Ordering Social Objectives:  
National Health Service and National Health Insurance  
as Policy Options in Organizing the Medical Care System  

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For many years, a sharp distinction was made between NHS and NHI on the basis of payment and program focus. First, NHS was defined as a program essentially based on Congressional appropriations (general revenues); while NHI would be based on premiums largely derived from the insured. Second, NHS guaranteed service while NHI guaranteed only payment for services rendered.  
The distinctions were later extended from these definitions to include differences in response to resource needs, changing task descriptions and personnel assignments, more equitable redistribution of manpower, centralized administration and consumer participation.  
In general, if the goal were equity, NHS seemed more responsive than NHI. However, in recent years, the approach to NHI has been modified in response to criticism as well as increasing recognition of changed needs, and proposals for NHI like the Kennedy-Corman bill have become more like proposals for a NHS. In short, the difference today is largely one of immediate as against eventual transformation of the medical care system into a social instrument aiming to achieve equity. The major disagreement is whether the present medical care system lends itself to modification so as to achieve that end.  

Much of the debate today regarding national health programs derives from the contrasting American and European experiences. Although America derived its medical heritage from Europe, it puts its own stamp on what it takes, and then only slowly. We absorb the European models, transform them a bit, add a few new approaches, educate the doctor a little differently, use the hospital system a little differently, deploy our resources a little more extravagantly, and impart a somewhat more democratic and less hierarchic cast to the whole system.  
Technology, scientific methods, and industrial skills overtook the medical care field more rapidly in the United States than in Europe, so specialization flourished more quickly and more widely than in Europe. This combination—greater technological development and larger numbers of medical specialists—has modified American medical practice markedly, made it more expensive and luxurious.  
From a social standpoint, the drive to bring medical care to all those in need of it, without regard to income or social status, did not achieve the visibility or strength of the professional movement in this country. Establishing a settled order of social intervention, either in welfare or health services, was slow in coming.  
America came to consider social insurance later than Europe, and medical care insurance even later. For one thing, Americans had more medical care available than
Europeans, thanks to the multiplication of schools and apprenticeship opportunities in the 19th century. There were 150,000 doctors for the 75 million people in the United States at the turn of the century, relatively widely distributed [1,2]. Then, the absence of large scale development of Friendly Societies, as in Europe, may have been an important contribution to the retarded development of health insurance in the USA. Also, in Europe many people were getting medical care from public hospitals and it was easier to introduce national insurance on a public model.

So it was not until the turn of the century that there was agitation for national health insurance, and a plank promising it appeared in the Bull Moose political platform of 1912.

National health insurance therefore was the response of a generation reacting to that simpler era of medical practice. The protagonists saw the basic defect as financial: some people did not have enough money to pay for medical care. They hesitated to seek care and so suffered longer illness, more disability, earlier death. Traditional insurance was the answer, with the government paying for those unable to pay for themselves. Medicine could go on in its customary way.

Until recently, then, all efforts to improve the functioning of American medical care system focussed on a national program of health insurance: take the curse out of paying for the services. Much of what has happened—inflation, dramatic stories of bankruptcy from medical care costs, astronomical costs for new kinds and types of equipment, the explosion of technology and associated multiplication of technical help—would seem to justify such an approach.

Arguments centered on choice between voluntary and compulsory health insurance. For the opponents, compulsion meant “socialized medicine.” “Socialized medicine” to them, meant British or Russian medicine and it raised the bogey of Bismarck and the specter of German imperialism as well. These were castigated as a compulsory service, raising images of doctors in goosestep, with the government calling the tune, downing tools as the factory whistle blew. Russia, the home of bolshevism, epitomized compulsion: state orders, patients found sick or well on political grounds, treatment politically ordained, medicine Lysenkoized [3].

Stereotypes governed the reactions. But it was not long before private insurance and government subsidies for welfare medical payments wiped out most of the “free” patients. The major raison d'être for an insurance program had to be modified somewhat. To some extent, time and the actors have changed. Time has altered some convictions, modified some of the positions of the protagonists. The language tends to be the same, of course, but new generations are using the terms with different modern meanings.

