The national health insurance plan

During congressional hearings in October 1978, Senator Edward Kennedy said: "We must face the hard reality. The current nonsystem of medical care is a failure. If left unchecked, that failure will become a disaster. ..." He proposed, in its stead, a national health insurance plan and predicted that "the next Congress will be known as the health insurance Congress."

The following report is based on a preliminary unveiling of that national health insurance plan as reported in the Oct. 2, 1978 issue of the Washington Insurance Newsletter.

The Kennedy Health Security Act will create a national health insurance program which will:

1. Make comprehensive health services available to all Americans. The mandated benefits will provide full coverage for in-patient services, physicians' services, in and out of the hospital, home health services, x-rays, and lab tests.

2. Control runaway health care costs through a prospective budgeting system. Upon enactment of the bill, budget caps (ceilings) will immediately be used to control hospital and physician costs.

How does the bill presume to provide every American with proper health care at the same time that it cuts costs? The answer is simple. It can't.

The bill states that it will lower the country's national health bill per year by $31.1 billion:

Total costs of health care will be less within a few years of the national health insurance program than they would be under current programs, because of the immediate and long-range cost controls applied. For example, total costs will be an estimated $361.6 billion in 1985 without national health insurance, and $330.6 billion, or $31.0 billion less with national health insurance. New on-budget costs for coverage of the poor and unemployed, and for improving Medicare, would be $14.1 billion in 1978 dollars.

The Kennedy bill is not concerned with cost *containment* but, if passed, would enact a nearly 15 percent *cut* in national health services.

There is only one way to cut the national health bill by 15 percent—by dismantling the national health system.

Closing the nation's hospitals

The assault on the nation's hospitals has already begun.

First, under the already passed National Health and Resources Development Act of 1974, the Hospital Financing Administration is moving on its stated goal to eliminate 10 percent of the municipal hospital beds in the United States by 1980. In New York, the Administration has done away with 15,000 beds since January 1976.

Second, the Hospital Cost Containment Bill, introduced into Congress by Kennedy in 1978, proposes that hospitals place a 9 percent ceiling on their total spending, resulting in a 3 to 5 percent cut in hospital services annually.

Third, the Hospital Systems Agency, established by Blue Cross to oversee hospital costs, is calling for an across-the-board elimination of 10 percent of all patient beds in both voluntary and nonprofit hospitals.

The passage of the Kennedy bill itself would result in the closing of hundreds of hospitals across the country.

Under the Kennedy bill:

Immediately upon enactment, the legislation will impose overall revenue and expenditure limits on hospitals and revenue limits on physician services. Budget caps will be used to restrain current rates of increase in these services. Future increases in health care costs will not be

Sneaking it through the back door

Pressure on the Congress to pass the Health Security Act has already been felt in the presentation to the nation's legislators of a series of smaller bills encompassing many important aspects of Senator Kennedy's overall plan. This bits-and-pieces approach not only prepares the climate in which legislators and citizens alike will have to debate the Kennedy bill itself, but is a crucial hedge for the Kennedy forces in circumventing resistance to the master plan. Among the bills already passed or actively being campaigned for by their sponsors are:

The Hospital Cost Containment Act of 1979. S. 570 is a Carter Administration bill which would impose mandatory, immediate controls on all hospital cost increases, with a 9.7 percent cap on permissible annual "inflation" growth. Cost savings in total health spending are calculated at $60 billion in the four-year period from 1979-1983, according to one of the bill's most committed backers, Health, Education and Welfare Secretary Califano. Intro-

permitted to exceed rises in the costs of other goods and services.

Placing such a budget cap on hospitals means first no improvement in health care and services. Second, since the system would carry an additional load of 20 percent of the population currently without access to hospitals, the overall quality of hospital care would be greatly lowered. The intensity of hospital care would diminish. Third, since most of the nation's hospitals are currently operating on a slim margin, the combined cut in reimbursements for care would simply drive many voluntary hospitals out of business.

