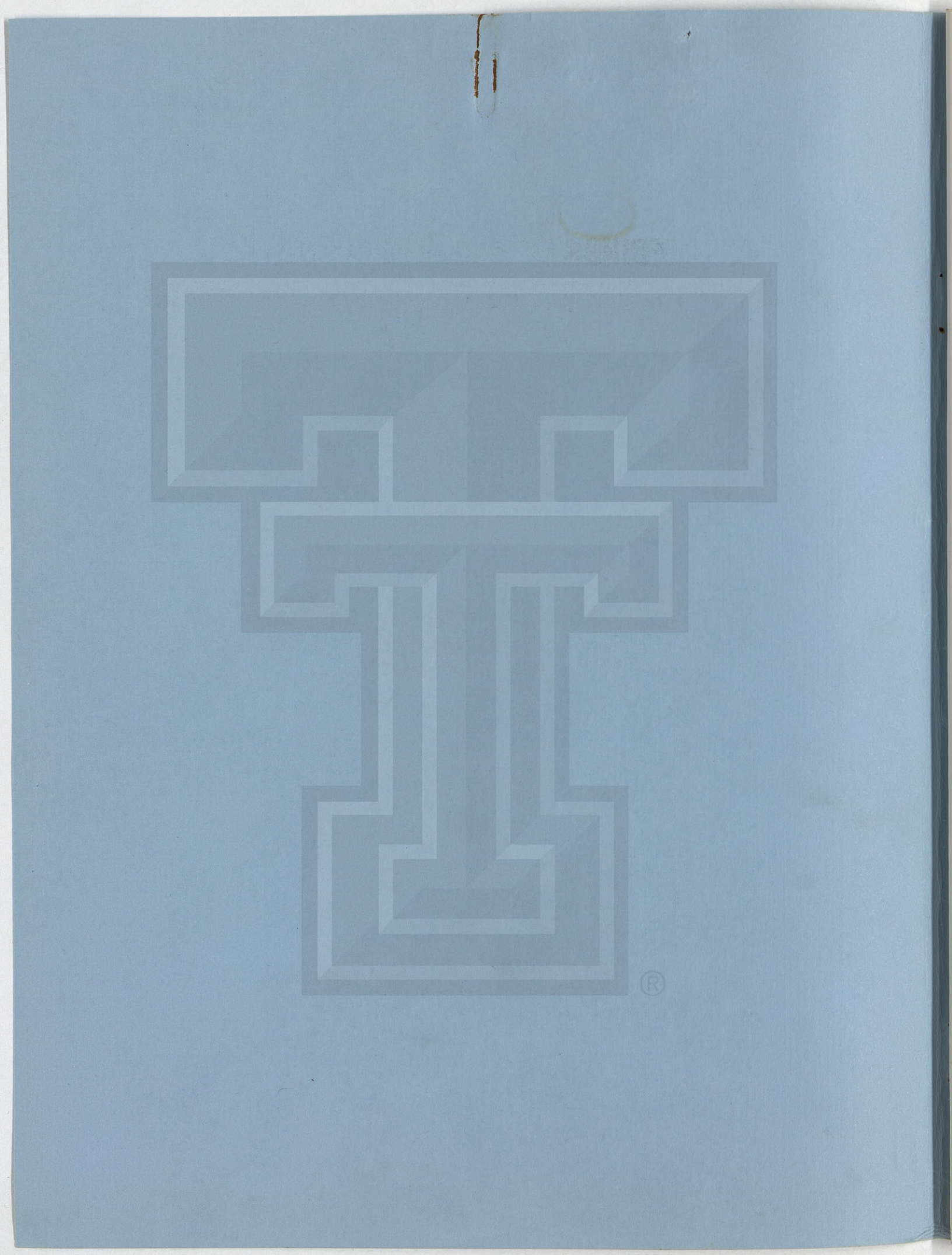
PROCEEDINGS OF THE INTERNATIONAL HEALTH EVALUATION ASSOCIATION SYMPOSIUM

MAY 5 and 6, 1978

VOLUME II

REIMBURSEMENT OF AUTOMATED PREVENTIVE MEDICINE PROCEDURES



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PREFACE

The International Health Evaluation Association (IHEA) is a nonprofit, international, educational organization founded in 1971 and devoted to the development and practice of clinical preventive medicine. The society is composed of diverse disciplines required in the application of computerbased systems and biomedical instrumentation to the process of health evaluation and diagnosis on the clinical level. The Symposium and Workshop held by the IHEA on May 5 and 6, 1978 at the Hyatt Regency Washington, dealt in depth with the benefits of such preventive medicine techniques and with the medical/scientific/technical factors underlying the self administered automated medical history. Volume I of this Proceedings covered this symposium and workshop in depth.

Volume II of the Proceedings deals with the equally important problem of third party reimbursement of preventive medicine techniques, of which the automated medical history is an important component. The session on reimbursement was organized in the realization that Medicare, Medicaid, Blue Cross and Blue Shield have given only lip service to the implementation of preventive medicine programs in the United States and, in actual fact, have generally refused to reimburse procedures of a preventive medicine nature administered on an outpatient basis. There is a strong body of evidence to support the contention that carefully organized preventive medicine procedures utilizing modern computer-based techniques will effect a significant reduction in health care costs; yet existing fee for service practices, combined with the inertia of third party reimbursement patterns, has effectively stifled widespread application of such techniques.

In addition to the advantages of computer-based health testing and related preventive medicine procedures in reducing health care costs, there is growing evidence that the quality of medical care and the associated level of morbidity and mortality of the population are improved in a significant way through the application of such techniques. Legislators, legislative advisors, DHEW administrative personnel, DHEW researchers, Social Security administrators, and "the Blues" have generally ignored or challenged these factors in establishing reimbursement procedures, and there is a growing belief that such "ignorance" is diametrically opposed to the welfare of the population as a whole. It is also the contention of experts in the field that the success of any future program of national health insurance will be heavily dependent upon widespread application of computer-based health evaluation techniques as already demonstrated by many medical organizations who are members of the IHEA.

The purpose of the symposium on cost reimbursement was, first, to present the case for computer-based preventive medicine as established by actual clinical experience in a controlled program of research and analysis and, second, to debate the issue of reimbursement among health care providers, experts in third party insurance, and legislators.

The session began with an address by Morris F. Collen, M.D. Director of Medical Methods Research, Kaiser Foundation. This covered "The Case for Preventive Medicine". It is appropriate that this address should lead off the Proceedings because it includes quantitative data which clearly proves the cost effectiveness and medical effectiveness of automated health testing when used properly in an outpatient setting. The data presented by Dr. Collen should be studied carefully by all legislators and Government personnel concerned with the reduction of health care costs.

The subsequent panel was chaired by Angelo Creticos, M.D., Medical Director, Henrotin Hospital, Chicago and former Medical Director of the Chicago Cancer Prevention Center. Dr. Creticos set the stage for the reimbursement debate with a carefully documented series of statements which defined the problem and established the need for corrective action on the part of legislators and third party insurance organizations. The panel talks were then delivered by the following:

- Honorable Marilyn R. Goldwater, R.N., House of Delegates, Maryland General Assembly,
- Juan de Dios Pozo - Olano, DSc(Med), PhD, President, Health Services International, Inc. and formerly Director of Outpatient Services, MEDICAID of Massachusetts,
- Mr. John F. Finney, III, Health Care Consultant and former Vice President for Marketing Maryland BLUE CROSS and BLUE SHIELD PLAN,
- Mr. Edward J. Brown, III, President, National Health Corporation.

These Proceedings cover not only the prepared talks but also the important and spirited debate which followed. Members of the audience - physicians, nurses, administrators, insurance company executives, representatives of DHEW, and involved lay personnel - participated actively in the debate. Their comments are uncensored and, because of this, there may be a few grammatical lapses. The reader will hopefully forgive these lapses in the realization that the comments serve to sharpen the issues in a substantive way.

All of these things are reported in the Proceedings that follow.

H.R. Oldfield, Jr.
Editor

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THE CASE FOR PREVENTIVE MEDICINE

Morris F. Collen, M.D.
Director of Medical Methods Research
Kaiser Foundation

There is a growing interest in our government for preventive medicine, and recently several important conferences have been held on this important issue. Public preventive health measures should be distinguished from personal preventive medicine; and the latter has been considered from the viewpoint of environmental and behavioral factors and health care services as shown in Table I below.

Table 1.

PREVENTIVE MEDICINE

PUBLIC-

PERSONAL-

ENVIRONMENTAL FACTORS
BEHAVIORAL FACTORS
HEALTH CARE SERVICES:
DISEASE PREVENTION DISEASE DETECTION
HEALTH MAINTENANCE HEALTH PROMOTION
PERIODIC HEALTH CHECKUPS
MULTIPHASIC HEALTH TESTING
LIFETIME HEALTH MONITORING

Environmental factors depend upon the physical, living and work environment. The societal and family surroundings are to some extent subject to individual control. However, the control of our pollutants and the removal of carcinogens from tobacco may be more cost effective for our country than large scale smoking cessation programs.

Behavioral factors and individual lifestyles are attracting general attention with increasing recognition of their influence on health; and these include use of tobacco, alcohol and drugs, nutrition and diet, exercise, problems-in-living and stress. These are controllable by the individual and are modifiable by appropriate health care services.

Health care services provided by health professionals are generally expected to provide the main thrust of personal preventive medicine, in addition to traditional diagnostic, therapeutic and rehabilitative services. Personal preventive health care services have as their objectives (1) disease prevention, (2) disease detection, (3) health maintenance, and (4) health promotion.

Disease prevention for the individual includes periodic immunizations for communicable diseases, identification of exposure to environmental health hazards and attempting to control or remove them, identifying individual high risks for specific diseases and attempting to correct or control them, etc.

Disease detection generally involves health status checkups which include tests for specific common conditions to attempt to identify abnormalities sufficiently early so as to be able to postpone or prevent disability and/or death from these diseases.

Health maintenance uses periodic monitoring of health status to retain one's health and prevent or postpone the effects from any health hazards or risk factors.

Health promotion is a positive approach to the improvement of health which employs health education and counseling so as to better health status through improved lifestyle, diet, exercise, etc.

These health care services involve a variety of tests and procedures, and there is no agreement on any one process for providing these. Criteria for selecting tests and procedures have been promulgated by many, most recently by a so-called "lifetime health monitoring program".
In traditional medical practice, the tests are selected by each physician and individually arranged for each patient on some periodic basis.

There is developing a consensus that in accordance with the examinee's age, sex and specific risk factors, one should prescribe (a) a selective cost-effective set of tests and (b) a rational periodicity for re-examinations.

There are a variety of processes available for providing the above, including (a) traditional periodic health checkups, (b) periodic multiphisic health testing, and (c) the recently proposed lifetime health monitoring program.

