcoming soon.

It is expected not to recommend any legislative action, at least for the present. In reaching this conclusion the study will point to the absence of a serious need for legislative action in view of the availability and growth of voluntary insurance, to the dangers of governmental intrusion in this area, to the possible adverse impact of increased employer costs on the State's economic growth and thereby on the welfare of its employees, to the absence of a philosophical basis for making the cost of such benefits a payroll tax, particularly with the possible inclusion of dependents, and to the danger of resulting inflation in health costs.

Last but not least we come to the recently enacted H. R. 12580, which amends the Social Security Act and includes the new federal-state Medical Care Plan for the Aged. The first part of this program provides federal funds for hospital and medical care for the 2.4 million of our aged who are the recipients of public assistance. Federal funds become available to match state funds up to a total expenditure, federal and state, of $12 a month for each public assistance recipient, with the federal share ranging from 50% to 80%, depending upon the income level in the particular state.

The second part of the program sets up an entirely new category of individuals who may become eligible to receive help from the state in meeting the costs of necessary health care with partial federal financing. This group will include those aged, sometimes referred to as the medically indigent, whose income and resources are sufficient to take care of their normal living requirements without public assistance, but who might not be able to pay the cost of unexpected medical bills. Out of the 13 million aged in this country who are not on public assistance, some ten million might eventually become eligible for medical assistance under this section, depending upon the provisions of the respective state plans.

Each state has wide latitude to determine the criteria for eligibility for medical assistance that it will impose. Consideration may be given, in whole or in part, to the income and resources of the individual, but consistent with the objectives of the law the standards must be reasonable and less stringent than those applicable to public assistance. For example, no lien may be imposed on the property of an individual during his lifetime.

In addition, the state must fix upon the scope of medical and hospital services to be covered by its plan within the broad range of such services that are eligible for partial reimbursement by federal matching funds. Then a state must decide how its plan is to be administered, that is,

whether through an existing or a new state agency, and how much of the administration should be carried out at the local level. Finally, a state must provide for its financial participation.

At first there were indications that we would move ahead quickly in New York to develop our state plan. But, recently, Governor Rockefeller has suggested that he may wait until he sees which way the political winds blow in November. He has often put himself on record as being in favor of the approach to health care problems through expansion of the federal Social Security system and an increase in Social Security payroll taxes.

Actually, because New York is already spending more than the prescribed $12 per month for medical care for public assistance recipients without any federal help, we will now receive approximately $6 million as our share of the public assistance funds provided under the new law. If this $6 million is simply allocated by New York to the medical assistance program, we will receive a further $6 million in federal funds. This will make a total of $12 million available to start a medical assistance plan without necessitating any additional state revenues, which is a significant sum, considering that our total expenditures for medical care under old age assistance are $26 million. To the extent that we are prepared to divert additional funds to the new medical assistance program, further federal matching funds would be forthcoming and an even more substantial plan might be established.

The matters that I have tried to describe for you briefly are intended to highlight some of the over-all problems of health care and health insurance. They are but part of a whole, which includes many other social and economic aspects time has not permitted us to consider, such as, for example, the availability and training of hospital and medical personnel and the adequacy of facilities. Our purpose is to show how complex the problem is and its many cross-currents and interrelated interests, as well as to illustrate the diversity of the situation from state to state throughout the country. I hope the discussion will help you to arrive at a better perspective on the many questions with which we are faced in this area.

C. MANTON EDDY:

In Texas we have an area which represents, as much as any other, diversity between agricultural and industrial interests, mixed populations, and large cities and small towns. Mr. Rietz will comment in regard to the situation in Texas.

H. LEWIS RIETZ:

I am here today to give you a local picture that contrasts in many ways with the New York story you have heard. In doing this I hope to

suggest that we in Texas, and I believe in many other areas, are meeting these social and economic problems in an adequate and sound manner.

Having accepted this assignment, I undertook to gather information by consulting various organizations and individuals connected with health care in our area, including the Executive Secretary of the Houston-Harris County United Fund, the Director of the Harris County office of the Texas Public Health Department, the Supervisor of the Houston Visiting Nurses Association, staff members of Baylor Medical School who are closely connected with and provide many services at our large city-county charity hospital, and others.

The information I have gained has been pleasantly surprising to me. I would earnestly suggest that any who are interested in this subject—and you all should be for several reasons—explore the facilities in your own communities. I suspect you will be surprised at the mechanics available to meet the health care needs with economy and adequacy at the local level.

