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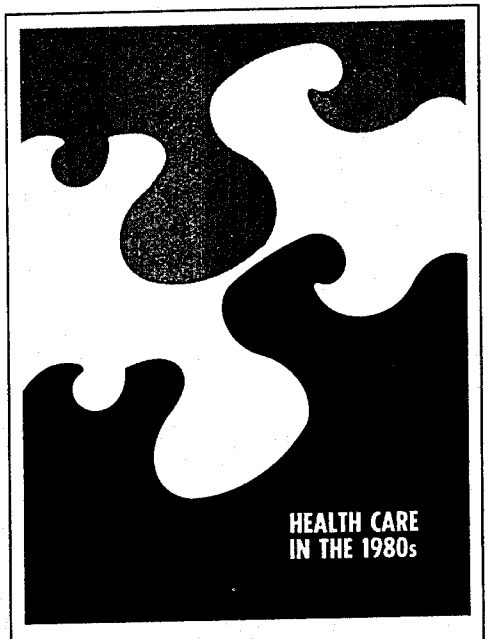


A Symposium

at the

Mid-South
Medical Center Council
Annual Meeting

June 10, 1970

Holiday Inn-Rivermont
Memphis, Tenn.

Participants

Joseph T. English, M.D.
Harold Margulies, M.D.
Eugene Fowinkle, M.D.
Harold R. Sims
Bland W. Cannon, M.D.
Moderator

The difficult task of charting new courses to better health care for citizens of the Mid-South puts the Mid-South Medical Center Council and the Memphis Regional Medical Program side by side in the same battles. In many instances the two agencies work closely together to reach common goals. Publication of these proceedings of the MMCC's 1970 annual meeting is one example of that cooperation.

Making health-care professionals and laymen alike more aware of the issues facing the region and the nation, now and in the years to come, is an important job for both MMCC and the Memphis RMP. Leaders of both organizations felt that forthright comments by participants in the symposium of the meeting would provide an excellent definition of the issues and some stimulating insight into them for professionals and laymen.

We feel that there are no more knowledgeable or more articulate commentators on the present and future crises in health care than the men who accepted invitations to appear on the symposium, Harold Margulies, M. D., now director of the Regional Medical Programs Service, Joseph T. English, M. D., then chief of Health Services and Mental Health Administration, Eugene Fowinkle, M. D., state health commissioner for Tennessee, and Harold R. Sims, deputy executive director of the National Urban League. The symposium was ably moderated by Bland W. Cannon, M. D., Memphis neurosurgeon and a member of the National Advisory Council of the Regional Medical Programs Service.

Dr. James W. Culbertson, program co-ordinator of the Memphis RMP, and Mr. Frank M. Norfleet, president of the MMCC, foresaw the benefit of publishing the proceedings and gave their earnest approval to the effort.

Staff members of the Memphis Regional Medical Program and the Mid-South Medical Center Council cooperated in tape recording the proceedings and in preparing the transcript necessary to the production of this finished documentation of that meeting.

This publication has been edited only when necessary to achieve brevity and conciseness and to eliminate passages which were garbled electronically or when some stray sound made a speaker's words incomprehensible. Occasionally, when garbling or noise interference left the speaker's meaning unclear, passages were deleted rather than run the risk of altering or obscuring his intent. However, in a few instances, a speaker's exact words and phraseology were left undisturbed, even if the precise meaning were unclear, when they helped maintain continuity of comments.

We feel that the end result is a fair and accurate account of the meeting and an important document for the edification of persons interested in health care in the Mid-South and the nation.

—The Editors

Clayton Braddock
Information Officer
Memphis Regional Medical Program

I. A. Metz, Jr.
Director for Voluntary Health Agencies
Mid-South Medical Center Council

"Let's Talk About Money"

Joseph T. English, M.D.
President, New York City Health and Hospital Corp.

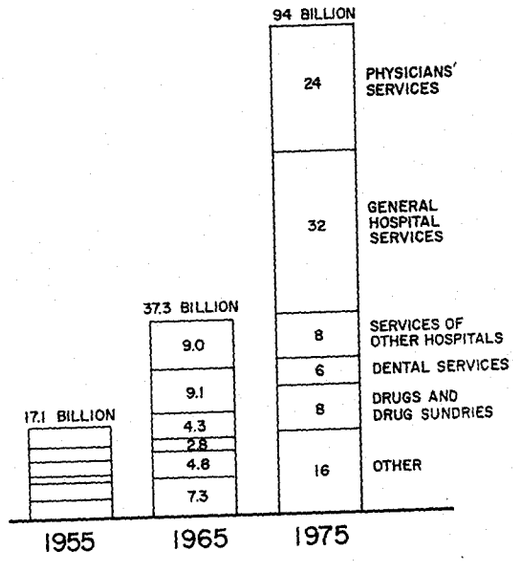
(at the time of this symposium, Dr. English was chief of the Health Services and Mental Health Administration in the Department of Health, Education and Welfare.)

I really treasure this opportunity to share some reflections with you about three areas of problems that I am going to try to state very briefly that I think you need to understand. The resolution of these problems is going to determine, more than anything else, the future of medicine and health in this country in the 1980s. The three problems are: (1) money (2) manpower and (3) some organizational things, that we who are interested in health are going to have to do in this decade if we are going to have any future in the next decade.

Let us first talk about money. (Slide 1—"Expenditures for Health Services and Supplies") Now, to take a very complex subject and try to review it very briefly, I want to show you a slide which reflects the money that is being spent in health and mental health services alone in the public and private sector of our economy; it is both public and private money. The source of this information is the President's Commission on Health Manpower, which produced a report some years ago.

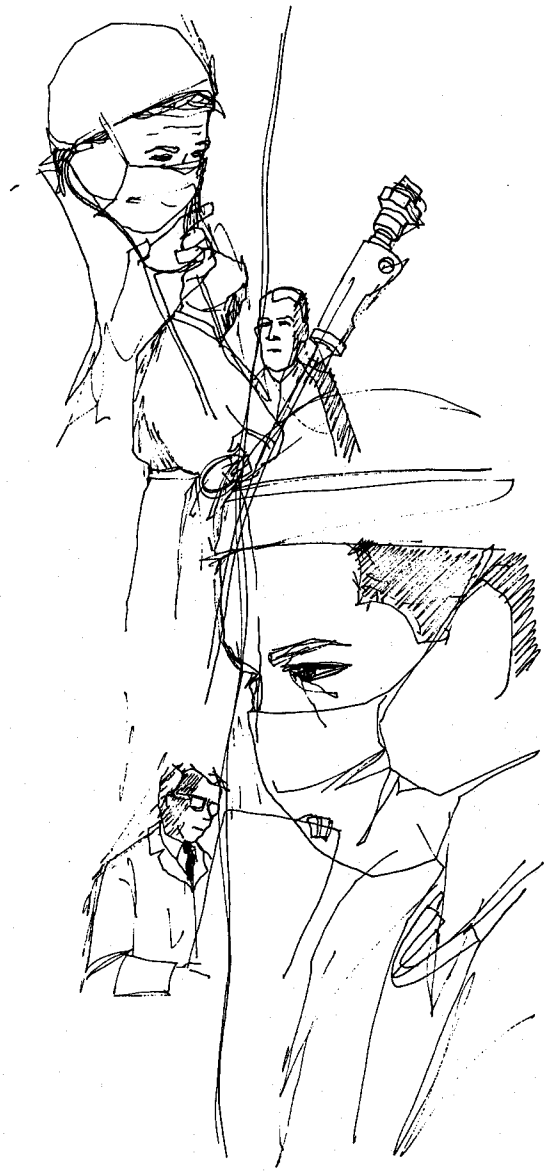
What it shows is that in 1955 we were spending for health and mental health services in this country about $17,100,000,000. Then in 1965 that figure had grown to $27,300,000,000. In 1970, . . . the figure is $62,000,-000,000, which is larger than the national budget of all but a few countries of the world.

EXPENDITURES FOR HEALTH SERVICES AND SUPPLIES



Slide 1

The projection is by 1975, which is only half way along the road to the eighties, that health and mental health services in this country will be close to a $100,000,000,000 enterprise. It now represents six percent of the total gross national product of the wealthiest country in the history of the world. It is now about two percent behind the Department of Defense which . . . is 100 percent public expenditure. You do not have the public-private split in defense that you do in health. Nevertheless, as a segment of the economy, we have already rivaled the Defense Department in size and by 1975 we may be equal to it or slightly ahead, depending on the situation with the war.



