Can Blue Cross Survive Its Own Success?

EDWARD T. CHASE

ALTHOUGH GOOD NEWS about miraculous new cures arrives constantly from our laboratories and hospitals, there is nevertheless a profound sense of uneasiness throughout the world of American medicine today. The symptoms take many forms. Doctors are concerned not only about their incomes but also about threats to their professional freedom and the time-honored doctor-patient relationship. The public, alarmed by ever-rising medical costs and particularly hospital costs, is voicing louder and louder demands for protection from financial hardship caused by illness. Baldly stated, the fundamental issue of the whole heated debate now going on is whether this protection can be secured within the framework of a private voluntary system of health care or whether it requires instead a large measure of government intervention.

BECAUSE Blue Cross, which covers hospital expenses for more than fifty-five million people, is far and away the largest and most important single institution in the private health-care field, it is inevitably right in the center of any discussion of medical economics. And Blue Cross is in trouble. It is racked by a series of inner conflicts and dilemmas. Worst of all, it may well be pricing itself out of the market it was established to serve.

The original plan was devised in 1929 by a Texas educator, Justin Ford Kimball, Ph.D., of Baylor University. The plan that is credited with starting the Blue Cross movement was a simple three-party agreement to pay the cost of hospital care. Subscribers paid fifty cents monthly into a common fund, the "prepayment fund," which was used to cover hospital bills. The hospital in turn promised to provide a certain number of days of service for a specified payment from the common fund. The entire transaction was nonprofit. Dr. Kimball's aim was not only to ameliorate the plight of Baylor University Hospital but also to help the citizens of Dallas, especially his fellow teachers, who were having serious trouble meeting their hospital bills.

Under the impact of the depression, plans roughly similar to the Baylor plan sprang up in various localities. The concept of individual prepayment for possible future hospital services through group enrollment and the co-operation of community hospitals soon became firmly established. In 1933 the American Hospital Association threw its national support behind the plans. The American College of Surgeons and the American Medical Association added their endorsements.

Even though they are not, strictly speaking, insurance companies, the plans operate by state charter under the supervision of state insurance commissions that administer regulations requiring reasonable reserves, make periodic examinations, supervise rates, and approve contracts. The plans are governed by private citizens, usually with a preponderance of hospital administrators, physicians, and business leaders. Some 1,800 people comprise the boards of the seventy-nine Blue Cross plans across the country. The Blue Cross Commission, with headquarters in Chicago, was created in 1946 by the American Hospital Association as the general co-ordinating body for all the plans.

Blue Cross in the Red

Blue Cross has been astonishingly successful—and in a way it is the victim of its own success. It is hardly necessary to point out here that the increase in medical costs, and especially hospital costs, has far outdistanced the general postwar rise in the cost of living. Hospital costs rise five to six per cent year after year. They are much the most important part of the medical bill, accounting for more than two-thirds of it as the hospital increasingly becomes the heart of our health-care system. And Blue Cross, it must be emphasized, covers only hospital expenses, in contrast to its younger, smaller cousin, Blue Shield, a doctor-run organiza-

tion that covers a number of surgical and medical services.

As medical costs have continued to rise, Blue Cross plans in city after city have made applications for increases in rates of from ten to fifty-three per cent. In New York, for example, there was recently a 26.5 per cent increase, on top of a 22 per cent rise the previous year. Blue Cross's problems are of course exacerbated by the revolution in medical science —the proliferation of costly new hospital apparatus, drugs, and extra services requiring more personnel. The patients, meanwhile, are demanding all of this and more. An ever better informed and better heeled urbanized population demands the best medical care available. And yet inflationary pressures in medical costs are only part of Blue Cross's troubles.

FROM ITS BEGINNINGS in the 1930's as a private voluntary institution, Blue Cross has been endorsed and hailed by organized medicine as the answer to proponents of compulsory government health insurance. At the same same time, Blue Cross has always insisted that it is not just another form of private insurance (which its leaders seem to regard as tainted with the profit motive), on the technical ground that it does not pay individual policyholders cash allowances toward expenses incurred, as insurance usually does, but instead provides service benefits in hospitals. Blue Cross's original appeal was the appeal of community service, and the appeal was effectively promoted. It succeeded in impressing upon organized medicine, the hospitals, and the public alike that this was the free American way of providing health care.

