HEALTH PERSPECTIVES

A NON-PROFIT TAX EXEMPT ORGANIZATION

Vol. IV, No. 1 PUBLISHED BY THE CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES, INC. Jan.-Feb. 1977

Pub. 5/77

NATIONAL HEALTH SERVICE I

The rapid escalation of the cost of health care is viewed by public officials, consumers and an increasing number of health care professionals with growing apprehension and alarm. In 1976, 8.6% of our gross national product was consumed by health services as compared with 4.6% in 1950.

Total private (non-governmental) expenditures for personal health services in 1975 were approximately $68.6 billion—more than three times the $19.5 billion spent in 1960.

Despite the fact that increasingly larger sums of money are being spent on health care, the current health care delivery system still fails to provide equitable, economical, and quality care to all segments of the population.

NHI MEANS NO HEALTH ASSURANCE

There are those who contend that government should continue its traditional role in the health care delivery system—financing care for selected population groups only. Others believe that this role should be expanded to support a national insurance program which would include a broader, or perhaps the total population.

The former point of view is unrealistic and politically untenable. The latter will only provide more tax dollars for unneeded and uncontrolled services. Even if a method could be found to contain health care costs and prices, a national health insurance system could not, and would not, effect needed changes in the delivery system itself. To insure care is not to assure the timely delivery of appropriate services at a reasonable cost by personnel rationally distributed throughout the country. In order to accomplish these important goals we need a national health service, built on the experiences of present government programs coupled with coordinated health planning and new provider compensation and reimbursement techniques.

CAUSE FOR ALARM

The United States health system has failed to provide equal, quality care at a reasonable cost for a number of reasons including:

1) the use of fee-for-service reimbursement to physicians and other health care providers,
2) the lack of incentives to encourage providers to deliver and utilize health resources economically and efficiently,
3) inflationary reimbursement systems which encourage overuse and unnecessary procedures,
4) the failure of government to develop effective controls over the supply and distribution of health services,
5) the lack of mechanisms to ensure public accountability of institutional expenditures,
6) the failure to coordinate cost reimbursement and health planning,
7) the profit motive and the excessive political influence wielded by a small number of self-interested groups and individuals which are endemic to the system,
8) the lack of incentives to provide preventive and occupational health services,
9) the exclusive use of peer review of quality,
10) the failure to define and enforce acceptable quality care standards,
11) financial and geographic barriers which make health care inaccessible to many people,
12) the prejudicial, secret entrance criteria which have effectively excluded the non-wealthy, women, and other minority group members from obtaining entrance to medical schools,
13) the lack of appropriate health consumer education regarding the choice, use, and monitoring of health services,
14) adequate information on health care delivery and costs has not been available to consumers,
15) the decision-making process in the health field has effectively excluded consumers.

THE MULTITUDES

The public sector of medical care in the United States is made up of a complex web of federal, state, and local appropriations and programs, administered by dozens of agencies in compliance with statutes enacted over many years reflecting various and changing public purposes. In the private sector health care is delivered by a wide range of providers who operate independently and virtually autonomously. Each type of provider plays an important role in the delivery of care. However, there is no coordination among these various providers nor between the public and private sectors. There is no *one* health system. The resulting fragmentation of responsibility makes it virtually impossible for government to create workable regulations and for consumers to monitor the care they receive. Consequently the public's interest takes second place to that of the providers of care. The results are predictable: fee-for-service and unreasonable cost reimbursement, concentration of resources on the treatment of sickness and disease rather than on prevention, provider-derived standards and quality review without adequate public and government input, excessive cost increases, and private sector attacks on the public sector to divert attention from the real issues.

It is apparent that the multiple and competing health subsystems must be merged under public control to insure adequate value for the costs incurred, to place emphasis on prevention of disease, to create sound standards, to establish publicly accountable cost and quality standards and controls, and to develop a uniform health care delivery system accessible to everyone.