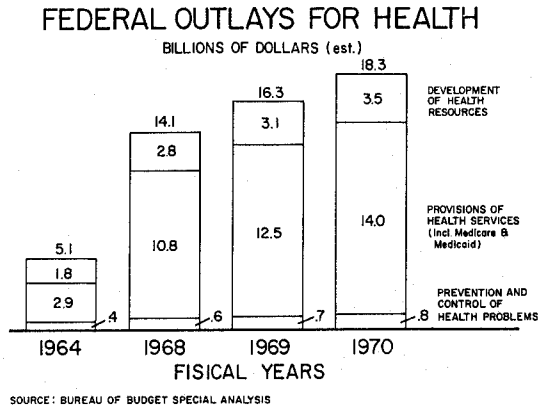
Therefore, one way to look at the money problem—as we are in a period of time when we want to do many things and money is tight—is to see that in this segment of the economy, not doing things for a lack of money is a cop-out, because we are guaranteed growth. Growth in some ways, as we approach the 1980s, is one of the great threats to us in health, for a very simple reason —because our country has been so generous in investing in health. This may not really be enough in terms of the importance of health to the national life of a country to even maintaining domestic tranquility in a country.

It has been said by many observers of countries in development that if you do not meet something as fundamental to life itself as health, that it may be impossible to maintain order in a country. And therefore, we are not first in the percentage of our gross national product in investment in health. There are other nations that percentagewise invest far more than we do and therefore I do not think that we should fear the growth we are going to experience; rather, we should fear the use that is made of that growth because that is the problem.

The thing that is frightening about this projection is the situation that we face in 1970. If there are not major changes in the way in which this growth is handled, we could find ourselves in 1975 worse off in terms of health and mental health services to the American people—the quality of health and medical care provided to the American people in 1975, despite nearly doubling of the investment that the total public-private sector puts in—than we are in 1970. I do not think that any of us would look forward to the decade of the nineties where, despite the tremendous growth of the sixties and seventies, in spite of that growth, people ended up less well served than they were in mid-1970.

Now, to get some understanding of how we can face that dilemma, I would now like to put the bee on the federal government, which shares responsibility for this pickle that we are in. And the next slide (Slide 2—"Federal Outlays for Health") concerns the nature of federal expenditures from 1964 to 1970. It is a small part of the $62,000,000,000 enterprise but a very significant part; and my own feeling here is that until very significant changes are made within the federal expenditures, it is going to be impossible for the total public-private sector of health in this country to get out of its present pickle.

Now let us first take a look at the way these expenditures have grown, because they have grown rapidly between 1964 and 1970. You can see that the federal share in 1964 was about $5,100,-000,000 and in 1970 it is up to $18,-300,000,000. There are not many segments of the federal economy, other than the Department of Defense, that can show that kind of growth in a relatively short period of time. So to begin to understand the problem, you have to see where the growth has been. But even more significantly, where the growth has not been. If you have binoculars in the back row, you may just be able to see a little brown line here which represents the investment made for the maintenance of health, the prevention of disease, and the control of health problems. It was .4 billion back in 1964; it is now .8 billion, but you know that is not even a real measure of growth because when you take into account what a health dollar is worth in 1970 as compared to what it was worth in 1964, you can really see there has been almost no growth at all. I consider that to be one of the serious problems which, if we do not face it in the seventies, is going to give us an incredible dilemma for the eighties.



Slide 2

". . . until very significant changes are made within the federal expenditures, it is going to be impossible for the total public-private sector of health in this country to get out of its present pickle."

Number two, if you look up at the yellow box, you can see the money that the federal government invests in basic medical research, in manpower production, in developing the capacity of the American health care enterprise to better deliver the excellence of American medicine and to be able to better deliver health care to the growing and pressing demand the 200 million people are making.

If you take a look at the growth that has occurred between 1964 and our support for developing the capacity of the American health care enterprise, to better serve the needs of 200 million people, again you do not see significant growth there. That is why we have a manpower shortage of physicians, nurses, and paramedical people. It is why we do not have the resources for the hundreds of experiments that medical societies, hospitals, group practices, physicians and other medical purveyors in this country would like to do to make the delivery of medical care more effective in this country in places where it is not, without necessarily diluting the quality and the excellence of medicine that we have learned how to produce in this country.

If you take a look at the federal investment for the development of health resources to better serve the growing health needs and the growing awareness of their health needs of the American public, you can see that there has been very little growth at all, even without taking into account the inflationary impact on the health dollar because the strategy has not been correct. Three and a half billion dollars is not very much for the development of the American health care enterprise within a $62,000,000,000 industry.

So therefore, the question is where has the growth been? As you can see, the growth has been largely in those sums of money which the federal government provides to pay for medical services but which do not necessarily help the purveyor increase his capacity to meet a growing demand. This is largely Medicare and Medicaid and, in the private sector, other third party payments. It is the money that is putting the pressure on a very limited capacity, a capacity that is inadequate to meet the needs of 200 million people.

Where we are going up in cost to the American public from six to twelve percent per year, it leads to dilution of quality, because a physician has to take care of five times the number of people because there are not as many doctors as there were before.

When you consider the strains that the hospitals are under, you begin to see what happens to the quality of care. Then thirdly, most of the resources go to care of the patient after he needs to be between the sheets and a very pittance of our total investment is going into the prevention of illness and in the maintenance of health.

But we have not yet seen the federal leadership that is going to be required first in the federal sector to reverse this absolutely elemental disproportion in the investment we are making in a rapidly growing segment of the economy. And it seems to me that until that begins to occur, it is going to be very difficult for the private sector of health in this country to help with the total problem that we are going to face in the eighties. And I think that is indeed why there is a crisis in medical care.

Now let us go to the next slide—manpower distribution (Slide 3).* This begins to get us into the second problem . . . which is manpower. Now I have chosen an illustration which I do not think will surprise any of you. It shows what has happened to the mythology of the mainstream of American medicine over the last 25 years.

Part of the reason why most of the federal investment is trying to buy people into the mainstream was because back when that term first was used, there was a mainstream of American health care. But there have been dramatic changes in the last 25 years that present federal policy has not yet taken into account. In a 55-block area in Harlem 25 years ago, for 25,000 people there were 50 practicing physicians attempting to take care of them, most of them being in the general practice of medicine. Look at the dramatic

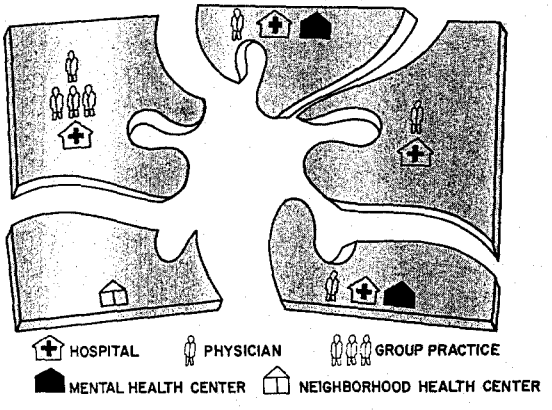
change that has occurred today where twice the number of people are living in that area, and there are now only five physicians there. If you look at who those five physicians are, you are going to find that they are, in general, older men and there are no younger men coming in to take their place.

You could give countless illustrations of this in most of the cities of our country. You could show it in poor rural areas too, but the next slide indicates that it is not just a problem of the poor; it is a problem of some relatively well-to-do areas in rural parts of our country as well. It is a problem that goes beyond socio-economic parameters. (Slide 4—"Physician—Population Ratio, 1943")*

This concentrates again on physician-population ratio in the urban core of our cities in 1943. Back at that time, the ratio of doctors to patients, potential patients, was 1 to 500 and out in the suburbs in 1943 it was 1 to 2,000. Take a look at what happened as early as 1968; the change was dramatic. You have a situation now where in the urban core of our major cities that ratio has gone from 1 to 500 to 1 to 10,000 and you now have a situation in the suburbs where it has gone, in that same period, from 1 to 2,000 to 1 to 500.

Just as the money problem is not simple, which I think the former illustrations tried to show, it is very clear that the manpower problem is not simple either. It is not just a question of producing more doctors, more nurses, more medical personnel of other kinds; it is a question of how, in a free and democratic society, we get those medical personnel and those medical facilities to the places where they are needed. And I again want to emphasize that this problem is not just in poor areas of our country, but in a great number of relatively well-to-do rural areas where you have the same kinds of changes going on.

Let us move on to the next slide now (Slide 5—"Physician-Population Ratio, 1943")* and just take a couple of minutes to try to project a little bit into the future what may have to happen by the 1980s if we are not going to see . . . federal medicine—government medicine, whatever that is. Because if there are not basic changes, if we keep investing more and more money in health, as we are at the present time, without the consumer, without the citizen seeing his medical care or health care improved as a result of that, the consumer outrage is going to produce a situation in the Congress that is going to convert us very rapidly to a public utility or to a federal form of direct medical care as has been done for the Indians and for other populations. I think that would be tragic in this country.



