ELEMENTS OF HEALTH INSURANCE TODAY

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THE TERM HEALTH INSURANCE, simple though it seems, includes within it conflicting philosophies of how personal health services should be provided and paid for. In practical terms, the conflicting ideas of health insurance involve questions of how much money should be spent on health care, how hospitals and physicians should be paid, and what services should be provided and how. These different views stem from different assumptions about how people behave toward their health needs and even different concepts of well or ill being. This discussion is chiefly for medical students, and it emphasizes the questions that relate most closely to physicians.

The modern era of health insurance in this country started in the 1930's and has grown rapidly since that time. In 1940 twelve million persons (9 per cent of our population) had some type of health insurance; today, 123 million people (72 per cent of the population) are covered by at least hospitalization insurance. No other country in the world has had this rapid a growth of privately sponsored health insurance, nor has so large a proportion of any other nation's population been covered by unsubsidized private plans.

The health insurance plans that cover these 123 million insured people are Blue Cross and Blue Shield plans, sponsored by hospitals and medical associations respectively; private insurance companies; and a number of independent group-practice plans, which are generally physicians' service plans sponsored and administered by industry (*e.g.,* the Kaiser Permanente plan on the West Coast), by community groups (*e.g.,* Health Insurance Plan of Greater New York), or by groups organized as cooperatives (*e.g.,* Group Health Association in Washington, D. C.)

All insurance plans together now finance about 60 per cent of the total general hospital bill in this country, almost 50 per cent of the total surgical bill, and close to 20 per cent of the cost of all physicians' services including surgery. In all, health insurance finances 19 per cent of the nation's total private personal health expenditures. At the present time, incidentally, these expenditures total over $16 billion a year, or about $94 for each person in the United States.*

Benefit Patterns The Blue Cross and Blue Shield plans and the private insurance companies are the major health insurance agencies, covering over 90 per cent of the persons enrolled and paying over 90 per cent of the money paid out in benefits. Consequently, they set the dominant pattern of benefits. The independent plans, which reorganize medical practice, represent experiments in new ways to organize and provide physicians' services.

The prevailing benefit pattern of Blue Cross & Blue Shield and private insurance today consists of coverage for hospital care and physicians' services in the hospital. Generally not covered are physicians' home and office calls, diagnostic services outside of the hospital, and drugs and medications, dental care, and other health goods and services. There are a few exceptions to the pattern. In medical care plans in the state of Washington and in Oregon, for example, home and office calls have been standard benefits for years. (They have also been added recently in a California county and are common benefits in medical society sponsored plans in Canada.) The independent plans generally provide hospital care and all physicians' services in hospital, home, and office.

Many private insurance companies and some Blue Cross and Blue Shield plans are also experimenting with so-called broad coverage or major medical contracts, which insure services in and out of the hospital after the enrollee has incurred a certain expense (ranging from $50 to $500). After the patient has paid this amount, the major medical insurance pays all or most (75-80%) of the remaining cost of services up to high levels, often to five, ten, or fifteen thousand dollars.

As health insurance plans have increased the proportion of the population they cover, and as the population has secured coverage for

*These estimates are from the HIF-NORC survey for 1958. Recent estimates of the Social Security Administration show $17.6 billion a year and $101 a person for private personal health expenditures, excluding expenses for administration of health insurance.

a wider range of health services, all phases of providing health care have been increasingly affected. As it helped to solve the original problem of financing health care, health insurance has created new problems in providing services. In part, the new problems are those that would arise with the application of any social innovation. As already suggested, however, significant problems stem from fundamental differences about the nature of health insurance itself. It is important that these be spelled out.

