SOME MAJOR POLICY DECISIONS FACING THE UNITED STATES IN THE FINANCING AND ORGANIZATION OF HEALTH CARE*

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LESS than a year has elapsed since the Social Security Amendments of 1965 were passed, and it is already evident that this law will go down in history as the most important piece of social legislation enacted in this country since the original Social Security Act of 1935, which still has pride of place. In the health field alone, however, the 1965 law can claim to be of first importance. Despite its limitations to the aged and to certain carefully defined categories of needy or medically needy persons its impact on every aspect of the provision of health or medical care has already been tremendous. Its implementation is making enormous demands on the time and energies and sense of public spirit of the professions concerned, on organized suppliers of health services, on hospitals and other medical institutions, and on governmental agencies.

And yet I venture to suggest that we are only at the beginning of what may well be a revolution in our methods of organizing and financing health services. After a period of digesting the measures enacted in 1965 I am convinced that we shall see further action to bring us closer to achievement of the goal so well stated by The New York Academy of Medicine that "all people have the assurance of an equal opportunity to obtain a high quality of comprehensive health care." As one studies the history of social legislation one fact becomes very clear: it is that if a new policy or program is found to be good, even though initially limited in scope, there will be pressure to extend it to other groups of people or to other problem areas. And this pressure will not be unduly weakened even if it emerges that a more comprehensive program costs much more than was originally thought. If people are satisfied with a program they are prepared to

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pay for it. In this respect and in this respect only I find myself on the same side as the American Medical Association, which has always asserted that the enactment of even a modest social insurance program would be the thin edge of the wedge of further governmental action. Needless to say, however, we differ in the emotional responses we make to this probability. The Association trembles and I rejoice.

Some Major Policy Issues

While the 1965 legislation will surely be no end but rather a beginning, it is a very important beginning for it embodies policies that are bound to influence future developments for good or bad. We need to be very clear as to what these major policy issues are so that if change is needed it can be accomplished before it is too late or, if a choice faces us, that we be aware of the alternatives and their implications. In fact, we have many choices, for the 1965 amendments embody many different and even conflicting principles.

Health Care as a Right or a Concession

Perhaps the most crucial of all policy issues concerns the principle on which governmentally financed health services are to be made available to people. Last year we simultaneously enacted two different principles. On the one hand, in Title 18, specified health services became available to the aged as a right through the application of the social insurance principle. On the other hand, under Title 19, various categories of needy people will be provided health care on a means test basis. Which of the two different approaches do we wish to promote in the future? Shall the social insurance approach continue to be limited to those 65 and over or should it be extended to cover some or all of those under that age? Should efforts be made to broaden the coverage of Title 19 (medical assistance on a means test basis) not only to provide federal financing for the general assistance recipients but also progressively to raise the income limits so as to include an ever larger segment of the population?

Comprehensive Care or Item-by-Item Provision, through Government

A second major policy decision is whether governmental financing of health services is to be made available only for specific types of health services on an item-by-item basis or is to cover all care needed

by the covered population on a comprehensive basis. Here again two different policies are embodied in the 1965 law. In Title 18 the item-by-item approach has been adopted. Only so much hospitalization or posthospital institutional treatment will be underwritten by government. Only certain types of hospital services will be reimbursable. Ambulatory care in hospitals, extended institutional care, drugs provided outside the hospital, dental care, and many other items of normal health care are excluded. Similarly, in Title 18 B, physicians' services are to be provided and financed on an item-by-item basis. In Title 19, however, in principle, governmental financing is to be available for comprehensive health services although in the first instance the states are required to supply only five broadly defined types of care. As we plan for the future, which of the two principles do we wish to follow?

