National health insuranceThe dream whose time has come?: Eighteen ...
Richard J.Margolis
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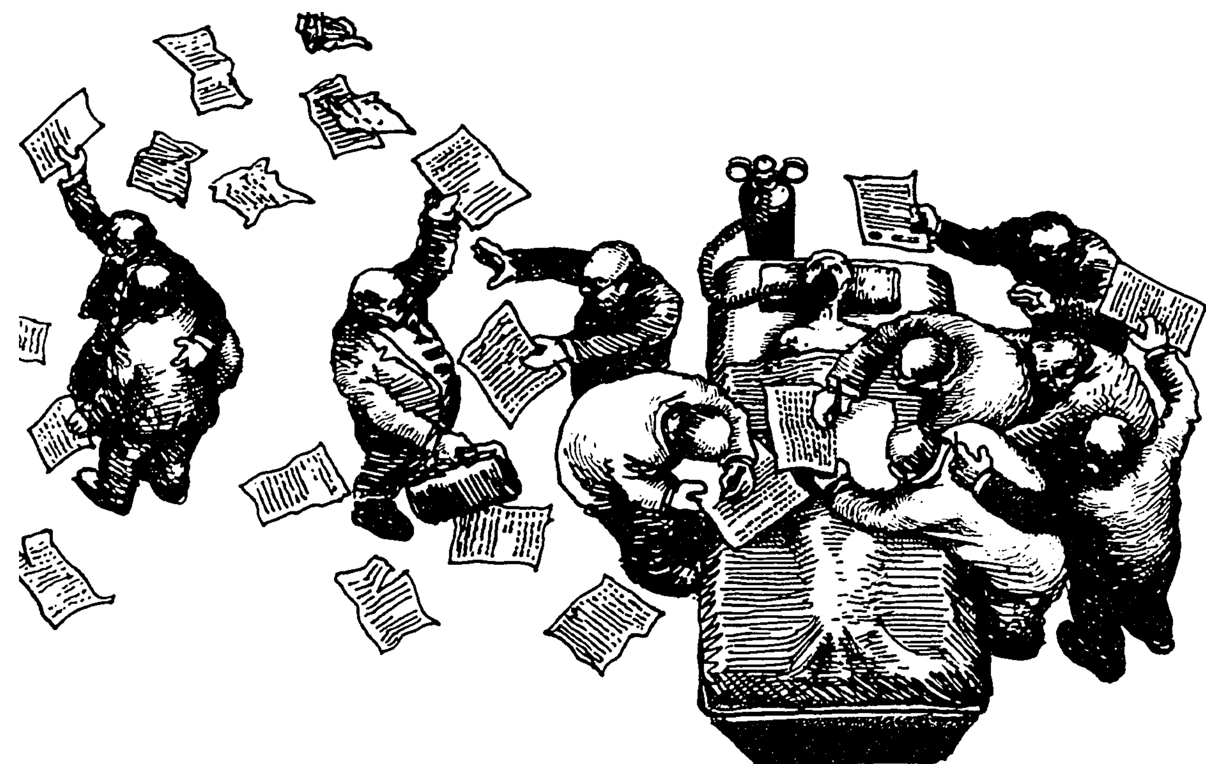


National health insurance—'he dream whose time has come?

Richard J. Margolis

Eighteen proposals for orming the nation's medical system await the new Congress. But can the system be reformed?

socialization of medicine is com- . . . The time now is here for edical profession to acknowledge t is tired of the eternal struggle dvantage over one's neighbor."

ring the next four years, Jimmy r and the Congress will probably e whether universal national h insurance—a dream so long de- d that scholars call it "the lost m"—shall at last be deemed an whose time has come, or whether all remain an idea that is merely overdue. Something more than health appears to be at stake: as other tough social dilemmas (seg- tion, for example), this one raises tions about the resources and ca- ies of our political institutions. articular, it tests our abilities to come the great weight of health- inertia, a weight that seems to omposed in roughly equal parts of history, bureaucracy and avarice.