I would also urge you to review and consider your present State laws in this area as a key to public philosophy of your area on health care from a social and economic viewpoint.

These local facts, I am now convinced, while highly important are inadequately recognized in the recent political discussions in Washington. In the last analysis who knows better than Texans what we need and what we can afford.

Irrespective to Mort Miller's statement, Texas was until recently the largest state—with a greater diversity in the economy than prevails in New York. Industry has a substantial place in our Texas economy, but agriculture and development of natural resources—oil, sulphur, hydrogen and timber, to name major categories—are relatively far more important than in New York. Cities such as Houston, Dallas, El Paso and others have had explosive growth patterns during the past decade and are prosperous industrial and service centers. The Houston area embraces over 1,200,000 people and continues a very rapid growth pattern.

With our population explosion Houston and the surrounding communities have encountered serious problems in many areas—freeways, schools and medical care facilities, to name a few. I think we have met these problems well. In the health care area a broad-based well-oriented medical center has been established with substantial hospital facilities—Hermann Hospital, a large private hospital with a well endowed and sizable charitable facility housed adjacent to its public hospital, Methodist, Saint Luke's, Texas Children Hospital, Anderson Hospital and Cancer Research Center, Baylor Medical School and the University of Texas

Dental School, together with the newly opened Women's Building limited to obstetrical cases but with full delivery and in-patient care facilities—this in addition to existing facilities and for the most part developed within the past ten to twelve years.

Within the six years I have been in Houston we also have three new suburban hospitals of 90 beds or more, Rockglen to the east, Northside on the north and Spring Branch on the west. We also have Jeff Davis, a large city-county charity hospital.

When I undertook my inquiries of various health and welfare organizations, my main purpose was to determine whether anyone in our area was denied needed medical care because of inability to pay. I am satisfied that all who want and need medical care can secure it independently of ability to pay and without social stigma.

Furthermore, the facilities are widely known to welfare agencies, hospitals and doctors. For example, here is a service directory that has been widely distributed to these groups entitled, "Directory of Services Available for the Cardiac Patient." Similar information is available for cancer, diabetes and other diseases.

Thus I believe that we are meeting with reasonable adequacy the social and economic problems of health care at the local level.

Now for a contrast in philosophy. You heard the numerous moves by government in the health area in New York. I had Texas legislation of the past several years in the health field reviewed. We have had no cash sickness and no hospital care bills. Very few laws have touched this area and only two could have any real impact on health care. One permits creation of city-county hospital districts with authority to incur certain debt and other obligations for construction and operation of hospital facilities and the other provides state subsidies for medical students who contract to practice in the less densely populated areas of Texas. Hence, government has not been interjected in the health care or the health insurance problem in Texas to any significant degree. For this I am thankful.

Texas legal limitations on the authority of our state government in the health area appear unusually restrictive, although from a recent article in the Dallas edition of the *Wall Street Journal* they are not unique. First, our Constitution severely limits the power of the State in aid to the aged, blind or needy children, imposing rather positive citizenship and residence requirements and limiting the total state expenditures in these areas to $42,000,000 annually. Second, our statutes place full responsibility for medical care of the indigent on the respective counties and specifically limit their authority to provide free care to persons on public assistance

rolls. This I believe indicates a public philosophy—that care in this area at public expense is a local community responsibility, and not the responsibility of a government even as remote as a state government.

Today we have serious questions being raised regarding H.R. 12580, as to its application in Texas. One hinges on our present Constitutional and legal limitations on the state powers. The other is economic—Texas is operating at a deficit because of the very low oil production allowables. Well over 25% of our state revenues normally come from oil production taxes. With our present deficit, additional taxes will be necessary to fulfill existing state commitments, and new programs involving substantial costs are, of course, a matter of serious concern.

Mr. Miller referred to nine out of ten New Yorkers having some form of medical expense protection. Although Blue Cross had its origin in Texas, indicating early recognition of the desirability of a prepayment mechanism, our ratio of covered people is substantially lower than New York's—only about six out of ten. Possibly, much of the difference is due to differences in geography and economy. We have several counties with a population of one to two persons per square mile. One west Texas county of over 6,000 square miles has almost exactly one person per square mile. The latest Texas Almanac states that the only industries are agricultural and trade and that there are 101 farms in the county with an average of 25,356.8 acres per farm. The population of this county is over 50% Mexican, primarily farm hands, about 1% Negro and 45% white. It has one county hospital, which I am told by a staff member of the Texas Hospital Association is not overcrowded and is equipped to render all the services that can reasonably be provided in so thinly a populated area. I do not believe that insurance companies or Blue Cross have reached, to any substantial degree, areas and population groups such as these.