Under the Kennedy bill:

In advance of each fiscal year of benefits, negotiations between representatives of hospitals and doctors, on the one hand, and the Public Authority, private insurers, and health maintenance organizations on the other, will determine hospital budgets and schedules of payments of physician fees.

No longer, therefore, will care and its cost be based on need and capability, but on a prearranged schedule of reimbursements. This provides not only a disincentive for hospitals to improve care but is a disincentive for the admission of patients.

Under the Kennedy bill:

Hospitals and doctors will not be permitted to charge patients more than the insurance plan pays.

Since, as we shall show, the designated care for diseases is no longer under the direction of the doctor but the agencies established by the bill to oversee its implementation, there is no room for improvement of medical care.

Under the Kennedy bill:

Fee schedules will be designed toward equalizing differences in rates of physician reimbursement for the same illness or category of service.

The effect of this provision is to put a maximum cap on treatment. It would constrict vital clinical research and innovations in treatment of disease. Patients would not be offered the options of using new methods of treatment; they would not be available.

Despite the fact that the Kennedy bill claims to enable a greater percentage of the population to be admitted into the hospital system, admissions to hospitals would be more stringent through a claims review process under Blue Cross that would screen hospitalization requests before entry.

Once the patient is admitted to the hospital, the usual battery of tests ordered would no longer be given routinely but only with a specific order from a doctor.

duced by Edward Kennedy and Gaylord Nelson in the Senate, and Charles Rangel in the House.

The National Health Planning and Resources Development Act of 1974 already passed, has as its stated goal the removal of ten percent of the municipal hospital beds in the United States. The Feb. 2 publication of HEW regulations, that would force states to follow impossibly stringent requirements of state authorities and the HSA before hospital construction or modernization could take place, has brought the country one step closer to the Development Act's proposal to stop all hospital construction.

The 1980 Budget, recently presented to Congress, includes a proposal from HEW Secretary Califano for the complete elimination of funding used for over a decade by medical schools to expand their enrollments. The grants, entitled "capitation grants," account for approximately 5 percent of total medical school budgets for the nation's 114 medical schools. Most schools claim they operate so close to being in the red, that to eliminate this source of funding might force some of them to close or at least lower first-year enrollments. One medical school, Meharry Medical College in Tennessee, may have to shut down shortly due to this expected policy decision.

The National Health Maintenance Organization Act of 1978, sponsored by Senator Schweiker, passed last year. It will eventually mean that health maintenance based on cost-cutting standards will be mandatory in every state. Currently, Secretary Califano and Senator Kennedy are discussing the funding aspects for putting the bill into effect.

The Health Security Act includes provisions for building more hospices. Legislation to implement these provisions is already on the congressional schedule. The National Committee on Intractable Pain (NCIP), the major organization along with Hospice, Inc. of New Haven, Conn. that is lobbying for "medicinal" use of heroin, is now writing legislation to legalize heroin for out-patient care, particularly among cancer patients. The legislation is projected for submission to the 96th Congress or the session thereafter. NCIP is looking for a congressional sponsor.

On Feb. 7, Walter J. McNerney, president of the Blue Cross-Blue Shield Association, declared that payment will be phased out for 31 surgical and 10 diagnostic services unless ordered by a physician in writing on an individual basis. This would eliminate routine blood counts, urine analyses, chest X-rays, and electrocardiograms—tests that often catch the irregularities signaling serious disease. This would deny health care particularly to the elderly and also those 21 million citizens who are referred by group plans and therefore have no individual doctors.

In summary, by placing strict ceilings on expenditures and adding millions to an already overburdened system, the Kennedy bill would legislate many hospitals out of existence through bankruptcy. By tightening requirements for hospital entry, the Kennedy bill would deny care to those who need it. By enacting strict fee schedules for the treatment of disease to those who are permitted entry and by holding a ceiling on allowed expenditures, the Kennedy bill would guarantee that the hospitals could no longer supply the kind of improved care that has greatly lowered the nation's mortality rate in the last decade.