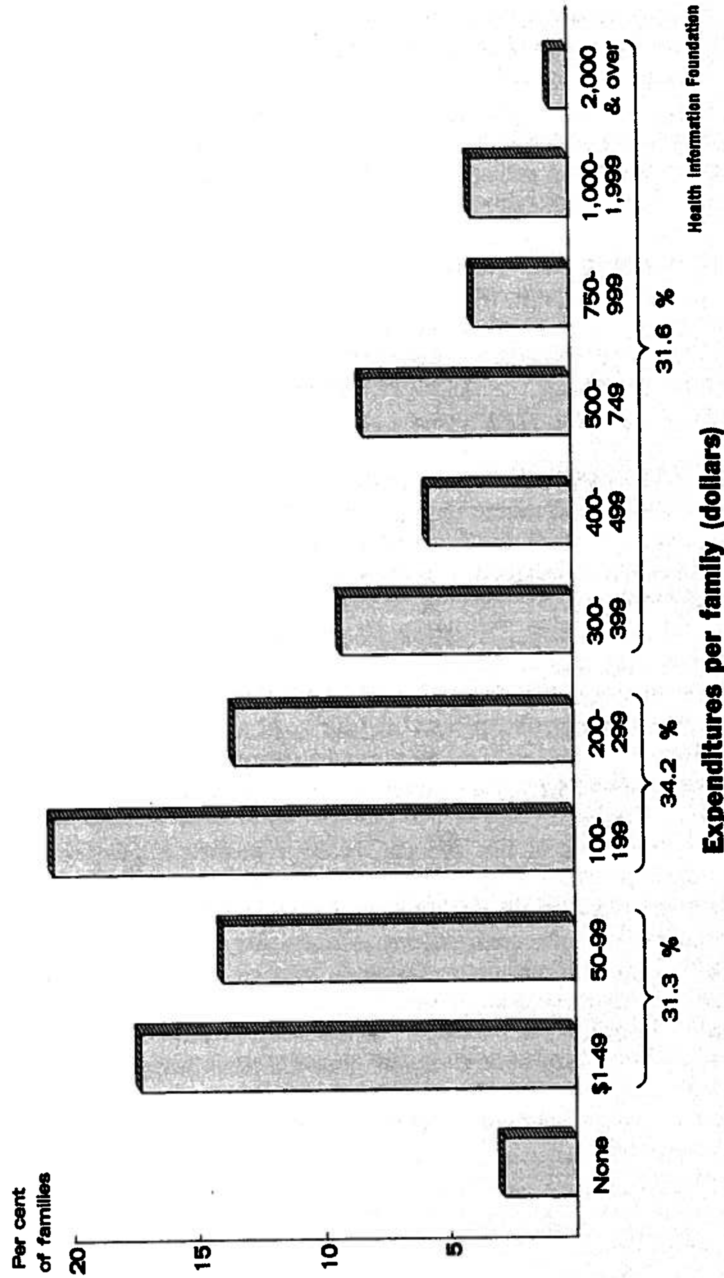
Concepts of Risk and Service Two different concepts of health insurance have existed side by side for many years. In the first of these two concepts health insurance is considered primarily a method of helping families pay for personal health services* by pooling insurance premiums of many families to repay the limited number who incur costs for services in any given year, i.e., "spreading the risk."

This view regards health insurance as protecting families against the risk of financial loss in the same way that life insurance, fire insurance, or auto insurance do. Just as life insurance replaces the income of the breadwinner in case of his untimely death, or fire insurance protects a home owner's investment in his house in case of fire, so health insurance is seen as protecting the financial solvency of the family in the event of illness. The insured family purchases personal health services as it might purchase any other needed goods and services. The insurance agency then reimburses the patient for the costs of whatever services it has agreed to insure, in the amount it has agreed to pay. Its payment is a "cash indemnity."

According to this concept, health insurance fulfills the classic requirements of insurance: (1) the event insured must be unpredictable for the individual or family but predictable for a group of individuals or families, and (2) the event insured must be unwanted, so that there is no built-in inducement to use the insurance. Thus, for example, a person's death is an insurable event because (1) its date of occurrence is unpredictable while the pattern of mortality for large numbers of insured persons can be projected closely, and (2) very few people commit suicide to have their beneficiaries collect their life insurance. Similarly, individual fires are unpredictable while the risk of fires among a number of homes can be estimated, and very few people burn their houses down to

*Personal health services include general hospital care, all physicians' services wherever rendered, drugs and medications, dental care, and all other goods and services, such as appliances, private duty nursing, and other recognized professional health services, such as those rendered by physiotherapists.

Chart I—Family Expenditures for Health, 1957-58



collect the fire insurance. The assumptions in health insurance are (1) that, while individual illness cannot be predicted, the risks of illness among groups of people can be predicted and (2) that very few people are anxious to go to the hospital or have surgery without good medical reason for doing so.

