

# Health Care in Britain and America

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## Dissatisfaction of High Cost and Inadequate Coverage

### Criticism of High Cost and Inadequate Coverage

Health care in the United States has been variously described as “a scandal,” on the “verge of a breakdown” or, in the words of President Nixon, facing a “massive crisis.” The dimensions of the problem have been thoroughly documented: costs have run out of control, medical attention has become inaccessible to millions of Americans, preventive care is minimal and dozens of different medical programs lack coordination and are beset by waste and duplication. There is general agreement by all parties that change is not only desired but anticipated. Now, as the Nixon administration prepares to offer its proposals for medical care reform to the nation, and numerous other comprehensive reform measures are pending before Congress, it is instructive to look at Britain's 25 years of experience with government-sponsored health care.

British observers tend to regard the United States as poor in health considering the amount of money the nation spends on health care.

These expenditures account for about 8 per cent<sup>1</sup> of the U.S. gross national product, in contrast to less than 6 per cent in Britain. And it can be argued that in a number of ways the British enjoy better health and health services than their American cousins. Health-care spending in the United States exceeded \$80 billion in 1972 and may reach \$90 billion in 1973.

Walter J. McNerney, president of the Blue Cross Association, contends that the health field “is particularly vulnerable to the forces of inflation—as are all service industries.” A complicating factor is that “the basic supply and demand forces of the classic market are weak, or apply unevenly. Thus, quality, efficiency and effectiveness do not materialize in the ordinary course of events between purchasers and providers of the service. They must be built in.”<sup>2</sup>

*Fortune* magazine took a look at rising health-care costs and reported in January 1970 that the growth of “third party” payment of medical bills through Blue Cross, Blue Shield, and group insurance policies was one cause of the “inflationary thrust.” The magazine added: “Cost controls have always been weak in hospitals, partly because many of the doctors have no stake in promoting hospital efficiency. Today, most of a hospital's income is provided by Blue Cross and the insurance companies, which dutifully reimburse on the basis of cost *after* they are incurred, rather than agreeing on a fee in advance.”

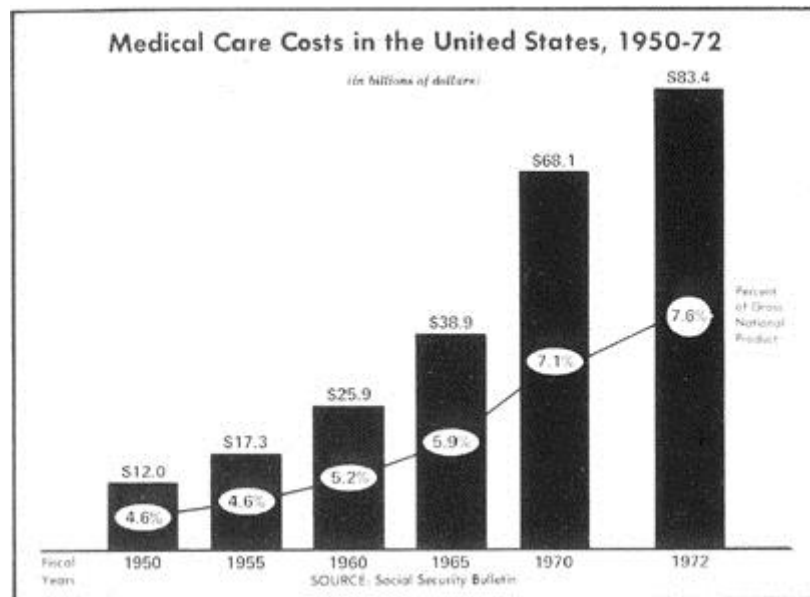
Sen. Edward M. Kennedy asserts in his book *In Critical Condition* (1972) that “the United States pays more per capita for health care than any other industrialized nation in the world.” Medical-care costs have increased faster than all but one other major category, that of home ownership, in the Consumer Price Index. The following table shows the relationship of medical-care expenses to the index as a whole (100 equals 1967 average):

Period	All items	Medical	Period	All items	Medical
1969	109.8	113.4	Jan. 1973	127.7	134.9
1970	116.2	120.6	Feb. 1973	128.6	135.3
1971	121.3	128.4	Mar. 1973	129.8	135.8
1972	125.3	132.5	Apr. 1973	130.7	136.2

In contrast to the British approach, 20th century medicine has grown in the United States with relatively little policy guidance from the government and, it has been charged, without a strong tradition of social commitment. Responsibility for health care in the United States is now dispersed among some 1,500 private insurance companies, 346,000 medical doctors, 8,000 hospitals, 10,000 health and welfare funds, 50 states and the federal government. The structure of health care is consequently so fragmented that no one group has been able to exercise the leverage to institute reform.