Slide 6

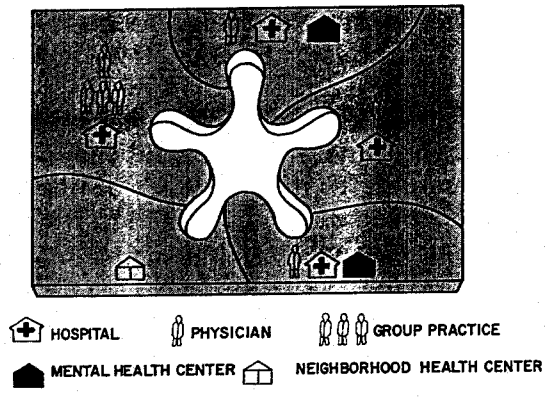
Now what are some of the things that are going to have to occur if we are to avoid unfortunate outcomes of this crisis? (Slide 6—"Community Puzzle of Hospitals, Group Practice, etc.")

The first thing I think you see evidence of is a variety of groups, representing the purveyor and the consumer and the teachers of medicine and the people

*Slides 3, 4 and 5 not reproduced for proceedings.

interested in medical research, coming together and recognizing that in one area of a community there may be no doctors at all.

This would be the case right here (referring to slide) and that might be the

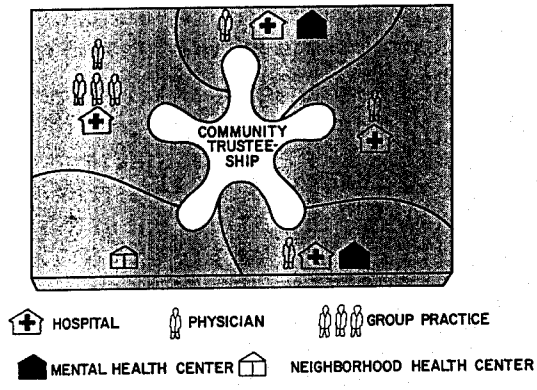


Slide 7

reason why, through some federal effort or some private effort, something like a neighborhood health center is started to try to re-attract physicians back into that area and to put them together with paramedical people that extend the hands of the relatively few physicians. In other parts of the country we may have a group practice in a hospital. Way over here (referring to slide) there may be a mental health center in a hospital and just a few solo practitioners. Over here there may be something else. But it is very rare, in most parts of the country, that there is any public-private institution developed to survey that whole scene and to try to figure out how to make the best use of the resources that are there, the new resources that need to come in, be they public or private.

We have not yet seen that institutional development in this country and it is really through Comprehensive Health Planning and the Regional Medical Programs that we are beginning to see the start. So I would suggest that by the eighties, if these programs are given the priority which they should have, in . . . what is already a $62,000,000,000 enterprise, this will help turn those dollars into better health care for the American people. If that does not happen, then I think we are going to be in difficulty.

I would hope that we would begin to see a variety of different ways of coming together at the local level, as we see being done here (on slide diagram) to see how those pieces can fit together more effectively, whether they are through an areawide health planning agency, a Regional Medical Program or cooperation between those two programs and other efforts. This is something which does not yet exist in this country in health: a community trusteeship—a coming together of the



Slide 8

public and private sector at the most local of levels where the citizen mandate is there with the community, where all segments of the community are represented—the taxpayer, who supplies the money increasingly for these services, and also all of the purveyors, too.

My conviction is that, though the responsibility of those in Washington is great, the real difference is going to be made by the initiatives you exert right here at the local level to do some of the most elemental things that need to be done if we are to be optimistic about what we can do in health, perhaps one of the most important dimensions of the quality of life in our society in the 1980s.

"Cost of Service vs the Value of Care"

Harold R. Sims
Acting Executive Director, National Urban League

(Mr. Sims was deputy executive director at the time of the symposium)

I thought as a sub-name I would choose the "Cost of Service Versus the Value of Care." I remember it was said that, "That which is immediate takes precedence over that which is important and that which is important only gets attended to when it is urgent, and then it may be too late."

You know, I am very happy to be here. I feel, sitting here on this stage today, that systems have changed, because when I finished Booker T. Washington High School (in Memphis) in 1952, I don't think there was any less likelihood that a student of the University of Tennessee would be sitting here or anywhere near anybody like me but there was no likelihood that I would get in the University of Tennessee Medical School or anywhere else. I am happy to make that note.

When I attended high school in Memphis during those years I mentioned, I became quite fond of an old Chinese proverb which followed me through the years; I am sure you are familiar with it: "If you would plant for one year," said the old quotation, "plant grapes. If you would plant for ten years, plant trees. But if you would plant for eternity, plant men."

Given the current status of man, woman and child in the American world today, our commitment to planting men rather than things is tragically in doubt. In the face of unprecedented scientific technology and technological progress, we fail to commit and demonstrate our capacity and resources to the magnitude of the problem which we have here at home. Our cities and rural areas are in an ever-deepening crisis, with both qualitative and quantitative defects robbing our children and our youth of the occasional opportunity needed to facilitate their maximum growth and development.

A housing crisis continues to worsen with blight decaying the slums, breeding crime and delinquency in every major urban city. Our living environment is in a crisis, through pollution, poisonous air, dirty water, the rodents rampant and clutter—it is becoming an increasing . . . problem.

Of all the crises we face today, none is more critical or urgent than the growing deterioration of health care and services. For without a healthy body and mind, none of the other crises or opportunities really matter in the marching hierarchy of human needs. Now, this health-care crisis in our age expresses itself in many insensitive and ironic ways.

Although the statistics are used from a variety of sources during the decade of the sixties, nothing has changed very much to alter the picture. For example, despite spending $62,000,000,000, or 6.7 percent of the United States gross national product on health care in 1969, our life expectancy is still only 18th for males and 11th for females in the whole worldwide rankings. Despite the fact that we have the highest level of medical competence and are expending greater resources for health-care services than any other nation in the world, our ranking again in the world order has consistently declined in the last twenty years, particularly in the area of infant mortality, where we went from second in 1953-55 to eleventh place in 1960 to fourteenth in 1967-1969. As of today, we rank below East Germany in this regard. And as for our black citizens, above all, they rank below Jamaica, Japan, Italy, and Greece—in 28th place on the world order scale.

This factor ought to be particularly important to you here in the South. In 1968, the East-South Central region which included Kentucky, Tennessee, and Mississippi and, I believe, Alabama, had the highest infant mortality rate in America for both races, white and black. Despite the creation and development of a multi-billion-dollar health

insurance industry which collectively took in about 11 billion dollars worth of premiums in 1967, the cost to the medical consumer increased 5.8 percent from 1965 to 1968 alone. For there was only a 3.3 percent increase in other consumer prices without comparable income increases.

During the period of deteriorating services and world standing in health care, despite the critical shortage of doctors and the necessity to "import" to survive, many of America's medical schools consistently complained and threatened to close for lack of funds. The other day in California, people were so insensitive to this great need that they voted down the creation of two new medical schools, despite the critical need.

Despite all the rhetoric of the medical profession of prevention and mainte-

nance, the health-care delivery system of this country is still designed to react rather than preclude, to support socio-economic classes rather than all people on the basis of need. At the present rate of United States retrogression in health-care areas and at the present order of United States priorities, unless drastic changes are immediately undertaken, by the 1980s the United States may very well be first in the race for the conquering and population of barren . . . outer space but last in the race for viable lifeful earth or human space.

The plight of health care today for black America is two to four times worse than white America, although proportionately more black males contribute to Social Security than white males. Given the present mortality rate, the average black man at birth cannot expect to live long enough today to collect his Social Security. Most black families without health insurance, and many with it, are confined to the wards of over-crowded municipal facilities where daily hospital charges are somewhat less than the voluntary hospitals. About six percent of black mothers—eight percent in the South—had no medical care before the birth of their child, compared to only one percent of white mothers—three percent in the South—in a national mortality survey in 1963.

At the same level of income and education, black mothers are more likely than white mothers to have been seen at public medical facilities rather than by a private physician. Both black and white mothers receive little dental care before the birth of a child, although pregnancy is known to affect the mother's teeth critically. Regardless of income, black mothers very seldom see a dentist before childbirth, or they see them much less often than white mothers do; over 90 percent of the black mothers—compared to 70 percent of the white mothers, according to a 1963 survey again—did not see a dentist at all during the twelve months before birth of the child.