And yet Blue Cross may be able to save itself only by adopting many of the characteristics of the very thing its leadership has always been determined to preclude. If Blue Cross should now cease to expand its membership enrollment and also fail to broaden the range of its services in response to public demand, or if any substantial number of the seventy-nine regional Blue Cross plans should go bankrupt in the attempt, it seems clear that there will simply have to be substantial subsidization from some outside source.

INITIALLY, Blue Cross covered employee groups only. These normally are in the younger, healthier segment of the population. But over the years, its philosophy of welfare service for the whole community gradually extended its coverage until it arrived at its present policy of individual as well as group enrollment.

The insurance industry, emboldened by Blue Cross's spectacular success in the health-insurance market, one it had theretofore spurned as profitless, launched into strenuous competition. The competition between Blue Cross and the eight hundred-odd insurance companies now in the health-insurance field has taken on the character of a mortal combat. By the 1950's the commercial carriers had caught up with and begun to pass Blue Cross in the numbers of persons they provide with hospital insurance. In Blue Cross literature, commercial insurance has been painted as the avaricious, unfair rival, uninhibited by ideals of community-wide service and thus able to skim the cream off the market.

Since Blue Cross's fundamental commitment to community rating means that practically everyone is eligible and pays the same rate, the proportion of the infirm aged subscribing to Blue Cross is naturally high. Among the fifteen million Americans over sixty-five, two-thirds of those who hold some sort of health coverage belong to Blue Cross, some three and a half million people. The commercial carriers, on the other hand, using the principle of experience rating to reduce adverse risks (that is, accepting only favorable risks, pre-eminently employee groups), are able to provide the younger people with cheaper coverage. Blue Cross loses them while it gains an ever greater concentration of the old, who are hospitalized more than twice as many days per capita as the population as a whole, at a cost three to four times that of the younger population. This has a great deal to do with the fact that the Blue Cross plans had an $8-million deficit in 1957 and a staggering $40-million deficit last year.

Should It Be a Monopoly?

Against this sort of pressure, how can Blue Cross maintain its ideal of nonprofit service benefiting the entire community? One solution, of course, would be for Blue Cross to become a national monopoly.

Monopoly has never been directly proposed in exactly so many words by Blue Cross leadership. Nonetheless, it is the clear implication of the position reiterated in rate hearings when Blue Cross constantly accuses the commercial carriers of preventing it "from serving the needs of the community." Moreover, the argument that one good program is cheaper than two or three overlapping poor ones and that this one program should be on the Blue Cross principle of service benefits rather than cash is a recurrent theme in Blue Cross literature. Late in August, John R. Mannix, a top Blue Cross official in Ohio, proposed that the American Hospital Association set up what in effect would be a super Blue Cross plan to be called the American Blue Cross: chartered by Congress, it would cover both major and minor hospital, medical, and dental bills and would be available to everybody, including the unemployed and the retired. Unless this radical step is taken, he warned, "the question as to whether or not we are to have a governmental health system in the United States will be decided affirmatively tomorrow."

Blue Cross has often aggressively sought a role as the government's agent in many medical matters. After first asking for all or none of Medicare, the government-paid health insurance for dependents of the military, Blue Cross eventually settled for two-thirds of the business, with the commercial carriers getting the rest. Should the Forand bill, which would provide hospitalization and related services to Social Security beneficiaries, ever go through—and it appears more likely of passage at each session of Congress—Blue Cross would probably become its fiscal agent.