Some see this diversity as desirable, including the American Medical Association which represents more than half of the nation's doctors.<sup>3</sup> In his State of the Union message on human resources, issued March 1, President Nixon reflected that point of view when

he said: "Federal health policy should seek to safeguard the country's pluralistic health-care system and



to build on its strengths, minimizing reliance on government-run arrangements.”

More than a dozen health-care bills with varying goals and provisions have been submitted to the 93rd Congress so far. Because the Republican administration and the Democratic Congress are approaching the problem from different directions, the ultimate form of a health-care system for America remains unclear. It has become accepted by nearly all parties, however, that every person should have accessible and effective medical care. Thus the debate turns on the means of delivering such medical care at the lowest cost.

Under each of the major proposals, modifications of the current system seem inevitable. The most costly and extensive of all the proposals was submitted by Senator Kennedy and Rep. Martha W. Griffiths (D Mich.). It would have the government replace private industry as the major provider of medical insurance benefits. However, the federal government would not own hospitals or employ physicians as in Britain. The Kennedy-Griffiths plan has not been pushed as strongly in 1973 as it was in 1971–1972 during the 92nd Congress. Kennedy has spoken before groups of doctors on several occasions in an attempt to lessen their opposition.

President Nixon, in his human resources message, subscribed to the philosophy of “adequate financing of health care for every American family.” The administration in 1972 proposed a National Health Insurance Partnership Act which provided no coverage for seasonal workers, unemployed persons or members of specific religious organizations. The plan required some payments by the poor, and it relied on private insurers. The administration has not yet perfected its 1973 plan; Caspar W. Weinberger, Secretary of Health, Education and Welfare, asked Hew officials to submit specific proposals to him by early June for consideration.

In the meantime, Congress has become the scene of a fight to restore health programs and projects that were reduced or deleted in the fiscal 1974 budget that Nixon sent to Congress in January 1973. These included community mental health centers, regional medical plans, hospital construction funds, and biomedical research and training grants. Congress recently extended 12 expiring federal health programs for one year, through mid-1975, at present spending levels over Weinberger's opposition. However, the extension bill is subject to a presidential veto, which some sources expect.

### Debate Over Ways to Widen Insurance Coverage

Health insurance of one type or another today reaches almost nine of every ten Americans. Nearly all persons 65 and older have coverage, mainly through Medicare. The main problem has become that of providing for about 24 million persons under 65 who have no health insurance at all and providing greater benefits for millions of all ages whose coverage is scant. According to the Social Security Administration, fully 75 per cent of the civilian population in 1971 was protected by private insurance plans for hospital and surgical services, up to varying specified amounts. Percentages decline when it comes to out-of-hospital services: 71 per cent for X-rays and laboratory services, 52 per cent for prescription drugs, and 8 per cent for dental care. <sup>4</sup>

The common element in all the proposals before Congress is that the federal government would provide the money to extend medical insurance coverage to those not yet insured. The basic difference is that whereas the Nixon administration would place greater responsibility in the hands of the industry, Kennedy favors a national insurance plan. Former Hew Secretary Wilbur J. Cohen has said: “There are pros and cons of both plans. This is not an issue where all virtue is on one side and all vice on the other, and that's what will make it very difficult for the Congress to decide.” <sup>5</sup>

President Nixon stated as early as 1971, in a health message to Congress: "There simply is no need to eliminate an entire segment of our private economy and at the same time add a multi-billion-dollar responsibility to the federal budget." Nixon said that such action would "deny the people the right to choose how they will pay for their health care" and "would remove competition from the insurance system." However, Nixon acknowledged in March 1972 that under the present insurance system "a single catastrophic illness can wipe out the financial security of almost any family."

Kennedy contends that "the health insurance industry has been a catastrophic failure in America." He accused it of taking enormous salaries, commissions and profits. According to the Social Security Administration, consumer expenditures for private health insurance in 1971 totaled \$19.8 billion. During that year, the latest for which official figures have been made available, private health insurers paid out \$17.9 billion in claims. The difference amounts to 9.7 per cent retained by the organizations for operating expenses, profits and additions to reserves. The likelihood is that whatever legislation is enacted, private insurance companies will have to comply with stricter requirements than they do now.<sup>6</sup> So complex are the policies sold that the insured may not know what his own policy pays until he submits a claim. He may be dismayed to discover that his specific illness was not covered.

