FOR RELEASE FRIDAY AM's
APRIL 30, 1976

Office of the Vice President

PROPOSALS FOR A NATIONAL HEALTH POLICY
ADDRESS OF VICE PRESIDENT NELSON A. ROCKEFELLER BEFORE THE
NATIONAL LEADERSHIP CONFERENCE ON AMERICA'S HEALTH POLICY
WASHINGTON, D. C.
THURSDAY, APRIL 29, 1976

(Ninth of a Series)

SUMMARY

"I recommend adoption of a comprehensive, two-phased National Health Policy: First, to control health care costs and broaden the health care delivery system; and Secondly, to extend the availability of health insurance to those who are not now covered...

"Let me emphasize that without the first phase of getting quality health care costs under better control, the second phase of expanding coverage would be of little value...(for) our health care system will just keep sopping up every dollar that it receives, without significantly improving the quality or delivery of health care..."

SPECIFIC RECOMMENDATIONS -- PHASE ONE

1. Enact amendments (now before the Senate) to improve competitive position of Health Maintenance Organizations.

2. Provide fast tax write-offs of start-up costsfor Health Maintenance Organizations and Medical Care foundations.

3. Undertake Federal experimental program of institutional licensing of health personnel to encourage use of paraprofessionals (medical corpsmen, vocational nurses, physicians' assistants).

4. End cost-plus reimbursement of hospitals under federal programs, setting Federal maximums by area.

5. Restrain demands for unnecessary care by requiring that consumers pay a portion of their health costs and health insurance premiums.

6. Enforce Health Planning Act to stop construction of unnecessary facilities and duplication of costly equipment.

7. Extend Professional Standard Review to care outside hospitals.

8. Establish Federal reinsurance pool to backstop malpractice insurers under State programs which set-up arbitration of claims and limit attorneys' fees.

PHASE II

1. Replace Medicaid with a nationwide, Federally-financed health insurance program for low-income families and individuals.

2. Provide option of Federally-reinsured health insurance policies at group rates to individuals.

3. Enact President Ford's proposal for insurance coverage against catastrophic illness for Medicare recipients.

FULL TEXT FOLLOWS

FOLLOWING IS FULL TEXT OF SPEECH:

I want to compliment Congressman Rogers, Congressman Rostenkowski, and the National Journal for sponsoring this invaluable conference on "America's Health Policy." And I personally appreciate this opportunity to participate. No subject is more vital to every man, woman and child in this Nation.

In our free society, two things are essential for every American to reach his or her fullest human potential, the opportunity for good education, and the opportunity for good health care. Given access to both these opportunities our people can go just as far as their God-given talents will take them.

My concern with the health problems of the American people is the result of growing up in a family dedicated to the advancement of medical science, research and good health for all. Among the first of the family's major philanthropies was the Rockefeller Institute for Medical Research, which my grandfather founded in 1901. This Institute focused its efforts on the cause and cure of major illnesses.

In 1913, the Rockefeller Foundation was founded and its International Health Division worked with governments at home and abroad in applying this research on a massive scale, which led to the virtual eradication of such widespread diseases as hook worm, Yellow Fever, and Malaria. This was the beginning of private foundation support of medical research and international health programs.

My first opportunity for public service came in the health field. In 1933, I was asked to serve on the Westchester County New York Board of Health, where I remained a member for over 20 years.

Then when President Roosevelt asked me to serve as Coordinator of Inter-American Affairs in the 1940's, we organized the Institute of Inter-American Affairs which undertook cooperative health programs in some 20 countries in the Western Hemisphere.

Later, President Eisenhower asked me to head a task force on government organization which led to the creation of the Department of Health, Education and Welfare. I was privileged to serve as the first Under Secretary of HEW, under Secretary Oveta Culp Hobby. Mrs. Hobby and I were appalled to learn at that time, that catastrophic medical expenses were bankrupting about 3 per cent of all American families each year. To protect against this kind of tragedy, we agreed to establish a Federal pool to reinsure private insurance companies if they would write health coverage for catastrophic illness. That was back in 1954 -- and, unfortunately, they failed to respond.