There is increasing support for taking a systems approach to personal preventive health care services. In contrast to the care of the sick, the care of the well is readily susceptible to a systems approach. Most people in a community are well; the "usual" person is not sick. Thus "sick care" is for the exception to the usual, it is less suitable for programming and protacols; and it is generally obtainable in good quality on an individual basis from physicians. Preventive health care or "well care" can be a routine, repetitive process, programmable for the usual person, or even for everyone. It thereby is well suited for the application of protocols, automation, and a systems approach, using allied health personnel trained in specific skills. This tends to exploit the economy of scale, the efficiency of automation and the quality assurance of control process monitoring; it can improve cost, service, and quality. The objectives of periodic checkups, especially when provided by the multiphasic health testing approach, can then be very broad as shown in Table 2.

OBJECTIVES OF PERIODIC HEALTH CHECKUPS

- HEALTH STATUS EVALUATION
- HEALTH MAINTENANCE & MONITORING
- EARLY DISEASE DETECTION
- DISEASE STATUS MONITORING
- SERVE AS ENTRY TO FOLLOWUP CARE
- IMPROVE QUALITY OF HEALTH CARE
- DECREASE DISABILITY, MORBIDITY & MORTALITY
- DECREASE COSTS OF MEDICAL CARE

Table 2.

A universal procedure for all people is, of course, not suitable. Which tests are cost-effective is dependent upon the sensitivity and specificity of the test, the cost of the test, and the prevalence of the condition in the target population. How often tests should be done depends upon the person's age and health status. Certainly the increasing incidence of disease with age indicates that older people need checkups more frequently than those who are younger. Most "health monitoring" packages show considerable agreement on their recommendations. Clearly, a system must be flexibly designed to select the most cost-effective test for each person.

We have more than 25 years of experience with one systemized approach to periodic health examinations which we call multiphasic health testing. Our experience shows that adults find such multiphasic checkups to be very acceptable and that a substantial percentage voluntarily avail themselves of periodic health checkups. Our studies have shown that this approach is very effective for early disease detection and health maintenance: Table 3 shows that for some asymptomatic conditions such as anemia, the great majority of patients and their physicians were unaware of the condition (78 percent "new"); whereas for most chronic conditions only about one-fourth were newly detected and the majority were returning for monitoring of a known disease and health maintenance.

FREQUENT DIAGNOSES FOUND IN 30,000 KAISER-PERMANENTE CHECKUPS

	PER 1000	%NEW
OBESITY	17	25
HIGH BLOOD PRESSURE	8	28
ANXIETY	7	31
ARTHRITIS	4	20
DIABETES	3	39
ANEMIA (Women)	2	78

Table 3.

By appropriate selection of tests which result in an acceptable cost per positive test (Figure 1), the checkup process can be very cost-effective.

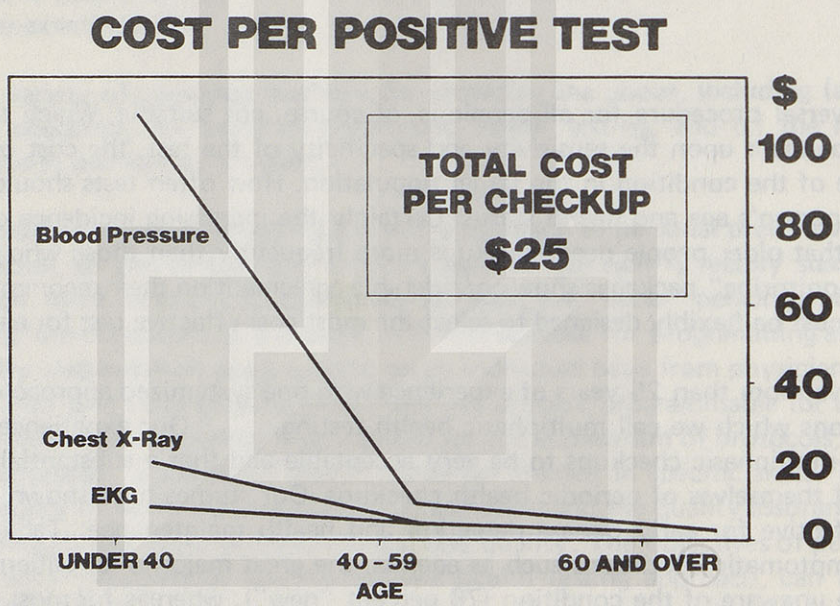


Figure 1.

SUMMARY OF 12-MONTH TOTAL RESOURCE COSTS ($/YR/1000 EXAMINEES, ADJUSTED FOR AGE, SEX AND HEALTH STATUS)

	TMC	MHT
MD COSTS	93,673	68,714
(% OF TRADITIONAL)	(100)	(73)
TOTAL COSTS	131,179	105,966
(% OF TRADITIONAL)	(100)	(81)

(Modified from Garfield, et al. [5,7])

Table 4.

Our studies have shown that such a systemized approach not only decreases the costs of the initial health status evaluation but decreases significantly the total costs of care for at least one year (by about 20 percent), as compared to the traditional mode of the patient-doctor encounter (Table 4). Urging periodic multiphasic checkups decreases significantly the mortality for all over age 35 for some potentially postponable conditions to which the checkup is directed (e.g., by one-half – Table 5); shows a lower mortality rate from all causes for those who elect to come in for checkups as compared to those who do not (Figure 2); and decreases disability and increases average net earnings for middle-aged men (Table 6).

DEATHS PER 1000

Among 10,000 Kaiser-Permanente Members
During 7 Years

	CHECKUPS URGED	CHECKUPS NOT URGED
ALL CAUSES (Including Accidents)	**35.6**	**39.2**
POTENTIALLY POSTPONABLE	**3.7**	**7.4**
HIGH BLOOD PRESSURE	**.6**	**2.2**
BOWEL CANCER	**.4**	**1.8**

(Modified from Dales, et al. [10,11])

Table 5.

CUMULATIVE DEATHS PER 1000 FROM ALL CAUSES

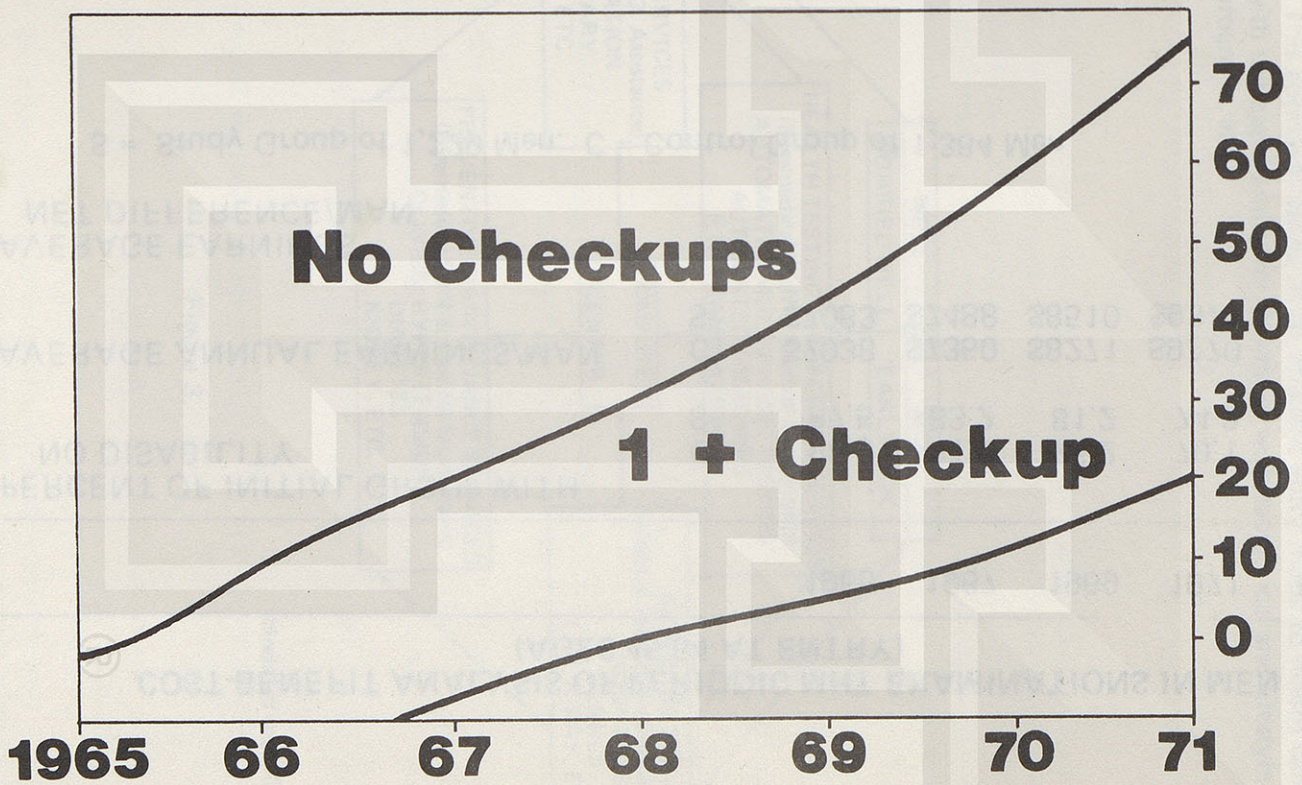


Figure 2.

COST-BENEFIT ANALYSIS OF PERIODIC MHT EXAMINATIONS IN MEN (AGES 45-54 AT ENTRY)

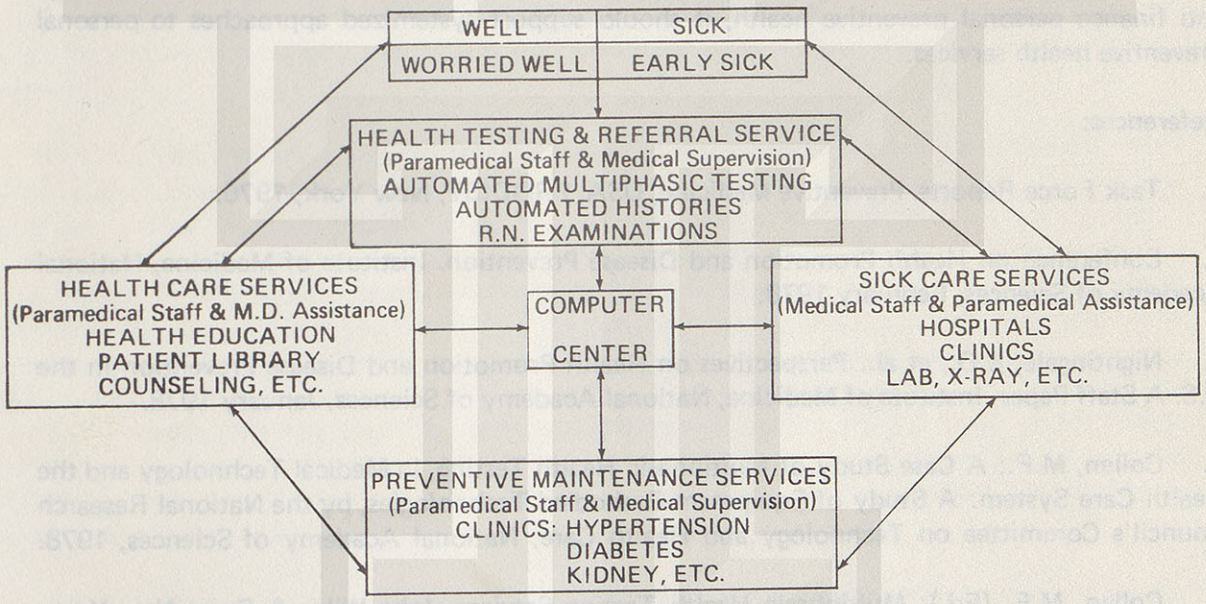
		1965	1967	1969	1971	1965-1971 TOTAL
PERCENT OF INITIAL GROUP WITH NO DISABILITY	C	86.8	81.0	76.2	70.1	
	S	87.5	83.2	81.2	74.2	
AVERAGE ANNUAL EARNINGS/MAN	C	$7038	$7350	$8271	$9270	
	S	$7083	$7488	$8510	$9371	
AVERAGE EARNINGS NET DIFFERENCE/MAN						$822

S = Study Group of 1,229 Men. C = Control Group of 1,364 Men.