'Alternatives' to hospital care

The logic behind the Kennedy bill was stated simply by David Rogers, M.D., president of the Robert Wood Johnson Foundation, who has prepared the provisions in the bill for medical education and wrote in *Daedalus* magazine in 1977: "While we can probably make hospitals more efficient, the continuing technological advances of medicine dictate that the costs of a day in a hospital bed will continue to rise. But there is good evidence to show that a well-organized ambulatory-care system for certain groups can significantly reduce the amount of hospital care needed per person. A program that would cut hospitalization for each patient now admitted to a hospital in the United States each year by just one day would save $2 billion. Obviously, logic suggests that we strive toward a system in which less hospitalization is required, if we are to contain the costs of medical care within tolerable limits."

Rogers suggests, and the Kennedy bill provides for, the reversal of the increased specialization of medicine and a new stress on "primary care"; reliance on Health Maintenance Systems in lieu of hospitals for service; the elimination of "unnecessary" surgery; the creation of neighborhood clinics to replace closed hospitals especially in cities; accelerated creation of hospices for the elderly and dying; and stress on "preventive medicine."

Under the Kennedy bill:

Fee schedules will be designed ... to encourage more primary care physicians, particularly in medically underserved areas.

The increased ability through vaccines and advanced methods to treat disease since the late 19th century and particularly in the last two decades has produced an increased specialization in the medical field. No longer is the ordinary doctor a general practitioner who is limited in his knowledge and experience of many diseases. The increased division of labor in the medical field, like the development of high technologies to detect disease and treat patients, has increased the *intensity* of health care delivered. It has saved lives.

The Kennedy bill, does not propose an interdisciplinary approach to solve coordination problems among specializations, but seeks to lower the level of medical skill to the lowest common denominator.

Proposed OSHA regulation to hit

The traditionally private relationship between corporations and insurance companies that has kept health benefit reimbursement standards high in the corporate sector will be jeopardized if Senate Bill 3450 with its regulations pertaining to employee medical records is passed.

Most corporations negotiate directly wiih the 20 major group health insurance companies in the United States for their employee benefit plans and often use this as a bargaining chip in labor negotiations. These insurance companies, with the exception of Blue Cross and the Prudential Insurance Company of New Jersey, have in the past joined with the American Medical Association to oppose the Kennedy Health Security Act.

But under Senate Bill 3450, proposed by Javits (R-N.Y.), Muskie (D-Me.), and Ribicoff (D-Ct.), the Occupational Safety and Health Administration will be handed vastly expanded powers to prosecute businesses and management for allegedly not providing their employees with "adequate and proper health care." The bill would give a special commission of "qualified personnel" within OSHA access to health records in order to determine if employees have been "unable to protect themselves from occupational diseases and exposure to toxic substances because their claims have been ignored by industry."

Patient access to medical records, presently forbidden except in cases deemed exceptional and in certain court suits, will also be allowed. This opens the way to litigation against occupational physicians, most of whom are attached to corporations, threatening millions of dollars in losses from suits brought by employees who claim exposure to toxic substances or occupational diseases.

corporate health benefit standards

Patient access would tie in closely with the proposed expansion of OSHA's role as a center for data-bank information providing evidence against major corporations that the introduction of new technologies into their plants and factories is harmful to workers. This indeed was the intention of the Occupational and Safety Hazards Administration Act of 1970. In the health-care sector specifically these guidelines will force government intervention into the benefit structure of private insurance carriers on the grounds that coverage is "inadequate."

For example, the data files could be used to prove that corporate white-collar employees are "treated favorably" by hospitals since they have corporate group health plans and are admitted for "unwarranted surgery and excessive hospitalization." This would provide the rationale to force insurance companies to lower their benefits structures as their corporate clients come under pressure from the expert OSHA committee.