The Respective Roles for the Federal Government and the States

So far I have spoken only of major policy issues: of the ends we wish to achieve. But important policy issues are also raised by the methods we have adopted to attain these ends. The first of these concerns the respective roles of the federal and state and local governments. Here again, we have followed two roads in the 1965 law. On the one hand we have two wholly federal programs (Hospitalization Insurance and Supplementary Medical Insurance). For although the state health authorities and private intermediaries also play a role, it is as agents of the federal government, which alone carries final responsibility for financing and policy formation. On the other hand in Medical Assistance we have what is essentially a state (or state and local) program where, although there is very substantial federal financial participation and a set of federal standards that for extensiveness surpass those of any previous grant-in-aid program, the initiative, and within quite wide limits, the nature and extent, of the program rest in the hands of the states.

A major policy question for the future is thus whether to increase the role of the federal government or that of the states. And it is a decision that must take account of existing federal and state responsibilities in health areas other than those affected by the 1965 amendments, where the trend appears to be toward a growing federal responsibility for construction, research, education and, more recently, the treatment of specific diseases.

The Role of Private Enterprise in Governmental Programs

A second policy issue raised by the implementing methods we have adopted concerns the role of private enterprise in what are essentially governmental programs. Here again we have started out on two paths. On the one hand, in Title 18 the legal structure provides for, although it does not require, the use of private intermediaries to perform many of the administrative functions of the programs. On the other hand, in Title 19 there is no provision for intermediaries unless the state decides to "buy into" the supplementary medical insurance for its aged needy persons. It seems likely that the use of private intermediaries in the social insurance programs was a political concession designed to overcome some of the opposition to Medicare on the part of organized medicine and the profit and nonprofit insurance companies. But what may have been politically expedient to secure enactment may or may not prove to be socially desirable once a program is established and in operation. Already some serious questions have been raised about this policy decision, some of which will be discussed at this Conference. As the program moves into operation it will be of the utmost importance to study experience and evaluate the wisdom of this use of private organizations in the administration of a governmental program.

The private enterprise concept is also evident in the methods adopted for the remuneration of professional personnel. Here, the policy of paying for professional services on the basis of the "reasonable charge for the service rendered" perpetuates the fee-for-service method of payment so dear to our private enterprise-oriented medical profession. As long as we conceive of the physician as a private enterpriser selling his services for the best price he can get from anyone who can afford to pay for them, the fee-for-service method of payment may make sense, though in that case one might then wonder what justification there is for governmental action to assure minimum collections and, if the doctor decides to bill the patient directly, to make possible the collection of more when the traffic will bear it. But the question that must be decided in the future is how far this concept of medicine as a private-enterprise undertaking is appropriate to a governmentally financed and operated program.

The "private enterprise" character of the market for health services has also permeated another feature of the insurance programs. The provisions for deductibles and for coinsurance, to the extent they were

not inserted as political strategy to keep initial cost down, can be justified only on the assumption that the buyer too looks on health services or medical care as he looks on automobiles or any other commodity. If it is cheap he will buy or use more of it, so deductibles and coinsurance are utilized to keep demand to a minimum. But is the parallel exact? Or must we realize that to the buyer health is not like other commodities and that the money barrier of the deductible may prevent some people from seeking care when they need it, especially care of a preventive character or an early diagnosis, while coinsurance will still leave some patients with a sizable bill or the unfortunate necessity of foregoing some types of treatment or care.

Administration by Health or Welfare Agencies

A third major policy issue in the implementation of the new programs concerns the allocation of administrative responsibilities among state agencies. Once again two roads have been simultaneously revealed. In Title 18 the various functions in connection with the social insurances that are delegated to the states are to be carried out by the Departments of Health. In Title 19 the states can designate whatever state agency they wish to administer the program although the determination of financial eligibility must be done by the Welfare Department. And at the federal level administrative responsibility for Title 19 is lodged in the Welfare Administration, with the Public Health Service serving only in an advisory and consultative relationship. The question of which of the two agencies, health or welfare, shall have administrative responsibility for the enormously important Title 19 programs must not be viewed merely as a struggle for power between two governmental agencies. The decision, as I shall try to show later, has far-reaching consequences for the future development of our health services.