INSTEAD of trying to eliminate the competition by acquiring a monopoly, Blue Cross could, of course, adopt the tactics of its commercial competitors by limiting service. It could do this either by using experience rating to avoid the bad risks or by providing so-called catastrophe coverage and thus limiting its coverage to the rarer big emergencies. There are already a few modest in-

stances of experience or merit rating, as it is called, in some of the Blue Cross plans, and more attempts can be expected in the future. Philadelphia Blue Cross, for example, has proposed somewhat lower rates for groups that had less hospitalization during the prior year than other groups. But this expedient cannot really work to any appreciable extent. The plain fact is that unless the healthy, productive young partially subsidize the ever larger number of aged by paying for more than their "actuarial" share, the aged will be confronted with impossibly high rates and Blue Cross will inevitably have to abandon community-wide nonprofit service.

Similarly, while provision of only catastrophe coverage would undeniably reduce costs, since minor infirmities would be paid for by the patient, most Blue Cross leaders feel that it would also lessen the utility of their plans and leave those least able to afford it the necessity for bearing the brunt of their hospital expenses. This would obviously relegate Blue Cross to the minor role of standby protection against economic calamity. Organized labor frowns on the idea because it feels the workingman might be deterred from getting needed care and that in any case he still cannot shoulder the burden of the relatively less costly illnesses by himself. A few in Blue Cross have suggested that two plans be offered: one the traditional coverage, the other catastrophe coverage. But others object that the higher overhead costs of administering two plans would tend to nullify the possible economies.

Too Many People in Hospitals

As if these difficulties were not enough, Blue Cross now finds itself backed to the wall by the fact that its coverage is, with only the rarest exceptions, confined to treatment in hospitals. The resultant overutilization of the hospital has become something of a national scandal, eliciting "view with alarm" articles, legislative inquiries, indignant letters to the editor, a plethora of conferences and speeches in the medical and insurance worlds, and much bad feeling among the doctors, the hospitals, Blue Cross, and the public.

The problem for Blue Cross is not only how to prevent abuses but also how to control the mechanics of coverage for outpatient care. This includes visits to doctors' offices (at the patients' initiative, of course), getting an X ray, or diagnosis at a clinic. It presents a staggering underwriting problem. Hence there has been an inevitable and disastrous stress on institutional care. Many physicians hospitalize patients bent on getting their money's worth out of hospital insurance regardless of genuine need. All too often patients are hospitalized purely for diagnosis under the guise of treatment.

As the insurance commissioner of Pennsylvania put it in his adjudication after a recent Blue Cross rate hearing, "Such conduct on the part of the doctor [unnecessary commitment of patient in a hospital] renders him a collaborator with a private party in the violation of his Blue Cross contract." But in accordance with the tradition that the doctor can do no wrong, county medical societies take no disciplinary action whatsoever even when pressed to do so by state medical societies.

Various studies have shown that a minimum of twenty per cent of the hospital population need not be there and could just as well or even more effectively be handled in much less expensive accommodations. The consequence of unnecessary admissions, overlong confinements by convalescents in overelaborate quarters, and similar hospital abuse has been to increase the already swelling costs of medical care; it has risen fifty per cent in the last decade. And so it happens that Blue Cross, which was originally set up to make hospital care available to everyone, finds itself asking for ever higher rates to compensate for the fact that too many patients with Blue Cross coverage have been sent to hospitals. Truly, it has succeeded only too well in accomplishing its original mission.

Some Blue Cross leaders feel that the hospitals themselves should take the initiative by augmenting their medical-care services so as to include more outpatient care, which Blue Cross could then cover in a new kind of contract. By why put all the blame on the hospitals? After all, Blue Cross itself is now a vital part of the hospital system, as evidenced by its relationship to the American Hospital Association. The truth is that both doctors and Blue Shield can get pretty nasty when a hospital takes the initiative in providing the outpatient services that traditionally have been a prime source of the doctor's income. What's more, the fundamental needs, according to experts in medical economics, are radical changes in hospital design and an expansion in services so as to provide for truly comprehensive health care—especially preventive and restorative care. This, of course, is a job that Blue Cross never asked for. It has simply been overwhelmed by the public's acceptance of its basic service and now finds itself a giant, charged with new and enormous responsibilities that it neither created nor anticipated.