Who is reportedly being proposed for this expert review committee?

- Anthony Mazzocchi, vice president of the Oil, Chemical, and Atomic Workers International Union and an ardent supporter of the Kennedy health bill.
- Alan F. Westin, a professor of law at Columbia University, a board member of the American Civil Liberties Union, and an advocate of the antitrust legislation that Senator Kennedy has sponsored in Congress.
- Alan A. McLean, M.D., the New York area medical director for IBM, a company with a massive electronic data base and surveillance capability, and president of the American Occupational Medical Association.

Dr. Rogers even goes so far as to suggest the "use of nonphysicians to deliver most primary medical care. ... Such a system would probably be, at least initially, most acceptable to the two areas that currently have the most serious problems in general medical care—rural areas of low patient density and heavily congested, inner-city areas now deprived of physicians."

A lowering of the standards of health care is not only projected for low income areas. The Kennedy bill mandates:

National licensure standards and requirements for continuing education.

The Kennedy bill would mandate priorities in medical education toward primary care and less specialization. Already, Secretary of Health, Education and Welfare Joseph Califano has proposed that federal grants to medical schools be predicated on an "incentive system" that would reward schools which admit a higher percentage of students for tracking in primary care. Many of the country's 114 medical schools currently operate on the financial margin afforded by government grants and would thus have to change their orientation toward primary care or close.

The U.S. health system does need more family practitioner specialists—a designation that requires three years of hospital residency. Dr. Rogers, however, suggests the training of two types of physicians—"first class" physicians would be trained like those today; "second class" doctors would be "rapidly trained practitioners."

The Kennedy bill further mandates:

Regulation of major surgery and other specialist services.

It is the contention of many backers and supporters of the Kennedy bill that since the number of types of operations varies from region to region, then some of this surgery must have been "unnecessary." Califano has established an HEW program "to get a second opinion free" if a doctor should order surgery. But, it has been shown that in cases in which surgery has been delayed—for example, removal of the gall bladder—the problem has recurred, making surgery necessary when the patient is older and less able to withstand it.

It might be argued that some surgery could be eliminated through the development of new drugs. However, the Kennedy-Javits bill for Pharmaceutical Revision Reform Code introduced in 1978 acts to deprive pharmaceutical companies of their research and development capabilities through divestiture of drug patent rights after a 60-month period.

Harvard's Dr. John Knowles, a likely candidate until his recent death to sit on the bill's national Public Authority, has claimed: "Ten billion dollars could be saved and made available for such (preventive) programs, if by miracle all unnecessary surgery were abolished." The claim that $10 billion a year is spent on "unnecessary" surgery is a ruse to rationalize the closing of the country's hospitals and pave the way for the "ambulatory" service that the bill's backers say will do just as well.

Under the Kennedy bill:

Health Maintenance Organizations and other nontraditional forms of health care delivery, such as neighborhood health centers, will be fully supported and their development encouraged through incentives.

As originally conceived, Health Maintenance Organizations were designed to provide a group of people—through business, school, or union—with

health insurance, and an interdisciplinary team of doctors and medical personnel. Under the Kennedy bill, HMOs become a barrier to the patient's entry to the health system, and particularly surgery. According to one of its designers, the Kennedy-funded Georgetown Health Policy Center, the purpose of HMOs is "to eliminate the second visit, that is, to make sure the patient doesn't come back." Primary screening and diagnosis of patients would not be performed by doctors but by nurses and paraprofessionals. The HMOs are thus intended to serve as poor substitutes for hospitals.

Under the Kennedy bill:

Special provisions will be made for neighborhood health centers, community mental health centers, halfway houses and other organized methods of delivering health care. Programs which are useful in reaching underserved populations will be covered.

Like the provisions for the HMOs, this would decentralize health care and thus diminish the *intensity* of health services delivered to each patient. More ominously, the handing over of health facilities to the "community" takes major responsibilities for health services out of the hands of medical professionals and places them in the hands of the "consumer." This policy is explicit in the enforcement section of the bill.