A SYSTEM IS THE ISSUE

This issue of HEALTH PERSPECTIVES examines some of the reasons why a national health service which would unite the private and public health care sectors into one single, coordinated health system should be established. This single system would efficiently allocate health resources to provide the proper balance of preventive, primary, secondary and tertiary care. It will have the capacity to deliver quality health services to all residents of the United States on an equal basis regardless of the ability to pay.

Due to the inadequacies of the private, free enterprise sector to provide quality care to all Americans, government has been called upon to increase its involvement in delivering, financing and regulating health care. With the long history of government involvement in health at all levels and government's responsibility to protect the health and welfare of the public, there is considerable precedent for this expansion of government function. Suggestions that government withdraw or hold the line in these areas primarily come from representatives of the private health care sector who seek to maintain their traditional control of the health dollar.

INVISIBLE HAND FAILS

Historically the majority of the delivery of medical services has been in the domain of the private sector. The private sector obtained and maintains the privilege of self-regulation based on the mystical nature of its healing mission reinforced by the capture of the focal points of political power and decision-making. This privilege, however, is not a right. As the delivery of medical services has become less mystical, it has become apparent that the exercise of this privilege has not been accompanied by commitment to quality care for all segments of the population at reasonable prices. The credibility of the private sector has suffered as the costs of care have skyrocketed and has led many to advocate public ownership or control of the private health care sector.

The medical market is sufficiently different from other commodity or service markets such that free market mechanisms cannot operate to produce an efficient allocation of resources. Some of the major areas in which the health care sector diverges from the free market model are listed in the box—Why the Health Delivery Industry is Different.

WHY THE HEALTH DELIVERY INDUSTRY IS DIFFERENT

1) The health product or service cannot be defined. It is often assumed that treatment or cure is the medical product. However, medical experts cannot predict the response of each patient to each treatment, nor determine with certainty which treatments are required; no ethical doctor can guarantee successful results after treatment. Hospital consent forms often explicitly state that no guarantee to cure is made.

2) The health provider does not bear the full costs of production. Physicians use other factors of production—the hospital bed, equipment, housestaff, and other personnel—without incurring costs. Hospitals, medical schools and physicians are subsidized by government loans, grants and tax exemptions.

3) The demand for health services is created by the provider, not the consumer. Although a consumer may well be a good judge of illness symptoms, it is the provider alone who decides how to treat those symptoms: a consumer cannot admit him or herself to a hospital; drugs are legally dispensed only on prescription by a physician; many services are accessible to consumers only on referral by a physician; physicians exercise extraordinary control over the type and extent of the services provided by other health care workers, e.g., medical social workers, therapists, nurses, etc.

4) Consumer/provider relationships—In contrast to the producers of other services, physicians see themselves as altruistic, non-self-interested parties. Comparison shopping is generally discouraged; in fact, consumers in Maryland and Virginia had to go to court just to be able to provide a doctors directory to other consumers; patients are almost always put in a position where they are fearful to ask questions. Contrast all of this to the principle found in most competitive markets that "the consumer is always right".

5) Budgeting for health care costs is not done by consumers or providers—Medical care represents an unwanted, intermittent expense for which most households cannot budget because of its unpredictable nature. Due to third party insurance, providers are encouraged to pass on costs without a sense of incurring financial liability. Many consumers are also removed from experiencing the costs of health care.

6) Oligopolistic and monopolistic practices—Price setting: except for the impact exerted by fee schedules set by third party payers, physicians can and do set prices unilaterally. This practice may be observed in studies of surgeons who operate on an average of less than four times per week, yet who are able to set prices so that surgery is the highest paid medical specialty.

7) Restriction to entry—Providers control entry into the medical services industry by limiting admissions to educational institutions, by controlling licensing and regulatory bodies, and by influencing lay governing boards of medical care institutions.

8) Lack of information for rational consumer choices—Most information is not available to the public for scrutiny (PSRO's, for example, are developing doctor profiles but will not release their information). Some technical and scientific information is beyond the comprehension of most consumers and resource documents are not written in easy-to-understand language. All possible effects, positive and negative, of many treatments are unknown, even to physicians. Advertising is considered unethical. Belief and trust are substituted for logic and reason.