However, the classic insurance principles are more difficult to apply to health insurance. People's medical needs and their expenditures for personal health services are much more complicated than death, fire, and accidents. These are events easily defined and predicted for the pooling of funds, and the extent of loss—or at least the liability of the insuring agency—can readily be determined for payment. Necessary expenditures for personal health services, although still "insurable" according to insurance principles, cannot always be as readily defined or limited. *What range of services should be insured? How much of the expenditures for services within this range should insurance pay?*

The other concept of health insurance views it as a means of providing people with needed health services. The emphasis is on the provision of service, not on reducing the risk of financial loss to the family. For a prepaid cost per person or family, health services are provided to insured persons with no extra charge—the patient, in fact, may not know how much the services cost. This is the "service benefit."

These two types of benefits—"service" and "cash indemnity"—are related to issues in the health insurance field which many feel are of a fundamental nature.* Basically, however, a "risk" concept underlies both schools of thought just described. Over any period, some families spend little or no money for personal health services while a small minority spends a great deal. For example, during a twelve-month period in 1957-58, less than 3 per cent of the families in this country spent nothing for personal health services. On the other hand, 16 per cent spent $500 or more, and just under 5 per cent spent $1,000 or more (Chart I). Thus expenditures for personal health services fall unevenly among families, so that the risk principle of insurance applies regardless of the type of benefit.

*Not the least of the problems is the invidious comparison that can be and is made between the word "service," which has a connotation of compassion for and concern with the patient, and "cash," which seems to smack of the market place. Indeed, occasionally I hear, "What people need is service, not cash." Overlooked is the fact that one cannot exist without the other.

Health Insurance and Human Behavior Those wedded to the risk concept of health insurance believe that the primary role of health insurance is to help families pay the otherwise crushing costs of major or "catastrophic" illness, while the families themselves pay the small, regular or intermittent health care costs. Those who subscribe primarily to the "comprehensive service" concept believe that all types of services — from simple vaccinations to very expensive procedures — should be provided in a health insurance program so that no family foregoes medical care for reasons of cost. The proponents of this approach believe that providing comprehensive service benefits will assure the intelligent use of the full range of personal health services available today, encourage early diagnosis and stimulate maximum use of preventive services such as physical examinations, vaccinations, and well-child and maternity care.

On the one hand, the risk concept seems to assume that people will act in their own best interests as purchasers and, on their own initiative, obtain desirable health services if some of the costs are underwritten. The service concept, on the other hand, seems to imply the reverse; and seems also to imply that money should not be directly associated with patients and providers of services. It can thus be seen that the two concepts differ in the nature of their concern with the health problems of the public and also in how they view human behavior regarding health services.

Advocates of these two approaches disagree (1) on the extent to which services should be paid by insurance (whether insurance should cover the full cost, from the first dollar on, or only a portion of major costs) and (2) on whether some services should be covered at all. It is easy to demonstrate from family surveys of expenditures for personal health services that not only do families vary considerably in the *total amounts* they spend for personal health services in a year, but they also vary considerably in the amounts they spend for different *kinds* of service. Further, the total expenditure for each of the various kinds of service may be substantial. While 34 per cent of the total spent for personal health services is for physicians' services and 23 per cent for general hospital care, according to a 1958 study, 20 per cent is spent for drugs and medications outside the hospital, 15 per cent for dentists' services, and 8 per cent for other medical goods and services (Chart II, page 8). Thus, virtually all types of health services carry an element of substantial financial risk.