(Modified from Collen, et al. [5])

Table 6.

Systemized health checkups can effectively identify each person's health needs and arrange appropriate services to meet these needs. Selective testing applies acceptable criteria for test selection to identify high risk persons and those who are early asymptomatic-sick. It then refers the sick to appropriate "sick care" services. (Figure 3.) The majority who are well can be referred to health education and health counseling services which try to further improve their current health status. This approach serves as an efficient entry mode to health care and provides each individual with the opportunity for assistance with categorical and lifestyle problems, such as stop-smoking programs, etc.



(Modified from Garfield in [5])

Figure 3.

Even though scientific efficacy of health checkups has not been demonstrated to everyone's satisfaction, a significant percentage of Americans are already receiving medical checkups, employment examinations, physical fitness appraisals, etc., for one reason or another. Many are following the model set by our Presidents, generals, and industry executives for periodic health evaluations. It is not possible to isolate expenditures for well person care in the course of physician office visits, but these expenses are already built into our nation's overall health care costs. Systemized health testing services, available to all people and all physicians in the community, would be much more efficient. At Kaiser-Permanente, these services and costs have been included since our inception; we believe this has been done in a very cost-effective manner and that this, in its own way, helps us compete successfully with alternative health care programs.

Since health status appraisals by a variety of modes are already built into our national health care costs and since there is more agreement than disagreement on which tests should be done and how often, the major issue is how our country should better organize its health care to provide checkups. Our experience suggests that if governmental policy is to encourage and finance personal preventive health, it should support systemized approaches to personal preventive health services.

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WHERE IS THE THIRD PARTY PAYER?

Angelo P. Creticos, M.D.
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and
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Introduction:

Although the periodic physical examination as a concept and as a practice has been an entity for well over 100 years, it has not really caught on so to speak because it was directed toward the more affluent part of our society and for those precious few whose employers saw fit to classify them as key employees and therefore worth any expense to salvage. It really took a new concept to shake the periodic examination concept out of its doldrums and to set the stage for a more probable success story. This new concept was the Multiphasic Health Testing System.

This concept embodies a merchandising approach never before used in medicine on such a mass scale - namely, the packaging of a number of tests into one test package, bringing together tests that would show a trend of disease and yet these tests would offer the examinee a bargain rate unheard of in the usual medical circles. Over the years the Multiphasic Health Screening Examination has undergone many experiments and developments by different groups to suit their own purposes - but in each instance the usual result was to effect a monetary savings while producing a high quality health package. There was no real standard by which the various centers would function except for the concept of "low cost with high quality." It should be noted, however, that much of the early and subsequent development of multiphasic health testing was directed to the well or near well individual, although some centers have succeeded in making these units an integral part of the health care delivery system of the health facility to which the unit was attached.

Thus developed the real concept of Clinical Preventive Medicine, which I prefer to equate to multiphasic health screening. This is not the same as public health or the usual concept of preventive medicine which is an academic coverup for preventive medicine. Clinical preventive medicine is an active science that deals with the debilitating illnesses that man succumbs to often insidiously until too late. Clinical preventive medicine attempts to identify early clues of illness, thereby alerting an unsuspecting patient or physician in enough time to either avert the tragedy or ameliorate its consequences by controlling the offense to the body. The least we can expect from such a science is an improvement in the quality of life that is lived. The most we can expect is prolongation of productive life and possibly total prevention of a specific disaster. There is no question in my mind that we accomplish much improvement in the quality of life and considerable improvement in the prolongation of productive life.

The Problem:

We must now address ourselves to the problems M.H.T.S. has faced and reflect on some of the reasons it has faltered in its development and success. Much of my thoughts are colored by my experiences as Medical Director of the Portes Center from June, 1971 to January, 1977. Please forgive me for the personal approach, but please remember our problems are most applicable to many centers.

At the Portes Center we succeeded in developing and delivering a comprehensive high quality health evaluation for a nominal fee and, although we enjoyed tremendous success, it is fair to say that the process was painful at times. It was difficult for us to understand why such a concept did not enjoy greater success instantaneously. Here was a most respected institution providing for the public and the health profession a $400 examination for $85. The Center did this without financial assistance from government, from grants or from heavy donations. Over the years our donations amounted to less than 5% of our budget. The entire program was therefore underwritten by the examinees' monies. It was a total cash flow business and this is how the Center continues to date.

By way of reference I would like to state quickly that the total examination package consisted of the following with most being on line with the computer:

- A detailed system review history
- A Glaucoma screening
- Visual testing for acuity and depth perception
- An audiometric test
- Pulmonary function screening
- 14 x 17 PA and lateral chest x-ray
- Complete urinalysis
- 3 stools for occult blood on test diet
- 12 lead electrocardiogram on computer
- SMAC - 20
- T-4
- CBC, differential
- Head to toe physical by an internist
- Pelvic and Pap by gynecologist plus G.C. culture
- Sickle cell screening
- Proctoscopy by a surgeon
- Thermography of breasts on all female examinees

All the above was accomplished in one 2½ hour session with a print-out produced by computer. The examinee had a choice to return in two weeks to have his findings reviewed by a Center physician and advice given.

The key to success in this system was and is traffic flow, high sustained volume based on a healthy backlog of examinees, a dedicated group of physicians and no deviation from the test procedures since such deviations usually result in delays and tend to strain the system which depends on the routine.

The Center succeeded in staying in the black each year and, in fact, it reduced a sizable debt that it incurred in changing from a regular clinic to a computerized M.H.T.S.. I might add that prior to 1970 the greatest number of examinees seen in one year at the Center was about 7,000 and these received only a fraction of the examination package I refer to above. From 1971 to 1977 the Center enjoyed a great increase in the number of examinees evaluated, the greatest year being 1975 when 26,500 individuals were examined.

In terms of success we should recall that in a 50,000 examinee sample we found about 65% of the individuals had not seen a physician in 5 years or more and of these 12% had definite need for further medical evaluation and follow up. At least 8% had significant trouble to warrant definitive treatment.

Again I ask the question - why has M.H.T.S. had so much trouble selling its concept and its successes? There are many probable answers and I will refer to only a few.

(1). M.H.T.S. itself is poorly organized - has not done an adequate job selling itself to the public and the profession.

(2). The medical profession's "jaundiced" appraisal and understanding of what M.H.T.S. is all about.

(3). Misdirected emphasis by M.H.T.S. centers in gaining the professional camps' acceptance.

(4). Isolation of many M.H.T.S. facilities from the health care delivery system per se.

(5). Heavy fiscal outlay to establish such centers without any guarantee of success.

(6). Lack of industry to see in such examination a way to force lower insurance costs.

(7). Lack of third party payers to perceive these examinations as eventual cost effective containment vehicles.

(8). Lack of government - both State and Federal - to enact clinical preventive medical legislation recognizing this phase of medicine as ethical and pragmatic - and offering the senior citizen and those on public relief the merits of such clinical preventive medicine. In other words, government must do more than express an agreement with the concept of clinical preventive medicine. It must help fund these examinations, thereby putting into action their blessings of the theoretical.

(9). Lack of government effort to explore the possible savings in medical care that can be effected if we were to elevate the general medical care to a higher and more even standard.

(10). Lack of government in exploring M.H.T.S. as a convenient, precise and reasonable approach to bringing comprehensive high quality medical care into the deprived neighborhoods of our cities and the isolated areas in our rural developments.

I could continue to enumerate the causes or faults - and I dare say we are all guilty of them. Needless to say we need to discuss them further.

The Solution:

I would be most presumptious in believing that I know the solution to this problem. I do have a few ideas that I believe might help.

(1). We in medicine must begin treating the well or near well individual as a different commodity from the usual ill patient. Packaged medical evaluation is not a dirty or demeaning concept to medicine. It is pragmatic and it comes immediately to grips with a basic concept with all people. They just don't want it to cost them a lot of money to find out they are well or near well. A patient paying $400 for a general examination must have something wrong - he feels gyped if he is well! Such is the psychology of the well. On the other hand, a sick individual is not usually concerned with money; he wants to see if he can be helped to survive. Cost becomes of relative importance and is always a later thought - or it should be.

The concept that a person will get a bargain is a most acceptable merchandising ploy. There is no reason why we cannot use it in medicine ethically.

(2). The medical profession must accept a known fact - namely, that the public will accept a form of sophisticated medical assembly line for routine evaluations, thereby cutting down the expensive physician examinee evaluation time. In the Portes Center each female examinee saw 3 specialist physicians and each male examinee 2 specialist physicians. In addition, all x-rays were read by a board certified radiologist, all electrocardiograms were counter read by a cardiologist over and above the computer, and all pathology was controlled by a clinical pathologist. Finally, each examinee had a consultation session with an internist two weeks later. Yet the Center was able to stay in the black, proving that proper use of highly paid personnel could be economic and the savings passed on to the public.

(3). This leads us to the concept that medicine must accept - namely, there is a wholesale and a retail segment to medical practice. I like to think of M.H.T.S. or a reasonable facsimile thereof as being the wholesale concept. Where predominantly physician involvement becomes paramount the retail concept enters the economic arena.

(4). Dedication by the medical profession is necessary to have such a concept succeed. Physicians cannot possibly command the same fee per examination as they would with their individual practice. For example, our proctologist could not possibly charge the Center $25 for each procto he did. Rather we streamlined his work so that the cost to the Center per examinee for a proctoscopic examination was about $2.50. Likewise the cost for two views 14 x 17 of the chest including films, technicians and radiologist interpretation was $5.75 instead of the $24 - $30 going rate for Chicago.

(5). The professsion should awaken to the fact that we as physicians are measured by the treatment we give our patients. We can, therefore, show that with greater use of M.H.T.S. the physician is allowed more time to counsel, treat, and educate his patients about his disease many of which we do not cure at this time but many of which we can control and keep in safe abeyance.

(6). Industry and Labor Unions should insist on broad application of this evaluation modality for workers other than for just the few upper executives. Industry and Unions should request pilot studies that would show such preventive medical procedures are cost effective in that early diagnosis and treatment will result in reduced morbidity, reduced absenteeism and reduced hospitalization.

(7). Third party payers can research out the cost benefits of M.H.T.S. to their general insurees, and especially in large health contracts. Such philosophical acceptance coupled with financial acceptance will do much to help M.H.T.S. succeed and bring it realistically within the grasp of the huge numbers of people who do not at this time enjoy its benefits.