When I became Governor of New York in 1959, I immediately initiated a study on the feasibility of adopting a comprehensive State health care plan. We had to abandon the idea, for the study revealed that a State-financed health program was not feasible because of its high cost to employers, employees, and taxpayers in the State. Unless all other States took similar action, the additional cost to New Yorkers would have jeopardized the State's competitive position as a place to live, work and do business. Therefore in 1964, I recommended that a form of Universal Health Insurance be considered on a national basis.

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The private sector and voluntary, philanthropic initiatives have made America the undisputed leader in training those who provide health care, in building the facilities where that care is provided, in developing health insurance to help cover the costs of that care, and in carrying out medical research.

In the past decade, Federal, State and local governments have accelerated their expenditures and are now investing over $50 billion annually in the health of Americans, with over 11 per cent of the total Federal budget currently going to health. Yet, the inescapable fact is that for all the progress, for all the concern, for all the expenditures, we find this Nation faced with serious and deepening problems in relation to the cost, delivery and financing of health care.

And even with all this expenditure, our medical care system does not assure adequate health protection for the 19 million Americans with no health insurance. We do not have comprehensive, total health care at all, nor do we have an overall, conceptual policy in this area of fundamental human necessity. What has been built up, through the best of intentions and efforts, is a piling of one program upon another on a piecemeal basis, by a multitude of private efforts and independent initiatives of all three levels of government -- Federal, State and local.

Today, I would like to trace the roots of some of our health care problems and prescribe some hopefully effective medicine for their cure. Medical care began simply enough in this country as a one-to-one relationship between the doctor and the patient.

Government's involvement in the beginning was limited to public health programs and only later followed by institutional care for the indigent and aged.

Individuals, in order to protect themselves against the cost, and with the desire to extend health benefits, expanded this simple doctor-patient relationship to a relationship with a third party, the health insurer, which involved individual insurance plans, group plans, company plans, and union plans, with vastly differing coverage, premiums and forms of payment. Another change in the individual doctor-patient relationship took shape as doctors formed into professional groups.

And then in the early 1960's, the Federal government began to get into the act in a major way. After 20 years of controversy, Congress passed Medicare as a contributory medical program for older Americans, and also enacted Medicaid for the medically indigent, but not in a coordinated or carefully thought way, witness the following example from our experience in New York State.

Since 1929, during Al Smith's time as Governor, New York State had provided marginal health care to its needy citizens. Just before the enactment of Medicaid in 1965, there were 1.4 million persons eligible for the State medical assistance programs. When Medicaid was passed by the Federal Government, New York State expanded its program of eligibility to add an additional 4.6 million newly-qualified persons.

When the members of Congress realized that as a result of the new eligibility standards New York State would thus be entitled to virtually all of the money the Federal government had budgeted for Medicaid that year for the whole country, they were shocked. As a result, Congress changed Federal eligibility standards and New York State was forced to change its law and drop some 1.2 million newly-eligible persons from its rolls. Obviously, this action created a deep feeling of disillusionment, bitterness and cynicism towards the government.

This example is a perfect illustration of what happens when the Federal government passes piecemeal legislation without considering its far-reaching implications. When it came to financing the cost of health care, the Federal government largely addressed itself to the paying of medical bills for welfare families, the disabled, and the elderly.

A great number of needy American families failed to qualify for this help. The tragic hardships these families faced when medical bills exceed their capacity to pay, or when life savings are wiped out by catastrophic illness, are still not being met by the Federal government.

In addition, it should be pointed out that preventive efforts, which could reduce the incidence of acute illness and lower the cost of medical care, have not been effectively addressed. In the absence of a coordinated national health policy, total expenditures keep rising at an intolerable rate, without a comparable increase in the quality or coverage of health care.

Health care costs are the most inflationary item in the Consumer Price Index, outpacing even the sharp increases in the cost of imported fuel due to price increases by the Organization of Petroleum Exporting Countries. Between 1965 and 1975, the cost of health care in America increased over 200 per cent. In just one year, between 1974 and 1975, total public and private spending for health care increased nearly 14 per cent.

With hospital rooms costing an average of $150 per day, the average stay in a hospital now costs almost $1,000, an increase of 16.6 per cent in the past year compared to a 6.8 per cent increase of the Consumer Price Index, exclusive of medical costs.