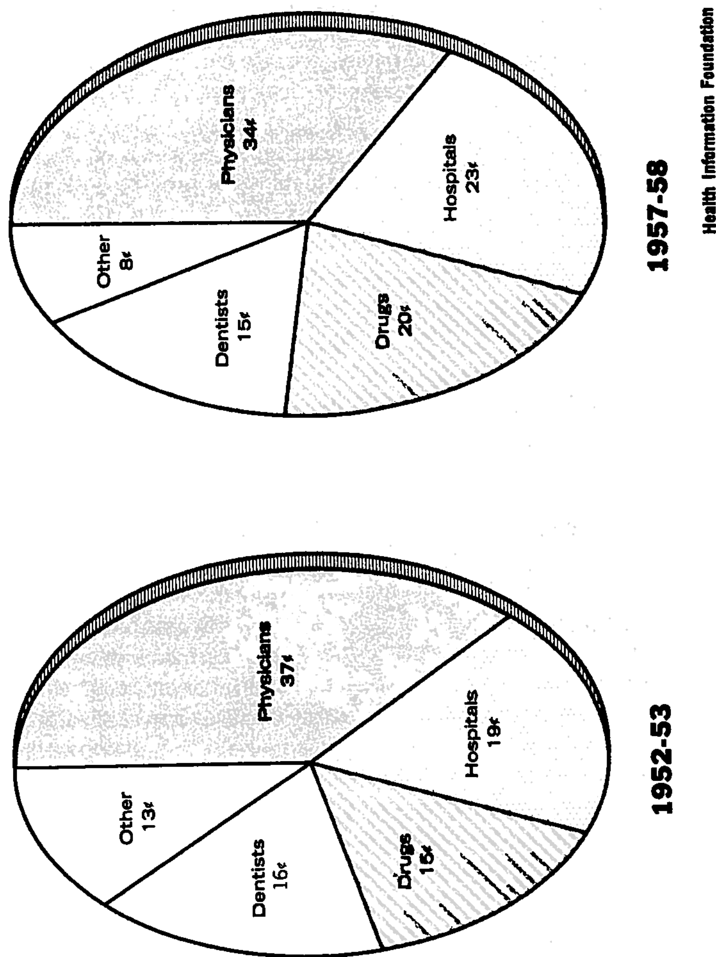
At present, health insurance written with a risk concept is more common in this country than the service concept, whether measured by standards of dollar volume or enrollment. However, the two are by no means mutually exclusive and, in fact, neither has found it possible to develop in its pure form.

Private insurance companies operate within the risk concept, as do any organizations writing major medical contracts. Blue Cross and Blue Shield plans can probably be classified largely within the risk concept, but their operation also includes substantial elements of the service concept. Many Blue Cross and Blue Shield plans provide both service benefits, in which the patient pays nothing over the rates agreed on between the plan and the provider of service, and also provide cash indemnity benefits, in which the patient may pay more than the plan allows for the specified service. The group practice plans are clearly in the service category because there is no money involved directly for each service between patients and physicians. Further, these plans often attempt to provide and encourage use of preventive services such as physical examinations, immunizations, and well-baby care.

Both concepts of health insurance raise profound issues in practice. This is because health insurance, whether service or risk in concept, must balance the needs and characteristics of three complex groups: the general public, the agencies which collect the money and influence the provision of service (various voluntary health insurance agencies, government), and the providers of service (physicians, hospitals, dentists, pharmacists, etc.). The requirements and inherent peculiarities of these groups must be reconciled in any application of health insurance principles.

The Health Insurance Agency The key need of the insurance agency or underwriter is to remain solvent by paying out no more money in benefits than it receives in premiums. (I deliberately put this ahead of the need to serve people adequately; if an insurance agency becomes insolvent because of unrealistic financing it is serving no one.) To maintain the balance between income and expense, all health insurance agencies follow practices which enable them both to predict and control their costs. Whether following a risk or service concept, they establish controls which often involve the subscriber (the patient) and the provider of service (the physician or hospital).

Chart II—The Medical Care Dollar 1952-53 and 1957-58



Group Enrollment One of the chief controls is group enrollment—most commonly, the simultaneous enrollment of all the employees of a business. The concept of risk discussed above includes the assumption that if the age and sex composition of a group of people is known, the amount of utilization of health services—and consequently the cost of services—can be predicted. A group of employed persons serves the health insurance enrollment purposes by being at the particular place of employment more or less by chance, thereby including a broad range of health risks. Another advantage, of course, is that the cost of enrollment and other administrative costs are held to a minimum when large groups are enrolled at once and premiums are "collected" for the insuring agency by company deductions from its payroll.

Health insurance agencies try to prevent self-selection in their enrollment procedures to avoid enrolling an undue proportion of "bad risks" (i.e., persons likely to use a disproportionate amount of health care). Group enrollment does not eliminate the possibility of self-selection unless all or nearly all persons in the group enroll. For this reason, insurance agencies usually require 60 to 90 per cent of the employee group to enroll under the group contract. They believe that without this requirement those who would use few services would not enroll.