### Doctor Shortage in Rural Areas and Small Towns

Aside from the cost of health care, availability is a major problem in many of the nation's rural areas and small towns. "Too many people simply lack convenient access to the services of physicians, too many communities are unable to attract physicians, hospital facilities are unused or under used," Hew stated in May 1971 in a paper titled "Toward a Comprehensive Health Policy." The physician-population ratio is 185 per 100,000 in metropolitan areas but only 76 per 100,000 in rural communities.

Over the past 20 years a number of studies, including those of presidential commissions,<sup>7</sup> have concluded that the number of physicians in the United States should be substantially increased. As recently as 1967, according to statistics compiled by the World Health Organization in Geneva, nine countries *Health*, and the Presidential Commission on Heart Disease, Cancer and Stroke, in its 1964-65 report *A National Program to Conquer Heart Disease, Cancer, and Stroke* had a higher ratio of physicians to population than the United States, as is shown in the following table:

Country	Physicians per 100,000 pop.	Country	Physicians per 100,000 pop.
Israel	236	Italy	175
Russia	221	Hungary	169
Czechoslovakia	197	West Germany	163
Austria	177	Argentina	162
Bulgaria	174	United States	153

Health maintenance organizations, known by the initials HMOs, are being regarded in Congress as outlets for providing better health services to both rural and urban areas, and making the best use of the doctors available. Although there is no single model, a health maintenance organization is set up so that a patient pays one fee per year to a group of physicians for the entire family's medical needs. HMOs typically provide comprehensive health care to those voluntarily enrolled in a specific geographic area. The Senate on May 15, 1973, voted to authorize \$805 million in grants and loans through fiscal year 1976 for planning, development, construction and operation of these facilities. The House has been considering a separate bill to authorize \$280 million for this purpose.

The Senate bill was a compromise between a version offered by Kennedy and another offered by Sens. Jacob K. Javits (R N.Y.) and Richard S. Schweiker (R Pa.). The AMA strongly opposed federal funding of HMOs as being detrimental to traditional medical practices. Javits spoke of health maintenance organizations as the "most promising" new form of health care delivery available. Moreover, he said the bill was "the opening card...to a great national reform."

President Nixon pointed out in a health message to Congress in February 1971 that the seven million Americans then enrolled in HMOs were getting a far superior service for each health dollar they spent. In his health message to Congress the following year, in March 1972, Nixon listed as reasons for HMO development:

Organization into one system with strong linkages between general practitioners, specialists, hospitals, clinics, laboratory.

Built-in incentives for controlling cost, efficient use of resources leading to self-regulation, not more direct federal involvement.

Vehicle for responding to all health-care problems: organization, financing, manpower, prevention.

Nixon said his administration would support the expansion of HMOs to reach about one-fifth of the American population. But the administration's support of HMO legislation in 1973 turned lukewarm; it favored only a limited, experimental approach.

## Allure of British Health System for Americans


Amid the welter of legislative plans, there has been a growing tendency to look toward Europe for alternatives. Despite the stigma of "socialized medicine," many journalists, legislators and ordinary American tourists have been favorably impressed by the health care offered to every resident of the United Kingdom. Moreover, the family doctor remains the central figure in British medicine. This general practitioner is able to deal with over 95 per cent of the illness and injuries of his patients. Those who require further attention are then guided to specialists at one of the hospitals. Contrary to early fears, British doctors have not been burdened by layers of bureaucracy or administration.

Britain's NHS is paid for mainly out of general tax funds. Except for private health care, which is available for those who desire it and can afford it, medical care is almost entirely free to the patient. Only a token prescription charge is applied for medicines and the NHS obtains only 4.5 per cent of its income from such charges. The annual cost of the entire service runs to \$6.3 billion. Out of this figure the NHS pays 20,000 family doctors and 750,000 employees, and for the use of 450,000 hospital beds.

The attractiveness of this health service is not to be measured in terms of cost or administrative simplicity alone. There have been improvements in Britain's health standards since the service began. Back in 1945, the infant mortality rate was 46 per thousand live births in Britain and 38 per thousand in the United States. In 1969 the rate in Britain had fallen to 18 per thousand, while in the United States it was 20.7. Moreover, the American male is apt to die two years earlier than the Englishman. The psychological benefits of the service may be as important as the medical. There is no fear among the poor that they will be denied access to a hospital and there is no fear among the well-to-do that their lifetime savings will be drained away by a sudden medical calamity.