(8). Third party payers can insist upon the improvement of standards of medical practice by insisting that a basic health evaluation be modeled after an M.H.T.S. program. What is wrong with upgrading a larger segment of our medical practice for a larger number of recipients?

(9). Government can also help. Think of the millions of senior citizens whose fixed income erodes daily by inflation and who cannot afford a thorough evaluation even at $85 such as described earlier. Think of the millions of senior citizens who need this type of general evaluation on some periodic basis, whose lives would be more comfortable, more fruitful and probably prolonged if they but had the benefits of clinical preventive medicine. No, the government wills that they be sick first before medical evaluation becomes a compensable item. But all too often symptoms in the aged are tantamount to far advanced untreatable disease. So we spend large sums to "save" the patient when a small amount might have averted the medical and economic disaster.

(10). Then government can look at its Medicaid and Public Aid problems and try to evaluate how it has contributed dearly to the problems that beset this segment of our society. Being on Medicaid or Public Aid is often a social disgrace and we often see our society respond to those less fortunate in such a manner. The medical care aspects of this problem are often horrendous and daily we see in the papers the flagrant abuse of the monies alloted for such programs. We are wont often to blame others for problems we have created and the system has helped create many of Medicaid's problems. Solutions are available and I offer but one. Let us examine our Medicaid medical care complaints. All too often we note that vast amounts are spent yet the patient is not properly cared for. I would venture to guess that overall only 20% of all public aid examinees have ever received a complete medical evaluation as a condition of their medical care. I venture to guess that most of those that did receive a complete check up did it in 10 or more visits to the doctor - the reasons being many why such is the case. These are obviously extremely wasteful techniques both in relation to monies spent, time spent, and talent not used properly. Would it not be prudent to study the problem and apply better techniques of care? For example, I would like to see an experiment where 5,000 public aid recipients are passed through a center such as the Portes Center, having their medical problems identified and the examinee properly referred to a competent physician or clinic for follow-up care. The governmental agency would be supplied with a file and could make inquiry as to the disposition the physician or clinic made in a given patient's case.

I would like to see such a group followed for 3 years and then compared to another group of 5000 public aid recipients who aimlessly seek medical attention and get aimless attention in return. It would be interesting to note the relative cost of these two groups of public aid recipients, noting that in the first instance a high quality care program was guaranteed for all, whereas the rather heterogeneous type care program was offered to those in the second group. I would venture a guess that the cost of the second group at the end of the 3 years could be similar, yet the care received by the first group is without a doubt of a much superior quality and effectiveness. The government would note its money was much better utilized.

Closing Remarks:

In closing this short presentation, I wish to remind my panelists that the direction of their remarks should be toward the economic acceptance of M.H.T.S. into the health care system. We need your input into this phase of our problem and we need to engage you and your talents in solving some of the economic issues that have befallen M.H.T.S.. Hopefully, you will agree with us that this is a science that should be saved and be better utilized. Hopefully, you will agree with us that clinical preventive medicine is economically feasible and that its time has come. Finally, we hope you will go back to your respective organizations and work for this concept even if modification is needed to have you accept this challenge.

LEGISLATIVE PROBLEMS

Honorable Marilyn R. Goldwater, R.N.
House of Delegates
Maryland General Assembly

It is indeed a pleasure to be with you today. I always enjoy meeting new people and I certainly appreciate the opportunity to talk about the subject of third party reimbursement. I am not involved in automated self administered medical histories, but I am a battle scarred veteran of many wars with the insurance industry concerning third party reimbursement in the health care field.

I speak both as a legislator and as a member of the nursing profession. Today I'm speaking to you primarily as a legislator from Maryland, charged with the responsibility of representing a constituency that is demanding change in many areas affecting their daily lives.

Many of the changes that they are demanding require government action. Responsible legislators - both state and federal - must be attentive to those demands and concerned with the conditions that have produced them.

No issue affects more American Citizens more deeply than that of health care. But I am concerned with the fact that we seem to have in this country an illness system rather than a health care system. The emphasis of medical education focuses mainly on pathology, its identification and treatment. There is a shameful lack of emphasis on preventive care, health maintenance, education and counselling.

If we are to meet the challenges for better health care and more accessible health care then we must revolutionize the present system and develop a total health care delivery system, a system that I believe must involve all the related health professions and make maximum use of their education and skills. It must also be a system that makes the maximum use of advanced technology and techniques. And it must emphasize health screening and education as a preventive practice which, in the long run, will not only help to produce a healthier population but will also help to produce a healthier economy.

Let me just briefly touch on the history of third party payments. The depression created human and economic needs that contributed to the establishment of health insurance. The 50s saw a phenomenal growth and by the time we reached 1975, 70% of all health costs were being paid by third party payments. Human and economic needs also accounted for medicaid and medicare. And today there are demands to extend third party payments to othe. health providers as well as for other health care services.

My desire to extend third party payments from health insurers and medicaid in Maryland to other health providers for new services led me to sponsor a number of pieces of legislation which would accomplish this. And this started my many skirmishes with the insurance industry - primarily the Maryland Blues - and with physicians.

In 1975 I introduced legislation requiring reimbursement for partial hospitalization for psychiatric treatment. I simply could not understand why payments were available for full hospitalization and for out-patient treatment but not for partial hospitalization. After much discussion and debate the legislation was amended so that it pertained only to group policies. Not a total victory but a step in the right direction. You can read a more detailed account in the June 1977 issue of Hospital and Community Psychiatry.

Another bill I introduced in 1977 in the field of mental health would have required reimbursement for a specified number of days (60) in a psychiatric half-way house. This bill has failed two years in a row but I plan to introduce it again.

Two other pieces of legislation I introduced pertain to third party payments. One was to directly reimburse nurse midwives and the other to directly reimburse nurse practitioners. Both bills were introduced in 1977 and failed. I reintroduced them in 1978 and the one to reimburse nurse midwives did pass. The other failed but I plan to reintroduce that one next year. I don't give up easily.

Let me give you some of the reasons given by the Blue Shield lobbyist in his opposition to the bills.

1. Insurance is a risk industry. If we pay screening, health maintenance, health education and similar services, we are eliminating the risk factor.

2. Every time the legislature mandates that we cover services the premium to the policy holder is increased and soon people will not be able to afford to buy our insurance.

To the first argument I answer - perhaps in order to meet the needs of today's society we are going to have to look at health insurance differently than other insurance. Health insurance should pay for health care, not just illness care.

The answer to the second argument is more difficult for in the case of Blue Cross-Blue Shield that touches the whole issue of how a non-profit company operates.

The arguments used by the physicians who opposed the third party payments directly to nurse midwives and nurse practitioners centered mainly around the philosophy of whether nurses are capable of setting up independent practices. In my view they definitely are capable. Nursing is an autonomous profession with its own Nurse Practice Act and its own licensure. Nurses practice nursing, not medicine. Nurses, in this day and age, can do physical assessment, screening, evaluation, education and health maintenance under mutually established protocols.

Federal legislation has been enacted which provides Medical reimbursement for services of nurse practitioners and physician assistants in rural clinics. The legislation also sets up several demonstration projects in urban areas. CHAMPUS reimburses for services of psychiatric nurses. Several insurance companies make direct payment to nurse midwives for their services. State legislatures are becoming more involved in enacting legislation that impacts on the health care delivery system. The Federal Trade Commission is studying the role that the AMA may have in regulating the other health professions. The Blue Cross-Blue Shield are also being evaluated by the FTC for possible monopoly practices. I think the handwriting is on the wall. In my view, for a variety of reasons, we are undergoing what amounts to a health revolution.

A national health policy is long overdue. The majority of Americans appear to be in favor of federal action; they are pressing for it. We will probably have a national health insurance program in the near future. Those of us who want to see a true health care delivery system developed must speak up to ensure that those designing the federal legislation are sensitive to and appreciate the need to include coverage for health screening, evaluation, and all the other health services that I've mentioned today. It is imperative that we do all we can to bring this about in order that people are able to be productive and healthy for the greater number of years made possible by our ever increasing life span.

MEDICAID AND PREVENTIVE HEALTH CARE

Juan de Dios Pozo-Olano
President, Health Services International, Inc.
and
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MEDICAID of Massachusetts

Medicaid is a federal/state matched fee-for-service assistance program for the medically needy. The Medicaid agency pays the bills submitted by providers in a manner similar to any private health insurance. This vendor payment program follows the overall national trend of purchasing medical care whenever it is needed and paying for whatever is required to restore the individual to health, that is, it is a reimbursement for "sickness" services. Because of crises caused by the fiscal complexity and the appearance of fraudulent practices, managers of Medicaid programs - both at the federal and state levels - are becoming aware that a continuing utilization review mechanism for this program is necessary. Standards for providing Medicaid services are lacking in most states, and people paying Medicaid's bills have no idea about the quality of care received by Medicaid's recipients.

Let me relate to you some of my experiences as manager of the Massachusetts Medicaid program. Some figures and percentages may be helpful here. It is estimated that in 1979, the HEW's health budget will be 48.6 billion dollars, 90% of which approximately will be used for Medicare and Medicaid programs. In 1977, Medicaid served 21.5 million Americans, each one costing an average of $532 annually. I would like to mention that 70% of all Medicaid expenditures are used in "institutional" services (30% in hospital settings and 40% in nursing homes). Government plans provide 54% of hospitals' incomes, the total cost of which was 31.3 billion in 1977, or 9 cents of every federal tax dollar. In 1977, the average Medicaid reimbursement to hospitals was $181.40 a patient/day. The remaining 30% of Medicaid expenditures goes into ambulatory services, but it should be emphatically stated that only a fraction of this goes into any preventive, health maintenance, or health promotion effort.

It is a fact that in order to reduce health care costs, health care delivery services should be shifted from those provided inside institutions to those given on an ambulatory basis. In addition, practices that are cost-effective, such as primary health care, should take precedence over treatment of acute illness. One should understand that primary health care is the most important tactic in any preventive and health maintenance strategy. The problem is that much of the broad range of preventive health services is not easily adaptable to the fee-for-service method of reimbursement. Furthermore, the specific preventive health efforts hardest to adapt to fee-for-service are the least expensive per capita, and the most cost-effective. The challenge is then to find ways to incorporate them into a vendor medical program such as Medicaid. These basic principles apply not only to the Medicaid program but they should be considered in any strategy for a national health service. I say this, because it should be desirable for the Federal Government to encourage and support efforts through its reimbursement programs to providers to develop health maintenance and health promotion programs, including nutrition and health education. Much of this could be accomplished by developing the incentives in Medicaid reimbursements for ambulatory care. The many billions of dollars spent by the Federal Government

in health care could, if channelled selectively, have an important impact not only on patterns of health care delivery, but in influencing people's health habits as to change certain ways of life detrimental to good health. This point can never be sufficiently emphasized, if one considers that the determinants of health are largely outside the medical care system, and therefore, improvement in health is likely to come from modification of the conditions which lead to disease, rather than from intervention in the mechanism of disease after it has occurred. If ambulatory services, especially primary health care, home health care, and preventive care services, are preferred over institutional services, they should be enhanced and encouraged via reimbursements.