Thus, I believe this accounts for at least a part of the difference between the New York and the Texas coverage ratios. But even with these lower protection ratios, the evidence I have gathered does not point to any unfilled health care needs justifying broad government intervention.

The social and economic impact of a broad governmental medical care program which could, and I am sure some of our socialistic friends feel will, grow even from an initial limited toe-in-the-door federal program are appalling to contemplate. We should take warning from experience in other countries.

The latest issue of *The Economist* reports that the British Health Program is costing currently 12.4% of all national expenditures. This is just under 44% of their total national defense expenditures. Overutilization accounts in part for the very high cost that has developed.

Reports from New Zealand, the oldest "cradle to grave" social security system, indicate a general public satisfaction with the services rendered, but reveal a growing concern with costs, which have risen from $36,000,000 to well over $200,000,000. Present annual costs, in excess of $100 per person, are against a fee schedule of only $1 per visit to the general practitioner, with medical specialists receiving the same $1 basic fee with authority to charge the patient some additional fees. All drugs are free when ordered by a physician and rising drug costs are currently of serious concern to New Zealand health authorities. Could we attract young men to medicine with the New Zealand work load at their fee schedules? I think not—which means higher per capita costs here than these.

In France the government, as a part of a social security system reform movement, has set fixed ceilings on medical and dental fees. Their system reimburses the patient for a percentage of his medical and dental fees, currently at the 80% level. Despite strong objections from the professional groups, the Government has fixed ceilings on fees at ten new francs (about $2) for office visits and thirteen francs for home visits in Paris. Generally lower scales prevail in the provinces. Some doctors and dentists have protested by temporarily closing their offices and accepting only very urgent calls.

Thus, rising costs with ultimate governmental controls seem inherent in any government-financed health care plan. Indications from Sweden are of rising discontent by the actively working population because of the high percentage of national production going to the oldsters through governmental housing, pension and care programs.

The late Senator Taft pinpointed the social and economic problems in this area when he said, "You can socialize just as well by a steady increase in the burden of taxation as you can by government seizure. The very imposition of heavy taxes is a limit on man's freedom."

C. MANTON EDDY:

We have merely scratched the surface of the problem this morning. I hope we have been able to introduce some facts that are worth contemplation. I hope you will feel as we all do that there is a great need for a careful objective evaluation of all of the proposals that will be made in the health field with respect to government entrance. The forecast of economic results, the forecast of social changes either in the practice of medicine or in the operation of our hospitals, the need for new construction and new types of construction, all of these things need far better evaluation than yet has been made.

There are some facts that have come out of this panel which I can

quickly identify. Canada has gone far beyond the United States in compulsory health measures. At the same time there are pressures for going still farther. On the other hand, it is an encouraging sign that the Canadian companies have not been faced with disastrous results to their business. In the United States there is obviously an increasing interest in health insurance and health care at all levels of government. There seems to be a change from the pressure of a decade ago for national health insurance to the present concern for health care for the aged, and that concern is very real and very much with us.

By and large, the method of solution seems to divide between the compulsory and the voluntary. The compulsory method, using the social security tax mechanism, is favored by the Democratic candidate for the presidency, by labor leadership generally and by many welfare workers and, as Mr. Miller points out, by the Republican Governor of the State of New York. The voluntary method is favored by the present administration, the Republican candidate for President, business organizations, doctors' groups and insurance groups. The legislation which has been referred to, H.R. 12580, seeks to preserve much of the voluntary approach. It requires decisions to be made at the state or local level. It is identified with need which must in turn be determined at the state level and it offers aid of federal funds to the states in carrying out the objectives through the means they themselves have set up.

I believe we will see the issues of health legislation very actively before Congress next year. What the future may hold may very well depend upon what the states do to implement the recent legislation. As insurance people I think we are well advised to continue all of the efforts we are making to extend voluntary programs much further and much deeper into the population, particularly in the older age groups. At the same time, I think we will serve ourselves well if we do all we can to see that our home states implement the federal program on a desirable and constructive basis.