Under the Kennedy bill:

A resources development fund will be established to support a nationwide program of demonstration projects for the development of services designed to assist the elderly and chronically ill to remain in their own homes rather than to be institutionalized.

The Kennedy bill thus legislates into nationwide existence the British-spawned Hospice Movement—otherwise known as the "Right to Die" movement.

In the case of the elderly, it can be shown that the increased hospitalization of those 65 and over has decreased the mortality rate. With the enactment of the Medicare program for the elderly in 1965, increased health care expenditures for the over-65 population included a 47 percent increase in real hospital services from 1965 to 1975. The death rate for the elderly during 1965-1975 fell 11.2 percent, compared to only a 2.4 percent decrease during 1950-1965. Thus, increased hospitalization correlates with greater longevity. The Kennedy bill would reverse this.

The Kennedy bill provision for hospices legislates the nontreatment of the terminally ill. In most cases, this involves those degenerative diseases like cancer, heart disease, stroke, diabetes, and chronic kidney disease that constitute the frontier of medicine today. It is here that a breakthrough is required in medical science through basic research and the continual innovation in detection and treatment. By relegating these patients to a hospice treatment of waiting to die, the Kennedy bill shuts the door on the advancement of medical science.

In October 1978, Edward Kennedy and HEW Secretary Joseph Califano were the two keynote speakers at the first annual National Hospice Organizing Meeting in Washington, D.C. The model for Kennedy's hospice program—which is also privately funded through the Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics at Georgetown University—is the St. Christopher's Hospice in London, created in 1967. Here, "patients" are administered a "painkiller" called the Bromptom Mixture. It consists of heroin, cocaine, alcohol, tranquilizers, and chloroform water. It is administered every three hours until the patient dies.

The establishment of such hospices in the United States is already underway through state legislation. In New York, the State Assembly passed a resolution in April 1978 that legally changed the definition of "hospital" to include "hospice." It mandated three hospice pilot projects to be established in the state by no later than 1980. Senator Hevesi, the bill's sponsor, is also the cosponsor of pending state legislation that would legalize heroin for "medicinal purposes."

In addition, the 1978 Kennedy-Javits bill for a Pharmaceutical Revision Reform Code provides for the creation of a special center to study heroin, LSD, and other mind-destroying drugs for their use as "painkillers." This dovetails with an ongoing program of the National Institute of Medicine, in conjunction with Califano's HEW, to enroll doctors at the National Institute on Drug Abuse in courses on "pain management" instead of cure.

Under the Kennedy bill:

Preventive care for all members of the population will be actively encouraged and fully covered.

Under a national health program that was concerned with ensuring the advancing health of the population as the guarantee for a steadily advancing economy and technology, this provision would include national immunization for diseases, regular guaranteed checkups for early detection of diseases, and foremost, raising the standard of living for the population as a whole. How can there be preventive medicine under a health system determined to cut health care by 15 percent?

The motivation behind this provision in the Kennedy bill is explained by Dr. John Knowles, who makes clear that "preventive medicine" is predicated on a decrease in the standard of living. In 1977, Knowles wrote in *Daedalus* magazine: "I will not berate the medical profession, its practitioners and its professors—they reflect our culture, its values, beliefs, rites, and symbols. Central to the culture is faith in progress through science, technology, and industrial growth; increasingly peripheral to it is the idea, vis-á-vis health, that over 99 percent of us are born healthy and are made sick as a result of personal misbehavior and environmental conditions. ... The cost of sloth,

gluttony, alcoholic intemperance, reckless driving, sexual frenzy, and smoking is national, and not an individual, responsibility. This is justified as individual freedom—but one man's freedom in health is another man's shackle in taxes and insurance premiums. I believe the idea of a 'right' to health should be replaced by the idea of an individual moral obligation to preserve one's own health."