'he opinion polls suggest that a ible majority of Americans is now dy for fundamental changes in lth care, and the President-elect ap- rs publicly committed to such nges. The 1976 Democratic plat- m, largely a Carter creation, calls "a comprehensive national health- urance system with universal and ndatory coverage"—meaning a pro- m that goes about as far as it can all of the people insured all of time for all of their care.

Nothing could be simpler; nor, if the it turns out to be prologue, more ficult to achieve. The fact is, we ve been here before. The history of tional health insurance in this coun- is strewn with predictions about imminent arrival.

chard J. Margolis is a columnist

complexity of our burgeoning dical system, which defies instant abilitation, and from the apparently h price we must pay for its reform. ny of the recently tried solutions, ably Medicare and Medicaid, have mselves become part of the prob- ı, encouraging waste and driving up its. Thus far, at least, reform has yed handmaiden to inflation. Nowa- ys, we spend 8.6 percent of our oss national product on health care, out double the portion two decades o.

The new Congress and the new Pres- ent will have to confront this general radox of social progress, in which asures designed to lighten the bur- n of some may end by increasing burden of all. As regards the medi- l-care paradox, it is not as if there

er since that A.M.A. Journal editor years ago urged doctors to quit ıe eternal struggle for advantage er one's neighbor," reformers have en plumping for national health in- rance (without, however, any further couragement from the A.M.A., which on changed both its mind and its adership). Franklin D. Roosevelt me within an ace of combining alth insurance with Social Security 1935, only to be dissuaded by the M.A., notably by Dr. Harvey Cush- g, author, brain surgeon and father- -law of young James Roosevelt.

Whatever recommendations F.D.R. ight decide to make, Cushing wrote the President, "no legislation can effective without the good will of e American Medical Association, hich has the organization to put it work." In the politics of health re- rm, Cushing's comment remains the eart of the matter; and nowadays oliticians must seek the cooperation ot only of the A.M.A. but also of her health interest groups that have own up in the interim. Over the dec- des our health-care system has in- ented a potpourri of patchwork hemes as substitutes for "the lost form," and each new expedient—

nd 40's—has given rise to a new or- anization in Washington. Like all ewcomers, these organizations have ecome instantly suspicious of change nd broadly committed to things as ey are. If Cushing were alive today, e could cite at least four other groups hose good will may now be required: e "Blues," the private insurance in- ustry, the hospitals and the medical chools.

The battle did not end with the New eal. Harry S. Truman took up the udgels, to secure passage of the Mur- ay-Wagner-Dingell bill, a measure the A.M.A. dismissed as "Marxist medi- ine." It never reached the floor of Congress, but it has since seen several eincarnations.

Considering the dis- couraging record, it wasn't any wonder that both John F. Kennedy and Lyndon B. Johnson chose to fight on narrower ground. Each came to the White House prepared to settle for something less than "the lost reform." With the passage of Medicare and Medicaid in 1965, the Congress conferred the blessings of free or low- cost medical care upon both the elder- ly and the poor. The new programs enlarged the public's sense of possibil- ities. If we are closer now to the Prom- ised Land, it is because the events of 1965 showed us a way out of the wilderness.

No sooner, it seemed, had the bills been signed into law than news of yet another "health-care crisis"—it was really the same old one—spread throughout the land. L.B.J. called on Congress to do something about "the soaring cost of medical care," and also about "the inexcusably high rate of infant mortality in the United States." (Seventeen countries still have rates below ours.) A few years later Richard M. Nixon sounded the familiar alarm: "We face a massive crisis in health care, and unless action is taken . . . we will have a breakdown in our medi- cal-care system."

The Congress began to consider new measures, a fresh generation of legis- lative proposals that would extend the protection of health insurance to some or all of the remaining population. Such proposals have grown more nu- merous of late. In the last Congress, the 94th, no less than 18 different bills were submitted, each alleging to offer the most practical solutions. These plans are Jimmy Carter's health-re- form legacy.

If the titles sound maddeningly alike, their contents exhibit some real differ- ences. By and large, they reflect the contradictory hopes of people and or- ganizations who have something to gain or lose from the redistribution of health care in America—doctors, hospitals, insurers, medical schools and patients. As consumers and tax- payers, one can try to test the merits of the proposals by keeping close to two familiar touchstones: the benefits offered and the costs incurred. In addi- to which it can be expected to reorgan- ize health-care along lines that make sense.