In this connection, the only exception to the Medicaid approach has been the implementation of EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) to provide medical services for children with emphasis in early detection and early intervention. A modification of this program known as the "Child Health Assessment Act" was introduced later. The program was designed to provide health care to children whose families do not have adequate resources to cover the costs of such care, to outreach children eligible for such care, to assure continuity of health care, to increase immunization levels in children, and to provide further incentives to states to arrange for and encourage quality health care for children. In summary, this program is prevention-oriented and tends to emphasize preventive services in comprehensive health care settings.

However, this program never attained its full intent. Medicaid recipients were never well informed about the availability of these services. Federal and state bureaucrats did not have the conceptual and managerial capacity to implement the program, and providers thought that this was just another Medicaid service. State medical agencies, with few exceptions, do not have the medical care skills and expertise to know how to proceed to develop a greater emphasis on less expensive alternatives to in-patient care. Inherent in EPSDT services was the principle that children were to receive adequate health care at all times, on a continuing basis, and that treatment and referral were available to them at any time and in any place. Such an approach meant to the bureaucrats the handling of additional data and information management, and for the physicians it meant additional bureaucratic burden to the overloaded practices. For providers and bureaucrats alike, EPSDT was focused almost entirely on diagnosis and treatment. They failed to see that the most effective approach to comprehensive, prevention-oriented children's health services must place major emphasis on the health promotion and specific protection levels of prevention. In addition, there were not enough incentives built-in to the program to attract pediatricians. The dilemma is that Medicaid reimbursement systems cannot be routinely adapted for the payment of programs such as this. Again, after more than a decade of experience with Medicaid, reimbursements and other policies have tended to enhance the role of in-patient services and, except for the EPSDT mandate, to actually discourage the utilization of prevention-oriented services. This trend must be turned around if health care costs are ever going to be contained.

I want to insert at this point what I consider the relevance of a purposive piece of technology, such as the one you have been discussing for 2 days now, namely the role of AMHT as a tool in the implementation of programs such as EPSDT.

The patient's medical record lies at the center of any health care system that is truly committed to provide services for individuals on an adequate and continuing basis. The patient's medical record is the single most important source of information available to any practitioner. This is particularly important in children, where early detection and early intervention can preclude serious complications and expensive treatment. In the practice of primary health care, when a health care team is available, the nurse practitioner can constantly update this record, and provide the physician with a health assessment of a patient. In addition, the nurse practitioner provides maintenance and educational information with emphasis on prevention and anticipatory guidance.

In a previous article, I have stressed that the character of the role of technology in health care delivery will depend on who designs future U.S. national health policies (1). Refreshingly enough, we are seeing a new generation of medical students and young doctors who prefer family practice to specialized medicine. However, in our technology-oriented society we are still very much in the process of developing new gadgets and methods for diagnosis and treatment. The vast majority of practicing physicians believe that this is the only way to practice high quality medicine. Nevertheless, when we look at patients who have undergone coronary by-passes, or a transplant, or have simply been hooked to a dyalisis machine, we have to ask ourselves if by practising this kind of medicine we have improved the quality of life of these patients. Or, the technology presently available ultimately has had very little influence upon the morbidity and mortality of the pattern of disease afflicting our affluent society. In fact, nosocomial and iatrogenic diseases are acquiring epidemic dimensions in hospitals. Patients become unwitting victims of a system that is supposed to safeguard their health, not to jeopardize it. Do we need then more CAT-like technology to increase our wisdom into managing the acutely and chronically ill, or do we have to look for a mass-oriented technology to promote and to maintain the public's health?

Physicians feel that treatment should not be determined by the expense. When the average physician orders between $15,000 and $20,000 worth of hospital services a week, it is in the public's interest to ask from the government to exercise more control over the use and distribution of physician services because the medical profession has failed to check runaway health expenditures. On the one hand, doctors often order expensive tests and equipment out of greed or out of ignorance of changes involved. The doctor-patient relationship should not be manipulated to pay for equipment by overutilization of by services that are not needed in the treatment of a particular patient. On the other hand, the use of highly sophisticated technology - usually an expensive one - is correlated to disproportionate earnings of hospital-based specialists, such as radiologists, pathologists, and anesthesiologists, because of unnecessary utilization in many cases, and payment arrangements between hospitals and practitioners. As in other industrial segments, the hospital industry tries to make up through volume anything it has saved by controlling costs.

To sum up, new health policies will require not only the application of mass-oriented technology with a high cost-to-benefit ratio, and improved managerial, reimbursement, and payment systems, but most important of all by drastic changes in the present sickness/fee-for-service health care delivery system, including attitudinal changes on the part of medical practitioners.

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THE ATTITUDE OF THE HEALTH INSURANCE INDUSTRY

Mr. John F. Finney, III
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Former Vice President for Marketing,
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Thank you Dr. Creticos. I would like to say right off the bat that I wish to notify Dr. Collen that I went through a screening myself relatively recently because I was a "worried well", and my family was plain worried. I found out that I am probably the healthiest 250 pound, 56 year old, according to the doctor who interpreted it. So I am no longer "worried well", I am "plain well". Long before that I really became a fan of the whole importance of preventive care, and early recognition of disease; So much so that if I did not prepare a paper and read it, I might bore you with too much to say and get too far off the track. So in order to discipline myself and hold myself to time I shall read you a little paper, some of which if I took the time could be eliminated because Mrs. Goldwater has already told you. But, I am not going to do it, I think that most important points to be made are the ones that tend to be repeated by more than one speaker. You must know that I appreciate the honor and the opportunity to join this meeting, to learn of the work of your association, and its members in the cause of health and to contribute, however slightly, to the panelists on the topic of third party reimbursement.

You should be apprised of the fact that I have some background of knowledge of the attitude and policies of commercial insurers of health care, and the public service corporations, such as Blue Cross and Blue Shield, as well as though prepaid mechanisms, those called Health Maintenance Organizations, three of which I recently participated with in obtaining either planning or initial development grants for their hoped for operation in both Maryland and in Long Island. My direct and in depth experience is centered on thirty year's work primarily within one state, Maryland, and concerned primarily with that market. Speaking from that perspective, and for the moment forgetting about the potential impact of any national compulsory health insurance legislation, I would say that the probability of making such procedures as automated multiphasic health testing broadly available to and broadly accepted by the american public is still a long way off. It seems to me that the reason we are talking about third party reimbursement is that large segments of the public will not buy it on an out-of-pocket basis, and most privately practising physicians will not order it, except in conjunction with hospitalization or in the few instances where it will be paid through insurance carrier.

There are a few groupings of people with paid access to screening facilities now. Some unions and a few employers foot the bill, but unless and until there is government subsidy, meaningful insurance programs widely available HMO facilities and the like, all well accepted by the public, health care here will not include high priority attention to preventive and early recognition programs, automated or otherwise. To evaluate the insurance carrier resistance to the introduction of benefits from multiphasic screening, you must not forget that while they call their product health insurance, they don't insure health. They deal primarily in paying claims against the high cost of unexpected illness episodes. That is an insurable risk. They sell

sickness insurance, and the more comprehensive policies do a good job of paying for everything that happens, relative to the treatment and convalescense in cases of acute illness. The rising cost of insuring that sort of loss has caused commensurate increases in premiums. Premiums are now so much an issue with industry, labor, government and public, that the carriers balk at the introduction of any new area of benefit.

There are about 150 Blue Cross & Blue Shield plans, They compete with several hundred commercial carriers. They vie for business where major customers budget sums and figure down to tenths of a cent per hour per employee for health care benefits, often on 36 month contract periods. They understand the cost of illness. They must be taught the value of health. They are claims oriented. They will resist the introduction of benefits that will create a high volume of administrative procedures with low dollar value. They call it dollar trading, uninsurable, poor financial management, and they resist adding benefits that they feel sections of the market might overuse at the expense of the rest of their policyholders. When benefits such as that are offered - and recently 22 of the Blue Cross and the Blue Shield plans have been cited as underwriting some benefit for multiphasic health testing for about 14 million members - it is usually priced into the premium under the basis of expected utilization and cost of administration, plus an arbitrary risk factor. I might say here really that Blue Cross and Blue Shield have 90 million members. The figure I quoted you was 14 million people with this kind of thing available, and that by the way is not available as a periodic health evaluation or anything of the sort. It is for the most part available through Blue Cross contracts on admission to hospitals and preadmission testing, and not otherwise.

There is presently inadequate experience according to the carriers to price the savings created by claims patterns resulting from early recognition and preventive measures. Now Doctor Collen presented to you some tables which really offer tremendous arguments in your behalf against that perspective. But, it is very interesting that people in your field keep telling that sort of thing, back and forth to one another. I do not know how well you do it to your public. I do know that I am a member of that public and I have not heard a great deal about it. Insurers do however innovate, they permit themselves to be dragged kicking, screaming, into new areas of benefit whenever the whole package is threatened, or whenever they are subjected to hearings. Then, once they have stepped into the next level of coverage, do not be surprised to find out that they invented it and have christened it with the new name. They are capable of independent movement, like a glacier about 1½" a year. You alone cannot change that rate. The third party payors respond first to the market, second to the government, at all levels, and third, to their controlling directors. Of the market the most influencial are the major unions and large employers. Influence them, and the rest will eventually fall into line. Of the governments, the most immediately influential are the state insurance department, the health department, but especially, the state legislature, I might point out to you that legislation was passed in behalf of multiphasic health testing in Maryland, I believe in 1977, and all that legislation said was that it will be offered and regulated by the Secretary of Health and Mental Hygiene, the regulations to be written by him, and the Maryland State Medical Society. I might further point out to you that the Maryland State Medical Society calls itself the Medical and Chirurgical faculty. Not since the renaissance writings have I read that word "Chirurgeon" anywhere but in the title of that medical society.

Major insurers will act like dominoes with the major force being competition. Remember too, that the Blues are still controlled by the provider. The Blue Cross boards are populated by consumers, public members, most of whom are hospital board members before they get to be on the Blue Cross board. The Blue Shield boards are populated by the private practicing physicians whom I also think you have a great big problem influencing. I might also point out to you that once you have done a good job of educating all of these factions in related interests, then, the concept has to be sold to the people who will ultimately become the members, who ultimately buy it, whether it is paid through employer, union, negotiation. But the people won't come in until they understand it too. And, I think that you are not in a position to teach the member public, the member public is best caught by its own peer and leader influences and those peer leader influences are basically their own local elected officials and primarily their own union shop stewards, and their own personnel managers, and of course, out of media and other exposure; spouses of employee members who have the access for the family to the programs.

THE MENACE OF THE HEALTH INSURANCE INDUSTRY

Mr. Edward J. Brown, III
President
National Health Corporation

I came prepared to do great battle today; however, most of it has gone before me and seems to be something that I can be excited about. I sat here and listened to a state representative talk clearly about the things that I have been standing on orange crates in parks talking about for 5 and 6 years. I also heard the man from the Blues recognize for the first time quite clearly what some of the problems are in terms of control. So I think that I can push all of the battle to the side and focus on one thing that seems to be pertinent.