A competitive market does not exist in the health sector. Monopolistic and oligopolistic characteristics make the present health care industry impervious to social control. Continued belief in the free marketplace myth only leads to ineffective attempts by government to control costs and quality. The present system cannot be regulated or controlled; therefore it must be changed.

The results of our tradition of non-decision making in health matters has led to a substantial redistribution of wealth into the hands of the providers of health care. The traditional belief that free marketplace forces will regulate the distribution of goods and services in an equitable manner and that private enterprise is "good," while public enterprise is "okay" only if the free market has failed, has prevented the public from recognizing that free market mechanisms do not operate in the health care sector. These myths have also prevented the government, as the *representative* of the people, from becoming more involved in the direct delivery of health services.

BEDS, BUCKS AND PROFIT

Private practitioners have been charged with performing unnecessary medical procedures. (It has been estimated that 3.2 million unnecessary operations were performed in 1975). Millions of unnecessary lab tests and x-rays are also performed each year. Spurred by higher third-party fees, physicians admit patients to hospitals (where third-party insurance provides coverage) for treatment which often could have been done in an ambulatory setting. At the same time, patients who cannot afford to pay for care are denied needed treatment or dumped into public institutions which are already starved by discriminatory funding and reimbursement practices. Doctors successfully withhold information from patients claiming it is confidential or not in the best interests of the patient that it be released. Hospitals refuse to divulge cost data or possible conflicts of interest. Inadequate licensure and certification, dominated by providers, allow many doctors to practice medicine outside of their particular clinical training. In fact, most doctors still do not have to prove that they have maintained basic skills since graduation from medical school or kept current with the newest scientific advances in diagnosis and treatment while in practice.

Most health care institutions are organized on a not-for-profit basis. (In 1974 81% of non-government hospitals were non-profit.) Since they cannot make a "profit", as that term is normally used, excess funds are invested back into the institution. Often this investment is in the form of highly technical, expensive equipment chosen without regard to the level of consumer needs. This costly capital expansion, undertaken primarily to lend prestige to the institution (attract highly qualified attending physicians, interns, and residents), has led to massive duplication of expensive services and facilities and the recruitment of well paid and highly specialized staff who make demands for more costly equipment. The underutilization of such equipment, staff and beds costs money (each empty bed costs the institution two-thirds of the costs of an occupied bed) which consumers pay for through Blue Cross, Medicare, Medicaid, etc. Hospitals have been known to respond to empty beds and idle staff and equipment by pressuring physicians to admit patients without regard for the need for surgery or inpatient care. Consumers pay again, both in the unnecessary cost of in-patient care and in the suffering, disability, and death which results from the performance of unnecessarily complicated procedures.

Despite hospitals' non-profit corporate status, they operate very much like profit-making enterprises. Expenditures are made in support of expansionist programs, hospital administrators and medical staffs make unconscionably large incomes, all of which are concealed from the paying public.

"...A closer look at current regulation of the financial dealings of not-for-profit corporations suggests, however, that a decision to bar for-profit corporations in the human services would not suffice to eliminate profit-making abuses. The reason is that omissions, ambiguities and loopholes in the laws and regulations governing not-for-profit corporations presently make it possible for the trustees and staff of not-for-profit corporations to engage in a variety of financial practices which bring them personal profits over and above fees, salaries and fringe benefits due them for work performed. The practices in question are not those generally termed "fraud", i.e. kickbacks, double billing, charging for services never performed, etc., which are clearly illegal whether they are practiced in for-profit or not-for-profit corporations. Rather we refer to forms of profit-making which are at odds with the underlying rationale of not-for-profit corporations, not as currently written in existing laws and regulations but as widely held and understood as legitimate expectations by members of society. Examples of these abuses of not-for-profit status constitute the body of the presentation to follow. They include rake-off schemes, self-dealing transac-

tions, unconscionable profits generated from conversion of real estate properties to not-for-profit ownership or management, and allocation of fees, salaries and fringe benefits vastly in excess of those considered reasonable and customary."