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## British Health Service After 25 Years

Although the circumstances were vastly different, Hippo crates in 450 B.C. and Labor leader Aneurin Bevan in 1946 were basically in agreement that the physician should do his work without reference to the social or financial position of the patient, and that the necessary medical attention should be given without a question of fees. Government planning for comprehensive health services began in 1941 as part of the Churchill government's consideration of postwar reconstruction problems. However, it was left to the succeeding Labor government of Prime Minister Clement Atlee, with Minister of Health Bevan in the forefront, to write into law the idea that everyone had a right to medical and dental care—just as they were entitled to police protection and public education. 

## Postwar Enactment of National Health Service

The National Health Service Act of 1946 was passed over the determined opposition of many British doctors. The act placed upon the minister of health the duty to establish a comprehensive medical service designed "to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness." With this centralization of responsibility came immediate action to coordinate a health-service system which was at the time as disorganized as that which exists in the United States today. The act enabled any resident, whether employed or not, to receive the following benefits:

Care by general medical practitioners and specialists and by dentists and oculists.

Complete in-patient and out-patient hospital care, with treatment continuing during convalescence and rehabilitation.

Home nursing and domestic help when required by the illness of the homemaker.


All necessary drugs and appliances.

Scotland was placed under the National Health Service plan by the National Health Service Act of 1947 and Northern Ireland by the Health Services Act of 1948. Both acts, together with the original 1946 legislation, went into effect July 5, 1948. This plan provided the most comprehensive system of state-run health services outside of Communist countries.

General practitioners contract with the government to provide initial and follow-up medical care to persons who sign up. The general practitioners are paid for these services through a complex system based on capitation fees. For example, a GP will bill the NHS about \$6.25 for a night-time house call. The average GP has about 2,500 patients and earns about \$14,500 a year. He may, of course, refuse to accept a patient and can even drop a patient already on his list; likewise, a patient is free to change doctors.

Practically all of Britain's hospitals, clinics and asylums were nationalized by NHS and affiliated and grouped under local hospital-management committees. These committees, in turn, formed a part of the large university-centered hospital regions. Each region comprised a population of two to four million. Local public health and domiciliary services in England, including ambulance and home nursing services, were provided through local health departments. Except for a few specialists who continued their private practices, most of the country's 9,000 specialists were employed by the NHS on a full-time or part-time basis. Such specialists were salaried

through the hospital system and were referred patients for consultation.

National Health Service did not accomplish miracles overnight. Hospitals were antiquated and there were not enough funds for new construction. However, it swiftly corrected the discrepancies in regional medical care which had developed through the centuries. After 25 years, NHS has greatly improved the health services to people in remote areas. In fact, it has become an established element of British life. Although administrative change has now become necessary in the organization, the principle of “socialized medicine” is no longer attacked by even the most conservative of Tories. 

### How the Health Service Functions; Criticism of It

A three-part division of NHS into (1) local authority services, (2) general medical services and (3) hospitals has resulted in a lack of coordination within the system. Repeated studies have shown, however, that the system works much better in practice than it appears to on paper. There have been relatively few complaints about duplication of services or manpower. Although paperwork and administrative chores are kept at a minimum for both doctors and patients, there are frequent complaints that the capitation system reduces the efficiency of many practitioners. Anthony Partridge, writing in the London *Telegraph* in May 1972, portrayed the following scene and attributed it to the fact that doctors are paid by the number of patients they handle:

The doctor sits at his desk with a fountain pen in his hand—his only necessary instrument—with his eyes down; he rarely raises them...As the patient comes through the door, he asks: “What’s the matter?” The patient says “I’ve got a cough.” Remedy—cough mixture, antibiotics and come back in a week. But no examination. The bad doctor’s finger is on the buzzer for the next patient. Patients file through at about three-minute intervals.

Administrative authority for the National Health Service is vested in the minister of health, who is advised by a Central Health Services Council made up of the heads of the principal medical associations, representatives of the medical professions, and persons with experience in hospital management and in public health activities. The trouble with this structure is that there is little management from the top.

