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

The insurance enforcers

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

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

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

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

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

—Karen Steinherz and Linda Frommer

What's behind the rising cost

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

Why is health care so expensive?

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

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

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

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

The question of medical technology

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

# of health care

of society have both produced and benefited from those technological developments that improved the quality and longevity of life. The cost of continuing such technology should, theoretically, cheapen, since it increases the productivity of society. But this is not the case now because of a relative collapse in industrial research and development and a tapering off of investment in physics research. In the past, biology has relied heavily on physics for technology, particularly in the development of diagnostically valuable X-rays, X-ray diffraction for crystallography to characterize biomolecules. Physics also played a key role in the development of other diagnostic and testing equipment such as the powerful electron microscope, computers for data analysis and experimental disease simulation.

The problem is that research and development for the country as a whole peaked in the mid-1960s and then plummeted. Basic biological and biomedical research held out longer largely as a result of President Nixon's war on cancer, but now is declining in real dollar terms.

While domestic cuts in R and D have affected equipment important to disease detection and research, similar effects have been felt in the area of instrumentation. The decline in physics and engineering has increased costs or has made certain technologies unavailable. Some of the cases in which bioinstrument suppliers have had to go it alone include laser application for studying photosynthesis and vision, X-ray diffraction used to study biochemistry, and the chemical research applications of nuclear magnetic resonance to biology.

In summary, the lack of development of a rigorous theoretical framework necessary to the continuous refining of precision equipment has cost us all dearly. The lack of scientific research and engineering have reduced the productivity of biomedial research and thus increased medical costs.

The 'opposition'

Those hospital administrators, insurance brokers, and others inclined not to support the Kennedy Health Security Act should be wary of the recommendations being given by two "conservative" organizations—the American Enterprise Institute and the Heritage Foundation—on how to defeat the bill. Their "free enterprise" counter-proposals would simply put the problem of controlling costs into the hands of the private sector. Nowhere is the quality of health care discussed. The following are excerpts of an article that appeared in Business Insurance *entitled "Medical Cost Containment" by Kenneth Keane, who is a senior vice president and director of the Johnson and Higgins insurance brokerage firm.*

George Orwell's book *1984*, which was released back in 1949, depicted a time and a place then considered unrealistic and farfetched by those readers inspired by the work ethic and freedom of enterprise code. *1984*, spawning a cult of doomsday sayers, is now only half a decade away—the year, that is, not the situation depicted in the book. Or is it? Orwell wrote about a society controlled by the state, that lived by five-year plans, and communicated with a vocabulary called "Newspeak" which consisted of such words as Goodthink and Badthink.

The time has come for corporate planners and other organizations to adopt a five-year plan of their own to avert a doomsday scenario in 1984. And the Goodthink today has to be *"cut medical costs!"* ...

Before things get really out of hand and the federal government steps in to run the whole show ("Badthink"), employers have to get a move on to keep costs in check. And the first place for them to start is in their own back yards—their health benefit plans for employees.

... One small corrective step would be adopting a strict coordination of benefits program so that employers can provide adequate (not duplicate) coverage coupled with cost efficiency.

... Employers might want to think about involving the employees financially in the outcome through greater deductibles and higher employee contributions....

Emphasis can be placed on encouraging employees and their physicians to opt for less costly medical treatment.... A revised plan could *increase* the deductible or coinsurance if the employee has more expensive and lengthy treatment on an in-patient basis....

... Private enterprise, and not the state, can effectively control costs. If it can't, then government-run National Health Insurance may become a reality by the middle of the next decade.