(*Profit in Not-For-Profit Institutions* by Amitai Etzioni and Pamela Doty)

IN GODS WE TRUST

On both a personal, institutional and system-wide level consumers have traditionally relied on medical providers to protect their interests in health care. However, all current indications suggest that this trust has been misplaced and often violated. Consumers need the force of government for protection if any method of organizing, paying for, or assuring the quality of care is to be to their benefit. Public ownership and control of health institutions and the development of a full-time salaried physician corps will be major steps toward controlling the excesses of fee-for-service medicine, centralizing decision-making regarding the amount of money to be spent on health care, and organizing and distributing services. At the same time, public ownership will offer the possibility of the development of a health system that incorporates social planning, budgeting, evaluation, educational opportunities and active health consumerism.

The human right to equal access to the best care available can no longer be abandoned to special private interests.

APHA SPEAKS OUT: NHS ONLY WAY TO GO

At their October, 1976 convention, delegates representing the 24,000 members of the American Public Health Association (APHA) endorsed a resolution supported by five of its former presidents calling for the establishment of a national health service. The delegates felt that the national health insurance proposals being considered by Congress would continue to support the inadequate private health delivery system already extant in the United States.

Inequities in the allocation of health resources amidst major unmet consumer needs calls for a well-coordinated health care system. The nature of health care demands that this system be in the public sector. Under a national health service priorities can be determined and implemented through an expanded federal Health Systems Agency program that objectively meets the needs of consumers at cost levels determined by public criteria.

APHA President, George E. Pickett, MD, MPH, in the December 1976 issue of *The Nation's Health,* said:

"Although it would result in some rather radical changes in the way health services are provided, the concept of a National Health Service is neither a departure nor radical.

The reason for favoring an NHS rather than NHI is that the latter is:

- **more prone to provider induced "demand-pull" inflation;**
- **it demands more and more regulation if we are to avoid bankruptcy and inequities;**
- **involves an inherent tendency to restrict benefits and access; and**
- **entices administrators to use out-of-pocket payment requirements to reduce utilization, even though such practices bear little relationship to true need.**

I am under no illusions that our Congress or our country is ready for an NHS but, if we truly mean to make access a right and not a privilege, and if we truly want to make our medical care industry work for us, a publicly financed, locally governed health service is the only way to go. By adopting that position we can work for changes in the current evolution of National Health Insurance so that its conversion to a Service program, at the appropriate time, will be possible, not a radical departure."

INVOLVEMENT EXISTS

The federal government neither operates nor finances the total health care delivery system in this country. However, federal, state and local governments do pay a major share of health costs and do directly provide medical care to a significant number of Americans. Some funds are spent directly and others are transferred from one government level or agency to another. At every level government is more involved in the health care delivery system than most health providers admit or most Americans are aware. In 1975 government expenditures accounted for 42.2% of the total medical spending nationwide. The federal government delivers personal health services to eligible categories of persons: the poor (Medicaid), aged (Medicare), merchant seamen, American Indians, migrant farm workers, veterans, active members of the uniformed services and their dependents and members of Congress and the President. State governments provide care for specific categories of disease—mental illness and tuberculosis—

and contribute to the care of the "poor", "the aged" and the "medically indigent".

Government support of medical education and research runs into the billions. Public expenditures for medical research in 1975 were $2.7 billion representing 91.5% of the total expenditures in this area for that year.

Government is also responsible for pure water supplies, sanitation, sewage disposal, food and drug regulation and inspection, communicable disease control, immunization, treatment of venereal disease and tuberculosis, vital statistics, public health, laboratory work, environmental control, health planning and occupational safety and health.

BLOCKS TO BUILD WITH

The building blocks for a national health service already exist in the United States' Veterans Administration, Public Health Service, Social Security Administration, Social and Rehabilitation Service and state, county, district and municipal hospitals. As we have seen government is already involved in planning, financing, regulating and delivering health services.