Who'll Cover the Deficits?

Such are the tensions in medical economics today that the friendship of Blue Cross and the hospitals has often degenerated into a feud. It is a complicated controversy involving once again Blue Cross's quasi-public welfare philosophy. The hospitals' complaint is that the reimbursement

formulas of the service plans do not recompense them properly for such essential expenditures as upkeep, expansion and remodeling, medical and nursing education, and research, let alone the burden of free care for the indigent. They argue that when Blue Cross claims for itself the prestigious role of welfare agent for community-wide hospital services on a nonprofit, public-service basis, then it must also acknowledge such costs as its own legitimate concern. In effect, Blue Cross is being asked to accept responsibility for the hospitals' survival and growth.

It is hardly that simple, however. From small and almost casual beginnings, Blue Cross has grown immensely because it met a vital public need, and it cannot be accused of sidestepping challenges, at least up until now. Blue Cross can contend, and on occasion does so with asperity, that charity cases, for example, are the responsibility of the county and municipal authorities and that a larger proportion of this hospital expense should be met out of taxes rather than passed on to those provident enough to subscribe to Blue Cross.

WHAT HAS HAPPENED, of course, is that charitable contributions are no longer sufficient to finance the frightfully costly kind of apparatus and construction the modern hospital requires.

Faced with somewhat the same problems, our medical schools have been in continual financial embarrassment and unable to expand rapidly enough to provide new doctors to serve the growing population. Medical schools, like the rest of American medicine, have traditonally been greatly dependent on private philanthropy, which now derives increasingly from corporation donations. But the principal source of support at present, sixty per cent of it in fact, comes from governmental tax funds—thirty per cent from the national government and another thirty per cent from local and state governments.

Since it seems clear that Blue Cross cannot meet the hospitals' deficits without pricing itself out of existence, there are many who feel that some such more or less amiable partnership between government and private auspices offers the only possible solution to the present argument between Blue Cross and the hospitals.

Labor's Love Lost

The hospitals are not the only friends with which Blue Cross has had bitter arguments. There is also organized labor.

The biggest single shot in the arm for Blue Cross's amazing growth was the wartime wage freeze, which put a new stress on welfare benefits. For many years Blue Cross was a great favorite of labor. But recently some important unions have abandoned Blue Cross, disturbed by its apparent inability to control costs and even more so by its limited coverage. Labor has been increasingly attracted to the so-called independent plans, involving group practice by salaried physicians providing comprehensive care, both preventive and restorative as well as curative, on a group prepayment basis. More than three million people, a large percentage of them in labor groups, are now enrolled in these prepaid group practice plans. Among the better known are Group Health Association in Washington, D.C., HIP in New York, the Kaiser Foundation Health Plan on the West Coast, the Ross-Loos Medical Group in Los Angeles, and the new UAW-sponsored Community Health Association in Detroit.

Moreover, organized labor, impressed by the decade of solid success achieved by the United Mine Workers' own chain of hospitals, has been seriously considering building and running its own facilities. A month ago, in a bitter denunciation of Blue Cross's high rates, limited coverage, and insufficient community representation, New York City's AFL-CIO Central Labor Council proposed that the unions develop not only their own system of hospitals throughout the five boroughs but also their own medical-insurance program and possibly their own medical school.

Labor has also launched a belated drive to unionize nonprofessional hospital workers, a grossly underpaid group that for years has been partly subsidizing the medical care of all of us. Once again, Blue Cross is caught in the crossfire.

Labor's attitude is extremely important for the future of Blue Cross. The size of the groups involved is not the only factor. The pattern set in labor-management negotiations among major companies establishes the pattern of rates and range of benefits for almost everyone else. It is worth noting in this connection that Blue Cross, by virtue of its character as a nonprofit community liaison between the hospitals and the public, cannot change benefits arbitrarily but must first get agreement from both labor and management.