Knowles proposes that the individual has a public duty to maintain a low cholesterol and caloric intake and to desist from smoking and drinking. Curiously, he makes no mention of the fact that over 48 million Americans are habitual users of mind-killing and physically destructive drugs such as marijuana, heroin, and cocaine.

Knowles proposes support for a "far greater national commitment for research in health education and preventive medicine with emphasis on epidemiologic studies, benefit-cost analysis, and the most effective and least offensive ways of changing human behavior."

The emphasis on preventive medicine and the role of the

damaged the treatment of cancer. Through agencies like the Environmental Protection Agency and the Occupational Safety and Health Administration, the "environment," particularly industry, has been blamed for cancer. This has had three effects: first, the closing down of plants and particularly nuclear energy facilities because of alleged environmental hazards; second, a decreased stress on the basic biological research into the function of cells, etc. where the source and the cure of cancer is to be found; and third, in New Jersey, an accompanying dismantling of state cancer *treatment* facilities, according to medical sources there.

Implement and regulate

The Kennedy bill would take the planning and overseeing of the national health system out of the hands of the medical profession and place it in the hands of the Department of Health, Education, and Welfare and coopted representatives of "consumers" and the health insurance industry.

Within HEW, the bill would be implemented by a Health Security Board under the direction of Joseph Califano.

Secondly, under the Kennedy health bill:

Universal coverage will be assured through a bipartisan federal Public Authority (PA) whose members will be appointed by the President, subject to confirmation. Not less than one-half of the members will be consumer representatives....

The PA will regulate and oversee the operations of the certified insurers and consortia and will consolidate the administration of Medicare, a federalized Medicaid program, and several other existing federal programs. Its major objectives will be to assure universal coverage through the combination of public and private programs, control the rapidly escalating costs of medical care, and to effect major reforms in the provision of health care by bringing private and public financing into conformity with the goals of the legislation....

The Public Authority will contract with each state and territory to establish State Authorities as agents of the federal agency to implement national policy. The SA's bipartisan members will be nominated by the State Governor and approved by the PA. Consumers will comprise not less than one-half of the membership....

Thus, the national Public Authority has absolute life-and-death control of the national health system.

Who will sit on this Public Authority? Those who have been involved in drafting the Kennedy bill say that the board will likely include:

- Senator Edward Kennedy.
- Joseph Califano, Secretary of Health, Education, and Welfare.
- Isidore Falk, M.D., currently Professor Emeritus of Public Health at Yale University who has spent a lifetime organizing for the nonhealth system mandated by the Kennedy bill.
- David E. Rogers, M.D., President of the Robert Wood Johnson Foundation in Princeton, New Jersey. The Foundation is recognized by the New York Health and Hospitals Corporation officials as being most responsible for the ongoing shutdown of the city's 18 municipal hospitals through its "private" collaboration with Mayor Koch.
- Robert Sigmund, director of the New York State Blue Cross Association. He is closely tied with the Milbank Foundation, which has funded lobbying for compulsory health insurance since the formation of the Committee on the Costs of Medical Care.
- Max Fine, director of the Zionist lobby-controlled Committee on National Health Insurance. He would represent labor on the Public Authority. Fine has pioneered the formation of Health Maintenance Organizations and has been instrumental in gaining labor support for the Kennedy bill.
- Ralph Nader, consumer advocate. Nader's role in attacking industry and high technology is well known. He was instrumental in the passage of the Environmental Policy Act, which in turn has enabled the campaign against industries that allegedly cause cancer. He is a major spokesman against "unnecessary insurance" for many illnesses. As a director of the Public Interest Research Group, he advocates the passage of the Kennedy-Javits Pharmaceutical Revision Reform Code.

These are the gentlemen likely to head up the nation's health system, if the Kennedy bill is passed. Theirs is the body count method of health care.

Under the Kennedy bill:

Programs such as state rate review agencies, health systems agencies, and professional standards review organizations, will be used to the maximum extent.