Another, more recently created, building block exists in the local Health Systems Agencies (HSA's). They are required by federal legislation to do population-based planning for health services at the regional level and to include consumers in their decision making. HSA's and the related state planning agency have authority over the allocation of public funds for certain health programs and over local planning for new and expanded provider institutions. Their decisions are to be based on a determination of the region's health care needs. Clearly, collecting current data to determine regional requirements and basing decisions concerning the expansion or limitation of institutions according to such requirements is a move toward a more rational distribution of health care services. The mere existence of a multi-level—national, state regional—planning structure could become a powerful resource in the building of a national health service.

Building on and coordinating the many fragmented programs which make up the present network of government involvement in health is a first step toward improving health delivery in the United States.

UNCLE SAM—DOC FOR MILLIONS

Although Uncle Sam doesn't make housecalls (yet) over 80 million people annually are eligible to get their health care through him. The formation of a national health service will eliminate the need to maintain the various government health programs. It will provide equal access to care for all at a lower cost with greater quality controls. The implementation of a uniform, publicly accountable health service can eliminate the defects which exist in the present multitude of private and public sector programs and the excesses found in the mythical free marketplace. Government, which is responsible to act in the public's behalf, in 1975 paid for over 42% of the nation's total health and medical care expenditures. As this figure continues to grow, the government's interest in and ability to effect the consolidation of present programs into one system is also increasing.

POLITICAL NON-REPRESENTATION

The decades of debate which preceded the enactment of Medicare illustrate how unspoken values and special interests influence provider and public decision-making. Shortly after World War II, a compulsory national health insurance system proposed in Congress was attacked by a coalition of health providers, insurance associations, business interests, the Chamber of Commerce and the American Legion as a basically un-American "socialist" idea. Public opinion surveys at that time consistently indicated that the public favored a universal national health insurance system. However political expediency forced coverage to be limited to a much smaller segment of the population—the needy and the aged; the administration to be turned over to private insurance companies; and the legislation to assure that nothing would interfere with private medical practice.

WHY (NOT) CHANGE?

Nevertheless, the private practice of medicine has already been greatly influenced by government. In order to participate in public financing the government requires institutions to meet certain minimum structural, organizational, and staffing standards. Additional controls are being imposed by Health Systems Agencies, Professional Standards Review Organizations, and, in some states, the requirement that government approve hospital reimbursement rates.

The need to protect the freedom of choice of physician by consumers is another argument offered by those opposed to a national health system. However, due to racial and economic barriers and geographic maldistribution of health providers, freedom

HEALTH CARE: A FEDERAL CASE

In addition to those covered by Medicare and Medicaid, about 35 million Americans are eligible to receive some health services provided or paid for by the federal government.

The Department of Health, Education and Welfare (HEW) is the most important federal health department. Its two major health expenditures are for Medicare and Medicaid services (nearly 60% of its total health outlays in 1975).

In fiscal year 1975, HEW administered 100 health programs through the Public Health Service, the Social Security Administration, and the Social and Rehabilitation Service.

The Public Health Service (PHS) dates back to an Act passed by Congress in 1798 which created the Marine Hospital Service. Its total budget of $5.3 billion for fiscal year 1976 covered the following six operating agencies:

1. Food and Drug Administration (FDA)—responsible for checking foods and their additives and the conditions under which they are produced and processed to keep food safe for consumption and free of dangerous chemicals. FDA also tests drugs and medical devices to make certain they are safe.

2. Health Resources Administration (HRA)—disperses its funds mainly for the training and education of health professionals, the construction of health facilities, the planning of health services and the collecting and analyzing of health statistics.

3. National Institutes of Health (NIH)—does research and provides grants to universities, medical schools, other research organizations and individual investigators in bio-medical areas.

4. Alcohol, Drug Abuse and Mental Health Administration (ADAMHA)—administers three national institutes each concerned with one aspect of the mental health status of the nation. It has programs and centers for the prevention, research, treatment and rehabilitation of alcoholics, drug abusers and those suffering from other mental illnesses.