In addition, this Nation's health manpower is not evenly distributed. New York and California, for example, have over 140 physicians per 100,000 of population, while Mississippi and Idaho have less than 90.

Most important, we have scarcely tapped the area of greatest potential -- disease prevention. The leading causes of death in this country, such as heart disease, cancer, and automobile accidents, can be significantly reduced through changes in our life style.

Consider how much medical and hospital care would not have been necessary had we been able to alter and control such living habits as: smoking, alcohol, fast and reckless driving, violent crime, drug abuse, pollution, overeating, poor nutrition, and lack of exercise. All these have been shown in study after study to be related to our national death rate and the high level of expenditures for medical and hospital care.

The establishment of the 55 miles per hour speed limit is a dramatic example of how a change in habits can affect health costs. In 1973, before the new speed limit was imposed, there were 55,000 traffic fatalities. In 1975, although there were more cars on the road, this figure dropped to 46,000. Over the same period, injuries declined by 200,000. This reduction in deaths and injuries saved $15 billion in accident-related expenses.

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Changing all these living habits requires education, self-discipline, and legal sanctions. What then should we be doing as a Nation to lift our sights and perspectives on the complex problems we face, and to achieve an effective health care system at reasonable cost?

A NATIONAL HEALTH POLICY

I recommend, as a first step, adoption of a comprehensive, two-phased National Health Policy: First, to control health care costs and broaden the health care delivery system; and Secondly, to extend the availability of health insurance to those who are not now covered.

PHASE I -- Initially, we must structure the delivery of health care in a way that will bring health costs under control, while assuring high quality medical care. Let me emphasize that without the first phase of getting quality health care costs under better control, the second phase of expanding coverage would be of little value. In the present absence of an effective cost control system, our health care system will just keep sopping up every dollar that it receives, without significantly improving the quality or delivery of health care.

Delivery Systems -- The necessity to have something better than the current hodge-podge of private and government health care efforts does not mean that we have to move to a rigid, narrow, single system. Both in terms of improved quality and greater cost efficiency, the Nation will benefit from a healthy competition among medical care systems. This has traditionally been the pluralistic American way. And it can serve us in improving health care just as it has made America the leader in virtually every other field of human endeavor.

Pre-Paid Medical Care Plans -- The recent development of pre-paid "Health Maintenance Organizations" has proven to be a promising method of stimulating competition. The number of these pre-paid plans has increased over the past five years from 30 to 180. Because of the pre-paid approach, they have an economic incentive to prevent illness instead of just focusing on treatment. In our brief experience with these pre-paid plans, the results in controlling costs are impressive.

For example, the cost to Federal employees covered by two conventional health insurance plans increased this year by 56 per cent. While employees covered by pre-paid plans experienced an 18 per cent increase in their payments. In other words, pre-paid plans cut the cost increase by two-thirds. At the same time, pre-paid plans usually provide more benefits, hence greater health protection.

Unfortunately, the 1974 Health Maintenance Organization Development Act mandated benefits which are more extensive than those normally offered under previous health insurance plans. This law has created a situation where certain Health Maintenance Organizations cannot be competitive in price, since they are required to include extraneous extra services.

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I recommend that the Senate move rapidly to adopt amendments now under consideration which will correct this situation and improve the competitive position of Health Maintenance Organizations. In order to expand and develop Health Maintenance Organizations, a massive influx of private investment capital will be required.

I therefore recommend special tax provisions for investments in the Health Maintenance Organizations which would allow a fast write-off of start-up costs. With proper fiscal control, Health Maintenance Organizations provide one of the best approaches for injecting competition into our delivery system. Their development should be encouraged by those who have the greatest stake in controlling health costs, business, labor and middle income families.

Medical Care Foundations -- Another form of pre-paid health plan is the Medical Care Foundation. These Foundations are private, non-profit organizations of physicians and are usually sanctioned by the local medical society. Persons enrolled have pre-paid coverage, while the providers are reimbursed on the conventional fee-for-service basis.

These non-profit foundations are run by physicians. Since the compensation of the managing physicians depends upon their efficiency and expertise, these foundations meet the goals of high quality and lower costs through physicians' review of the care provided.