Payments to the family doctor and for general dental, ophthalmic and pharmaceutical services account for 25 per cent of the health budget. Local authority services—maternity and child care, midwifery, home nursing, health centers, ambulances, mental health services, after care and the like—account for about 10 per cent. Hospital and specialist services take up the remaining 65 per cent of the budget. The specialists, because of their influence and prestige, have been able to push through an ambitious hospital program at the expense of institutions for the aged and mentally ill. This imbalance is one of the reasons why there has been pressure to reorganize the health service.

### Reorganization Plans to Take Effect Next April

A reorganization of the British health service is scheduled to take effect on April 1, 1974. The government plans to integrate the three different branches of the National Health Service—hospitals, general medical services and local health services. The objective is to end the fragmentation of authority which runs counter to the intended “national” character of the health service. Area Health Authorities are planned to serve districts of 200,000 and 500,000 people; each district will have at least one general hospital. An elected doctor-nurse-dentist board will plan services on a local basis. Above them will be regional and national boards. Remaining outside the new system will be community mental health services, home help services, residential accommodation and social services departments. However, the Ministry of Health will continue to be responsible to Parliament for the service as a whole.

The need for reorganization has been widely accepted. Nearly all Britons complain about the long wait for any but emergency hospital treatment. The average delay for the removal of tonsils is 22 weeks, and the wait for the treatment of varicose veins or hernias may amount to several years. There are at present more than 500,000 persons seeking hospital admission in the United Kingdom.

It is also said that the present system encourages general practitioners to refer all serious or complicated cases to hospitals for further treatment. This means that there is no incentive for the family doctor to improve his equipment or knowledge. The prevalence of referrals, the lack of privacy in hospital clinics, the long waiting periods and the conflicting advice and care resulting from the lack of coordination between general practitioners and specialists cause some patients who can afford to do so to turn to private medical treatment.

Elderly patients pose a particularly serious problem for the overcrowded hospitals. These patients may become bedfast for months or even years. It is now planned that many chronic invalids, geriatrics, and mentally handicapped patients gradually be returned to their homes or to local institutions where they can be cared for by general practitioners and attended by nurses supplied by local health authorities. It has been estimated that close to half of the elderly patients and chronic invalids now in the public hospitals could be transferred without detriment to their condition.

The NHS reorganization bill generated criticism, however, primarily for putting emphasis on management and for neglecting consumer participation. Some of these complaints were assuaged when the House of Lords in December 1972 strengthened the bill’s provisions for community health councils. But more faults were outlined in a new book, *Blueprint for Health*(1973), by Dr. Stark Murray of the Socialist Medical Association. Commenting on the book in *The New Statesman*, journalist Donald Gould wrote “there is no chance now

of modifying the present sterile bill to any important extent.” But Gould suggested that the Murray book “would at least make MPs [Members of Parliament] aware of the fact that they must soon face the task of reorganizing the NHS all over again.”<sup>10</sup>

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## Pertinence of British System to U.S.A.

There has been a gradual but unmistakable swing on the part of the American public to the idea that health care, like education, is a fundamental right of citizenship. “Medical care has become in the public mind a right rather than a privilege,” Benjamin Cohen, the former Hew Secretary, has said. Federal involvement in the overall health care of the nation is already so substantial that ideological debate on government intervention is only a faint echo of years past.

The debate today is largely over which approach is best. The general direction of the Nixon administration is to shift away from central regulation of social services toward greater state and local control.<sup>11</sup> While Senator Kennedy's approach to health care differs from Nixon's, both men have said they do not want American medicine “socialized.” Kennedy has said health-care reform can be achieved within the existing “free enterprise system.” Nixon warned in March 1972 that “to nationalize health care as some have proposed and thus federalize medical personnel, institutions and procedures ... would amount to a stunning new financial burden for every American taxpayer.”

## Expanding Role of U.S. Government in Medicine

President Truman in 1945 made the first proposal for enactment of a federally operated health insurance program. The Truman plan would have covered the entire population, not just the elderly or needy—those modifications would come later. In a major lobbying war that reached its peak in 1949, labor unions and liberal organizations lined up behind various proposals for national health insurance but could not overcome the opposition of the AMA, the private health insurance business and conservative business groups.

Clearly, the prevailing American social values and the country's tradition of private medical practice put comprehensive planning in disfavor. Nevertheless, the federal commitment to health care continued to expand. President Johnson told Congress in 1965: “We can—and we must—strive now to assure the availability of and accessibility to the best health care for all Americans, regardless of age or geography or economic status.” Congress that year passed the Medicare program of health insurance for the aged and the Medicaid program of aid for the needy.<sup>12</sup> This year more than 95 per cent of all Americans over 65 will be enrolled in Medicare at a cost to the government of more than \$10 billion.