5. Center for Disease Control (CDC)—is responsible for prevention, control, and research in communicable disease. CDC had the responsibility to track down the cause of the Legionnaires Disease.

6. The Health Services Administration (HSA)—With a budget of over $1.2 billion in 1976, HSA administers the direct service programs of HEW. Its responsibilities to provide direct care for several groups of people for whom the federal government has assumed special responsibilities, to provide financial support for non-federal health care delivery projects, and to administer federal quality of care programs, are divided among four bureaus:

Its Bureau of Medical Services (BMS) is responsible for the delivery of health care to 200,000 merchant seamen, 130,000 Coast Guardsmen and dependents, and federal employees with respect to on-the-job injuries and illnesses. It operates eight general hospitals, a leprosarium, 30 outpatient clinics, and 101 occupational health units.

The Indian Health Service (IHS) is responsible for providing health care to about 500,000 Indians, Alaskan natives, and Aleuts living on reservations. The IHS operates 51 hospitals with 3,000 beds, 86 health centers and 300 field stations.

The Bureau of Community Health Services provides "formula grants" to states for health services and grants and contracts for maternal and child health centers, family planning and neighborhood health centers, the National Health Services corps, Health Maintenance Organizations and health services for migrant workers.

The Bureau of Quality Assurance (BQA) administers the Professional Standards Review Organization (PSRO) program which reviews care being provided to beneficiaries of the Medicare, Medicaid, and Child Health programs. It also

of choice of physician does not now exist for many millions of Americans. Even in those cases where consumers appear to make a choice, that choice is often based on hearsay or chance, not on facts, logic, or on any rational basis. In fact, those who argue that patients now have a choice to pick their own doctors also argue that consumers must not be involved in quality review because they have no way to evaluate doctors. Most referrals of patients to doctors leave the patient little opportunity for choice and in a few specialties (radiology, pathology, anesthesiology) the patient or family makes no choice at all. Often an intern or resident performs surgery for another physician without the patient's knowledge. The issue of freedom of choice of physician

administers the program under which treatment is being provided to patents with end-stage renal disease and acts as technical advisor to the Medicare and Medicaid programs concerning provider standards and certification.

Social Security Administration (SSA)—operates the federally financed health insurance program, Medicare, for persons aged 65 and over, the disabled, and persons suffering from chronic kidney disease. Medicare part A covers hospital insurance and Medicare part B provides supplemental medical insurance on a voluntary basis.

Social and Rehabilitation Service (SRS)—provides federal funding for the Medicaid program. Federal funds are matched by state and, in some areas, local government funds to provide medical services for persons on cash assistance programs and to those who are medically indigent according to the definitions set down by each state which participates in the program. The Medicaid program benefits vary by state with each deciding which of the voluntary benefits it will fund and each administering its program according to state and local regulations.

(The federal administrations spoken of above are currently in the process of reorganization. Nevertheless our intent has been to show the degree of federal government involvement in the health services sector rather than to extensively describe the organization of this involvement.)

The Veterans Administration (VA)—The VA, an independent agency of the federal government reporting directly to the President, operates the largest centrally-directed hospital and clinic system in the United States and is the third largest source of federal employment. Over 29 million veterans or 13% of the population, are eligible to receive medical care in VA facilities, and over a million actually do receive care each year.

In fiscal year 1974, the VA operated 138 general hospitals with 70,000 beds, and 33 psychiatric hospitals with 24,500 beds. The VA operated 87 nursing homes, 218 outpatient clinics, and over 10,000 beds in 19 separate domiciliary facilities.

During fiscal year 1974, the VA employed almost 184,000 persons including about 27,500 physicians (in 1975 there were 350,000 MDs in the US), 1,350 dentists and 24,400 nurses (either full or part time intermittent professional staff).

The total cost of the VA medical program during fiscal 1974 was over $2.84 billion. This included: $2 billion spent for providing hospital care to 1,140,750 patients for 42 million days of hospital care and another $490 million spent to reimburse physicians on a fee-for-service basis for 12.3 million outpatient visits to VA facilities.