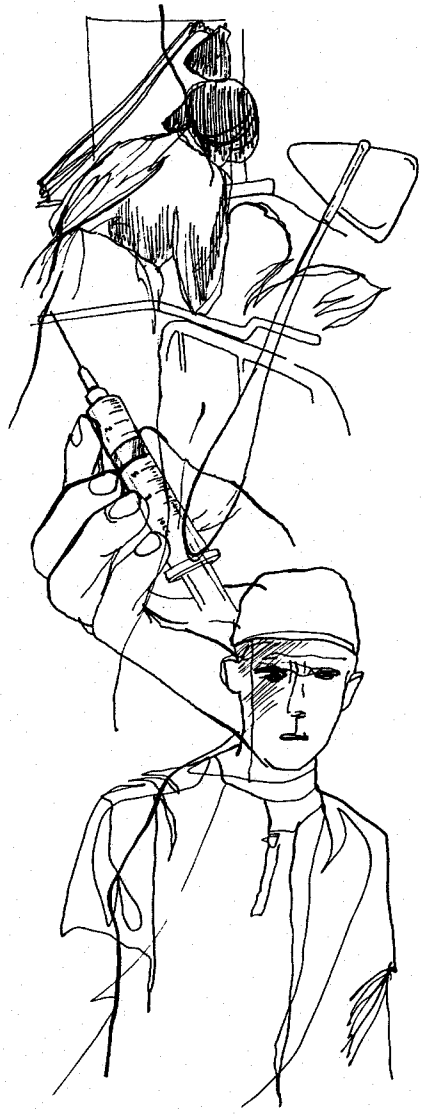
"The plight of health care for black America is two to four times worse than white America, although proportionately more black males contribute to Social Security than white males."

The black maternal death rate is almost four times the white, in spite of the drastic reductions in the last three decades (69.5 compared to 19.5). Life expectancy is lower for blacks than for whites of all ages. In the prime of life, the prime working years, 20-35, black men and women average five years less life expectancy than white men and women. The difference begins to taper off in later years and is greater among women than among men. Blacks have a much higher death rate than whites in communicable disease. Particularly blacks are more than likely to die more often from tuberculosis, influenza, and pneumonia.

One positive note: suicide is more prevalent among whites than blacks and is consistently lower among black women. And someone rationalized this in an article in The New York Times that talked about the psychic advantages of urban life. That may have something to do with it. I do not want to simply re-emphasize the horror but to dramatize the opportunity available to us. I want to differentiate something that ought to be clear to you. I won't elaborate on this because of the time, but do not get too optimistic about the status of white health in this country, because even the optimum average white health care is still much lower than in some Communist countries. And we turn to the relative improvement the whites have made in the last ten years. Really what has happened is that the blacks are moving closer to the inferior level.

Since we did not come here to dramatize the horror that dramatizes the opportunity, let's talk about the planning. An alternate range of strategic planning in all areas may have many controversial meanings, but more practitioners agree it is to plan for and put in place today, which will maximize what we want to happen tomorrow. The National Urban League has recently recognized the critical nature of the seventies. No telling what may happen in the eighties.

We called for a consumer-oriented national health system—a framework which addresses itself to designing mechanisms by which health, as a right and not as a privilege—and we maintain health as a right—can be achieved as a reality for all Americans.



We called for an action-oriented health system with a program and a platform which encompasses all employees of health, health maintenance, disease prevention, medical care delivery, financing consumer participation, training, and education.

In this new system—for maximization in the eighties, and for maximization now—we called for a complete new organization of the health care system of the United States, an organization that would reflect the national health policy which is responsible for the five basic assumptions which I hope to elaborate on during the discussion period.

We also called for a commitment to a system of public education for all categories of the health profession—doctors, nurses, technicians, with a service commitment which can be utilized to provide a more even distribution of health care services.

We also called for the re-orientation of the health care system to help add its maintenance rather than only attending disease and illness. If you will carefully examine most of your health policies and all the things you carry, you will find that they are not designed to help you prevent and maintain yourself; they are designed to react and to respond.

We are calling for a national health insurance plan, which we will also elaborate on during the discussion period. For the final analysis, we agree with the late Walter Reuther, who said: "We call for, plead for, indeed demand a health care system now that will eliminate the waste and the inefficiency of the present non-system, a system moreover that will bring the poor into the mainstream of medical care, a system that can, in an organized manner, begin to bring about the effective use of our health manpower, our health facilities, and our economic resources."

Public Concern and Professional Judgment

Eugene Fowinkle, M.D.
Tennessee Commissioner of Health

Ten years ago I heard Dr. Cannon say, "What this community really needs is an effective planning organization that can develop good appropriate plans for the future development of this medical and health community." We saw the birth of this idea. We saw it nurtured through birth and childhood by Dr. Cannon, Mr. Norfleet, and many of you here in this room and now we have an effective and mature organization and I think we are all justly proud of it.

Public health, as its name implies, is both public and health. Consequently, public health is acted upon both by public forces and by forces which are generated from within the health industry. One important and profound public force which is influencing us now is that all institutions, agencies, systems, traditions, or even individuals, are on trial now by society. We are being tested continuously for our validity. The American health system now is certainly on trial and is being tested for its validity. I think in the 1970s and on into the 1980s the system will be tested. The various components of the system will be contested for validity and some replacements and changes will doubtless be made. This phenomenon was put very nicely by a well-known physician: "These are days of deep dissatisfaction. Cries of dissension and loud demands for change fill the air. Nothing is fair—government, the press, industry, labor, religion, the educational system, philanthropy. Nothing! An uneasy concern blows across the land and around the earth, already shaking all the leaves and already some worthwhile mighty trees have fallen. Necessarily caught in the relentless movement is the field of health, with all its various manifestations, its professional schools, its established disciplines, its traditional programs, its time-honored approaches to planning, public relations and service." So what he is saying and what I'm saying is that we are on trial. We are being tested for our validity. I think we will see many aspects of our health system strengthened by the existing testing process because a number of those components that are not valid will fall by the wayside.

Another public force which has had a profound effect upon the health system is, of course, the social mandate that

was referred to by Mr. Sims, that every American citizen receive essential basic health services regardless of his ability to pay. This mandate has been read out in a number of ways. Some have read this to mean that every citizen should have gold-plated health care; others say every citizen should have token health care. I think, in general, what we hear is that every American citizen should have at least essential basic health services. This social mandate has manifested itelf in a variety of ways. One is that it has produced, in the mid-1960s, two of the most profound health legislative acts in American history. The health system is staggering under the weight of this socio-political decision now and will continue to wrestle with it through the 1970s and hopefully will find solutions as we go into the 1980s.

Another public force or influence which is acting upon the health system of this country and which is a corollary to this social mandate is involvement of the federal government. This was pointed out to you very clearly by Dr. English. The question used to be, "Will the federal government involve itself in the health industry?" but the question now is, "How will the federal government involve itself in the health industry?"

As I see it, there are two major alternatives. One is to socialize the system, to put health providers on federal payrolls and develop national health programs as some of the European and Asiatic countries have. I think that few clear-thinking Americans at this time think that this is the best way to provide health care for the citizens of this country. Built in and ingrained into our very way of life is the quality building, quality maintaining, private enterprise motive that exists not only in our health system but in our entire economic structure. The other alternative to federal involvement in the health industry is federal subsidy to the existing health system.

"Built in and ingrained into our very way of life is the quality building and quality maintaining private enterprise motive that exists not only in our health structure but in our entire economic structure."

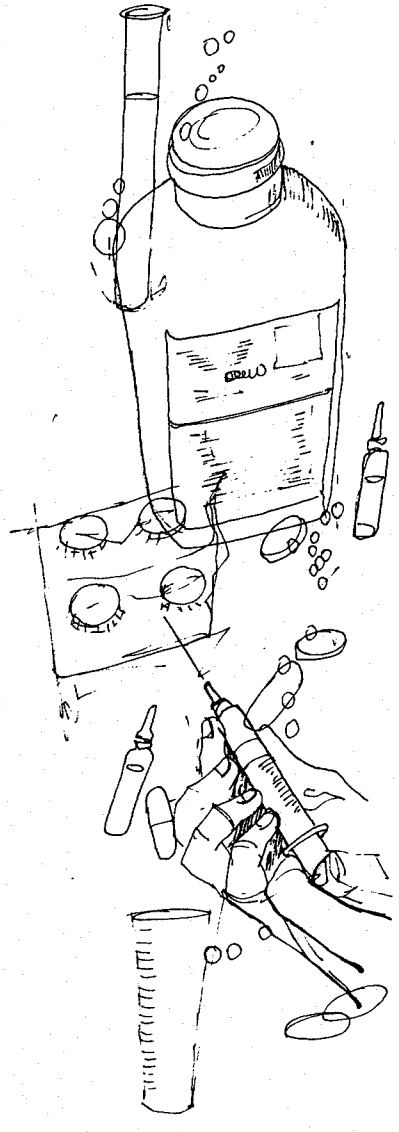
This, in fact, is the present trend, Medicare and Medicaid being the two most profound examples. As you know, they provide buying power to individuals who can then go to the private market if they so choose, and purchase their health care just as any other individual. So the present trend is federal subsidy to the existing health system, both private and public. I think that we have to say, however, that there are some red flags waving.