An Ounce of Prevention

In the long run, the most serious of all Blue Cross's problems is the paradox that while it is the outstanding American creation in the field of health insurance, by its very nature it has inhibited the most promising developments in health care—preventive and restorative medicine. The result of Blue Cross's tremendous growth as a prepayment mechanism for hospital care is its total absorption with curative care of acute diseases and disorders within the confines of the general hospital. This happens to run directly counter to the prevailing trend in contemporary medical thinking. The new emphasis on prevention and rehabilitation is being dictated by great economic pressures as well as by medical progress. Thus by and large, the best medicine is the cheapest medicine. This means that people must first of all be kept healthy; if sick, cured expeditiously, and more than cured—rehabilitated for a secure return to society, with minimum chance of relapse.

Blue Cross is not contributing to realization of this ideal. Quite the contrary. One of the ideal's essentials is that there be a more precise fitting of medical services to particular patients' conditions, not the lumping of all the disabled into the general hospital. According to the experts, the general hospital may be the nucleus of the new comprehensive community health centers that are required. But preventive practices performed at moderate cost in facilities designed for outpatient services —health examinations, diagnostic tests, laboratory tests—are crucial if we expect to avoid the excessive medical costs that arise from keeping our

hospitals filled with a huge population of the ill and the ostensibly ill.

Likewise, facilities must be designed that will adequately meet the more simple needs of the ambulatory ill and the convalescent, who now, partially from the pressure of Blue Cross, exploit hospital services that have been designed strictly for the *acutely* ill. This also means development of better nursing-care units for the chronically ill and the elderly, as part of the community health center but distinct from the general hospital itself. It means rehabilitation facilities and self-help units within the community health center and it means home nursing-care services. In short, it means a more elaborate and subtle articulation of health services on a continuing and not an episodic basis. This sort of health care is both cheaper and better.

The Middle Way

It is difficult to foresee just how Blue Cross will manage to extricate itself from all its harassments. Blue Cross in Canada has been largely superseded by government hospitalization insurance as of this year. In Washington this spring a momentous 117-page report was submitted to the House Ways and Means Committee by the Secretary of Health, Education and Welfare, Arthur S. Flemming, on the pros and cons of Federal hospitalization for Social Security beneficiaries (the objective of the Forand bill). Significantly, though Mr. Flemming later went on record against government action as advocated in the Forand bill, at least at this time, the introduction to his departmental report took no sides. It posed the question in this way: Should the Federal government undertake to pay hospital and medical-care costs for the aged now, or wait to see if voluntary private insurance will rise to the challenge of meeting the requirements of the elderly? The report then listed the pros and cons of government intervention with admirable impartiality.

The insurance industry, organized medicine, and business in general, while all willing to concede that covering the aged presents a very pressing problem, are against government action. They are convinced that a decision to let Federal government provide even limited hospital insurance for the aged would decisively slow down the rapid growth of voluntary health insurance.

On the other hand, speaking for the Forand bill on behalf of labor, Walter Reuther contends that far from destroying voluntary private insurance, it would furnish a "basic minimum standard" of protection for the aged, on which private insurance could build. Most of the proponents of the bill are satisfied to point out that only about forty per cent of those over sixty-five have any kind of health insurance and that according to the Flemming report private insurance will not succeed in covering more than seventy per cent of the aged population even if given a free hand until 1965.

Some opponents of the Forand bill have argued that Federal hospital insurance for the aged would not only slow down the growth of private insurance for all but would lead inevitably down the road to government control of all health services. On this score it should be noted that forty-four per cent of the nation's $6-billion hospital bill is already being paid by government via public funds (fourteen per cent by the Federal government through its various veterans' and military programs, thirty per cent by state and local governments), as against only twenty-eight per cent paid by private insurance, including the $1,357,392,014 in hospital payments made by Blue Cross (1958). As to the cost of total U.S. personal health services—this excludes public expenditures for military and community health services—about twenty-five per cent is paid for by government compared with around sixteen per cent by private health insurance. In short, government is already very much in the health-care business, and has been for some time.