Of the 18 now before Congress a half-dozen perhaps can be considered "major," either because of the power and celebrity of their Congressional sponsors or because of the influence of their outside backers. Like the lobbies that support them, these six are a mixed bag. All but one would make health insurance compulsory. They range from a modest proposal that would extend benefits to citizens who have incurred unusually high medical costs—the so-called "Catastrophic Health Insurance and Medical Assistance Reform Act," introduced by Democratic Senators Russell Long of Louisiana and Abraham Ribicoff of Connecticut—to the sweeping "Health Security" measure that Senator Edward M. Kennedy has been promoting since 1969.

Taken together, the six proposals offer a fair sampling of what the experts are thinking, what the health-care industry is demanding as ransom and what the public is wishing. What we see is what we may get. Before we pursue this pharmacopeia—an all-Democratic drugstore, no less—it may be well to glance at one object of great attention, what commentators are pleased to call "the national health-care delivery system." In truth, it is less a system than a collection of medical sins and services, a network that appears to be ever-expanding and evermore remote from the patient. Most of us have sensed the new remoteness, both in the reckonings we get and in the services we do not.

We are the world's only industrialized nation without a universal health-insurance program; yet no country on earth spends as much per capita as do we on health care. In a single generation, the total price has soared from $12 billion (in 1950) to $133 billion (in fiscal 1976), making health care America's third largest industry, just behind agriculture and construction. Some of the increase reflects genuine improvements in medicine, and some can be attributed to a wider distribution of services; but much of it must be chalked up to medical inflation pure and simple. Hospital charges, for instance, have risen four times as fast during the past decade as the Consumer Price Index itself.

Health-care inflation is not a new problem; it has long been a fixture on the medical landscape. "Every where," lamented the health demographer Louis I. Dublin in 1927, "there is a feeling that something is wrong with the economics of medicine. Large numbers of middle-class families . . . chafe under what they generally consider the unjustifiably heavy cost. With the passage of Medicare and Medicaid, however, inflation took a quantum leap: Costs more than tripled while annual per capita expenditure shot up 250 percent. In 1965, the average American spent $198 for health care; last fiscal year the sum was mo[re]

confoundedly resistant to voluntary self-controls and to Congressional tinkering, like the introduction two years ago of "peer review" for all treatments paid for by the Federal Government.

The dismal history of the medical dollar has made many wary of starting another round of reforms. Yet there seems nothing mysterious or inevitable about medical inflation; in theory, at least, it can be controlled. Richard Nixon came close to doing just that with his 1971-74 price freeze, when health-care prices climbed at about one-third their usual rate. What seems chiefly at fault is Medicare's and Medicaid's peculiar method of reimbursement, whereby they pay whatever the doctor or the hospital claims to be "reasonable" and "customary." In effect, the Congress has handed a blank check to the health-care industry, with predictable results. Not only has the industry jacked up prices for unimproved services, in many instances it has submitted bills for services never rendered. Fraud begets inflation.

It is true that only about one-third of the national health care bill is charged directly to consumers. The rest is paid for by the Federal Government, the states and the private insurance companies. But the citizen ultimately pays those bills, too, in higher taxes and stiffer premiums. Medicare premiums have been hiked a half dozen times since the program's inception; during the same period, Blue Cross rates in some areas have risen fourfold.

Although four-fifths of the population is covered by some kind of health insurance, the protection afforded is often skimpy and unreliable. In last year's recession an estimated 27 million workers and their families were deprived of coverage because of layoffs. Many of the policies still in force, moreover, fail to protect patients against the costs of home care or visits to the doctor's office. Close to half the people who file pleas for bankruptcies each year do so because of medical debts.

Americans might bear these medical burdens more cheerfully were they getting their money's worth; but if the price of health care isn't right, neither is the product. As nearly everyone knows by now, the medical network suffers from several strains of maldistribution, both professional and geographic. Chief among these is a surplus of specialists, particularly of surgeons, and a shortage of primary care physicians—internists, pediatricians and general practitioners.