Another powerful public force which is acting upon the health system, especially on public health, is the public demand to stop further deterioration of our environment. During the ten years I have been in public health, I have seen a variety of levels of public interest and concern on matters related to health. However, I have never seen any reaction of the public to any matter related to health as strong and as intense, as enthusiastic as the present expressions of concern about our environment that are now being given to us. We have a very strong signal from the public that further deterioration of our environment is to stop. Public demand is here; it has not always been here on the environmental problem. Ten years ago I heard the surgeon general of the Public Health Service warn that this country is headed toward serious environmental health problems. However, at the same time, he predicted that very little would be done

years because of the lack of public concern. We have public concern now—but just how adequate to develop adequate environmental quality control. Although public concern and public demand, whether they relate to the environment or to the predicament of the present health system of this country, are important and essential, they must be tempered by professional judgment.

One of the greatest problems which we are going to encounter in the 1970s is dealing with the public clamor that now exists about our health system and about our environment. This is important but yet perhaps it is being overdone.

Let me illustrate. A few weeks ago our Apollo 13 space ship got into trouble



and the immediate response of 200 million Americans was to say, "turn it around, bring it home." This was an expression of public concern that we wanted our people back home safely, but it was tempered with professional judgment, in that the men at the controls in Houston realized that if they were to try to turn the ship around immediately and bring it back, it would be destructive to the people that it served. So with the intent of getting them back, they used the momentum, the forward motion, that the ship had, but they guided it on the proper course. They made periodic and frequent adjustments to it, got it on the right course, and steered it back home safely. Public concern was there, but it was tempered by professional judgment.

There are those who say, "Let's completely do away with our existing health system and start over." There are those who say, "Let's immediately solve our environmental health problems." I think this will have the same effect as trying to turn the space ship around while it is going away from the earth. It would be destructive to the very people that we are trying to serve. I think we must temper these expressions of public concern with professional judgment.

So in summary, I do think we need public involvement. We need public criticism. We need public participation in policy decisions in the health industry. But yet I hope we can have the ingenuity, the knowledge and the strength to temper this appropriately with professional judgment so that we do produce the best possible product for our consumer in the 1970s and into the 1980s. Comprehensive Health Planning brings together, at interface, the public concern and the professional knowledge and experience and judgment. So I think CHP is one of the best tools that we have to achieve the task that lies ahead of us in this decade.

Making Hard Choices

Harold Margulies, M.D.
Director, Regional Medical Programs Service
(at the time of the symposium, Dr. Margulies was acting director of RMPS.)

You've heard a number of things this afternoon which are pointing toward what may be our health-care system or our health-care problems in the 1980s. But because I have to deal with them in a very direct fashion, I think I am going to have to be a little more explicit. We have heard problems and I think I can add to them, but I would like to balance up the record very quickly and point to some of the things which I think are going to occur and make it as clear as possible to you that the answer to the question of what medicine will be in the 1980s is not at this table. It is in this audience. And I don't think you quite begin to recognize that fact.

Dr. English told you some things that the federal government has been doing, which he thinks it should not have been doing, and he pointed to a certain level of inexpertise in the federal government from which I am sure he exempted me and himself. I feel confident about that. But I would like to point out, just to balance what we are talking about today, what has gotten us into the kind of situation which he described and with which you are familiar.

Because I have only briefly entered federal service, I think I can look at it with that kind of a perspective. What has happened since I finished medicine at the University of Tennessee? In those years there has been a rapid increase in the use of hospitals, a rapid increase in specialization, a rapid increase in physician concentration and nurse concentration in certain areas and abandonment of others, a rapid rise in the cost of medical education with a disappearance of private sources and funds to pay for it, and a rapidly increased dependence upon allied health manpower, all of which you are familiar with, none of which was created by federal government or any other kind of government. These were the products not only of the medical professions but of the public.

At the present time—and I think Mr. Sims' presentation is fairly characteristic of it—we are still not able to narrow our purposes down to what it is we really want. We have a whole kaleidoscopic range of interests saying we want this, and this, and this, and this, meaning we want everything all

at one time and not really being able to settle down on exactly what we will give up in order to get what we really want. We hear the usual range of more physicians, more allied health people, more hospitals, more acute care, more chronic care, more preventive care, and so forth. What is it that we are really willing to bargain for with the six percent or eight or ten percent of the gross national product we are talking about? I think this is going to get settled, and I think it is going to be settled before the 1980s so what occurs then is really the issue of the 1970s. And more than that, it is the issue of the next three years.

I believe we must recognize the fact that, despite the interest of the people at this table and the interest of those who are in the audience, concern with health care in this country is still marked primarily by apathy. This is true of the medical profession and all levels of health skills. It is true of the public in general. Look at any general survey of the major issues which people spontaneously bring up and somewhere . . . they will talk about health issues. This will change. It will change as the political climate of this country is progressively changing. Because, in this decade, the issues are going to move away, as they already have, from those we are familiar with, to those with which we are becoming increasingly familiar.

They are going to have to do with such things as peace, as something we believe in, and for which young people are going to prefer candidates. They are going to have to do with education available to everyone—all colors, all areas, all creeds. They are going to have to do with decent housing which is currently not available and which is disappearing even more rapidly than it is appearing. And it is going to have to do with health. And in this decade, the issue of health is going to rise to a major political issue, and I mean political with a small "p" as well as with a big "P." And what happens as a consequence is going to be a reflection of how successful the present efforts are to do something about the health care system.

We are lacking certain kinds of basic ingredients. One of the ingredients we are lacking is an understanding of what it is that we wish to have as our major priority. And our choices, because this is going to become political, and increasingly federal and increasingly governmental in the payment system, our choices are going to be tougher and they are going to be a combination of political, fiscal, and moral choices. What are they going to be?

We are going to have to decide on whether we are going to preserve the life of 85 year olds or preserve the life of eight year olds. We are going to have to decide whether we are going to put all of our efforts into acute episodic care for people who may or may not die or put them into the maintenance of health. And we are not going to have the opportunity to do both. Because in the next three years the problems which we have been describing here today, which Dr. English laid out for you very effectively, are going to get worse. Our health manpower shortages are going to be exaggerated. The costs of medical care are going to go up. The deterioration of hospitals is going to be accelerated. Access to medical care is going to be unimproved. Medicaid is going to be as paralyzed as it has been in the past and have very limited benefits for very limited numbers of people. And the agony will increase progressively until we are ready to make the kinds of political judgments about what we really want out of this health care system and what we want to purchase with our money.

And then some things are going to occur. If I had more time, I could sketch for you, I think without much difficulty, a logical conclusion about where we are going to be very quickly. If I did that and ran through the range of things that have happened these last ten or twenty years, I would come to this

"There is still a reluctance in make the choices, the hard choices between what is obvious and visible and exciting and what is much less attractive like preventive medicine, health maintenance, and the whole concept of planning for the total community."

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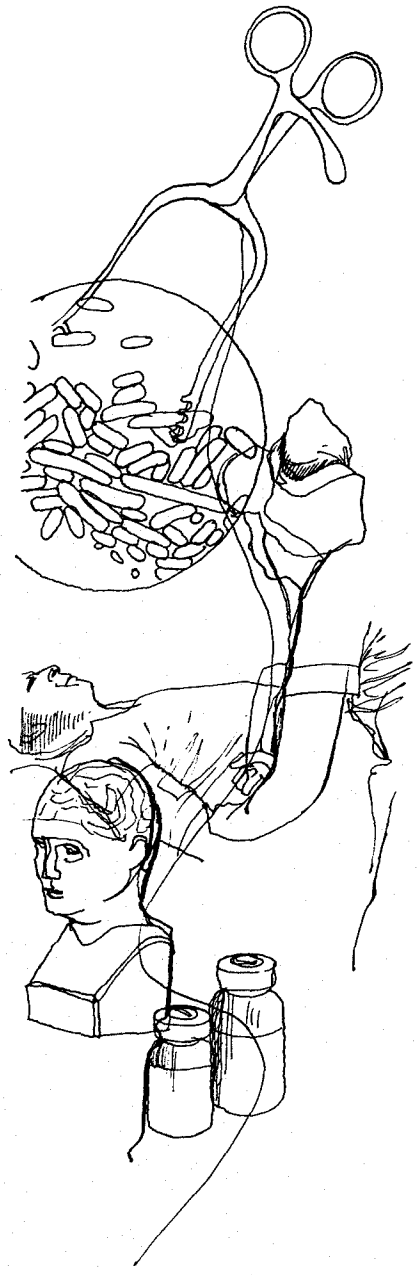
conclusion: That the high cost of medical care, which can be increasingly identified as being from federal sources, is going to lead to an increasing demand that we have a measurement of what we are purchasing. And one of the rising issues before 1975 is going to have to do with the quality of medical care which is being purchased by federal and private money. And this is going to produce some profound changes in attitudes.