We must understand the basic problem in this country in terms of health care and high cost of health care. We talked about the crisis in medicine, and let me assure each and every person in this room that it is not the medical community that has created that, it is not the politicians that have created that, but it has been, in fact, the third party carrier. When we talk about reducing cost from $400 to $85, for a complete physical, when we talk about $25 - $35 procto for $2.50, when we talk about an $18 - $22 x-ray for $1.75, when we talk about $33 worth blood work for $5.50, why don't you tell me who is going to get hurt if our industry ever reaches to that low plateau of cash flow. The cash flow, ladies and gentlemen, is the god of Blue Cross/Blue Shield. It is one of the most insidious situations of national hypnotism I have ever seen in my life. They have got us all tuned up in terms of physical fear, and we say if we don't insure with them, or if we don't insure with a third party carrier, we could get hurt. My company is servicing unions around the country, and we have been responsible for the Blues losing approximately 100 million dollars in premiums, and I think that we have another 100 million dollars on the boards in the state of Maryland alone.

Our company is putting up centers in various parts of the world, and as I travel they refer to this national hypnotism in terms of the high cost of health care. When I talk health care they understand it. When we talk health care in America, we have not learned as a people the difference between health care and medical care. The Europeans are not the same. They are not the same at all. If you can take a look at a three color photograph, the only way that goes together is not in a collage of color all bubbled up, but it goes over color, by color. And, what we have is a very confused collage in medicine today, and we must separate the colors and take a look at them and put them back down.

Number one, the medical foundation today is build on a very shaky foundation. We the public, must help build the new foundation. We have the finest doctors in the world, the finest medical schools in the world and yet, in spite of that, we are 23rd in the world in male mortality, we are 17th in the world in female mortality, and yes, we are 12th in the world in child mortality.

You know, in our centers, and I don't want to talk much about that, all of the fellows who

have been in the business, the Dr. Emerson Day's and the Dr. Barney Oldfields, and the men who have been dedicated to this for years, have statistics upon top of statistics. I have sat here today and listened to someone use the term, "reasonable assumptions." We've got a whole file full of facts instead of reasonable assumptions. The last report that George just brought down from Baltimore for me today, covered a group of 365 patients in a warehouse group in Baltimore, Maryland. We picked up enough early pathology using the insurance industry's own actuarial tables to save that union $385,000 over the next 3 years. Now, we've got another 700 people to go. By the time we've picked that up, we will have been able to reduce the cost in that fund by some $400,000 a year, which is a pretty substantial amount when they're only running at 1 million dollars a year for that population.

Where does the problem lie. When we talk about cost reduction, and I noticed that on the notes, that we are here to hopefully induce the third party carrier to put AMHT into their program, we must understand the mentality of that industry. Number one, 32% of all of those funds that go in stay with the third party carrier. Its not the doctor that is at fault, it is certainly not the patient that is at fault, but we have an empire that is built on some tremendous numbers of dollars and those people are very concerned about reducing those numbers of dollars as they flow through their giant facilities. It is my personal opinion that Blue Cross/Blue Shield today is the biggest advocate of national health insurance. You know why? Because instead of having two thirds of the market, they're going to end up with all of it, because who's going to be their administrator, who's going to be their consultant to the federal government, who's the consultant now, who sets the rate, who negotiates the doctor's wages? The doctors have a tough time fighting it, simply because they don't have to negotiate with anybody, the Blues do that for them, giving them a 7%-8% increase every year. So, we have today the Blue Cross/Blue Sheild as a federal government's advisor in the field of health care in setting usual and customary rates. And, we're standing here, and I've heard men tell you today, that we can deliver x-ray's for $1.75, we can deliver blood work for $5.50, just carry with you a thought, who's going to get hurt the worst if the cost of health care comes down? Not the doctors, I have never talked to a doctor in my entire 9 years in this business that is not in agreement with me that early detection and prevention was the most necessary thing there is. Then, you know what the insurance industry does? They put out the propaganda that the reason the cost of medicine is going up is because the high cost of procedures, the high cost of medical care in the hospital. Okay, if that's the case, why is it the cheapest part of the policy and why? In other words, you can take a group of 5,000 men and you can buy them a major medical umbrella; that's the cheapest part of the program. When you look at health care as it is delivered today, and you look at the duplication that has to occur because they will not get on to a system, they will not expose themselves to reducing the cost, and I had the Vice President of a Blue Cross/Blue Shield organization tell me that if I ever repeated it or use his name he would deny it, so I won't do that, but he said, "Ed, we know that the cost of health care can come down," he said, "but, if it does come down, think of what it does to our cash flow"!

Now, let me take you one step further, the actuaries came up with a beautiful piece of information, when they decided that, "you know boss, if we go into this and if we permit this to be part of the program, the first 18 to 24 months, we're going to get all these earlier sick. And,

if we get all these early sick, actuarily that is going to cost us hundreds of millions of dollars, and you know what boss, in addition to that, we can never recover it. We are not going to get it back, because now they are going to be healthy and they are not going to be sick!"

The blues have made two mistakes, the first of which is not only the Blues, but that of the whole insurance industry. They have been selling their program wrong, and that's why they are moving into HMO's, and that's why they are getting into other things, because for 50 years now, they have sold insurance on the basis of a curve, "Okay, if you use less, we will give it back. If you use more, you know we've got to charge you a little bit more." The problem with that is that now they are fire-walled economically because their actuaries made a very serious mistake when it came to their financial planning. They are planning their reserves and their cash flows-and that empire must plan 5 years in advance-on the basis of the historic relationship that we have with health in this nation. In our centers, and if you go back to all the multiphasic screening and look at the statistics, because of our lifestyle, our occupation, and our hereditary relationships, 49%-51% of all the people who go through the screening centers need additional medical attention to some degree. Good god, we're not dying of measles, mumps, chicken pox, and I'm not going to bore you people who understand the industry with all of that, we're dying of treatable, reversible diseases. And, when I ask who the architect is, of the health care delivery system, who is it, it is not the doctors, it's not the federal government, who designed the plan it is the Blues. When we sit down and we buy a health care plan for a group, who's giving it the statistics, who's giving us the specifics? Blue Cross/Blue Shield. They are not going to put anything in there that is going to cost them money. Then, they set a pattern today, where we are, in fact, fire-walled in terms of the cost of care. Now, if 49%-52% of our nation needs medical attention in varying degrees, because of early problems, the very real answer to bring down the cost of health care, is bringing that abnormality range down, damn it, bring it down, get it down to 18%-22%, and it's something you can do. If we bring it down to 22%-15% in terms of serious abnormalities, we've reduced the cost of health care in this country by 50%, who's going to get hurt? Just the third party carrier!

I don't think it is so much a crisis, I think it is a holocaust, and I don't mean to pick up on the recent word, but I sat there and watched that, and I followed back, that there is a small town where 51 people just got killed because they fell off some scaffold. Who really was to blame? The architect? . . . In terms of his lay-up he was finally identified as the guy who drew a wrong line. There were 10 million jews butchered in that other holocaust, we all watched a couple of months ago. Where did it start? In the ovens? No it started with the architect, and the designer. During a recent earthquake in Urguay, one of their most prized buildings which was only up for 3½ years went down and hundreds of people were killed. Who was to blame? The architect . . .

One movie that I enjoyed a lot was The Blazing Inferno, but damn it, we've got to focus on it, and in that movie we saw the greed of the architect, we saw the greed of the people who were in the original design stages of what they were doing. Unfortunately what we are faced with is third party greed; that's what we are faced with because they are not going to design anything before you that is going to cost them money. It is just not going to happen. The utilization

curve kills them, if we think of them setting the rates, setting the salaries of the doctors, it makes it very difficult for the doctors to compete. If the third party carrier is permitted the right of designing our health care focused around their own personal corporate cash flows, we will never stop the long, long lines of what I call the ovens of heart disease, cancer, and diabetes. We must do three things; three very simple things: 1) recognize how we got into the problem, and then start to look at it a little bit differently in terms of the problem, but let's cut the medical dollar free, let's let it become competitive kind of thing. I heard a doctor here today say, a hospital administrator say, that CT scanner will do more for mankind than automated health testing will do in 100 years. You know what he was really saying? He was taking a negative position with AMHT, and why? Because he has never learned to use the system, he's never learned how to use it for the good of the community, he's not thinking of the 10,000 people around that hospital, he's thinking about how many sick people he can get in there. He hasn't learned how to make a profit in preventive health care. I understand that, I'm not being upset about that, it's just that he's conditioned to think differently about health care. If it isn't profitable, we can't do it, and that's right, we have to pay our rent, we have to pay our mortgages, we have to pay our people.

But there is, and there can be, and there should be, a very real program in terms of health care in this country, and we can make it profitable, for the doctors, and the physicians, and the hospitals. I'm not a doctor and I'm making a profit, because I understand the problem. Our company has entered into something because it is a personal dedication of our people, but there is a very real need for that kind of health care today, and we must take forward steps, . . . As the gentlemen from Blue Cross/Blue Shield said, "You know I haven't heard much from you." He said, "I hear these other things, but I don't hear much from you people about the good that you are doing, and why we don't you have a forum.

Who's got the dollars, who's got the money, who can make that mass publicity, who can condition the minds of the people? The insurance industries that are selling us our policies. The actuaries cannot possibly get into a cost reduction curve, because the entire empire in that industry would collapse. I say that Blue Cross/Blue Shield has not only sold out a nation, but they've sold out an entire medical community.

THE DEBATE

Dr. Creticos

The stage is set, and I think you now have ample oportunity to ask our panelists some questions. However, before I entertain questions I will have to say to Mr. Finney that I tried very hard to talk to companies, to go back to their insurance agent, underwriter, and say to them, we want to put into our policy a preventive medical program, whereby our employees, at certain level of ages would have the examination at certain intervals, depending upon their age, and they would as part of their employment; one total examination, and then maybe every two or three years they would have another one. This is to be underwritten by the insurance company on 5,000 employees, like U.S. Steel, with the understanding that the insurance company would reduce our premiums because we will be giving our people good preventive care, finding illness early, and having less absenteeism. I've tried to get many other companies to take this challenge and go out and prove it, but over a three year period, I have had no takers. I am a very poor salesman obviously, but somewhere along the line we have got to find some technique for doing this. Now, I will open this up for questions.

Mr. Oldfield: Listening to Ed Brown, and his comments on the Blues, I wonder if he has a remark to make on what he thinks we should be doing about it?

Mr.Brown. No 1, we've got to change the architect firm we are working with a little bit and get them out of this end of it. It's a very simple situation, really. If the administrators who buy large packages in the medical care field who are, you know, protecting the large groups, if they'd just walk across the street to their banker. You know, I've got a situation right now, with a major group that was spending 6 million dollars a year on 4,000 people, and their rate was going up at the rate of 10%-12% a year, and I said, "Look, why don't you take that 6 million dollars go across the street to your banker, get a good administrator for 4% and draw interest off of that 6 million dollars, and in the very first six months, the projected savings that year was 2½ million dollars.