The Determinants of Policy

Time does not permit the enumeration of all the many policy issues we face, and I have necessarily had to be selective. I have chosen five that seem to me to be crucial for the future development of our governmentally financed and administered health services. I am no better prepared than anyone else to forecast what answers we shall have given 25 years hence. But I am sure that in the last resort what happens will

depend on the importance the people of the United States attach to certain values and objectives. Specifically, I shall try to show how the importance attached to the concept of health care as a right, to equality of access to health services, to high quality of care, to an orderly organization for the provision of health services and to economy in the use of resources devoted to health will influence our policy decisions, not only on the five major issues as I see them but also on others as well.

The Importance Attached to Health Care as a Right

In a recent policy statement The New York Academy of Medicine says "The availability of health services, as a matter of human right should be based on health needs alone, not on a test of ability to pay."* This is of course what the social insurance technique, as opposed to medical assistance, achieves, and it is of the utmost importance that we understand the implications of the two approaches. The essence of social insurance is that whatever benefits are included in the program are made available as a right, subject only to proof of insured status and the existence of the condition calling for health care. No account is taken of the economic status of the claimant at the time he is in need of care. Proof of insured status, in turn, involves the application of objective tests that are specified in the law and apply to all covered persons. They typically leave little room for argument or the exercise of official discretion in the individual case. It is this objective, nondiscretionary method of determining eligibility that accounts for the great popularity of social insurance among our independent self-respecting citizens and that, incidentally, justifies prevailing terminology. For we always speak of social insurance *claimants*, whereas those whose eligibility is based on passage of a means or needs test are referred to as *applicants*. And no one likes to be an applicant.

Still less is the position of the applicant an enviable one when we look at the reality of the means test as it is typically applied by departments of welfare in the United States to applicants for public assistance. Detailed reporting of all income and other resources and of expenditure needs, verification of all statements by house visits, confirming reports from relatives, employers, landlords, and often neighbors, coupled with the exercise of wide discretion in the withholding or granting

*Bull. N.Y. Acad. Med. 41:795, 1965.

of specific items that are not included in the basic budget and, in far too many instances, the arbitrary application of additional eligibility criteria relating to the behavior of the applicant—all these explain why the means test as the door to social services is so heartily detested, not only by those who must undergo it, but also by all observers of the effect on human dignity and morale of submission to this kind of treatment.

It is true that the 1965 legislation contains a number of provisions designed to render the needs test, as applied to eligibility for medical assistance, less offensive and deterrent. Relatives' responsibility has been greatly narrowed. Only resources actually available, rather than presumably so, are to be taken into account. Arbitrary income limits that would exclude people regardless of the size of their medical bills have been ruled out. Resources must be "reasonably" evaluated. Furthermore, the federal welfare administration is urging the states to simplify the needs test and the verification process. And, in theory, there would be no legal barrier to prevent a state that so desired, from setting very high income limits, using income tax returns or simple affidavits for verification purposes and with predetermined eligibility wherever possible, in effect turning its Title 19 program into a full-fledged state health service, available to almost everyone. It could do this and still claim federal matching for all those whose age, family composition, or physical disabilities identified them as persons who, but for the size of their incomes, would be eligible for federally aided categorical public assistance.

I emphasize "in theory," for it is highly unlikely that this will happen on any large scale. However, if there are no further extensions of the social insurance principle to other age groups we are likely to see very extensive liberalization of medical assistance in this direction in some of our wealthier and/or more progressive states in the next few years. Realistically, however, we must expect that for the vast majority of the states the means test for health care, apart from the statutory restrictions already referred to, will be administered in a manner and a spirit that is not different from that applied to the applicant for public assistance.