Public hospitals which currently provide miserable medical care for people because they are indigents are going to have to face the fact that this care is unacceptable. Payment systems are going to identify the difference between good and bad care at levels of sophistication which none of us feels ready to take on. Now the government is well aware of this; you are well aware of it. The federal system is lunging in a number of directions trying to decide how we are going to cope with this very difficult problem. Of the total increase of over one billion dollars for this next fiscal year in health, 83 percent is going for Medicare and Medicaid, merely meaning paying more money without any increase in the access or quality of medical care. This is an uncontrollable cost which at the present time is strangling all other efforts.

Now you know that one of the things which has been going on in this country is an attempt at some kind of decentralization. The federal government has said to itself, "We really can't handle this. It is too big for us. The problem is out there; the solution should be out there."

On the way down here on the plane I read an article by Dwight Ink, who is one of the leading budget managerial theorists in the country and in the federal government. He described a variety of basic ways in which the political process is going to move toward the solution of problems which have become too central and must be decentralized. It intrigued me that he did not identify the very special quality of the Regional Medical Programs in this country. Because of the whole federal system, they have remained unique. There is no arrangement available to any branch of the federal government which allows for a federal-private mix to identify problems, to attack problems, and resolve those problems. This is the one option in the health system which remains open as an effective mechanism for dealing locally with local issues.

Now since I have come into the Regional Medical Programs, and I knew it well before that time, I have been even more impressed with the very special character of that activity, not only for the health field, but as a measure of what kind of mix we can maintain between federal and private efforts and skills and talents to produce a desirable result. I have to say that what I have seen so far in . . . those programs is not very exciting. I have seen a range of activities which continue to reflect concepts and priorities which are already



out of date at the time they are initiated. I have seen very little real integration of the concept of planning totally for the total population on one hand and total response and total conflict from the professional side on the other hand.

Regional Medical Programs by itself is a totally ineffective instrument. Comprehensive Health Planning by itself is a totally ineffective instrument. They are so interdependent upon one another that the failure to recognize that interdependence constantly astonishes me. And unless there is a way in which these two can serve total community needs, can reflect federal thrust, can be responsive to consumer interests, unless these two can do it, then clearly they will have to be abandoned in favor of something which is much less likely to be successful.

Now what disturbs me about it more than anything else is that it is new, it is fragile. It represents, in its essence, the best of the American genius, which is the capacity for people of different kinds to work together toward a common purpose within their own community, But there is still reluctance in making the choices, the hard choices between what is obvious, and visible, and exciting and what is much less attractive like preventive medicine, health maintenance, and the whole concept of planning for the total community. Because these choices are ones which people are reluctant to make, I have my own skepticisms.

Now I can pledge to you that so long as I have the responsibility for Regional Medical Programs and have the access I have to thinking about Comprehensive Health Planning, research and development in the medical area, so long as I have that responsibility, I will do my best to bring these functions together because I am confident that if what we are trying to do now is not successful, it will be replaced by something else and in the course of time will have to start all over again to create what is now Regional Medical Program and Comprehensive Health Planning.

I also recognize the fact that they are young and have had very little time to find out whether or not they can work. In the same moment I must tell you that there is no time left to be deliberate, to be doubtful, to be hesitant. If you mean to make this area, the Mid-South, an area which the whole nation is looking at, one in which people wish to live because health care is available to them at a good quality level, you will have to work vigorously and effectively and with a kind of humility which is essential to good community activity.

QUESTIONS AND ANSWERS

DR. ENGLISH: Let me read two of the questions that I have just received: **"Who really makes the health decisions at HEW? Concurrently, why is health receiving the short end of the stick at HEW? Dr. English, you implied that the White House should have an advisor in health. Could Robert Finch fill that role? If so, will he be asked to do so?"**

I think they are very good and pertinent questions and, not necessarily sticking with the tradition of federal bureaucrats, I will try to be direct, honest and most responsive as well as brief in my response.

Who really makes the health decisions in HEW? The big decisions are not made in HEW. The big decisions have been made in the White House. Part of the reason that poses a problem is that the nation's top health officer is excluded from the decision-making process in the White House. He has publicly lamented that fact on numerous occasions. Who makes the decision in the White House is very difficult to determine, except to say that in this situation it is almost without precedent. No one within the White House is presently assigned that we know about to the $62,000,000,000 enterprise which health and mental health services now is in this country. Regardless of where the decisions are made, I do not think we are going to see progress in the crisis in health care in this country until, within the place where the decisions are made, someone is assigned the responsibility for knowing something about this critical area of the American economy.

And now the second part of the question: "Will Mr. Finch's going to the White House as counselor to the President help with this?"

I must say that all of us are terribly optimistic that he may be able to help. Others would point out that if he had difficulties as Secretary, will it really be different as he joins the White House staff itself? I would say that most of us retain great optimism, because the Secretary understands these problems. We hope that he will be helpful. I doubt that he would become the President's health advisor. I think he realizes the greater need for expertise. Hopefully, he may be able to get the nation's top health officer into the White House decision-making process where up

until this time he has been excluded, the reason being given that he is a physician and a physician in those councils could not be objective: he would be an advocate.

DR. CANNON: Dr. English, I think I should ask you one question for clarification. Some people might associate the White House as meaning President Nixon. I think you ought to give some clarification to that, because really it may be a different ballgame than is perceived by your comments. I do not want to put you on the spot.

DR. ENGLISH: No, I am delighted to be on the spot. These are times when a public official should be on the spot and I am delighted to be in that position. I do not think that this reflects the terrible problem of any president during times when the national crises are too numerous to mention, when his attention is focused on many things. With his dependency on the people that both control access to him and advise him, I think that the President would be far better served if there were someone, recognized by the departments of government, by the professions in this country, by the consumers who are interested in health in his own house, in the decision-making process, to insure that the President gets the advice of the nation's top health officer.

MR. SIMS: I have several related questions here: **"What are the four major items that you observed during your talk to be the top items to be considered in health care for the future? How do you think that compulsory national health insurance should be financed?"**

First of all, let me explain something. Perhaps I am the consumer up here, in terms of my actual involvement. If you give a little credibility to what I am saying, I am from a very successful family of purveyors. I am from a family of doctors and teachers. I have lived around them all my life. Secondly, the input through the National Urban League is rather unique, in that it brings together, if you will, the "establishment" of the people. The recommendations come from people who are eminently involved in the medical field. And we developed our position on our thorough examination of the AMA draft bill on health care and health-care insurance, the AFL-CIO proposal, the Griffin Bill, the Jackson proposal, the Committee for National Health Insurance, the Rockefeller proposal, and a variety of taxpayers' proposals. I also want to emphasize that we are not talking here about socialism. I think that the Urban League is committed to the democratic process and we have committed to the process a surge of people, as well as machines and things. So all that concerns you is delivering this kind of thing.

Perhaps if I can read in full as quickly as I can the position of the Urban League on health care and health insurance, I may answer a lot of these questions. We called for this reorganization of the health care system, which did not mean so much throwing out as better utilizing. Our aim is not so much to provide for new kinds of costs, although we believe it is inadequate cost effectiveness to the American people, to the consumer, to bring about a greater value for the current medical dollar. And the five assumptions we talked about, in reference to what health care, or health care policy, or the health care system ought to contain, are:

1) That we believe a national health system should be conceived and function to meet the needs of the consumer and provide opportunity for appropriate consumer participation and control of the system that will serve him. More consumer-oriented than provider-oriented system. The current system is mainly oriented toward the provider. The consumer should have something to say about his health and the health care of his children.

2) The national health system should be oriented toward health and its maintenance rather than simply disease. This involves prevention and distribu-

tion, not simply reaction. For example, how many health care policies pay for your annual physical, which may be critical to your survival? We say the fee-for-service concept is not acceptable in a health care system in which the basic concern is for the health care needs of the consumer. The elimination of a fee-for-service principle will be useless without the development of interrelated positions of health professionals, the redefinition of roles and tasks, and a reorientation from disease to health care.

3) And we assume, and we say, that the health care system must be designed to provide an even distribution of comprehensive health care services in all communities, irrespective of their racial and their economic base. A system of tax-supported public education with a service commitment for all health professionals is essential to achieve an equitable solution for manpower needs. It is inconceivable that America would value its soldiers more than it values the people who make those soldiers possible.

4) The general tax revenue should be the source of financing for universal health insurance. Economists say, "While the social security mechanism . . . can be perhaps modified, a progressive taxation method is preferable." We do not see this costing you about the same money for better services for all people, irrespective of your age or economic status. A major concern of ours or any national health insurance program is to place a significant emphasis on the improvement of the geographical distribution of health services. We say that national health insurance must be committed to the development of a single health system without social or racial discrimination. We oppose reimbursement formulas and the utilization of private insurance carriers.