So obviously, if you have groups over a thousand my recommendation is to self insure. Because you can set up your own same reserves, and then buy a major medical umbrella which is the cheapest thing you can buy today, at $17 a month per person, and you never have exposure above $500. We've just been fed bologna in terms of the propaganda as to where the cost of health care is. It is not in the hospital, it is not in the doctor's pocket, it is in the pockets of third party carriers, and these monuments to man's miseries, that the Blue is building all around the country to do one thing, and that is to capture the national health insurance program, and 100% of those dollars to make it up, 'cause they'll have the computers to do it. So, self insuring, buying more reasonably, establishing your own reserves, in the only way to go.

Dr. F. A. Gilbert: I would like to ask the legislator from the State of Maryland what would be wrong to plan to ask every individual to self insure himself. If you start a self insurance program with a savings and loan organization when you're one month old, and this continues, and

there is then umbrella coverage from the government or for somebody else which is very cheap, for very good reasons, what is wrong with that type, and has the legislature ever considered this as an alternate to the third party carrier?

Mrs. Goldwater: I don't think that there is anything wrong with that and I think there has been movement and discussion in this area. The legislature as I said earlier is composed of so many businessmen and lawyers, that it is very hard to move a legislature in a certain direction unless the demand comes from their constituency. One of the things we are trying to do in Maryland to that end, is to form a state wide health care network of coalition of all the various groups in the state. Maybe their prime focus is not on health care, but they have a component within their organization that's concerned with health care, like senior citizens and the many handicapped groups. I really think that there is a lot of education that has to be done, and that's one of the ways you start to move a legislature, and I might just say that it is easier to accomplish it on the State level than on the Federal level, because you have less diversity, therefore, you have less controversy. All any of you have to do is to find a legislator who is willing to introduce legislation. There are two reasons for introducing legislation. One is to respond to a problem and to work damn hard to get that legislation through; second reason is to start discussion and debate and educate people. Very often it takes several years before you can get an idea through, but it is worth the discussion and the debate that goes on.

Mrs. Oldfield: I'd like to make a comment in response to several things that were said by the panelists today, and that is that last evening when I met Dr. Warner Slack and we were talking about patient compliance, patient understanding of his various programs, I said that I wished more of the physicians who have been engaged, my husband, Dr. Collen, Dr. Day, Dr. Slack, Dr. Haessler, Dr. Gilbert, Dr. Caceres, Dr. Creticos, would write not only for your professional medical journals. As Mr. Finney said, you talk to each other, through the professional journals, but if you would begin to write for the media, the women's media, and I am, you know, speaking for the housewife, the lady who buys the pills, the lady who shuffles the kids to the doctors, drives her husband to the doctor, appeal to the women in this country, then perhaps the whole component that Mr. Brown's referring to and Mrs. Goldwater is referring to, and what Juan was talking about in Massachusetts, the Medicaid mother who has no other outlet because she doesn't understand the system, and the number of things that Mr. Finney alluded to, you put it back a little bit and then through consumer education, and she might begin to make herself felt as part of the constituency to which Mrs. Goldwater refers.

QUESTION: I have a question to two people, Dr. Pozo-Olano, and Mr. Finney. . . . The dollars that go into whether it be a governmental or a administered program, or a third party, what portion of the dollar going in goes to administrative costs?

Pozo-Olano: In the Massachusetts Medicaid program, actually we have something like $600 million dollars for the medicaid program, of which $300 million are supposed to be contributed by the commonwealth and $300 by federal government. First of all, let me explain to you that the system itself is not effecient we are understaffed, we don't have sufficient staff, we don't have an optimal system of administration, so I would say that probably not even one fifth of that budget is going to administration.

Finney: The Blues, essentially talk in terms of retaining somewhere in that neighborhood, this is a broad average, because they are seventy-seven Blue Cross plans and seventy-five Blue Shield plans at one point in time, but that changes from time to time, but that is about where it is now.

The Crosses say that they spend less than 6% of the premium dollar on administration. The Shields say that they spend less than 10% of the premium dollar on administration. Now that's 3 years ago, I did a study and made a proposal to the Blues, unsuccessfully, on their entering into a project of funding health care innovation, because I found out that, in aggregate, they had about 10 billion dollars in reserve. Now these monies are in reserve in what they call contingencies, and risk factors, and maternity reserves, and all kinds of things designed, I think, to make insurance commissioners kind of pass them over. But there is an awful lot of money there, that gets put aside for reserve, and investment outside the field of health care innovation, research, health delivery research, and what not.

Goldwater: I just wanted to pick up on something that Mr. Finney said, . . . In Maryland the Blues are coming under scrutiny because of their investment practices, and there has been a great deal of concern about that, I don't know where the investigation will lead, but it's the insurance commissioner who has initiated it. Secondly, there was a piece of legislation introduced in the legislature this year which would give the blues the right to sell life insurance, and it was really a hot debate, it lost, fortunately. Many questions were raised about why should the Blues get into selling life insurance. The argument given by the sponsor of the bill was that the Blues needed to be competitive with other carriers and offer a total package to their insuring holders, and I suspect that bill will come back again next year. There was also another bill that would have allowed the Blues the right to go in and audit hospital records and that created a considerable amount of debate, it also failed, fortunately. There are about 10 pieces of legislation that the Blues convinced their various legislators to introduce that would all benefit the Blues, and none of them passed this year because the public was really alerted to many of those pieces of legislation and there was a great deal of lobbying against it, and I think for the first time this year in Maryland legislature, the Blues were feeling very depressed because they were not getting their way this time. Their favorite expression is, you really don't have to legislate anything, because if the market place demands it, we'll provide it.

E. Brown: The national average on the Blues as nearly as our research can indicate, runs up as high as 36%, you got a basic 19% figure, and then they spin off of that and the figure throws you because they are a very hard group to get any figures out of. It is the reserve contingencies, and when they run these monies up into reserves they say that they are operating at a 4% profit, but that doesn't include the reserves. Now, the one thing about health care dollars, those are always wages, they are either wages out of personal persons pocket, or they are wages out of the working man's pocket, and one of the largest happened to be closer to one of the biggest groups that they loaned money to here in the state, for instance is Beneficial Finance, okay . . . What does Beneficial Finance do with our wages, they turn around and loan it back to us at 18%. It is a ridiculous cycle of events. So that you are running anywhere from 32% to 36% in

terms of cost structure, and other states are higher.

Pozo-Olano: Before we go away from the subject I would like to take up Norma Oldfield's word about consumer participation in the health sector. I think that you are quite right in that aspect. I remember that when I was in Boston I went three times in three different channels to address specifically the Puerto Rican population in their own language, because they were not utilizing all the medicaid services they were entitled for. And, I think that this was not only the case for Puerto Ricans that may be because of a language barrier were having difficulties in accessing themselves to the system, but think that there was also a problem of many blacks, and this is very important. Now, in getting into a broader area. It is very refreshing to listen to People like Mrs. Goldwater about the enormous importance of educating people into health issues in general, not only to the housewife, but in general I believe that in very little participation and decisive participation of the consumer, in all health issues in general. One of the things that becomes evident at this point is that HEW is incapable of coming forward with any national plan, and the thing of postponing it for 1979 or 1980, is only as it shows its inability to buckle down to a program. There is no such a thing as a national health policy in America. DHEW cannot come forward with any national policy because it is non-existent. And, when we start to establish our health policy, the first thing following our classical way of thinking, is payment, and the way of payment, and the manner of payment, who is going to administer payment, how the payment is going to be done, and what we are going to pay for. But, the important thing to do is to establish national health priorities. What are the nature of services to be provided, should we emphasize preventive medicine over crisis medicine, should we put forward new matters of creating incentives to move from institutions to ambulatory basis, all those things are completely untouched.

Finney. Related to something that you said, Dr. Creticos, and sort of related to Mrs. Oldfield's remarks and these too. You've said earlier that you had talked to quite a few companies and not gotten a taker. I could say to you, very flippantly I'm sure, that well, okay, talk to more companies. I spent 22 of my years trying to market this thing Blue Cross/Blue Shield. I think that what recognition that I received and promotions and that I received winding up on their national marketing advisory committee, and what not, was no particular talent or skill on my part, it was just that . . . a matter of being able to accept the rejection and talk to more companies. And, I know that you are in a different kind of business, in a different kind of league, and the primary thrust of your work is not talking to companies. And, I understand that you have to marshall your time a great deal differently. But, I do think as a matter of degree, you talk to companies and some other people here talked to companies too, some people might talk to Chambers of Commerce, to trade associations, to labor unions, to groupings of labor unions, to school teachers, to college social-economics classes. There are all kinds of ways to get the word around, and kind of word the kind of thing that I am trying to say to you is get the word around to people who talk to their own peers. Everybody does it to a degree, but nobody is doing enough of it. The message that the people want to hear isn't all of the statistics that knowledgeable minds absorb but it is the benefits. If you go this route, then these things will happen to you. For employers, it is economics, for labor union leaders, it is getting re-elected, and by God if they think a benefit for preventive care will get them reelected, they'll introduce a benefit for preventive care in the next round of the negotiations.

Dr. Creticos: I have to say that for almost 7 years, I had a hard time with my Board. There are only three physicians on the board, and the other 32 people are lay people. It was very difficult to talk to them of the concept of merchandising public relations. We finally got going on the basis of free public relations through the media in terms of their obligations, and we happened to catch on to this, so that we got free publicity that way. My Board never did get around to actually hiring a merchandiser who I thought should be doing a lot of the sales work. Now, at the hospital where I am at now, in spending about 1½ years in this type of work, as a medical director, we are getting up one of these AMHT centers, and one of first priorities I insisted which the hospital has now accommodated me with, is to hire a full time merchandiser, someone who is in the merchandising field to go out and sell and actually make the contacts. I will assist on the basis of when it is necessary for the medical person to come and explain it from a medical standpoint that I would be involved, but I have to tell you I am having a much easier time with the medical profession at the hospital on the concept of merchandising than I have had with the Board where primarily I am dealing with people and business. One person of the board happens to be a Vice President of merchandising of a big company, and I had a hell of a time selling him on the concept of a merchandiser for the hospital.

Mr. Williams: Thank you doctor, my name is Don Williams, I am a Vice President of a very small third party carrier. Like Mr. Oldfield, I am not a doctor, and I am obviously not a computer, which probably explains why I am so unfamiliar with your association and its aims, and incidentally I am completely in agreement with your aims. But I believe that Mr. Finney must have been sitting by our lunch table because one of the doctors next to me, and this is an idea of what your own people feel, this doctor said to the man sitting next to him, he said, "we sit around here like a bunch of ministers, and we keep saying people should go to church more often, but we don't do anything about it". I think you hit the nail right on the head when you said your top problem, your No. 1, is a lack of communication. I also spoke to Dr. Collen after lunch, and he makes a very convincing argument for clinical preventive medicine. I believe that if he could present the same slides to a group of life insurance medical directors you would have no problem selling your program. Thank You.

Dr. Linaweaver: In this regard my predecessor at the Santa Barbara medical clinic, John Rutton, who is well know to quite a few of you in this room, established the first multiphasic health testing center in the Santa Barbara area and set it up with a specific name as the Community Health Evaluation Center. When he went to do his proselyting among his peers, and to announce to the community of Santa Barbara what was available, the ethics committee of Santa Barbara Medical Society threatened law suits against the clinic. So, we have a difficulty when a physician gets on the orange crate and tries to promote a new program of medical care.