This is the more likely in view of the unfortunate provision in the 1965 amendments that the financial eligibility requirements must be administered by the welfare departments. One would have thought that our best chance of developing a nondeterrent, liberal, and nonoffen-

sively administered income test for health services would have been to have lodged its administration in the hands of agencies not identified with a long tradition of deterrence, namely the health departments. After all, many of our other social programs, such as housing or educational scholarships, involve the application of an income test, but its administration is not, for that reason, lodged in the departments of welfare.

If we desire to move toward the objective of medical care as a right we shall surely push for further extension of the social insurance approach and change our administrative arrangements in medical assistance. We shall also find it necessary to reconsider our policies on deductibles and coinsurance. For if, as indicated by administration spokesmen, the two parts of Medicare will cover only between 40 and 60 per cent of the individual's medical bill, many of the aged will discover that all that has happened is that they now must go to a welfare department to meet 60 to 40 per cent of their bills instead of 100 per cent as previously. They will not have been spared the necessity of contact with a means test system and they will have the added disadvantage of having to deal with two agencies.

At the same time we must never forget that social insurance is only one way of implementing the right to needed health services. It is a useful social invention that has made it possible for societies troubled about the possible effect of free payments or services on initiative and self-dependence to accept the idea of conferring rights freed from any needs-test requirement. Its contributory character supported the parallel with private insurance and made it possible to argue that people had earned their rights because they had contributed toward their benefits. But by the same token, those who had not contributed or had not made a sufficient number of contributions for whatever reason, within or beyond the individual's power to control, are denied benefits under social insurance systems. In other words, insured status as the door to rights to service inevitably excludes some people. Exclusion from benefits may under some circumstances make sense in a cash-payment program, but do we want to exclude anyone from needed health services?

Rights to services can be conferred, however, without making eligibility depend on insured status. In this country we already do this for veterans with service-connected disabilities. Some other countries, of which Great Britain is the most prominent example, have extended

this right to all people who, while in Great Britain, need medical care. They treat health services, in other words, as we treat elementary and high school education. Is there any reason why health services should be less universally required than education?

Thus if we are really committed to the idea that health services should be available as a human right based on health need alone, perhaps we should raise our sights and move toward a free health service for at least some sections of the population. Children suggest themselves as the obvious target for such a service.

The Importance Attached to Equal Access to Appropriate Health Services for All our People

A second major determinant of future developments in the organization and financing of health services will be the importance we attach to equality of access on a geographical basis. Because of the limited scope of Title 18 in terms of persons covered, types of health service insured against, and the presence of deductibles and coinsurance, it is Title 19 that we shall find it necessary to rely on as the main instrument for ensuring that no one who needs health services is denied them. And Title 19 deals only with that part of inability to secure needed care that is due to financial inability to pay for it. It does not deal with such other obstacles as the nonavailability of personnel or facilities.

Even as a means of solving the problem of financial incapacity I fear that Title 19, despite its high potential, will result in great geographical inequalities in care. Its full implementation will involve large additional expenditures on the part of the states, which are already finding themselves under heavy pressure to finance growing educational and other state-supported services. More important is the fact that there is great variation in the per-capita income of the different states. Even with the best will in the world and with an 83 per cent federal matching, some states will be unable to raise the necessary sums. In addition, state attitudes vary greatly. Not all of them are convinced of the importance of making health services available under self-respecting conditions to everyone, especially if a large number of the beneficiaries are likely to be nonwhites or people such as unmarried mothers, who are held in social disesteem.

As a result we are likely to find wide variation from state to state

in the Title 19 program (just as we did, incidentally, in the Kerr-Mills Act, of which much of Title 19 is an extension and broadening). There will be vast differences in the range and quality of services offered and in the income limits that will determine how many people benefit from the program. We may even find that some states, when they realize all the conditions they must satisfy to benefit from the Title 19 federal grants, may prefer not to participate at all and that, as 1970 approaches, the date by which states can no longer secure grants for vendor payments under the old public assistance formula, and it is compliance with Title 19 or nothing, that we shall find great political pressure to postpone the deadline.