5) We support a system of public financing, including stipends, for education in the health professions. Such public financing would make inherent a community service obligation and is based on the premise that all members of society must have equal access to education in the health professions for which there will be in turn an obligation to that society. We feel that some form of funding for health profession education must be an essential criteria of any national health insurance program.

DR. FOWINKLE: "What part should a real group practice play in the 1980s?"

Until the mid-1960s, the major problem of entering into the existing health system was the financing. As Dr. English indicated, the big input into the financing of health care has been in the area of providing service or financing. We have somewhat overcome the financing problem and have overdone it so that now we have put on the health system such a tremendous demand that it is overwhelmed and is producing predictable results.

If you overwhelm any economic subsystem with an excess demand which has taken the form of some $12-14,000,000,000 of new buying power within the past half decade, you can predict that you will get an increase in cost and a decrease in quality, and an increase in consolidation of bigness or institutionalization. And this has, of course, occurred in the health care system. So what we have now is not a financing problem but a capability problem, as Dr. English said.

Group practice fits into this question in my opinion as being a potential solution to part of our capability problem. We have a number of capability expanders. One is Comprehensive Health Planning. Anything that can make our system more efficient in delivery will expand our capability. CHP would be one of them.

Another important capability expander is operations or systems or administrative research. I think group practice should be classified at this point in history as a research endeavor. I would hate to see group practice implemented totally and widely without an adequate

period of testing. I am afraid that we have run into the same types of unexpected problems that we did with Medicare and Medicaid. So it is a thing that needs to be totally researched and is being researched in many areas. It does many things to the delivery system. First, it changes the mechanism or organizes or systematizes the mechanism of entry into the health care system. Furthermore, it carries the individual in an orderly fashion through the system in accordance with need rather than in accordance with the perceived wants. It changes somewhat the motivation and control of utilization. I consider group practice at this point as a very good idea in concept that needs to be further tested, applied on a fairly large scale—and it is, in fact, going to be—before it is totally implemented in delivering health care in this country.

The next question, in short, asks:

"We cannot hope to get enough physicians produced in the next few years to meet our physician manpower needs; consequently, we will have to use 'physician-expanders' of some type. How will these physician-expanders be accepted by the public and by the medical profession?"

I think they would be accepted both by the public and by the medical profession, provided certain things can be done.

You know, when you go to a bank, you do not always expect to see the president and do not always need to see the president. Your needs can be taken care of very adequately by another type of individual. When you go for health care, the same situation can and probably should exist. However, there are certain medical, legal and technical problems that make this very difficult and somewhat impractical in many instances. I think we are moving rapidly now toward surrounding this concept with adequate medical-legal support with standards, licensing, and definition of specialties.

Many physicians are using the concept without the medical or legal definitions. There are some question marks around this, but I think through practice we are developing a trend which will make the legal aspects of it much easier.

DR. MARGULIES: Some of the questions I received are also on the subject of health manpower. Let me lump them together and pick up what has already been said; and then there is another explicit question which I will address in a moment. In order to do that, I think I should retreat back into the 1980s because I was not specific enough when I spoke earlier about the way I think things are going to be. For one thing, I believe pre-payment systems probably will be fairly universal by that time. Secondly, I want to remind you that we have been addressing certain myths up here and some of those myths are going to be examined even further.

A myth we did not speak about is that biological research necessarily means better health care. We found that was not true. The second myth was that if you increase the ability to purchase care, the system is infinitely expansible and can respond. We found that is not true. And the third one, which we are getting into a better understanding on, is that increasing the number of people available to provide medical services is the way to overcome the manpower shortage. That is pre-eminently false. If you are to trace an investment in the education of a physician, relative to an area of need in the middle of Arkansas, you will find that the drop off between the thousand dollars invested in the medical school and the point of service in the middle of Arkansas is astonishing. Now as a consequence, we are facing an interesting dilemma as we go into the seventies and eighties. If we are to maintain expertise in the quality of medical care and make sure that it is available, what is the role of the physician and what is the role of the people? I believe the following event will occur by the eighties:

Specialists will continue to be trained; they will be confined for the most part

to hospitals; they will be governed by the hospitals rather than by other kinds of systems. The majority of medical care is going to be provided by other individuals under a system of maintenance and supervision which will depend upon a different kind of physician. Some of this will be in group practice, but I must say that if there is anything worse than an incompetent physician in solo practice, it is a group of them.

So we have a few things to learn about how to manage group practice. But, in general, I think we will discover that it is not necessary to see a physician for a very large percentage of those ailments which are now brought to the attention of a physician. And if we look a little further into the seventies, I think we are going to discover that a significant portion of the time spent by professional people is spent giving attention to individuals who do not need to be into the health-care system at all.

A major input is going to be the use of automated techniques and I believe this will include screening methods which will have their concentration on health maintenance rather than on the identification of acute kinds of illnesses.

As a consequence, there will be a different use of allied health manpower. And although this may startle you a little, I think our current efforts to (1)* increase the output of medical schools, associated with our efforts to (2)* reorganize the way in which health care is being provided, will lead to a discovery somewhere along the line that we are training too many physicians. If the latter is successful, the former is unwise. If the former is pursued and the latter is not, we are going to have to get around to it at a later date. So all these efforts to vastly increase medical schools, with the illusion that this will provide medical care, are going to be re-examined and, in the course of time, I think are going to be dropped.

The solution lies, not in adding to the numbers, but in making more effective use of the way in which they spend their time. This means that responsibilities for all levels of providers are going to be increased and under supervised circumstances. And people are going to be free to do those things which need to be done, where they need to be done, which is where people are ill. I think that as a consequence there is going to be a regulation of the way in which hospitals are used.

Now the other question has to do with a much more precise issue, which sounds rather small after I had been operating at that positive level. **"Should RMP and CHP be combined?"** The answer to that question is unequivocally "no." They serve a different kind of a purpose and if I have my preferences, I would say that CHP and RMPs should operate in such a way that they have a **productive tension** between them, one forcing demands on the other, the other dealing with those demands. They should have a basis between them for an effective negotiation between what the community needs with a resolution in capacity, the identification of reasonable priorities, and the reaching toward those priorities by a common understanding.

DR. ENGLISH: Just to express a slightly different shade of opinion on that manpower question, I agree with Dr. Margulies totally that we are moving into the area of a new mythology if we think that manpower, in terms of producing more of the same, is going to be the solution to the crisis of health care. It obviously is much more complex than that, as he has pointed out so well. But even in medical care systems where there has been an attempt to utilize physician manpower better, where other kinds of present health manpower are being utilized better or where new kinds of health manpower are being utilized very effectively, there is much yet to be learned.

I would say there is one example of this that I think you probably know well. It is becoming increasingly known in this country as the Kaiser Permanente Program. Even there, when you talk with

*Numerals added.—eds.

they will tell you that one of their major problems in trying to expand is a shortage of medical manpower. I think the problem and the mythology is that just producing more manpower is not the solution any more than investing in biomedical research would solve our problem.

I think to really deal with the health care crisis, you have to face a whole range of strategies without tolerance for any mythology that begins with the new conceptions of how to organize and deliver care. Only when you have worked that out with a variety of experimentation . . . can you figure out what your real manpower needs are and only then can you figure out the purchasing power mechanism, the third party payment mechanisms that will support these new structures. I think our problem in the past is that we have never had united strategy covering financing, manpower production, and the issues of organization and delivery.

This leads, I suppose, to a question that was asked, and which is, I think, pertinent to many of the questions that we received. I will just read it to you. **"Why does health care expenditure continue to increase without corresponding increase in the quality of care?"**

I think everyone up here has dealt with that. I think Dr. Fowinkle in his last remarks dealt with it with real clarity.

Suppose that five years ago the Constitutional scholars had discovered that the Constitution had a basic human right in it that nobody really ever noticed before. And that basic human right was to have in the living room of every American family a 23-inch color television set with a 14-foot antenna up on the roof and a lifetime maintenance contract to make sure that it worked terribly well. It was there in the Constitution all this time but we just never paid attention to it. So the Congress decided to redress this oversight. And it realized that it would cost about $600 a year to provide that television set to every American and that some could need some help in trying to pay it so they started working on what was called a National T. V. Aid Bill. And it was very clear that it was a very politically popular measure and it would take a little work to get it through the Congress. But within three years it would get through, and it would provide to every American—some on a 100 percent basis, but others would have to contribute something to the cost of that set—the purchasing power to put such an instrument in every American home.

If we were back at that time, I think you could imagine what outfits like General Electric, Zenith, RCA, and Admiral would be doing. It would be my prediction that they would be out borrowing money to expand their ability to produce, even if the interest rates were 15 to 20 percent. Why? Because they were going to be guaranteed a tremendous source of purchasing power when that legislation went through. It would compensate them very well for taking that risk, even at very high interest rates. I think it is also very predictable that you and I would be out buying all the stock we could in those companies, because with that kind of guaranteed purchasing power it would not be hard to predict how they were going to do.