Mr. Timken: You all recall in our business meeting, those of you that were there last night, we did discuss this very subject how, we as an association IHEA, could get to groups beyond us. One of the things that Cesar Caceres and Mr. Oldfield and I were talking about were the Proceedings for the meeting. But it occurs to me that aside from doing the total Proceedings, if we put the paper together with just Doctor Collen's talk at lunch, plus this panel and prepared it so it could be widely distributed we might get the total message across much more effectively that way, and I would like to suggest that you as our leader and IHEA consider whether we

couldn't use that in some manner to get a very wide distribution of this subject.

M. Goldwater: I'd like to make another comment on how to get a message across and how to change a system, and I am really not being flip, I am being very, very serious about it, and that is that those of you who really care about the system, some of you ought to get out there and run for office, others of us who are in state legislatures, or anyplace else where we effect health policies, even staffing committees, particularly in congress where committee staff is almost more important than the elected official, because it is the committee staff that makes the decision. I know I have been out there urging nurses to take a closer look at the system and to get more involved in the system and to run for office and to serve on boards in commissions, and to serve on committees. I know that that takes a lot of time when you have another profession that you are working at. You know, it is pretty lonely being in an elected position in a state legislature when we are 141 in the house of delegates, and there are maybe 4 of us that are trying to change a health care delivery system.

Dr. Gilbert: I would like to say something in favor of the open market place that was mentioned earlier. Well over ten years ago we started in Hawaii an automated health screening unit. We went to the Board of the Blues, and I did realize before then that the Blues throughout the country have a predominence of physicians on their Boards, which does create some problem in Santa Barbara, and Hawaii, and elsewhere. You run into a problem of turf and you recognize this as part of the game. No one ever says, "No". They say "well, this needs more study", or they think that you are the only organization that can do this, it would deny the rest of the community the accessibility to their own physicians to have this type of examination. So, ten years went by, and in the meantime we had talked to the meeting, two meetings, of the Western group of the Blues, and still nothing happened.

With regard to Kaiser/Permanente, I wish Morrie Collen were still here. In a sense he is a competitor in a different type of health plan. We are fee for service while his is a prepaid patient plan. They introduced a plan in Hawaii that had been quite successful, for good reason, they are doing a good job.

After they were there several years, and the Blues were aware of the shift of the population into a prepaid capitation plan, the Blues director came back and said, "Look, you haven't brought this back to the board in the last few years, are you still interested and should be doing more about this?" I knew very well what they were talking about. They were talking about this because they were seeing a shift in the sign-ups, particularly in the labor unions. And, they had, at that time, which I knew about and they knew about, and we both knew that each other knew about this, that the carpenters union was negotiating a plan; one of the key issues was whether there was or was not provisions for a periodic examination without out of pocket expense. I had heard for 10 years that you don't ever try to insure anything that's 100%. Point was made earlier. Why try to insure something if 100% of the population are going to utilize this somewhere along the line, and they should, so why insure it. Why pay to an insurance company what you are going to pay out of the pocket yourself? There is certain sense in that. The carpenter's union had heard that one also, but they wanted their plan to have this, they wanted it to have it, because they also had the leverage of not only the out of pocket, but the

leverage of the entire union to say we want this and we want this for not more than a certain price.

Well, as a result of all of this, it now is in the carpenter's union, a number of unions are following this, so the Blues are now including this after a decade, in their plan. It is part of the plague of the open market. It has nothing to do with talks that I have given. I has nothing to do with logic or presenting the very good data that Morrie Collen has; it has everything to do with the competition in the free and open market.

E. Brown: I'd like to take a crack at that. We have three groups here in the state of Maryland who have asked, who happen to be insured with the Blues, and they said well, when they came up for policy renewal, and the Blues will absolutely refuse to put AMHT or early diagnostic testing entered in this state, and only for one reason, they don't want to set the precedent until they have to. So, these unions went out and took a separate fund with which they're paying, but the gentlemen from the insurance company, scares me a little bit because where you said, if you talk to insurance administrators they will absolutely go along with you. Well, let me tell you something, the insurance actuary and his financial group who support him and know where the numbers are, will never let AMHT in, and they will fight it until the last day, simply because they know it is the one cost effective tool to reducing health care costs by 30%-40% and they don't know how the hell to get out of that corner. The small insurance companies can well start a new structure in terms of marketing that would not get them into that box, but they will not put it in unless they are absolutely forced. We've got three unions asking for it. They have put it in , in a couple of other states. As you say, if they are going to lose the whole damn contract because of these issues, they'll put it in. That's the kind of force you've got to put on them. And, I say don't force them, just get rid of them.

Comment: There seems to be some suberfuge in third party payments, and I have had this argument with the Blues because, while they do not pay for the routine physical examination, I think that most of us know that you can go to your physician and say you've got a pain, or your hemmorhoids are bleeding, or any number of things, and in a sense you get a routine physical examination, which really is not diagnostic, although it is listed a diagnostic. I have argued this point with Blues going back to when they never paid for outpatient diagnostic tests, thought everybody was to be hospitalized. Finally, they realized that wasn't the way to go, and I think that eventually they are going to be forced to pay for some of these things that they are now paying for, but not owning up to the fact that they are paying for it.

H. Channer: I am not part of your organization, and perhaps it might be of some interest. My name is Harold Channer and I do cable television in New York City, and there was some talk about communicating with the general citizenery about the issues involed, I'm generally concerned with that general proposition in terms of technology in a broad comprehensive kind of way. We just concluded an interview with Dr. Collen He had to leave, and we had had an interview with Mr. Oldfield earlier. Someone said that it was important that your message should be adequately communicated to the American citizenery. I wonder who here feels that they could very sucinctly summarize exactly what that message is. The question

of finding a new way of introducing technological capabilities in the area of health care applies in other areas of the economy as well. But I just wonder who is able to make a very succinct kind of summation of exactly what the issue is and what the message is that you have the American citizenery understand in terms of the thrust of the thinking of the members of this association.

A. Creticos: For the moment, I can say Dr. Gilbert would be a very good one, and I believe Dr. Caceres would be a very good spokesman, I am sure Mr. Oldfield would be a very good spokesman, they have all been involved, both two doctors and one non-doctor but I think that they could easily, and Dr. Linaweaver, who is actively involved, seems to be a good speaker and deliverer. So, maybe one of these gentlemen can help out.

H. Oldfield: The message, Mr. Channer, is simply that the proper application of automated multiphasic health testing techniques in the country's health care delivery system represents the one application of new technology that reduces costs rather than increasing them. The figures presented by Dr. Collen completely prove this contention, as do results from other clinics and hospitals. It is apparent that a policy of reimbursement for such outpatient procedures by third party carriers would reduce health care costs. It is the sense of the panel's deliberations that questions of cash flow within Blue Cross/Blue Shield have created an economic climate in which the insurance carrier may have selfish reasons for suppressing this powerful technique of preventive medicine.

A. Creticos: I want to address myself for a minute to two things that I mentioned in my little preamble which I would like Ms. Goldwater to address herself to, and maybe Dr. Pozo-Olano, and that is, is it possible for us to look upon medicaid as setting out a pilot study and making a study of 1,000 or 5,000 examinees, going through and identifying their illness compared to another 5,000? I attempted to do this in Illinois two years ago with a Senator who I sucked into the system by having him come through for free examinations so he could see what it is all about. He was very thrilled with the exam and what it was offering to him, and maybe to his clientele, his constituents, and he also was chairman of the welfare committee of the state of Illinois. Unfortunately, under that governorship the state had run out of money and they had to pull back. I bring this up as a plea that maybe you can address yourself to this, and also, the possibility of what can be done in terms of Medicare on the national basis. This is a very serious problem in my estimation with the inflation going up and the fixed incomes of these people. Many is the time that I have seen people come to the window at the Cancer Prevention Center, saying, "well I'll come through this time, but I can't come through again I just can't afford to pay $85 even 3 years or 5 years from now." So, if you would address yourselves to those two possible concepts I would appreciate it.

M. Goldwater: Well, Medicare is a totally federal program and the state does not get into that. So, I really can't address myself to the Medicare program, as such. Those guidelines are set and fully funded by the Feds. As far as the Medicaid program is concerned, that is a state/federal partnership. The Feds do set guidelines and what can be, what kinds of programs there can be, and they pay for part of this, and the state pays for part of it. Now, over the years the Medicaid

program no longer mandates as many programs as they used to, and that's primarily because of economic reasons, because the funds are just not there. Our state Medicaid program and our systems secretary who is in charge of Medicaid is very sympathetic to the preventive aspects, and they were very supportive of legislation that I introduced. Let me say that while obviously, as a member of the nursing profession I fight for the economy of the nursing profession and the independent practice, the real gut issue and the one that concerns me most is not who provides these services, but the fact that they should be provided to our citizens, and I am concerned with the State of Maryland, because obviously that's where I can legislate. But, our systems secretary in charge of Medicaid did come down and support the program for medicaid reimbursement for services of nurse practitioners and nurse midwives based on the fact that the state health department has found that that their use frees up the time of the physician for the more acute cases. A hyper-tensive diabetic coma type of patient who gets very apprehensive calls up an emergency room, an ambulance comes and that's a very expensive way of doing it. I'm working with the health department now in planning legislation for next year that centers on the preventive aspects.

Dr. Pozo-Olano: I think that going back to EDSDP, EDSDP has acute medical services components as well as preventive ones, is not entirely a preventive program, because if a child is sick you can treat the child or you can refer him to any specialized doctor in the Medicaid regulation. There is nothing that prevents you from using one method or another to gather medical data on the patient. So you would not find any federal regulation that will prevent you from gathering, for instance, of establishing the patient's medical record for the child. In this case, I think that what you ought to do if you really want to implement one special State, such as Maryland, to get in touch with the corresponding chapter of the American Society of Pediatrics and get several pediatricians who participate in the EDSDP to utilize a common share of facilities that we have on automated multiphasic health systems to run on children.

A. Creticos: We will ask Dr. Haessler here from Massachusetts to get together with Dr. Pozo-Olano to plan such a program.

Dr. Pozo-Olano: Okay, and the second is the availability of funds and I think that one of the federal agencies such as the National Center for Health Services Research should be contacted I am sure that Gerry Rosenthal will be delighted to consider this as an immediated project to test the validity of such an automated system.

Comment: Although I am not a member of this association, I would like to make a suggestion to the gentlemen from the meeting. It seems to me that one of the messages we want to try to get across to the public is, first of all, health care is a basic right. A second message is the difference between health care and illness care, and the need for accessibility to health care. The self-administered medical history and the other as peers of AMHT components of the total broad picture of what is a health care delivery system.

I really don't think that message has been gotten across. Too many people use the words medical care and health interchangeably to mean the same thing, and there is a real difference between the two. It is very important that your association publish a Proceedings of this meeting and distribute it widely so that the congress and the medical profession will have a clear

picture of the benefits.

A. Creticos: We appreciate the spirited discussion which has lasted well past the assigned time. We thank you all for your comments, and we will carry the message forth to legislators, health care providers, and third party carriers.