Inequality of access to health services on a state-by-state basis may be regarded by some as the inevitable price we pay for our much vaunted federal form of government and our desire to leave maximum freedom to the states. But if growing importance comes to be attached to ensuring equality of access to high-quality health care for all our people we are likely to see a much greater degree of federal involvement. Because it will be difficult to pretend that the program is really a "state" program if federal matching goes much above the already high 83 per cent I suspect that federal involvement will take the form not of additional federal matching but of the assumption of additional wholly federal responsibility for certain categories of people or for certain types of disease or for certain components of health services such as medical education, the construction of hospitals, of nursing homes, or of health centers.

If we are to select certain categories of people as the beneficiaries of new federal programs we need to weigh our priorities carefully. So far we have selected the aged. Children, unless they are crippled or retarded or suffering specific handicaps have been given no priority although one would have thought that a rational society would have given them the highest preference. It is true that under Title 19 all children under 21 must be covered under medical assistance if they meet the financial eligibility criteria and that a small sum is available for demonstration projects providing comprehensive health services for needy children, but as I have just indicated, these criteria and the scope of services are likely to vary greatly from state to state. The task for the years ahead is to redress the balance in favor of children, wherever they may live.

The Importance Attached to the Objective of High-Quality Medical Care

A deep concern for high standards of service would surely have led us to lodge administrative responsibility for Title 19 clearly in the hands of health departments rather than in welfare departments (with a provision for appropriate consultation and cooperation with health agencies). At best, administration by welfare will lead to a parallel organization, the creation of an almost wholly health administrative unit within welfare departments. At worst it will create the danger of perpetuating a two-standard system: one for the means-test population and one for the rest. Even if, as it appears to be envisaged in New York, the responsibility for standard setting and control of quality is delegated to health departments, we are creating a most difficult situation in which one agency calls the tune and another pays the piper. Given the well-known proclivity of legislators at both state and federal levels to be more liberal in granting funds for functions labelled "health" than for those labelled "welfare," which typically seem to have the lowest appeal to appropriating bodies, it is unfortunate that the vast new medical assistance program was not clearly identified as a "health" rather than a "welfare" program.

I am second to none in my admiration for the welfare departments of our country which, in the majority of cases, have shown a commendable concern for the well-being of their clients and are carrying out, often with conspicuous success, an important and difficult task and one for which they receive little public recognition and much abuse. And there is much justice in the claim of the spokesmen for welfare that in the country as a whole the health departments are not as highly developed as the welfare departments, that they have taken a very narrow view of their functions and have resisted involvement in programs of direct service to people that might create for them difficult administrative relationships with the medical profession. Yet I venture to suggest that this is a short-range view, and one that disregards history. For the short run I agree that under the vigorous and imaginative leadership of the federal welfare administration and of some of our state welfare departments the new programs will get off to a quicker start and that the administrative interpretations will display more knowledge and concern for the needs of the clients than would have been the case had administration been lodged in the health

departments. Yet for the long run a necessary condition for placing emphasis on quality, for bringing some order out of the present medical chaos, and for the development of policies that do not involve one set of standards for the assistance patient and another for the rest of us, is the creation of strong health departments. What the welfare spokesmen forget is their own history. Before 1935 welfare departments with experience in making cash payments and administering services connected therewith did not exist in many parts of the country, and those that did took a very narrow view of their responsibilities. It was the Social Security Act of 1935 which, by providing federal funds for public assistance (including its administration) coupled with the requirement that these funds be administered or supervised by a single state agency and accompanied by federal standard-setting, stimulated the development of the great welfare departments that we know today. It is sad to think that we missed the opportunity to do the same for state and local health departments in 1965.

The Importance Attached to an Orderly Organization for the Provision of Health Services

An orderly organization for the provision of health services would include coverage of all health needs from prevention to rehabilitation, the elimination of gaps in service, the assurance of continuity of care, the avoidance of duplication or overlapping, and the prevalence of knowledge as to what is available and where to go to get it.