There was a gradual change in the assessment of both the problems and the solutions. In the thirties, there was considerably less that doctors could do to find out what was wrong with patients and less in the way of treatment [4]. There were relatively few specialists and these were not widely distributed. If you felt sick a general practitioner examined and treated you. Hospitalization was relatively infrequent, consultations reluctant. Most surgery was performed by non-board qualified physicians; most deliveries by general practitioners. Insuring against the cost of medical care was (a) against hospital costs, (b) against heavy in-hospital specialist costs. Doctor visits were fewer and physicians charged as little as $1.00 in the office and $2.00 for a house call [5].

In the 1970s, hosts of new kinds of questions are posed to the medical care system. Maldistribution of resources militates against the possibility of obtaining any or all that is needed in medical care for millions of Americans. The rising tide of social
conflict has imposed a demand for equity: equal access at least, for all Americans to good quality medical care. Epidemiological and social studies have exposed the lethal consequences of discrimination against the poor, the minority groups, isolated rural population [6].

Growing concern is expressed about health, not just medical care. The medical care system is expected to be responsive to questions of nutritional needs and adequacy, the efficacy and safety of drugs, occupational health and safety, the pollution of air, water and food by dangerous and lethal contaminants and carcinogens. The thorny problems of equity and quality in the delivery of medical care services is seen as only a part of medical responsibility. Where earlier cost and financial barriers were seen as the primary vexing subjects for legislative action, inflation of cost is now seen as only one part of the problem and especially important because it obstructs coming to grips with all the problems.

The increasing complexity of practice and medical specialization also lent a new kind of urgency to the cause of medical care system reform. Payment for services is seen as only a part of the problem. System elements must be reformed, alternatives to expensive care provided, improved organization, regionalization of expensive services, group practice of specialized physicians.

National Health Insurance legislative proposals, once merely directed at insuring cost, began to include sections dealing with organization and resource distribution. Some of this derived from the new generation of social activists, nurtured on the evils of the AMA, the scandalous profiteering of the drug industry, and the view of health services as an industry itself, with a managerial elite and a profit motive (for the managers) tucked away in its non-profit bosom. The anti-establishment crusade attacked the medical establishment as a generation raised on Nader faced off against the traditional medical provider groups. This group now reached beyond simple reform and an insurance concept.

They sought a totally new national health program under consumer auspices. They wanted a National Health Service.

Visualize the events, therefore:
- Increasingly expensive services
- Increasingly technologically complex systems
- Increasingly demanding public
- Increasingly fretful poor and minority groups
- Increasing dissatisfaction with the status quo.

From 1939 on, as the determined proponents of national health insurance reconsidered legislative proposals, modified in each Congressional session, the proposals soon began to accrue elements that aimed at resolution of more and more of these difficulties. After the battle of Medicare was won, and health insurance for the aged was a fact, it was found not to be good enough in itself. Utilization Review and Professional Standards Review were added to help contain costs and improve quality; HMOs were proposed to foster group practice and prepayment; Certificates of Need legislated to reduce costs, inflation, and improve cooperative health institution interaction. Gradually, the legislation introduced was on a pattern of National Health Insurance but what emerged contained many elements of a National Health Service retaining only the financing pattern of insurance.

The NHI bills began to tinker with ways of providing incentives to reduce specialization and increase family doctors; assure a better distribution of these doctors; to provide incentives like scholarships; to try to give all Americans access to the medical care they needed or wanted.
After all this has been put together, it is a long way from a simple NHI bill, although it may carry the same label. Also, if on top of that one adds local planning and local control, and maybe even local fund allocation, we have come about as far from the original simple payment mechanism as one can get and still be in the same ball park. What we have is surprisingly like what the proponents were calling NHS in their persuasive presentations as to why NHI was not enough.

In this increasing preoccupation with broader aspects of medical system reform, the similarities of concern of NHI and NHS becomes evident. There are many bills that treat only with payment: insurance mechanisms, tax credits, but most bills now attend to one or another of the points below:

1. Design, supervision and control of the system
2. Standard setting and cost control
3. Staff and reimbursement patterns
4. Quality control and assessment
5. Resource development

Nearly every bill with more than financial concern recognizes that cost control alone is not quality control, not redistribution of resources, not equity. It is not economic considerations that have become overriding in the debate, but social considerations.

Also, it has taken about 10 years of experience with America's own system of socialized medicine—Medicaid—to lead to more constructive views of earlier stereotypes. We may be afraid of government intrusion in the medical care field, but it isn't because we're afraid there will be too much control of doctors and hospitals. We're afraid there won't be enough control and the social responsiveness of the medical care system will be diminished instead of enhanced.