A recent study indicated that Medical Care Foundations had an average length of stay in the hospital of about eight days for surgically-related cases, while health care provided for on a cost-reimbursement basis ranged up to 14 days. Foundations have found that as much as 15 per cent of the insurance premium rates can be saved through careful monitoring and cost controls. The expansion of Medical Care Foundations will provide one more element of competition in the delivery system. I recommend,therefore, that non-profit Medical Care Foundations be granted tax incentives to stimulate capital investment, similar to the proposal I recommend for Health Maintenance Organizations.

Health Manpower -- To make the competitive health care delivery system effective, we must remove many present obstacles to the more efficient use of health manpower. All too often, licensure laws have protected the professionals rather than the patient. Overly restrictive regulation in licensing has been a serious deterrent to the use of para-professionals, such as medical corpsmen, vocational nurses, or physicians' assistants.

Hospitals, clinics, and physician groups need more flexibility in the hiring and use of their personnel. Institutions themselves should be allowed to determine the most productive use of the various types of health personnel.

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One approach would be to license an institution and permit it to establish the qualifications of their employees under general guidelines. Understandably, this approach may be unpopular with many doctors, registered nurses, and certain other licensed professionals. But it is essential if we are serious about trying to hold down costs. The armed services have proven, particularly during wartime, that paraprofessionals can relieve highly-trained specialists of many routine duties.

I recommend that the Federal government undertake an experimental program in this respect. If successful on a national basis, the law should be changed to permit licensing of individual health care institutions, instead of the present detailed establishment of credentials for individuals.

Cost Control -- Ever since third-party insurers, private and public, began to pay medical bills, there has been little incentive for doctors, hospitals or patients to hold the line on rising health costs.

In fact, the incentives are in the opposite direction: The more often the patient sees a doctor, the more money the doctor receives; the longer the patient stays in the hospital, the more money the hospital receives. Under our cost-plus reimbursing system, there is no effective restraining force against unnecessary or excessive hospital stays, laboratory tests, the purchase of expensive equipment, and unneeded hospital construction.

There are two alternative primary approaches to controlling medical costs: (1) Government control, which could range from total Federalization of the health care system to the imposition of wage and price controls. However, total government control through a National Health Insurance Plan, under which government would pay all the health bills, would add at least $60 billion to $90 billion to the Federal budget, which already faces a $75 billion deficit.

And our recent experience with cost controls has demonstrated that while they may temporarily stabilize the average costs for services, they do not get at the root causes of medical cost inflation over the long run, for inefficient use of medical services and duplication of facilities continued to drive the overall cost of health care up during the period of price controls. (2) Therefore, we must find an alternative to total Federalization, or excessive government control, and develop systems which respond to competitive forces and thus provide incentives to control costs.

Reimbursement -- In developing systems that respond to these competitive forces, one of the biggest problems is overcoming cost-plus reimbursement of hospitals.

I recommend, therefore, that the government annually determine the appropriate hospital reimbursement rates in a particular area and use these rates as the maximum which hospitals in the area would be paid for services to Medicare and Medicaid patients. Under this reimbursement system, hospitals would have an incentive to operate below the established rate, in order to share in the savings they generate. Legislation, similar in concept, is now pending before the Congress and it deserves careful consideration.

I further recommend that we move toward a structure where consumers pay a portion of their health costs and health insurance premiums. Under this plan, a sliding payment schedule based upon income should be instituted. Otherwise, when the patient pays nothing out of pocket for medical care, there is little restraint against demanding unnecessary care and excessive hospitalization.

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Planning -- A major contributor to the rising cost of health care has been the construction of unnecessary facilities, and the purchase of expensive equipment which duplicates that already available in a community. During the late 1960's, we were able to get some control over this problem in New York by instituting a prior-approval system over health facility construction or expansion.

There is no need for the government or third party insurer to pay for building and maintaining maternity units in four hospitals in a city when each of them averages only 25 per cent occupancy during the year -- as is the case in some communities. Such wasteful practices hit consumers, business, labor and government alike.

I recommend strict application of the provisions of the Health Planning Act, aimed at reducing the construction of unnecessary health facilities and the duplication of expensive equipment.

Quality Control -- One cannot stress too strongly that cost control must not be achieved at the expense of quality medical care. Under current law, the quality and appropriateness of care provided in hospitals to Medicare and Medicaid patients must be evaluated by a Professional Standard Review Organization in the area.