The more importance we attach to this objective, the more we shall surely move away from the item-by-item approach where separate units or types of care are identified and paid for with public funds while others are not. No word has appeared more frequently in medical literature and in health conferences in recent years than the word "fragmentation," and it has been used as a term of abuse. The item-by-item approach adopted in Title 18 can only intensify that fragmentation.

But more is needed than avoidance of intensification of fragmentation through our public programs, important as this is. Given the existence of both public and private operation of a great variety of health programs and services, a situation we shall face in this country for many years to come, there is a crying need to create a structure whereby some central health planning agency or council, on the com-

munity, state, and federal levels, is given responsibility for looking at the provision as a whole, is given authority to do something about it, and is adequately financed to do the job. Of all the innovations contained in the British National Health Service Act none in my judgment has been more far-reaching in effect than the implementation of the first sentence of Part III of the famous White Paper on Health Policy of 1944, namely: "If people are to have a right to look to a public service for all their medical needs, it must be somebody's duty to see that they do not look in vain." It has been this centralization of responsibility for looking at the structure as a whole (lodged in Britain in the Minister of Health) which, more than anything else, has stimulated critical inquiry into all aspects of the health services. It is this which has led to the many improvements which, as all students of the National Health Service in Britain know, are slowly transforming what was a 19th-century system of services into one more appropriate to the needs and scientific knowledge of the 20th century.

Concern with the nature of the over-all provision can hardly be expected of the administrators of a social insurance system, even with as dedicated and public-spirited a leadership as we fortunately have in the Social Security Administration. More especially is this so when social insurance is concerned with meeting only the costs of specific items of care. But even with more comprehensive social insurance systems the social insurance agencies have typically been concerned with structural organization and the availability of facilities and personnel only when existing structure leads to cost escalation (a subject to which I shall return) or when the lack of facilities and personnel to provide the specific services contracted for is so glaring that the program is in danger of falling into disrepute. I suspect we shall see something of this kind happening in regard to the supply of nursing homes and medical personnel as Title 18 goes into full effect.

The more we are concerned with a rational organization of health services, the more we shall question the wisdom of the use of the private intermediary, especially the profit-making insurance companies. Unless their functions are very narrowly confined to the mechanics of paying bills, and it does not look as if they will be, their existence as an integral part of the administrative structure can only complicate the task of community planning. They are not community-based or oriented. As fiscal agents paying on an item-by-item basis they are unlikely to

be concerned with the appropriateness and adequacy of available services. At best they create yet one more agency that has to be brought into the planning process.

The Importance Attached to Economy in the Use of Resources Devoted to Health Care

It is obvious that the implementation of the policies and programs to which we are even now committed will require the allocation of a greater proportion of our national resources to the health services. More people will be entitled to claim the services of professionals and to utilize medical institutions. The quality of the institutional care for which they are eligible will be superior to that previously received because the aged can now claim semiprivate rather than ward care and because, as a condition of participating in the program, hospitals and nursing homes will be held to higher standards. The funds devoted to the health services will also be increased because of the payment to suppliers on the basis of reasonable charges or costs. No longer will services to the indigent be paid for at submarket rates.

The costs, in the sense of the volume of resources devoted to health services, will inevitably rise. How high they go will depend in the last resort on the priority people attach to health services as opposed to the other things they could have bought with the same amount of money. And in passing I should like to disabuse those who think costs can be kept down by fixing, as a matter of policy, a maximum sum that can be spent on the health services. For, as I said earlier, if people want something badly enough they will, if necessary, give up other things to get it. But all this only emphasizes the importance of economy in the use of resources devoted to health care, and I was glad to see that The New York Academy of Medicine's policy statement emphasized "the importance of using the nation's resources in the most effective and economical manner consistent with the enhancement of individual dignity and high standards of care."