Congress stated in the Comprehensive Health Planning Act of 1966 “that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person.” Since that time, however, there has been increasing concern with the costs and complexities of programs already enacted which provide health care for specified segments of the population. Rosemary Stevens, in her book *American Medicine and the Public Interest* (1972), pointed out that “provision for the organized or subsidized payment of bills is scattered across numerous programs, each geared to selected diseases and population groups.” As seen from Britain, the federal role has not been one of planning as much as of prodigality.

## Differing Attitudes of Doctors in Two Countries

The commitment of the medical profession is naturally crucial for the effectiveness of any health plan. Dr. Max Parrot, chairman of the AMA's board of trustees, has stated that one obstacle is “the doctor's natural reluctance to apply a new system of health care broadly till we are pretty sure it will work.” According to a poll of 17,219 doctors taken by *Modern Medicine*, physicians if given the final say would reject every one of the major national health insurance plans under discussion. Most doctors seem to be unconvinced that any one system of delivering national health care would improve on the present pluralistic course.

How much to pay for doctor services is a major question in the establishment and effective operation of any governmentally run system of health financing. From the point of monetary returns alone, American doctors have a vested interest in maintaining the status quo. No English doctor working under the NHS would ever have a chance of making an American physician's income. In a study published in 1972, the Social Security Administration reported the earnings of U.S. physicians averaged \$40,500 a year. Describing a “typical” British urban physician, a Dr. Leonard Jacobs, *Newsweek* reported he “earns the equivalent of \$12,700 a year, drives a low-priced Fiat and lives on one half of a gray brick semidetached house in a leafy old neighborhood.”<sup>13</sup>

The place of the general practitioner and the specialist is so different on opposite sides of the Atlantic that the British system cannot readily be transplanted wholesale to American shores. In England the family doctor has the central role in the provision of health care, while the hospital-based surgeon or specialist only has cases referred to him. The general practitioner is the bedrock of the system. In the United States, many citizens have no family doctor. They go to a different specialist for each ailment. Forty years ago only 17 per cent of all U.S. doctors were full-time specialists; today specialists represent close to 80 per cent.

Specialization is held partly responsible for the shortage of doctors in America, but another major factor is distribution of doctors. Dr.

Kenneth M. Endicott, director of Hew's Bureau of Health Manpower Education, put it this way: "We don't have enough doctors, and we don't have them where we need them. Even if all health services were organized for maximum efficiency—which they certainly are not today—they could deliver only minimal health care to every American."<sup>14</sup> Dr. Boris Senior and Beverly A. Smith, expressed a different point of view in the *Journal of the American Medical Association*, Oct. 9, 1972:

What to the layman constitutes irrefutable evidence of a shortage of physicians may be interpreted differently: that physicians organize their office hours poorly; that a patient is better seen at a well-equipped center than at home; and that some towns may be less attractive to live in than others.... There is no unambiguous evidence of a critical shortage of physicians. The distribution of physicians, geographically and among the specialties, is uneven, but is unlikely to be corrected by an augmented output of physicians. Potentially more capable of effecting a redistribution would be a comprehensive federal program of financial inducement....

In any case, surveys have indicated that 38 per cent of the American public believes that "not enough doctors" is the chief reason America's health-care system is in trouble, and the same percentage of doctors surveyed said they considered the shortage of

physicians a "pressing problem" second only to the high cost of medical care.<sup>15</sup> The training of medical students now stretches over eight or nine years. The number of medical degrees awarded annually in the United States did not exceed 8,000 until 1969, but may reach 11,000 in 1973 and 16,000 by 1980. If this goal is met, the generally accepted ratio of one doctor for every 500 people may be reached by the decade's end.<sup>16</sup>

In Britain, because of the NHS support of the general practitioner, specialists are able to concentrate their attention on patients already screened by another physician. This explains why England has fewer neurosurgeons, for example, than San Francisco. Richard D. Lyons of *The New York Times* has observed that not only are there twice as many surgeons per capita in the United States but that they perform twice as many operations as their British counterparts.

### Continuing Faith in Diversity of American System

British doctors and health personnel tend to view health care in America as a maelstrom of ideas, proposals, and conflicting programs. Rosemary Stevens sees the "diffusion of energy and efforts as the major feature of American medical care." Americans, according to President Nixon, are proud of the "pluralistic, independent, voluntary nature of their health care systems" which they see endangered by pressures for "monolithic government medical care." The diversity of choice offered the average patient is presumed to give him a better chance to get the type of care he wants. Given such a philosophical outlook, a single system—no matter how rational or efficient—is probably unacceptable.