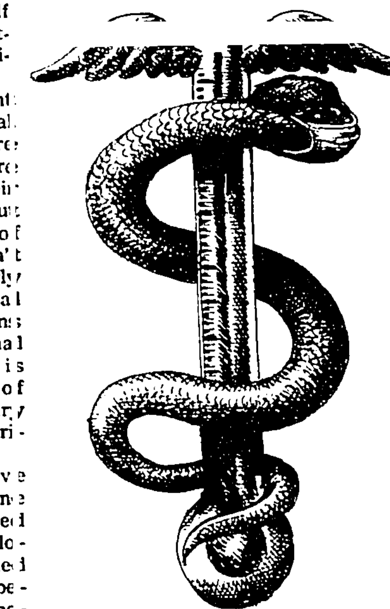
Officially certified specialties have been part of the health-care scene since 1917, when eye doctors founded the American Board of Ophthalmology. Since then physicians have created more than 20 board-recognized specialties along with some 200 subspe-

percent of the nation's doctors were specialists; today the figure is 72 percent.

The imbalance has tended to drive up costs still more (specialists usually charge more than G.P.'s) and to reduce patients to the status of machines with broken parts; it is another symptom of medical remoteness. In surgery, according to more than one Congressional committee, the surplus of specialists has created a greater "demand" for operations, which is to say that some surgeons examine their bank accounts before they examine their patients. At least two million of the operations performed each year are said to be unnecessary, and these lead to some 15,000 preventable deaths.

The geography of health care seems equally unjust, but for the contrary reason: too few doctors, in some places, rather than too many. Because most of the nation's 378,000 physicians locate their practices within easy reach of the affluent, the residents of urban ghettos and rural areas frequently find themselves shortchanged; they are medical orphans. To cite one of the many available statistics, the state of Mississippi, relatively poor and rural, has only 82 doctors for every 100,000 citizens while in suburban Westchester County, N.Y., the comparable ratio is 26[?] per 100,000. At last count some 5,00[0] towns in 135 counties in the United States had no doctor at all: One of them was Webster County, Ga., the county next door to Jimmy Carter's.

The desperate shortage of health care personnel in some areas works to strengthen local medical oligopolies inviting its practitioners to profit at the patient's expense. I came across an instance of how this can occur, and the misery it can cause, when I interviewed a wom- *(Continued on Page 3*



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ealth Insurance

'ho lives in the hills ıtern Kentucky. One day, old me, her 4-year-old Danny, complained of a n his stomach.

lidn't have much money, anny was in awful pain, paid somebody to ride nto Prestonsburg. The r, he looked at Danny. aid the boy had to be ted before his appendix red, but first I had to things out with the hos- director. Me and Danny to the director. He told : would cost $350 and I d have to give a $100 ı payment. I said I didn't no $100. He said, 'Well, ı you get it come back, we'll fix your boy up.' Danny was vomiting right in the director's office. /as real sick. I went and owed the money from a ın, and I came back with money. The director, he 'You have to show you ın income so as you can the debt.' I said all I ever is a check every month the Veterans for $57. He that would be just fine. ı he made me sign a paper nising to turn over the k to him each month till bill was paid. I couldn't : him. My Danny had to perated."

ne story does not make a ern, but the hearing rooms ongress over the past few s have resonated with dreds of such tales. The ession one gets overall is something has gone sour American health care and money has had a lot to with it—which may be more patients are writ- their Congressmen now- /s.

verlaid upon all these laches is the increasingly espread suspicion that the th-care network, having amok, is now beyond tical reach and therefore ond redemption. Its phe- nenal growth in recent rs has been unruly and lanned, and that is a ma- part of the problem. But he political arena the in- try, for all its disunity competing claims, has sented a single face to public. It is the face of institution that does not fer reform gladly.

So: back to the pharmaco- a.

