The Health of the Public—
Decisions for the '70s

There is a growing concern of Americans in all walks of life about National health policy. More and more they are asking: “What must we do, collectively and individually, to promote and protect our health?” Unfortunately, laymen as well as those of us toiling in the health vineyard, show all the signs of being like the choleric executive depicted in a cartoon many years ago: “We don’t know what we want, but we know we’re not getting it.”

As is usually the case in the evolution of social policy, attention is focused on glaring deficiencies, on extreme situations. From all sides we hear that there is a health crisis in America. We are repeatedly being told that we rank 12th or worse among the nations in our infant mortality rates, that the very survival of the human race is threatened by pollution of the environment, that the only way to solve our health problems is to do away with what exists and substitute a “system” that would somehow bring health and well-being to all. Little is said about accomplishments or progress or the potential for improving our current machinery.

No serious student of public health will deny that change is needed in an effort to bring necessary health services to millions of Americans now inadequately served. No such student would try to argue that we as a nation are doing all that we should to protect and improve environmental quality. None of us can ignore the economic burden put on many individuals and families—poor and well-to-do alike—by existing methods of financing medical care. At the same time, no thoughtful person can possibly believe that there are instant solutions to these problems. Nor can one seriously contend that a massive public program replacing existing patterns for delivering and paying for services will assure better health for all Americans.

Under the circumstances, those of us professionally concerned with the nation’s health must hold our emotions in check as we participate in policy formation. There is abundant reason to examine major proposals critically and thoughtfully. At the very least we should assume that they represent sincerely held points of view.

It is in this context that the Nixon Administration recommendations should be looked upon as a serious attempt to correct what is wrong in the health ma-
National Health Insurance

"The ill and unfit choice of words wonderfully obstructs the understanding."  
Francis Bacon

National health insurance has become an issue. The debate gathers momentum. Thus, there is an increasing need to define terms, to set criteria, to articulate basic principles. Only if this is done will we be able to debate substance, not slogans; will we be able to judge whether a new proposal represents a change in product or in packaging; will we be able to examine and compare the various legislative programs.

Surely by now there is agreement that the availability and utilization of medical care should not be dependent on individual or family income, that barriers to care that are unrelated to health needs should be removed. To achieve such a goal—and, at the same time, to be responsible in the way funds, facilities, and personnel are used—will require that we alter current financing patterns and restructure the health delivery system. What are the basic principles that must be met in a program of national health insurance? What criteria should we use as we examine various proposals?

National health insurance must embody the principle of universality—the same benefit package must be available to all, regardless of economic circumstances, place of residence, employment status, and so forth. Universality does not—and cannot—mean retention (and certainly not expansion) of the number of existing categories of beneficiaries and recipients. Multiple categories of beneficiaries, different benefits, persons moving between categories, and in and out of coverage status—all these violate the principle of universality and contribute to administrative chaos. Yet, this is what is suggested in the proposals offered by the Administration, proposals which it terms a "comprehensive national health insurance program."

A second principle of a national health insurance program is that it should be financed with regard to equity considerations, to ability to pay. Indeed, failing that, it is difficult to conceive of meeting the goal of universality. Medical care—prevention, treatment, rehabilitation—is expensive. Its costs must be shared if those at the lower end of the income distribution are to receive the benefits. In essence, this means that tax funds must be used. Leaving the purchase of health insurance to the individual and his employer, and requiring flat-amount payments (representing a higher percentage of income and of payroll for low-income workers and for marginal employers) cannot suffice. Yet, the Administration's proposals (which would leave the financing of health insurance largely in the private sector) fail to address equity considerations and would leave millions of Americans without coverage.

To achieve a meaningful universal and equitable national health insurance program also requires that the program cover major parts of the cost of care. The critical variable is not only how the benefit package is financed but the size of the package itself. If economic barriers to care are to be removed, the benefit package must be broad. Reliance on significant fixed deductibles and coinsurance payments and the setting of upper limits to the benefit package (limits which necessarily penalize those most