Dr. Max Parrot told the House Ways and Means Committee on Nov. 10, 1971, that "the search for a perfect health care system...that encompasses universal access, low cost and high quality is difficult. It is for this reason, I think, that we have developed a pluralistic system of medicine in this country." The cost of such diversity is that today the United States ranks first among the nations of the world in per capita spending.<sup>17</sup> All of the countries with better health statistics than the United States have some sort of national insurance program.

Diversity also means waste. The AFL-CIO publication *Federations* has calculated that the consolidation of hospital maternity and pediatric services into fewer hospitals would free 8,000 beds. Irving J. Lewis, writing in *Scientific American*, concluded that a proliferation of neighborhood health centers and community hospitals, of group practices and even prepaid comprehensive insurance schemes would not suffice unless the parts were structured into an effective whole.

If the United States is to achieve comprehensive health care, as Lewis believes it must, without establishing a unitary national health service as in Britain, "it clearly must create a real health-care system with structure and order." Lewis believes that the solution must be at a personal and family level, through community organizations. This essential layer of middle-level organization, in between the patient and the state or federal authorities, has hitherto been badly neglected.

If the British example is of any guidance to America, it is that the cost of improving health care should not be the primary concern. Sen. Abraham Ribicoff (D Conn.) has complained that "too much time is being spent talking about money, rather than discussing reform of the health system that would benefit the people." There is a widespread fear in the United States that if patients pay virtually nothing for health services, there will be runaway abuse. The English experience has proven such fears to be unfounded.

One point that has been made with increasing urgency in recent years is that the human environment may be as important to health as economics, organization or delivery systems. Many medical professionals have advocated taking a broader ecological view of health. Walter J. McNerney wrote in the *Journal of the American Medical Association* Nov. 27, 1972: "If we are to avoid spending huge sums of money unproductively, we must attack factors such as income, housing, nutrition and education along with improving actual health care services. It is only in such an approach to total health that we shall find the answers to health problems." Robert Bazell took a similar position in a review of four recent books on health care. "That people should continuously indulge themselves in energetically marketed health hazards such as cigarettes and high-cholesterol foods, while seeking relief from both when they see their doctor, is certainly illogical," he said. "But it is no less so than the government's decision to spend millions more on a crash program to cure cancer at the

very time it condones the spew of tons of cancer-causing industrial pollutants into the environment.”<sup>18</sup>

In the field of health care, increased spending has not proved to be the solution for America. The British experience suggests that with reform of the delivery system, more health services of higher quality could be offered at less cost. Any major public insurance plan approved by the Congress will ultimately affect the way the health services in America are organized. In addition, the increase in government spending will inevitably be accompanied by stricter government controls. After 25 years, NHS has proved that so-called socialized medicine need not be bureaucratic, inefficient or even restrictive of individual freedom of choice.

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## Footnotes

[1] The chart on p. 441 showing 7.6 per cent of GNP in 1972 is based on official data which excludes health insurance premiums and administrative expenses of public programs, as well as spending for medical research and hospital construction. When these factors are added, the figure rises slightly above 8 per cent.

[2] Address to the Forum on Medical Affairs, American Medical Association, San Francisco, June 18, 1972.

[3] AMA figures show that dues-paying membership in 1972 was 155,861, a drop of 338 from the previous year. There are about 50,000 additional members who are not required to pay dues. These include physicians who work for the government and those over age 70.

[4] Figures cited by Marjorie Smith Mueller in *Social Security Bulletin*, February 1973, p. 3. For background, see “Future of Health Insurance,” *E.R.R.*, 1970 Vol. I, pp. 61–80.

[5] Quoted by Henry Brandon in *The Washington Post*, Feb. 4, 1973.

[6] See Congressional Quarterly *Weekly Report*, Oct. 21, 1972, pp. 2731–2733.

[7] The Presidential Commission on Health Needs of the Nation, in its 1953 report *Building America's*

[8] See Dr. Stark Murray's *Why a National Health Service* (1911). See also “British National Health Service,” *E.R.R.*, 1949 Vol. I, pp. 23–40.

[9] See “Socialized Medicine in Great Britain.” *E.R.R.*, 1961 Vol. II, p. 583.

[10] “The NHS Whitewash Paper,” *The New Statesman*, April 20, 1973, p. 575.