Ten million people in the United States (5% of the population) are eligible to receive health services provided for by the Department of Defense (DOD). In 1975 6.75 million persons were eligible to receive care directly from the 131 military hospitals run by the DOD in the continental United States. Another 3.25 million dependents of military personnel are covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) which purchases care from the private sector. CHAMPUS was the model used by Congress to develop Medicare.

Public Hospitals—Public Hospitals include other federal, state and local government hospitals. They serve tens of millions of Americans. The scope of services, range of bed size, sources of funding and other characteristics vary widely. Yet, public hospitals have several common threads:

—they are publically accountable,

—they are located in areas of greatest need,

—they cannot refuse to treat patients based only on the inability to pay.

The VA, Indian Health, Public Health Service and other public hospitals provide a significant amount of care in America today, and are a vital health resource. (The issue of how to convert non-governmental health institutions to public control will be examined in a future issue of HEALTH PERSPECTIVES.)

is not relevant to patients who are either financially or geographically unable to get to a doctor, do not have the information necessary to enable them to make a choice of a good doctor, or do not have the power to prevent services being delivered by others without their prior consent.

A greater freedom of choice can exist under a national health service where panels of doctors, monitored and certified by publicly accountable bodies, would be available to all consumers. (The issue of how to organize physician services under a national health service will be developed in a separate issue of HEALTH PERSPECTIVES during 1977).

EFFECTIVE WORTHWHILE CHANGE: NHS

None of the proposed national health insurance bills presently before Congress call for all the needed changes in the health delivery system. To obtain cost and quality controls and public accountability of providers, the health delivery system needs a major overhaul. Only a publically controlled national health service will bring about the needed changes which will:

1) create a nationwide mechanism to finance the reorganization of health and medical services in this country;
2) place institutional and individual providers under public control;
3) establish realizable health goals;
4) allow for the placement of services in areas of greatest need;
5) establish and implement a coordinated health plan based on regional needs throughout the country;
6) provide equal access to care;
7) permit evaluation of services;
8) eliminate unneeded and duplicative service;
9) expedite shared services;
10) improve services rapidly;
11) control costs;
12) involve consumers and the public in the decision making process;
13) establish health care as a right; and,
14) replace the dominance of provider interests with societal goals.

ILLUSIONS MUST GO

The myriad of government and private agency monitoring, surveillance, inspection, and accreditation activities gives the illusion that quality and costs are being brought under control. However, the continuous underestimation of how much specific programs will cost and how much aggregate costs will increase each year coupled with the continuing exposés of abuses concerning both the cost and quality of care, belie this appearance of control.

The existence of HSA's, peer review, utilization review, JCAH inspections, validation surveys, Professional Standards Review Organizations and state inspection programs indicate that efforts are being made to control the health delivery system. However, the built-in conflict between the interests of individual and institutional providers and those of society, coupled with a system of economic and intellectual incentives which favors the pursuit of individual over collective goals, reinforced by a value system which glorifies competitive, self-interested private enterprise, work together in the creation, design, and implementation of programs which are destined to be ineffective in controlling costs and monitoring and improving medical care. Providers continue to attempt to maximize reimbursement rates, increase their power and extend their influence. Agencies, hospitals, health centers, planning bodies, lobbying groups, etc. pursue their own goals while the patient, community, city, region and country remain secondary considerations.

The multiple and overlapping points of responsibility and funding diffuses a sense of individual involvement in the health system's inadequacies and an ability to take effective corrective action. One of the most important outcomes of the organization of a national health service will be the concentration of responsibility for funding and policy-making so that national goals and priorities are examined, decided upon, implemented and monitored by a publicly accountable identifiable entity at the national and regional levels.