But if we are really concerned about economizing resources, would we have adopted what is essentially a major-medical type of insurance in Title 18 B? All experience has shown that this method of reimbursement tends to escalate costs by making it easier for suppliers to raise prices or to provide unnecessary services. Would we have fragmented our governmentally financed services, thereby running the

risk that, for instance, people may find it necessary to utilize costly hospitals because there is no provision for reimbursing hospital-based ambulatory care? Would we have envisaged the involvement of private intermediaries in control of utilization? Even now the effectiveness of utilization committees run by the professionals concerned is very uneven. How much more concern for the public interest in economy of use can we expect when assistance to hospitals and related agencies "in the application of safeguards against unnecessary utilization of services" is placed in the hands of competitive profit-making concerns whose orientation will surely be primarily toward what makes life easy for their clients and attractive to themselves as administrators? A concern for economy in the use of resources would surely have led us to make provision for more effective representation of the public interest on the many committees that are setting policy in the application of the "reasonable cost" provisions. It might have led us to make arrangements for the separate organization of consumers of the health services who are also taxpayers, to counter the pressures of organized medicine and the insurance companies on the federal agency. The short time elapsing between passage of the act and its coming into effect means that many major policy decisions and interpretations must be made in a hurry and, inevitably under such circumstances, existing organizations exert what in retrospect may well come to be seen as an undue influence. No aspect of our new programs is in more need of study and reconsideration than the provision made for proper representation of the public interest, for publicity, and for accountability.

Waste, in the sense of more resources being devoted to a particular service than is really necessary, occurs not only when patients are kept in costly facilities because equally appropriate but less costly methods of caring for them are not available or not reimbursable, or when suppliers, through the exercise of monopoly power, are able to charge an excessive price for their services. It also occurs when procedures that could be performed by less highly trained personnel under professional supervision are carried out by expensively trained professionals. It occurs when unnecessary tests or procedures are applied. It occurs when too many hospitals are built in a community or when there are too many acute general beds or hospital laboratories or when, for prestige considerations, individual hospitals create specialist depart-

ments, as for brain surgery or cobalt treatments, which in total are far in excess of the total community need.

A concern for economy in these respects will lead ultimately, I am convinced, to a reconsideration of the status and independence of the voluntary hospital. Given the large proportion that hospital costs form of the medical bill, given the many possibilities of reducing costs (as itemized, for instance, by the Folsom Report in New York) of which the hospitals could have, but have not, taken advantage, given the importance of assuring a uniform accounting system to permit effective interhospital cost comparisons and given finally the crucial importance of the hospital in the total organization of health services, we cannot much longer permit the voluntary hospital to operate as a purely private concern, answerable only to its own governing board. The recent so-called Folsom Law, which introduces a measure of public control over hospital expansion and operation, is a significant straw in the wind. And I wish to add that what I have said about the essentially "public-interest" character of the voluntary hospitals applies equally to "private" health insurance, both profit and nonprofit. All of them are, in fact, public social utilities.

In our concern about economy in the use of resources devoted to health care we must, however, never forget that in the broader sense waste also occurs when we continue to treat as exclusively medical problems, conditions that might be prevented by appropriate policy and program changes in other areas, such as housing, or the reduction of poverty, or the improvement of education.

The Agenda for the Future

I have tried to suggest to you that the problem of how we organize and finance medical care has by no means been answered by the Social Security Amendments of 1965, important as they are. Even within the limited areas with which the act is concerned, essentially the aged, the indigent, and the medically indigent, a number of highly questionable and sometimes conflicting policies have been adopted. But it has started us on a road from which there can be no returning. Governmental involvement in the financing and organization of our health services is here to stay and there is every indication that it will increase. Resolution of the policy issues at stake provides an agenda that will make the greatest demands on our ingenuity and our resourcefulness for the

rest of this century. It will also make great demands on our courage and our sense of public responsibility. Above all, it will be a crucial test of the strength of our conviction that all people should have the assurance of an equal opportunity to obtain a high quality of comprehensive health care under self-respecting conditions.