Enrollment of individuals is considered a very risky undertaking (as well as a costly one) for a health insurance agency because it is assumed that individuals who seek health insurance will use more health services than those who do not. Enrolling aged people is also considered a great risk. However, people of all ages are now usually allowed to enroll as members of a group. The practice is increasing also of permitting those who retire because of age to continue their enrollment, usually at a higher premium. Enrollment of people not in employed groups, however, continues to be a difficult problem for voluntary health insurance.

Although group enrollment helps to assure a spread of risks among those enrolled, health insurance agencies use other controls to protect the pooled fund from costs that would exceed premium income. These controls are exclusions of conditions, limitation of benefits, and extra payments by subscribers. All of these are limits to the subscriber's use of his insurance, presumably for his long-term benefit by assuring the financial solvency of the health insurance agency.

Exclusions Exclusions are underwriting rules which specify that prospective subscribers having certain disease conditions at time of enrollment may be excluded altogether or may have that one disease condition excluded indefinitely or for a specified time. In addition, some diseases that are considered unmanageable are excluded from coverage. In group enrollment, however, treatment for some conditions is not excluded, but waiting periods are usual for such procedures as tonsillectomies and adenoidectomies and for maternity care. Such waiting periods or the exclusion of relatively common procedures are intended to reduce costs. Obviously, these conditions could be covered by insurance, but premiums would be higher. Health insurance, then, may apply to all the components of medical care* or, to only one of them, or to a combination of two or more.

Benefit Limits Another method of control is the limitation or exclusion of benefits. In the dominant pattern of health insurance, services other than hospital care and physicians' services in the hospital are simply not insured (with the exceptions noted earlier). Even for the services that are covered, limits to their use are often set so that no service is entirely "open-ended" in cost. Hospital insurance contracts may, for example, limit the number of days of hospital care that will be covered for any one condition or for an enrollee per year. Insurance for physicians' services may limit the number of in-hospital calls per patient.

Extra Payments One widely used control is financial, either in the form of "deductibles" or "coinsurance," which require that a patient pay for some part of the service himself. In hospitalization insurance he may be required to pay for all or part of his first day in a hospital, or part of the total hospital bill. In insurance covering physicians' services the patient may be required to pay for the first office call or for a fraction of the physicians' total bill. These devices give the subscriber a financial stake in his care which, in insurance thinking, results in more careful use of services. With coinsurance and deductible provisions, the physician or hospital may collect from two sources—the patient and the health insurance agency.

No systematic study has been made of the effect of deductibles and coinsurance on the use of services. *At what point will a deductible discourage unnecessary care? At what point will it discourage necessary care?* These questions are almost impossible to answer. Presumably, if the deductible is high enough the use of services will be reduced, but it may discourage needed care.

*Medical care in its broad definition includes services of physicians in hospital, office, or home; hospitalization, drugs, dental care, and a miscellaneous category of appliances such as eyeglasses and hearing aids.

This brief exposition of the nature of controls used in health insurance should show why they are thought necessary for the financial solvency of health insurance agencies. Their elimination would certainly increase the total cost of health insurance. The weight of informed opinion is, in fact, that costs would soar out of sight. I believe it more likely that costs would stabilize at some higher level (prices remaining constant). However, the level at which they would stabilize might well be higher than people are willing to pay for health insurance.

Controls affect the subscriber and the insurance agency more directly than they do the physician. Methods of direct controls on the way physicians practice have been discussed for years, but none that are systematic and generally acceptable have been devised. One method is a review of physicians' claim forms by medical review committees on behalf of insurance agencies. This is an attempt to detect variations from usual patterns of practice. Confusion results in not differentiating between controls to prevent unethical and gross variations in practice and controls to limit the range in which medical judgment is permitted. Any substantial reduction in cost would lie in controls limiting the range of medical judgment. This opens the possibility of interference with the basic characteristic of a profession, that of being permitted a wide range of discretion and authority in carrying out its functions.

Other methods not necessarily associated with insurance are medical audits in hospitals, periodic review of patients' records by medical staffs in hospitals, and so on. These are mainly quality controls and only indirectly affect cost. Moreover, adequate attention to quality does not necessarily result in lower cost.