[11] See “Future of Social Programs.” *E.R.R.*, 1973 Vol. I, pp. 251–268.

[12] See Congressional Quarterly's *Congress and the Nation* (1969), Vol. II, pp. 745, 751–759.

[13] Martin Kasindorf. “Britain's Bedside Manner,” *Newsweek*, Sept. 11, 1972, p. 86.

[14] Quoted in *U.S. News & World Report*, Feb. 19, 1973, p. 53.

[15] The public surveys were conducted in October 1971 and June 1972 by the Gallup Organization for Potomac Associates, a research organization in Washington, D.C. A mail survey of doctors was conducted in December for Potomac by Erdos and Morgan, Inc. The findings are published by Stephen P. Strickland in *U.S. Health Care* (1972).

[16] In *The Case for American Medicine* (1972), Harry Schwartz predicted that America will be faced with a doctor *surplus* by 1980, although he said maldistribution will still be serious problem then. The thesis of Schwartz' book is that U.S. medicine is not in such poor condition as many argue, and that drastic reform “cures” may be worse than the disease.

[17] Mark Pauly, *National Health Insurance: An Analysis* (publication of the American Enterprise Institute, 1971), p. 3.

[18] “I'm Sorry, the Doctor is Busy Making Money,” *The New York Review of Books*, Nov. 2, 1972, p. 40. The books reviewed were *In Critical Condition: The Crisis in America's Health Care*, by Edward Kennedy; *National Health Care: Issues and Problems in Socialized Medicine*, by Ray Elling; *The Biological Imperatives: Health, Politics, and Human Survival*, by Allan Chase; and *Away With All Pests: An English Surgeon in People's China*, by Dr. Joshua S. Horn.



## Special Focus

### Major Health Plans Proposed

**Nixon Administration:** It abandoned the National Health Insurance Partnership Act which it introduced in the 92nd Congress and is now considering two alternative proposals. One would combine government-financed health insurance for catastrophic illness with a federal requirement for private health insurance for all employees, jointly financed by workers and employers. The other would divide the nation into health insurance regions.

**Kennedy-Griffiths:** Establish universal, comprehensive “cradle-to-grave” national health insurance coverage for all Americans. The only limitations would be on adult dental care, private psychiatric care, some prescription drugs and nursing home care. Half of the cost of the plan would come from general tax revenues, 36 per cent from an employer payroll tax and the rest from a 1 per cent tax on income and a 2.5 per cent tax on self-employment income.

**American Medical Association:** The AMA “Medicredit” plan would provide tax credits to help offset the costs of approved private health insurance. The federal government would pay all premiums for the poor and between 10 and 99 per cent for others based on individual or family income. The plan stresses preventive medicine, and includes home health services, children’s dental care and emergency dental care for all.

**American Hospital Association:** AHA supports a bill sponsored by Rep. Al Ullman (D Ore.) to provide comprehensive health care benefits to all Americans primarily through reliance on state and local facilities. Employers would be required to purchase for their employees certain benefits, paying at least 70 per cent of premium costs.

**Health Insurance Association of America:** Provide tax incentives to employers and individuals to buy broad private insurance coverage, with poor and low-income persons covered through government-subsidized state insurance pools. Financing would come from general tax revenues and Social Security. Insurance policy purchases would be 100 per cent tax-deductible if they met federal standards for coverage.

**Senate Finance Committee:** Sen. Russell B. Long (D La.), the committee chairman, has proposed a uniform national health care program for the poor as well as a catastrophic health insurance plan for all those under 65 now covered by Social Security. The insurance plan would be similar to Medicare but without limits on hospital days, extended-care facility days or home health visits. It would be financed by Social Security with a 0.3 per cent tax on employees’ wages and employer payrolls.

**Committee for Economic Development:** The CED, a business-oriented research group, in April 1973 proposed a comprehensive national health insurance program to provide three forms of coverage: (1) Employers would be required to provide insurance for all employees and their dependents; (2) Medicare would be continued for the aged and disabled; (3) and the federal government would extend coverage to those remaining—estimated at about 20 million poor, unemployed and self-employed persons.

### Who Pays for Personal Health Care

Private health insurance	25.9 per cent
Direct out-of-pocket payments	
Private philanthropy	1.4 per cent
Total funds from private sources.	63.8 per cent
Public funds	36.1 per cent

Source: *Social Security Bulletin*, February 1973, p. 221. Data based on the year 1971.

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