It is not voluntary against compulsory insurance any more. We know that payment alone cannot handle the problems.

The background has changed, but the language has not. We are still fighting about national health insurance, as if the issue were simply one of payment. A new concept has arisen: the need to guarantee service, not just payment.

It may be important at this point to define the entities, National Health Insurance and National Health Service, to distinguish between them, even though in essence the distinction may have become irrelevant.

NHI: commonly considered to be guarantee of payment for services rendered; with scope, content and limits defined in terms of the insurance. While quantity may be scrutinized more closely, some qualitative measures will also have to be observed.

NHS: a guarantee of service, rather than payment, with a greater likelihood therefore of supervision of both quantitative and qualitative aspects. Cost control is more likely because of a necessity in budgeting for establishing of budgetary ceilings.

Much argument takes place among protagonists of each, based on experience with European models: insurance is seen to be more inflationary, more subject to cost pressures; service less so since prospective budgeting imposes ceilings. Either or neither is said to be more receptive to innovative approaches. Insurance presumably will pay for anything, ergo more flexible; service aims at cost effectiveness, ergo more likely to juggle reimbursement formulas.

Clearly, physicians and hospitals would prefer an insurance system, patients a
service. But the ironies are such that insurance may impose vastly more controls, particularly if the government becomes the key insurer; and service provides less protection in supervision of patient care, if the government becomes the controlling force in a bureaucratic system.

From the experience of other countries, one cannot argue that either is better for doctors or patients: The Danes and Swedes and Norwegians have an insurance system that seems to satisfy doctors and patients reasonably well; British service type and Socialist service patterns seem to offer more satisfaction to patients than doctors. The Canadians have been able to merge successfully both insurance and service, by offering freedom of pattern development to the provinces, with a federal support structure. The Dutch insure acute and longterm care differently, using aspects of service and insurance simultaneously in treatment. And in preventive services, the Dutch place heavy reliance on the private sector for operations!

One lesson that seems implicit in the foreign experiences is that in the United States we rarely introduce national programs without having had a state model or experience. Canada had Saskatchewan as a model universal health insurance scheme before they embarked on a national program. Do we need a state model in the United States?

To return to the issues: in the United States, the problem is no longer simply scarce resources or lack of funding. The problem is also not one of political opposition. Both political parties are committed to a health insurance program of one sort or another, every poll or sampling of the American people has found them very heavily in favor of a national health program of one sort or another.

Finally, it is not a problem of radical innovation. Every industrialized country in the world has a national health program of one sort or another.

You will have noticed in the above statements the repetition "of one sort or another." This was done deliberately, of course. It is because we are all committed to a program "of one sort or another" that so many people eagerly peruse articles such as these, hoping to find the final complete solution and resolution of our aggravating social medical problem: decent medical care for all Americans at a price they can afford, in a way they like.

Marmor writes,

Any sensible national insurance plan must balance conflicting purposes. It must be fiscally possible, administratively manageable, politically feasible, and capable of improving the health of Americans without accelerating the worrisome rate of medical inflation... [7].

So must a National Health Service.
So several different kinds of conflicts have to be resolved:

1. in financing medical care: shall it be,
   —A social security type, government operated payment system for medical care?
   —A voluntary contributory (worker and government) insurance premium system for payment of medical care?
   —A wholly tax-supported payment system for medical care?
2. in management: shall it be,
   —Governmental or non-governmental agency?
3. in content and scope: shall it be,
   —Simply paying bills?
—Developing and distributing medical care resources as well?
—Quality control?

Is it not logical to make such a system part of the nation's social insurance program? This has a lot to recommend it. "Trust funds" are not reducible by Congressional action the way annually appropriated general revenue funding might be. Some argue that a social security tax is not as progressive as the income tax, however, when you raise the taxable base to what 90% of the population is earning, it surely is progressive enough! Lately the agonies of the Social Security Trust Fund, as it operates in current income and falls progressively further into debt, has raised the graver issue as to what happens when a trust fund becomes inadequate to meet its obligations. To which the cheerful response is that general revenues can be added! In which case, why not start with general revenues and assign them to a "quango" for management? (Quango, for those of you who enjoy the sound but aren't quite sure of the sense, is a quasi-governmental non-governmental organization.)