The control mechanisms are not the exclusive concerns of either the service concept or risk concept, but seem to apply to any form of health insurance. What matters is the degree to which the controls are applied, but even this is difficult to relate to the underlying insurance concept as one examines the great many health insurance agencies today. Some private insurance company contracts, for example, are very com-

prehensive, while others apply many limitations. Some group practice plans set up many restrictions; others have hardly any at all. The presence or absence of controls seems to stem from the boldness or timidity of the insuring agencies, and the price that buyers are willing to pay for coverage, rather than to the "risk" or "service" philosophies *per se*.

Service vs. Cash Indemnity The service and risk concepts of health insurance seem to split most neatly on the issue of service benefits and cash indemnity payments. All private insurance companies and many Blue Cross and Blue Shield plans use the cash indemnity principle, at least in part. It is an integral component of the risk concept, with a long insurance tradition. A cash indemnity benefit is a fixed sum paid for a specified service without regard to the actual charge for that service. (It is assumed, however, to be less than the actual charge.) Consequently no rate or fee agreements are needed between the providers of service and the insurance agency.

The service benefit, on the other hand, requires rate or fee agreements between providers of service and the insurance agencies. Hospitals and physicians may not change the rates or fees they charge enrollees during the contract period. In the group-practice plans, the physicians on their staffs negotiate periodically with the plans for their level of remuneration. Those Blue Cross and Blue Shield plans operating with a service benefit negotiate rates and fees periodically with hospitals and physicians. Obviously, the service benefit places greater responsibility on the insurance agency and also, of course, places the providers of service under tighter financial control. They become accountable directly to the insurance agency, which acts as the insured person's agent. Subscribers should have a better knowledge of what their insurance buys in the service type of benefit. The cash indemnity form of benefit opens physicians to the criticism that the presence of insurance has a tendency to increase the average fee. However, as noted earlier, the majority of dollar volume of health insurance benefits in this country is paid out as cash indemnity, and is probably increasing. The strongholds of the service benefit principle are, by and large, Blue Cross and Blue Shield plans and the independent plans.

Experience vs. Community Rating A major issue in health insurance is whether insurance agencies should set the premiums for each group (1) on the basis of the amount of medical care utilized by

the group, or (2) on the basis of all groups in the community. The question of experience rating or community rating is thought to have great public policy implications. Insurance companies compute a group premium on the basis of what they estimate the utilization of the group will cost the insurance company (with a portion left over for overhead, reserves, etc.). Since illness rates vary considerably by age and sex (women having higher illness rates than men and children under five and adults over 55 having higher rates than those in the ages between) subscribers in groups with different age and sex composition—or in different occupations—may pay different premium charges even in the same area. Each group is thus intended to bear its own cost.

Under the community rating principle, used mainly by Blue Cross and Blue Shield plans and the group practice plans, the same premium is charged for the same scope of services to any group enrolled. Consequently, some groups pay more than the cost of the services they use, while for other groups the opposite is true. The community rate spreads the cost of personal health services equally over all groups. Community rating has been found difficult to sustain because some big buyers of health insurance, such as industry and labor unions, can sometimes negotiate a lower rate than the going community rate if characteristics of their employees lead to lower use and cost than the population in general. It is contended that community rated insurance agencies might ultimately be left only with "high risk" groups if competing insurance agencies using experience rating are able to enroll the groups that use less care. It is further contended that if the community rating principle collapses the high risk groups will be unable to afford health insurance at all because of the high rates they would have to pay to be self-sustaining. This is a very complicated issue, and it is not at all certain that the theoretical arguments outlined here are borne out in practice. Suffice it to say that for the community rate principle to work in its *pure form*, Blue Cross and Blue Shield plans would need a virtual monopoly. Further, the big buyers of health insurance would have to support the principle of community rating to a greater extent than they have done so far throughout the country generally and be willing to pay the going community rate and refrain from negotiating lower rates.

Health Insurance and the Physician For the physician the most obvious change caused by health insurance is the shift in his source of income from the patient to an insurance agency. This simple change

brings other changes in the physician's practice. When the patient is the source of payment, the physician is responsible for his own collections. He bills the patient, and the patient pays the bill promptly, delays, or perhaps does not pay at all.