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In short, doctors will be policed to ensure that no physician oversteps the prescribed guidelines of what is necessary. The bill particularly relies on the Professional Standard Review Organization, composed of local bodies of other doctors who monitor a physician's activity and behavior. Established in 1972, persistent resistance from the American Medical Association has rendered them ineffective. Under the Kennedy bill, their use would be mandated by law.

The insurance enforcers

Under the Kennedy Health Security Act, private insurance companies will be given a role enforcing the drastic cutbacks in both quality of patient care and the amount of investment in hospitals. And, despite the carefully neutral tone of the legislation, Kennedy's staff stated this March that the Blue Cross Association of America and the Blue Shield Association will oversee the entire insurance consortium along the following lines:

... The insurance industry will offer uniform, comprehensive insurance benefits at earnings-based premiums equal to or below the maximum set by the Public Authority without experience rating ... provide only those other forms of medical insurance or disability income benefits which do not duplicate or conflict with the uniform health insurance benefits offered by the federal program ... reimburse health care providers (both institutional and professional) for all services covered by the uniform comprehensive benefits, and at fees and rates not to exceed those established in negotiation with the providers and approved by the State Authority.

... Allow the Public Authority or its designees access to financial and management records as they pertain to the administration of the mandated benefits package....

... Develop medical care profiles on treatment provided and facilities used to rapidly detect any minimizations or excesses which would conflict with the rendering of quality care and the efficient delivery of medical services. ...

The insurance provisions are thus some of the more revealing sections of the act. They describe a set of self-policing structures as a result of which no insurance company will be allowed to provide coverage beyond that the Public Authority determines is permissible; any firm that does will be hounded out of the industry. This means standardized upper limits will be set on insurance coverage for the patient and for the hospital performing the treatment. Patients accustomed to the now prevalent method of reimbursement on about 80 percent of total hospital costs above an initial deductible sum are in for a rude shock.

—Karen Steinherz and Linda Frommer

What's behind the rising cost

The variety of health care reform programs that have promised cuts in the rising costs of health care are generally based on two interrelated myths. The first is that the U.S. economy is a fixed pie with health care allocations regulated to a fixed percentage of the pie, not to be exceeded. Secondly, much of the new health proposals are geared away from high-technology care, focusing instead on keeping the patient "comfortable." The assumption is that "expensive" high-technology health care has only a marginal effect on the overall well-being of the population.

Why is health care so expensive?

It is true that the cost of services, particularly hospital and laboratory services, has increased greatly over the past several decades. In 1950, 4.5 percent of the GNP was spent on health, while by 1977, this figure had increased to more than 8 percent. In recent years, the annual increase in national health spending has grown by 12 to 15 percent, a good deal above the calculated consumer price index of 9 to 10 percent.

Where is the money going? Nearly half of it is for improvements in the quality and quantity of services, not in so-called excess profits on the part of health care providers. In fact, the increase of health care costs as a result of price rises for the same services is actually *lower* than the general rate of inflation.

Consider hospital costs. If the cost per service is rising slowly, then why are the base daily rates for hospitalization climbing so quickly? The answer lies in the increased *intensity* of services provided for the patient by the hospitals as part of the base hospitalization day. The American Hospital Association calculates a Hospitalization Intensity Index (HII) that combines more than 40 aspects of hospital care, including number of doctors per hundred patients, number of nurses, number of lab personnel, quality of other services such as food, and so on, to produce an overall measure of intensity of services.

Between June 1977 and June 1978, daily hospital rates increased on average $22.42, or 12.2 percent. Of this increase, $12.89 (or 56 percent of the increase) was due to increased costs (inflation) of goods and services purchased by the hospitals, while $9.53 (44 percent of the increase) was due to the increase in intensity of services. When adjusted by the HII factor, the price segment of the increase for 1969-1978 amounts to only 8.1 percent annually.

The question of medical technology

As for medical research and development, it cannot be argued that the qualitative and quantitative advances