Besides Kennedy-Corman l Long-Ribicoff, four pro- als seem worth consider- ing, that runs from the relatively broa and generous to the relat vely narrow and penny- pinc ing:

Tl : "Comprehensive Health Insu ance Plan" (CHIP), in- trod ced by Kentucky Demo- crat Representative Lee Car r — no relation. It has beer called a "block off the old 'HIP" because it closely rese ibles a bill of the same nam that the Nixon Adminis- trat n submitted to the Con ress in 1973. A nearly ider ical plan, moreover, in 197 almost got past Wilbur Mill s House Ways and Means Con nittee, the historic gate- kee er of health reform.

A complex proposal sub- mit d by Representative Al Ullı an, an Oregon Democrat, wh succeeded Mills as Ways and Means chairman; it is call d the "National Health Car Services Reorganization and Financing Act," quite a mo hful, and it has the of- fici blessings of the Ameri- can Hospital Association.

T e A.M.A.'s latest entry, "Tl Comprehensive Health Ca Insurance Act," spon- sor d by Representative Rich- ard Fulton, a Tennessee Dem- ocr t.

A d "The National Health Ca Act," a favorite of the He th Insurance Association of America (H.I.A.A.). It was int oduced by two conserva- tiv Democrats, Senator Th nas McIntyre of New Ha pshire and Representa- tiv Omar Burleson of Texas.

s might be expected, not all f the bills confront all of the problems; by and large the concentrate on ways of de aying patient costs and of sp ading patient benefits, wi the unspoken hope that th rest will take care of it- se Still, with the exception of Long-Ribicoff—which con- tir es Medicare's blank-check sy em of reimbursement — th proposals do make an ef- fo to curb inflation. The ch f restraining device envi- si ed in these bills entails an annual round of negotia- tic s, with doctors and hospi- ta , on all fees and rates; an at mpt to commit the health- ca industry each year to an in nutable schedule of cl rges. In all but the Ken- ne y-Corman measure, the re ponsibility for negotiating th se schedules is assigned to th individual states; only

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nnedy-Corman, which we all consider first, sees the deral Government as prime gotiator.

The Kennedy-Corman Health curity bill calls for a com- lsory federalized system of alth care managed within E.W. by a five-member alth-security board, and fi- nced chiefly through a half- ıd-half combination of pay- ll taxes and general rev- ıues. As is the case with ost of the other bills, the ıyroll taxes are shared by nployers and employees. he benefits offered by Ken- edy-Corman are broad, gen- rous and virtually free of e kinds of restrictions one nds in the other proposals. ut the benefits are not the /hole story; what distin- uishes this bill from all thers is its unique approach o budgeting, an approach hat makes private enterprise n instrument of public policy.

Health Security stops short f nationalizing the health- are system, but it does na- ionalize the health-care udget. Every dollar spent— whether for construction of a new hospital or for purchase of a new tongue depressor— becomes a Federal dollar. The budgeting process is supposed to begin at the local levels where groups of consumers and professionals annually as- sess their health-care needs and estimate the costs. These estimates filter up through a regionalized system and even- tually land in Washington on the health-security board's desk, becoming part of the year's national health-care budget.

Cost controls under Kenne- dy-Corman turn traditional procedures upside-down: The bill stipulates that the annual health-care budget cannot ex- ceed expected revenues, thereby tying the medical budget to the fortunes of the general economy. If the economy should slip, the Federal Government would have to negotiate a reduced budget, and the bill's support- ers insist that the burden of such a reduction would be as- sumed not by the patient but by the health-care providers. In other words, rather than curtailing services, Kennedy-Corman would curtail the fees and rates paid to doctors and hospitals. The proposal thus jeopardizes the industry's time-honored privilege of con- trolling fees and services, one reason for the measure's bad reputation among medical practitioners. On the other hand, it enjoys sustained sup- port from both the A.F.L.-C.I.O. and the United Auto alition of church groups and liberal-leaning organizations like Common Cause and the Urban League. It is the only proposal thus far to have at- tracted substantial consumer backing.

The Long-Ribicoff proposal is a "major-medical" plan to insure patients against costly illness. Its benefits, presuma- bly, begin about the time a patient has run out of money: after he has spent $2,000 for medical services or has been in the hospital for 60 days. An employer can buy this in- surance for his employee ei- ther from the Government, in which case he pays a 1 per- cent payroll tax, or he can choose a Government-ap- proved private plan — Blue Cross, for instance. (As with nearly all the bills, this one makes special provision for both the self-employed and the poor.)