When a physician treats a patient who has *cash indemnity* insurance for the specified service rendered, the insurance agency will pay either the patient or the physician the amount specified in the insurance policy. The physician may or may not charge the patient more than the insurance allows, but many feel that the cash indemnity form of payment results in a rise in the average fee. If the insurance benefit is of the *service* type, the physician has contracted with the insurance agency to provide services to insured patients at specified fees, which he will be paid by the insurance agency. In either case the physician in private practice has come within the administrative sphere of an insurance agency; he must account to a party in addition to the patient for the services rendered. In the first instance, he will receive no payment from the insurance agency unless he notifies the agency that he has rendered a service. In the second instance, he must not only notify the insurance agency, but the payment he receives is a pre-arranged one. Usually, in either type of arrangement, the insurance does not cover all the services patients may use. In these instances the physician also bills the patient directly for the additional services. The physician's collection problem is made simpler and his practice more complex; collection is assured for insured services, reducing his bad debts, but forms must be filled out, records kept, and rules and regulations seemingly extraneous to medical practice must be learned and kept up with. The physician may be bewildered by the exclusions, limitations, and other contract provisions described above. On the other hand, he may gain satisfaction from knowing that his insured patients have less reluctance to seek needed medical care and that he is freer to prescribe what medical care has to offer.

Forms of Payment Health insurance has changed the *source* of payment, but it has done little so far to change the *form* of payment. The dominant form of payment is still a fee for each service, which the majority of the medical profession prefers, although some inroads have been made by the group-practice plans. The fee-for-service method of payment is not a simple form of payment in a medical insurance context, but it is workable. It entails keeping records of every service per

patient and setting a fee for each of the many types of services rendered by physicians.

Most Blue Shield plans make a compromise with physicians' practice of scaling their fees according to patients' incomes. They require member physicians to accept a fee schedule as payment in full for subscribers below specified family income levels. Above these income levels, the physician may charge more than the scheduled fee and the insurance is, in effect, a cash indemnity for upper income groups. The maximum income a family may receive—while still qualifying for the fixed-fee schedules—varies throughout the country, ranging from $4,000 annual family income to $7,500 or so.

The group practice plans pay salaries to their physicians, an annual amount per potential patient ("capitation"), or some combination of the two. With these methods of payment, insurance costs are more easily predicted, since they do not rise or fall with the number of services rendered as they do with the fee-for-each-service method of payment. There are many debates over the relative merits of the different forms of payment to physicians. Some say that the fee for each service encourages unnecessary care because giving additional, unneeded services can readily enhance the physician's income. Others say that a fee for each service is essential to the physician-patient relationship; the physician gives better service and the patient is more appreciative. The proponents of "capitation" and salary for physicians say that these payment forms allow the physician to forget the cash nexus in dealing with patients and concentrate on good care. The salary or "capitation" method are an important brake on costs because they do not necessarily vary directly with the volume of physician services provided. Opponents say that these forms of payment lead to lack of interest in the patient on the part of the physician. The list of pros and cons can be expanded, but it can at least be said that the issue continues to be discussed. The factors of administrative ease, physician desires, and patient preferences may eventually work out an accommodation. Related to the issue of payment methods is the question of free choice of physician, valued by physicians and patients alike, however it is defined. The principle of free choice is more easily applied in a fee-for-each-service arrangement than in other arrangements, although it is not precluded in other arrangements.

Insurance and the Public Some of the issues in the application of the health insurance principle that affect the public have already

been mentioned: the question of service vs. cash indemnity benefits and the community-rate vs. experience-rate methods of establishing premiums. The primary criterion apparently used by the general public to judge the effectiveness of their health insurance benefits is the extent to which insurance pays their bills. More subjective, but nevertheless just as real, is the extent to which the possession of health insurance relieves anxiety about possible large expenditures for personal health services and reduces reluctance to seek services, particularly early diagnosis.