I recommend that this important review be extended to include care provided outside the hospital as well.

Malpractice Insurance -- Another factor in the cost and quality of medical care is malpractice insurance. The steep rise in the cost of malpractice insurance has had its effect on both health care delivery and rising cost. Physicians in certain specialties in some areas are now paying in excess of $30,000 a year in malpractice insurance premiums; and many hospitals have seen their rates increase 10 times -- or 1,000 per cent. Traditionally, States have dealt with malpractice matters. In my opinion, the problem has grown to a point where some form of Federal action is needed.

I recommend, therefore, that the Federal government establish a Federal reinsurance pool, to provide a financial backstop to insurers within a State when malpractice claims exceed $200,000.

Insurers would be eligible for this assistance only after the States: (1) Set up a system for arbitrating claims similar to the Workmen's Compensation Appeals Board, thus reducing the load on the courts; and, (2) Adopt regulations to limit fees which attorneys may collect from malpractice suits.

The Federal law should give the States two years to develop and enact their State plans. But Federal leadership is needed to halt the rising costs and unnecessary services traceable to the malpractice insurance problem.

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These are my views of the things we need to do now to: A) Control health care costs, and B) broaden the delivery system. Once the effects of these measures begin to take hold, then we can better deal with the problems of expanding health insurance coverage.

PHASE II -- EXTENSION OF COVERAGE -- About 19 million Americans have no health insurance coverage. The reasons vary from low income and unemployment, and prior illnesses which are uninsurable, to the difficulty which self-employed persons have in obtaining coverage available to groups. Many low income or unemployed persons are not covered by Medicaid because they do not fit the current description of welfare categories.

The benefits available under Medicaid vary widely between States causing significant inequities and costly administration. These problems must be corrected.

I therefore recommend that: Medicaid be replaced with a nationwide, Federally-financed health insurance program for low income families and individuals. The program would be administered by the States and a national uniform level of benefits and eligibility would be established.

Eligible persons would share in the cost of their health care according to their means. This would assure protection to persons living on a low income and, as their income increases, they would transfer to a regular private insurance plan.

The self-employed and high risk individuals who cannot obtain adequate private coverage also need to have protection available. To assure an available source of health insurance for this group:

I recommend that the insurer who processes Medicare claims within a State be required to offer Federally-reinsured policies to individuals for whom group insurance is not available, and at rates and levels of coverage comparable to group policies. If these two proposals are instituted, I think we will have the most significant coverage problem solved, at a cost that would be manageable both in terms of the Federal budget and the private sector.

A major remaining area of health insurance that has been the subject of concern and discussion during recent years, is protection against catastrophic illness. Currently, several proposals are pending before Congress relating to such insurance.

In response to this debate, private insurance firms now provide catastrophic coverage for most working Americans who desire such insurance. Over 75 per cent of new policies being written provide insurance against medical expenses of $100,000 or more. Major underwriters are beginning to offer this coverage to individuals as well as groups. There is every reason to assume that this trend will continue, which reduces the need for an extensive Federal program.

Since the elderly are most vulnerable to costly medical care, catastrophic coverage should be included in the Medicare program. I urge the Congress to enact the amendments proposed this year by President Ford, which provide coverage against catastrophic illness for Medicare recipients.

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Conclusion -- If we continue to delay in getting started on these essential programs, the major health problems of the American people will become more severe, and short-sighted, government-dominated, policies will become more attractive. Unless we move vigorously to structure the delivery and economics of health care, we can only look forward to deteriorating quality at skyrocketing prices.

The Congress and the Administration must work together in developing a comprehensive health policy for this Nation. The many committees of Congress concerned with these issues should be pulled together into Select Committees on National Health Policy in the House and in the Senate. These Select Committees would develop an overall framework for dealing with this crucial issue.

Within the Executive branch, all health programs should be coordinated by one office at the Department of Health, Education and Welfare -- to allow for the administration of a strong, consistent policy.

I have outlined the direction I think the National Health Policy should take. A two-phased approach which would -- first, broaden the delivery system and get costs under control, and second, move toward comprehensive insurance coverage.

The problem will not go away. It must be confronted, and soon, for the health of our people, for the health of our economy and for the health of our country.

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