Compared with Kennedy's Health Security proposal, Long-Ribicoff seems both pal- ry and narrow. It leaves the gears and levers of the health- care enterprise untouched, and the benefits it provides, while they may save some families from bankruptcy, are far from dazzling. Still, the measure has a certain appeal. It is simple and can be im- mediately "put into place," as the health analysts like to say, whereas most of the other plans would take years to be- come fully effective. It is also inexpensive, at least from the standpoint of Federal budget- ing; and it can be seen not as the Grand Solution but as merely a first step toward eventual enactment of "the lost reform."

Finally, the bill gives the health-insurance industry a piece of the action, an idea that may or may not have merit, but which in any case can be seen to make some tactical sense. It will come as no surprise that the private insurance companies are said to have bestowed their tacit approval upon this modest measure—in fact, to have taken a hand in its drafting. A Kennedy-Corman aficiona- do claims last year to have seen "at least a dozen of the insurance boys from Hartford in the back of the hearing room, just before the hearing started, making last-minute changes in the bill." The Ribicoff aides I have talked to say this is news to them; but it is true that an earlier version of the Long-Ribicoff bill provided for *Federal in surance only*, leaving no room for participation by private companies.

In any event, because Sena-

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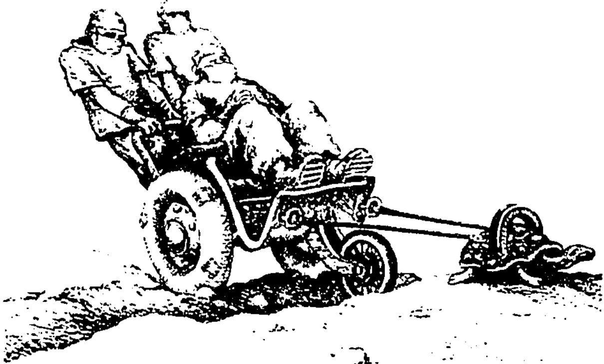

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tor Long is chairman of the Finance Committee, the womb from which any successful Senate bill must issue, the proposal has not lacked for a public platform.

Nor has CHIP, the Nixon bill that never dies. Benefits under CHIP are in some respects as far-reaching as those under Kennedy-Corman, but they include a $150 deductible for each person and also a 25 percent "coinsurance" requirement: that is, the family must pay either one-fourth of its health-care charges or $1,500, whichever is less during a given year. All this is to be financed not by taxes but by premiums paid directly to private insurance companies by employees and their employers; the latter group pays the larger share.

Unlike the other two bills, CHIP leaves virtually all of the program's management to insurance firms and to the individual states, with the Federal Government playing a small, regulatory role. Each state makes its own reimbursement policy, deciding how much money doctors and other providers should be paid for their services. The formula is similar to that now being used under Medicaid, and given that program's record, it is not a promising one. Nevertheless, CHIP has impressed some Congressmen as a workable compromise between "the two extremes" of catastrophic insurance and Health Security. It offers citizens more than the first and it costs the Government less than the second.

The remaining three proposals, like CHIP, give citizens a chance to buy private health insurance at modest cost, entitling them to a variety of benefits, but the benefits are hedged with coinsurance charges and other limits, and they, too, are essentially devoid of cost controls, with all administrative responsibility ceded to the states. What makes these proposals interesting is not the substance of their ideas but the nature of their support. Each is officially backed by a different lobby, and each can tell us something about the aspirations of the health-care network.

Al Ullman's bill, backed by the American Hospital Association, may be the most Byzantine. Besides the insurance and financing provisions, the act mandates creation in every locale of health-care corporations to which citizens may subscribe in advance of services. Apparently, these corporations would function as health-maintenance organizations (H.M.O.'s), which is what medical commentators now call groups that offer services on a prepaid basis. The doctors working for H.M.O's earn salaries or else are paid capitation fees—so much per member-patient. Either way, they are cut loose from standard fee-for-service arrangements and thus from temptations to overcharge or overtreat. Studies have shown that in H.M.O.'s the incidence of needless surgery is far less than it is in fee-for-service practice.