The prevailing pattern of health insurance benefits in this country —coverage for hospital care and physicians' services in the hospital— emerged for two interrelated reasons. First, hospital care and physicians' services in the hospital, particularly surgery, were regarded by insurance agencies and actuaries as relatively easy to predict and coverage for them easy to administer. Second, hospital care and surgery were normally sudden, expensive and unexpected services which were difficult for families to pay for. Other services, such as physicians' home and office calls, drugs and medications, dental care, and the like were presumed to be needed intermittently and to cost small amounts, so that families could pay for them directly without the assistance of insurance. Equally important, services outside of the hospital were—and still are— regarded as difficult to handle administratively and their costs not easily predicted or controlled. (It might be added that hospital insurance developed initially to relieve the financial plight of the hospitals as well as to assist families in paying hospital bills, illustrating further the interlocking nature of the application of health insurance.)

One of the issues being debated is what part of people's medical costs should be covered by insurance. The latest systematic survey of health insurance benefits in this country was conducted in 1958. Approximately 65 per cent of the population in the United States was covered by some type of health insurance at that time. For all types of insurance agencies this composite study revealed that people who carried hospital insurance and were hospitalized had a median of 88 per cent of their hospital bills paid. The parallel figure for surgery was 81 per cent. These are national averages; there would be variations among the proportion paid by different insurance agencies. In all, insurance paid 24 per cent of the *total* expenditures for the full range of personal health services by insured families. It is clear, then, that health insurance covers only a portion of total health care costs.

It is clear also that from a risk standpoint personal health services outside of the hospital are sometimes difficult for families to pay for without some form of insurance. Surveys of family expenditures nationwide have shown that during a year families are as likely to have relatively high expenditures for home and office calls, drugs and medications, and dental care as for hospital care and surgery. Frequently, expenditures for different services are incurred simultaneously, because rarely does an illness require only one type of service. In the nationwide family survey of 1958 referred to earlier, for example, expenditures of $200 or more by type of service were as follows:

Type of Service	Per cent of families reporting expenditures of $200 or more in a year
All services	45%
Hospitals	10
Other physicians' (home and office)	8
Medicines	6
Dental	6
Surgical	4
All other	2

Proponents of "comprehensive service" benefits suggest that the full range of personal health services should be paid for by insurance. In actual fact, however, the "comprehensive physicians' care" plans, together with hospital care, now cover only from 30 to 50 per cent of their enrollees' total medical costs, although there is now discussion and planning to cover the cost of drugs and medications and dental care as well.

The proponents of the risk concept, on the other hand, are likely to approach the idea of comprehensive care in terms of including under insurance the full range of personal health services, but only after the patient has paid for a certain portion of the charges. Thus no services would be excluded, but the patient is covered for "catastrophic" expenditures.

Observations and Conclusions It is obvious that medical care is in a ferment and that the past relationship between individual practitioner and individual patient is being greatly altered. It is being altered by the twin factors of a more complicated, more effective medical tech-

nology and its increased expensiveness, both of which have created problems of organizing and paying for services. Basically, however, medical care still must require a person to person relationship no matter how complex the environing technology and financing have become.

I believe enough has been said for the purpose of this essay about the range of types of benefits and the problems facing the underwriter and the physician. One additional problem involves the underwriter, the provider of services, and the public, and, further, leads directly to problems of money and public policy. For the first time in the development of medicine, and of methods to bring physicians and patients together, we are in sight of the goal of bringing adequate medical care to all people. I will not quibble over a definition of adequate because with present knowledge no definition is possible, but clearly health insurance and generally rising income have resulted in more people receiving more services than ever before. One major consequence of the increased use of services is that more money is being required for health care. This in turn presses on the level of premiums of the insurance agencies. There is now a concern that a great deal of the increased use may be "overuse" and "abuse." The implication is that if this "misuse" of health services could be eliminated, costs would revert to a "normal" level—actually to a more accustomed level. This requires careful evaluation of the current methods of controls described earlier and the testing of new methods. The increasing extent to which personal health services are being paid for by sources other than the patient directly at time of service has brought into the picture the manifold concerns of other interests such as insurance agencies, labor unions, industry, and government regulating agencies. The climate of opinion today is in the direction of tighter financial and quality controls on the medical establishment than has been true heretofore. So far there are hardly any scientifically established criteria for determining the proper level of utilization and quality of services and the cost entailed. The fundamental question is· *What forms should these controls take and can they be applied equitably?* ■

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