EXPLOITING THE PUBLIC SECTOR

As a tactic to divert attention away from its failure to protect the public, the private sector constantly holds up public health services, municipal hospitals, county hospitals, etc. as examples of the inability of government to provide decent care at a reasonable cost. However, the reality of the situation is that public services have been financially starved, resulting in their inability to provide comparable care. Public hospitals have been forced to care for all while private sector hospitals treat only those able to pay. The public institutions are convenient scapegoats for the private sector. As long as there are two distinct health care sectors, one private and one public, and American values and the dominant influence of the private sector remain constant, the public hospital system will continue to be relegated to second-class status in the United States.

AS FOR THE REST, NHS HOSPITALS BEST

In England, Sweden, Switzerland and most of the other highly industrialized Western European countries, it has been possible for a national health service to exist within a system which suports free enterprise in other sectors, including some privately supported health institutions. Studies in those countries have shown that the best hospitals (i.e., those providing high quality and cost effective health care) are those owned and operated by government. Hospitals are regarded as publicly owned resources serving the entire population, similar to the education, energy supply and transportation industries. A public health care system is consistant with free enterprise in other areas of the economy.

LABOR AND INDUSTRY'S STAKE

Controlling health care costs also controls the costs of employee health fringe benefits to American industry. According to one car manufacturer, health benefits for auto workers cost more than the steel in its new automobiles. A national health service can relieve some of the excessive fringe benefit costs now carried by American industry and labor.

PUBLIC AND PRIVATE GOALS UNITED

One of the goals of a national health service would be to seek mechanisms which better align provider, consumer and public needs. Currently, each agency, institution, and individual, in seeking to reach its own objectives, works to subvert those of others.

With government as the employer of all health workers, the attainment of its goals—the provision of appropriate, quality medical care to all Americans at a cost which reflects its social priority—will of necessity become more important to its employees. Although it is to be expected that employees will continue to seek their own self-interest, hopefully the effects of working for the same employer will benefit rather than obstruct social objectives.

TRANSITION STEPS

Below are several areas to be explored by the Consumer Commission in future publications:

Local Input—A national health service will require the creation of regional boards to be responsible for health delivery programs in each area. They will be responsible for health planning, budgeting, and delivering of all medical services in the region. The present 200 HSA's can be converted into the regional boards.

Participation—Provider participation in the national health service will be based on the needs of the community. Unneeded institutions will not be included. Services will be evaluated, and those which are needed will be upgraded to meet higher standards of care. New services will be developed. Sharing will be encouraged with the objective of rationalizing and regionalizing services.

Quality Controls—There will be a need to develop a uniform, national and independent quality assurance program. External audits and other new quality controls will be included.

Cost Controls—Provider compensation methods will encourage closed panel services, salaried employees, etc. Physicians wishing to work outside of the national health service will not be paid by government for any service. During the transition period, fee schedules (and capitation arrangements) will be established.

Public Consumer Representation—A national health service will require greater participation by all segments of the population. All health institutions and regional boards will have members representing the demographic breakdown of the community or area. Mechanisms will be developed to select members to institutional governing bodies.

Funding—A national health service will require a mixture of funding sources but will rely heavily on general tax revenue.

Patient-Provider-Government Relationships—A national health service will require new provider-government-patient, and patient-government relationships which will be reduced to written enforceable contracts.

Accountability—To assure public accountability and responsiveness independently funded consumer advocates/ombudspersons will be needed at every level of the policy-making and service delivering structure.

In this issue the Consumer Commission has begun an examination of the need for a national health service capable of providing equitable and quality health/medical care services to all the people in the United States without regard to their ability to pay. The Consumer Commission is interested in your ideas and opinions on this subject, and shall consider the publication of supporting or opposing views in future issues. Articles forwarded to the Consumer Commission for consideration should be between 500-1000 words.

Consumer Commission on the Accreditation of Health Services, Inc.
381 Park Ave. South, New York, N.Y. 10016

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PUBLISHED BY CONSUMER COMMISSION ON
THE ACCREDITATION OF HEALTH SERVICES INC.
381 PARK AVE. SO., NEW YORK, N.Y. 10016
TELEPHONE: 689-8959

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