All of which sounds promising—but it is not clear from the bill how these local health-care corporations would operate or whether, in fact, an employer or employee could not skirt the corporation entirely and buy his health care from other sources. What does seem clear is that hospitals would play a central role in the new system, since in most places they are the only institutions extant that are capable of developing and managing so complex a plan.

The A.M.A.'s bill is less generous than CHIP and less ambitious than Ullman's. It would leave fee-for-service practice and private-insurance precedents unscathed, with the Federal Government content to mandate the size of the premiums the subscribers would pay and to let the system lurch ahead on its own. To the self-employed wishing

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to buy insurance, the bill offers a few tax advantages; to the poor it provides "subsidy certificates" they can cash in at their local insurance company. As inadequate as this seems, it represents the farthest A.M.A. members have yet traveled down the road to "Marxist medicine." An earlier, and less-liberal, A.M.A.-backed measure, Medicredit, had to be discarded after the post-Watergate elections of 1974, when 55 of its Congressional sponsors were defeated. (The A.F.L.-C.I.O. ran a nationwide campaign to unseat these enemies of Health Security, using the slogan "Your Congressman may be dangerous to your health.")

Finally, there is the "National Health Care Act," the darling of the H.I.A.A. It has the distinction of being the only plan among the six that permits employers to dismiss it—which is to say that the program is strictly voluntary. If an employer chooses not to buy in, his employees are out of luck. In consequence, the bill has been given short shrift everywhere but in the executive suites of insurance companies. As a labor lobbyist remarked recently, "When you get a proposal that offers less than the A.M.A. does, what have you got? . . . Nothing."

We can pay our money, then, and take our choice, though it is not at all certain just how much money we shall have to pay. A recent H.E.W. study indicates that all six programs are costly—some are more costly than others, but the differences may not be all that great.

The man who conducted the study is Gordon R. Trapnell, a consulting actuary. According to Trapnell, if we enact no new health-care programs during the rest of the decade and continue spending at the present rate, medical costs will rise to $180.2 billion by 1980—a gain of about 30 percent over this year's tab. From that empyrean base, Trapnell calculated the additional costs that might be incurred by each of the six plans, concluding that the three cheapest were Long-Ribicoff, CHIP and the H.I.A.A.'s voluntary plan. Each would cost at least an extra $10 billion annually. The other three proposals would each run more than twice that amount—an additional $20 billion in the case of the A.M.A.'s program, and an extra $25 billion for Ullman or Kennedy-Corman.

Trapnell's estimates suggest that health-care inflation will remain part of the picture regardless of which program the Congress enacts. Any new plan, he notes, will increase administrative expenses and encourage wider use of medical services, especially among the poor. Yet supporters of Kennedy-Corman continue to insist that their proposal is more or less inflation-proof—in part, because it subsidizes *preventive* medicine and, in part, because its budget is linked to national productivity. "We have the only measure with built-in controls," says Max Fine, who directs the Committee for National Health Insurance, a labor-financed lobby.

Many remain skeptical, among them H.E.W.'s Saul Waldman, whose detailed 210-page summary of all 18 health-insurance bills is the bible of analysts and lobbyists alike. "Nobody really knows whether Health Security could keep the lid on," he says. "True, there's a ceiling on the budget, but there's also a clause in the bill that says Congress can be asked for supplemental funds in case of emergencies. The emergency wouldn't necessarily have to be medical, like an epidemic; it could be an *economic* emergency."

On balance, though, the Kennedy-Corman bill does appear to encourage a fiscal climate in which health-care prices will rise no faster than prices overall. The probability under Kennedy-Corman is one of controlled inflation, something we haven't seen in health-care circles since the Nixon price freeze; it would amount to a mild revolution within the health-care industry—a revolution of reimbursements.