Secretary Flemming has spoken of government and insurance "agreeing" on an imaginative program to meet the hospital-insurance needs of the aged. It is known that he is having his department draw up proposals to provide Federal subsidies for private insurance carriers to enable them to cover the worse-than-average risks, presumably with Blue Cross participation. He will probably present this proposal to Congress at the next session when the Forand bill comes up again.

Spirited public debate is bound to revolve around this problem. But the most likely outcome, as Secretary Flemming apparently realizes better than most, is that the peculiar American talent for combining governmental, private, and philanthropic enterprises will continue to dominate American health care for some time to come.

The Meaning Of the British Election

H. G. NICHOLAS

LONDON

THE BRITISH predilection for taciturnity carries over into election statistics. The great wealth of correlatable detail provided by the American ward or precinct records has no equivalent here. What the British general-election returns of 1959 supply is simply the votes cast for each candidate in each of 630 parliamentary constituencies. Carefully translated, however, even these figures can be made to yield some information on how and why on October 8 the Conservative Party won its third victory in a row with a greatly increased majority.

At the outset it may be as well to dispose of a widespread misconception about the over-all result. Correspondents and commentators have repeatedly talked as if there were something truly extraordinary in the fact that a swing of 1.5 per cent of the popular vote produced a Conservative majority in the House of Commons twice as big as before. But this is pretty much what is likely to happen in any country with a predominantly two-party system and with election by plurality in single-member districts. In the United Kingdom it could be paralleled on many previous occasions. The increase from sixty-seven (the Tory majority in 1955) to 107 simply repeats, in almost exact arithmetical progression, the increase in the election of 1955 from twenty-six to sixty-seven, and this 1955 increase was itself the result of an almost identical swing of 1.8 per cent. It is the familiar magnifying effect seen in the workings of the electoral vote in U.S. Presidential races.

ALLOWING for this multiplying factor, just how are we to assess the Conservative achievement? Just how wonderful is "MacWonder"? Or (to use Labour's language) how successful was the "Tory Swindle"? Two records have been broken: there have been three successive Conservative victories and there have been rising majorities each time. But the base line for this meteoric graph was a very modest one—the exceptionally small Conservative majority of 1951, when Labour actually had more popular votes but had them where they could do the least good. There is nothing in the victories of the 1950's to compare with the sweeping Tory majorities of the 1930's—427 in 1931 and 247 in 1935. By British standards, 107 is a comfortable but not a huge majority. It enables the whips to allow members some latitude without encouraging any serious delinquency on the backbenches. Yet for all his success, Mr. Macmillan persuaded only 49.4 per cent of the actual voters to cast Conservative ballots (only 38.8 per cent of the eligible voters), and the hope of getting a mandate from a majority of the electorate eludes this government as it has eluded its predecessors.

Moreover, the Tory triumph is uneven. Mr. Macmillan can rejoice in his showing throughout the Midlands and the South in particular. He has won back a majority of seats in Birmingham, the old Joseph Chamberlain bastion that Labour captured in 1945. He has scored gains in Coventry, Nottingham, and Rugby—but not in Manchester, Glasgow, the Northwest which pivots on Lancashire, or the industrial belts of South Wales or Scotland. He is drawing closer to Labour in London. It is as if the Republicans had won back Philadelphia, gained in Detroit, Los Angeles, and throughout Ohio, but failed to take the lead in Chicago, Boston, industrial New England, or Pennsylvania, while New York City had split almost fifty-fifty. This is no landslide.

The Three Who Switched

Be that as it may, the Conservative growth over the decade remains impressive. For a party that has had three leaders, one of them lost in the middle of a national disaster of his own contriving, the mounting popularity is remarkable. And it is not a trick that has been pulled while the electorate has been looking the other way. Whatever may have been the original Tory strategy of keeping the election cool and quiet and clean on the principle that a low poll is a Tory poll, by the end they were barnstorming as lustily as anyone. The 78.7 per cent turnout on which they won was respectably high, only a little lower than the 82.6 per cent of 1951 and above the 76.8 per cent of 1955. And the Conservatives' total