Our problem in health is that we have been misunderstood and thought to be like that. First, we kidded ourselves into thinking we had the capacity in this country in health to serve the needs of 200 million people and then we saw that mythology exploded when $14,500,000 of purchasing power was given to consumers to test. That is the seed of the present crisis, and it seems to me that's the reason why, although the money going into health care is rising dramatically, the quality on this overburdened system—if you can call it a system—of health care is being exposed greatly every day. And of course the implications of national health insurance— which would expand the purchasing power almost beyond our present ability to imagine—would demonstrate our present inadequacies to respond even more dramatically.

That is the critical importance of the Partnership for Health and Regional Medical Program. If we are not given, publicly and privately, the money to expand, whether it is in manpower or new methods of organization and delivery, whether it is in the new things we need to know about how to deliver high quality care, the new kind of research that is required, we will continually be in this bind, even though the total number of dollars grows. I think that is what we have got to understand and that is what we have got to help the American people understand and that is why the next question is a very pertinent one: **"What are the chances that the private sector will move rapidly enough and the voters be patient enough to avoid a government-controlled monolithic system?"**

How do we encourage provider change and voter patience? On the basis of past performance, the chances that the private sector will move rapidly enough are very slim. Federal leadership has been very important. We are not seeing that federal leadership today necessarily in measure to what the crisis is. So therefore I think our dependency on the private sector is greater than ever. I do not see sufficient optimistic signs that the private sector is going to move rapidly enough except in such programs as RMP and the Partnership for Health, medical societies, health departments and hospitals and programs like the neighborhood health center.

But the major hang-up right now is resources in that area to do all the things they would like to do. That is why the only thing that is going to help us with the voter is the extent to which he sees we are concerned and that we are trying, the extent he understands our difficulties and helps us change the way that $93,000,000,000 is going to be spent in 1975.

DR. CANNON: If the response is not adequate, how much time before we consider the crisis to have reached the point of a burst and something rather radical happens in the health care system?

DR. ENGLISH: I think that when you consider that it took us nearly two centuries to develop the excellence of American medicine, an excellence in this country that is unrivaled anywhere in the world, maybe you should argue that we should have another century at least to deal with the next great issue, which is "equity"—how to translate that excellence into equity and efficiency and respect for human dignity in the delivery of that excellence to 200,000,000 Americans.

But I think the real problem is that we are not going to get a century. As a matter of fact, things are changing much too rapidly for that. The consumer is becoming much too sophisticated and he recognizes for the first time that our national resources are limited and there is going to be great competition within major segments of the society for those resources. I believe that we have about five years to do what needs to be done and I think that is going to take tremendous initiative from the private sector in our country if we are going to make any progress.

I think if it is not done in five years—that is, if we do not increase our capacity to provide care in five years—then in the second half of this decade, we are going to see things like national health insurance and they are going to absolutely expose our present inadequacy in delivering care ten times as dramatically as it is being exposed today. We will see our profession, whether it is the practicing physician or the hospitals of this country or any other segment of that profession, thoroughly discredited before the consumer will understand that the money is going up, that the costs are going up and the service is getting worse. I think that is how a country finds itself in government medicine. That is why I think this will be the most historic decade in medicine in this country rivaled by only that first decade back in 1785 when the first medical school, hospital, and mental hospital were started in this country in Philadelphia.

SUMMARY STATEMENTS

MR. SIMS: People with not as much experience as Dr. Margulies, their main concern was that the distribution of services and the public health profession's education ought to be major components of any health care system . . . We are concerned with all kinds of manpower . . . Doctors are extremely concerned about consumers taking pre-eminent roles in what they feel ought to be their roles determining what medical care ought to be at any given point in time.

DR. FOWINKLE: On the consumer, I think it is clear to most of us in the health administration business that the consumer is going to be involved more substantially in the determination of health policy. I think what the consumer really wants is a good product and he wants it at an affordable price. I think he is telling us very clearly what he wants and is probably telling us that if he does not get it, he is going to try some method of his own to help us produce it.

I think we will have to deal effectively with the consumer and his demand, but yet I still feel very keenly about the need for professional involvement in the policy-making process. I think the consumer is going to have to tell us what he wants and he will do it fortunately as a voter. Yet I am hoping we can temper this with professional judgment and knowledge. The consumer wants a good product and he wants it at an affordable price and he is burdening it on our back to produce it.

In summary, I would like to deal with the question of national health insurance. When will we have it? Should we have it? As an administrator of the state program for financing medical care to the tune of about $50,000,000 —I would very much like to see national health insurance. It would relieve from the state at least part of the burden of their share of the financing and a tremendously overwhelming administrative task of running this thing. We have a $50,000,000 program superimposed upon a $20,000,000 agency. So we have the tail wagging the dog and this is happening all over the country. States are staggering under the administrative and physical load of Medicaid. So I think from the state standpoint, I would like very much to have national health insurance. This would standardize it and lift the burden somewhat off the state.

Looking at it from the health-system standpoint, I think we must emphasize

that it would make a more efficient financing mechanism, which would have the same effect and adding to the financing of health care, which would simply throw coal on the fire by producing further inflation and further decreasing quality. So we have got to change our national, state, and local priorities for capability expansion rather than financing, and this includes national health insurance in the foreseeable future.

DR. MARGULIES: I would like to answer one question, because it did not come out of the audience and because its deficiency disturbs me. In deciding what health care should be like in the eighties, determining it by what happened in the seventies, we have to face one of the most difficult issues, which is the concern more at this point of the non-professionals than it is the professionals. Over the last 25-30 years, the public has been lured into having appetites for yellow refrigerators, or whatever it may be, which we must learn to change into other kinds of appetites.

The creed now is a transplant in every garage—the exotic, the sophisticated, in fact, the whole kind of concept the RMP began with and with which I never agreed, even in the early days. If we are to be effective in RMP and CHP, the problem is a double one. Not only must we be responsive to consumers, but we must be able to interpret to consumers the difference between an irrational and the rational effort to meet their basic needs. And because it is a sophisticated issue and because the health care system is complex, it means that the professional efforts of an RMP or any other organization needs the full understanding, the full exploitation, and the most minute interpretation to the community so they can appreciate the difference between the visible, the glittering and the glamorous and what really is essential for health maintenance for control of cost and for the basic health of the community.

DR. ENGLISH: I would like to share just two dreams. One would be to proceed with confidence and go to the places where we are going to need help before we can do the job in the 1980s. One of the places I think we need to go, as practicing physicians, as hospital administrators, as officials of the states, of the cities, in the whole purveyor system, is to the school of business. I would like to see by 1980 two to three percent of the graduating class of every school of business administration in this country producing people who will come and help us with what, by that time, will be a $100,000,000,000 enterprise. I do not think the physicians and health professionals should become the major managers in an enterprise of this magnitude, of this size, of this complexity. There is little in our training and there is little in what brings us into the field of health that equips us for this.

So, I think we should welcome help from those institutions which produce people who have this kind of expertise but who have not yet come, often because they have not yet been asked, to help us in one of the largest segments of one of the most important segments of our national life. That, I hope, will occur by the 1980s.

The second thing that I hope will have occurred by that time is that we would be having meetings like this but expanded into what one might call, "town meetings" in health, around the crisis of health care all over the country, that health would become the critical issue that I believe Dr. Margulies and other members of the panel have predicted it will increasingly become.

The consumer is the best ally we have in the tremendous competition for resources. But rather than waiting for them to come to us, we will go out to them, gain their understanding, their help, their partnership. If in the 1980s we see that alliance between the health professionals and the consumers in this country, I think we can proceed with great confidence to be sure that we will serve the national interests as the public in this country hopes that we will.

"Should RMP and CHP be combined? The answer to that question is unequivocably 'no.' They serve a different kind of a purpose and if I have my preferences, I would say that CHP and RMPs should operate in such a way that they have a productive tension between them, one forcing demands on the other, the other dealing with those demands. They should have a basis between them for an effective negotiation between what the community needs with a resolution in capacity, the identification of reasonable priorities, and the reaching toward those priorities by a common understanding . . .

"If we are to be effective in RMP and CHP, the problem is a double one. Not only must we be responsive to consumers, but we must be able to interpret to consumers the difference between an irrational and the rational effort to meet their basic needs. And because it is a sophisticated issue and because the health care system is complex, it means that the professional effort of an RMP or any other organization needs the full understanding, the full exploitation, and the most minute interpretation to the community so they can appreciate the difference between the visible, the glittering and the glamorous and what really is essential for health maintenance for control of cost and for the basic health of the community."

—Dr. Harold Margulies