But the revolution that Health Security invites us all to join goes beyond fiscal policy. At bottom, it represents a major shift of power and responsibility within the health-care network, a shift away from state governments and private insurance companies toward H.E.W. and the Federal bureaucracy. All other plans cede administrative control to the states (under Federal guidelines) and commercial control to the private insurers. In opposing Kennedy-Corman, the health-insurance industry is fighting for its very existence. The stakes are high. Last year the industry collected nearly $30 billion in premiums.

Dr. Cushing's law writ large is that no legislation can be effective without the good will of health-care interest groups. In assessing the various alternatives, Congress and the President will have to ask themselves whether the superior efficiency and the more generous benefits claimed by Kennedy-Corman are worth the wrench. The other bills' sponsors have already answered the question. "Health Security is too risky," notes Dr. Susan Irving, a health economist who works for Senator Ribicoff. "You can't simply dismantle the insurance industry and expect no consequences. Besides, who said that H.E.W. could run the program efficiently? Its record with Medicare suggests the opposite." Ned Helms, a health specialist on Senator McIntyre's staff, says, "There are 500,000 people working in private health insurance. Are we supposed to fire them or turn them into Federal bureaucrats in the name of health reform?"

The public could make a difference by agitating for one or another approach, but in matters of health reform the public has always been remarkably passive. Even in recent years, with all those bills floating around Congress, citizen interest has seemed anything but keen. The health-reform debate of the past eight years owes less to public pressures than it does to Presidential politics. Because, until recently, Senator Kennedy was viewed as a prime Presidential threat, his introduction of Health Security in 1969 acted as an enzyme in the chemistry of health reform. Richard Nixon responded by announcing his own Family Insurance Plan (FIP), a measure he never got around to submitting. A few years later, with Kennedy again a Presidential possibility, FIP gave way to CHIP, a plan Nixon at one point insisted was $47 billion cheaper than Kennedy's.

In 1974, Gerald Ford was in the White House; Wilbur Mills was still presiding over Ways and Means, and CHIP came close to winning that committee's approval. It did so because Ford, looking to 1976, needed an answer to Health Security, and Mills needed a bill that would buttress his rickety reputation. And the measure failed, largely because most Americans were not aware that it existed. (It failed, too, because the labor unions withheld support; they were counting on the fall elections to bring them a "veto-proof Congress" ready to fling Health Security in Ford's face.)

"The politicians," recalls Paul Rettig, counsel for the Ways and Means health subcommittee, "did not perceive national health insurance as a deeply felt public issue." In the end, and without much fear of public complaint, Ford pulled out, personally telling one of Mills's deputies that CHIP no longer had Presidential backing. "After that," says Rettig, "we were just dancing."

The dance goes on, while lobbyists mark up their bills and patients await "the lost reform" or a reasonable facsimile thereof. "Political life," observed the late Hannah Arendt, "is based on the assumption that we can produce equality through organization." If, in the case of national health insurance, that cheerful supposition seems shaky, it may be because there is so much to organize and so little equality to start with. Perhaps Jimmy Carter, a passionate reorganizer, will be able to make sense of it all; perhaps he can come up with a plan that pleases everyone, even the health-care industry. Thus far, he has kept his own counsel. The few utterances he has made on the subject have been tactful but contradictory. He has, on various occasions, emphasized his belief in "compulsory health insurance," "voluntarism," "immediate action," "a phased-in approach," "universal and comprehensive benefits," "inflation controls," "a Federal role" and "local initiative." No wonder every Congressman I talked to thought his particular health bill had Carter's secret support. They were blind legislators feeling different parts of the Carter elephant (or donkey).

Nevertheless, after the rhetoric of transition has settled, Carter will have to face up to the hard choices. The best guess is that he will appoint a health task force similar to the Committee on Economic Security that F.D.R. created in 1934. The task force will make recommendations; more important, it will give Carter time to do what Presidents before him have had to do: negotiate. The upshot, to continue the guess, may well be a CHIP-type program (Nixon's legacy) that offers a slice of the pie to everyone—doctors, hospitals, insurers and patients. Such a prospect is both scary and pleasing: all that money, all those benefits. But no one can predict anything for certain about the future of health reform. Like Jimmy Carter, it remains a mystery.

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