On the other hand, the spate of reports on the failure of regulation—C-O-N, UR, PSRO, and state regulatory commissions—renders a government service operation risky. And one may speculate how successful group practice facilitation, family practitioner production, and resource distribution will be as evidenced from recent legislation [8].

In short, NHS advocates are looking to changing the system in order to accomplish the objectives that both they and the NHI advocates seem to be in agreement need achieving. Yet the NHI advocates no longer propose simply insurance. The issues resolve themselves into whether it is possible to achieve equity by reforms that focus on insurance, regulatory elements, promotional approach—gradualism, in other words. Or whether the present system is so badly designed and so resistant to change that only radical reconstruction can provide even modest reform.

There is a matter of objectivity involved. Some people have tried many things, watched legislation fail over the years, and have concluded that cautious steps will be resisted as forcefully as radical ones and so one might as well go for broke. Others feel today's problems cannot be solved by yesterday's solutions, that these are simply inappropriate. They see the aging legions in the van of the NHI struggle as "yesterday's men."

Furthermore, NHI is a doubtful cost control measure. Economists, not noted for their prescience, but very wise in hindsight, point out as Russell, writing in a recent Brookings Report, states:

> Nothing inherent in the nature of national health insurance guarantees that it will make the cost problem any better, or worse. Everything depends on the design of the program. [9]

and they quote Sigerist who himself eventually became disenchanted with NHI and in the year of his death wrote as follows:

> "... I am no longer in favor of health insurance and I think that better solutions should be found. Health insurance in many European countries has become rigid, and is in the hands of groups that have a vested interest in it. The machinery is frequently very clumsy and we generally find the tendency to perpetuate under an insurance scheme an outgrown type of medical service. Hence the time has come to reconsider the whole set of problems and seek new ways of solving them, ways that will make the best possible use of the present technology of medicine" [10].
But there is the matter of political reality. Those who have toiled for so many years, and now see the achievement of the goal on the horizon, are unwilling to sacrifice this for a possible better brand. And the experienced battle-scarred political realists know with what difficulty even small changes are steered through the Congress—especially national legislation with no prior state experience or sponsor.

If a NHS is defined as government-sponsored, government-controlled, government-financed medical care system, then it is possible to see elements of NHI coalescing eventually into a NHS.

If NHS is described more loosely, as a national program to ensure equity in medical care, certainly the elements of NHI can be put together just as described for NHS.

It would appear that, just as over the years the factional splintering of political groups has obstructed the creation of an effective progressive political party, the splintering of the reformist elements in the medical care arena obstructs and postpones effective change and improvement in the medical care system. The only ones to benefit from this constant factional dispute have been the interest groups with a stake in the status quo—the physicians, the hospital administrators, medical educators and industrialists, health officials—the elite managerial and producer class of the medical care industry.

Debate, as if NHS and NHI were mutually exclusionary, is another nail in the coffin of reform. As we fight about language, the Carter Administration and the Congress continue to fund Medicaid and Medicare in astronomical figures that reflect the doctors' definition of how medicine should be practiced and paid for; the hospitals' dictation of how they are to operate and be paid; the drug prices; the equipment hawking.

The issues need to be rephased:

Can equity be achieved through modification of the American medical care system? If not, is a radical reorganization the only way of achieving equity? And if so, how do we deal with the political realities?

Are we prepared to modify the conditions of medical practice? Attack the traditional American way in medicine and insist that it become patient-oriented rather than provider-oriented? Put the control of funds, planning and operations into the hands of consumers? Or do we wish only to continue to tinker with the system, allowing the current systematic looting of the treasury, uneven and discriminatory performance and wasteful and negligent style of medical practice to continue?

Political scientists reject compromise. Marmor writes:

But compromise in medical care financing brings together the worst of the private and public worlds. [7]

These are our policy options:

1. Continue in the present system, but with some constraints, recognizing that the ultimate social objective of true equity, dignity, and equality will not be met.

2. Overturn the system altogether, guaranteeing equity but risking the very real accomplishments of technical excellence.

NHI and NHS can do either or neither. The attempt to put the problem in the light of a struggle between them is a false antinomy.

Basically, the nation is being asked to adopt a social policy. The implementation can take different forms. It is not NHI vs. NHS.

It is equity vs. inequity.
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