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REPORT OF A SPECIAL COMMITTEE
ON THE PROVISION OF HEALTH SERVICES
AMERICAN HOSPITAL ASSOCIATION

AMERIPLAN
—A PROPOSAL FOR THE DELIVERY AND FINANCING
OF HEALTH SERVICES IN THE UNITED STATES

AMERICAN HOSPITAL ASSOCIATION • CHICAGO, ILLINOIS
LETTER OF TRANSMITTAL

November 19, 1970

TO: Board of Trustees

SUBJECT: Report of Special Committee on the Provision of Health Services

I have the honor of transmitting to you the report of Special Committee on the Provision of Health Services named by the Board of Trustees a little over a year ago and charged with the task of studying and reporting on the organization and financing of health care in the United States. This was indeed a very broad charge and one going to the very basics of our health care delivery system.

We confirmed the fact so well known to leaders in the health field that it is not merely a lack of finances that keeps Americans from getting the best health care possible, but far more importantly, it is the shortcomings in the organization of our delivery system. These result in our being a less healthy nation than would be expected from the tremendous expenditure made for health care—almost seven per cent of our gross national product.

We found, as have other study groups before us, that for many, especially in our inner cities and in our sparsely populated rural areas, health care is not readily available; that there are shortages, maldistribution, and ineffectual deployment of health manpower, particularly physicians and nurses; that our health care system is, to a great extent, illness-oriented rather than concentrated on the maintenance of good health; that the delivery of health care is more fragmented and disorganized than it should be or needs to be; that the patient is too frequently regarded without respect for his uniqueness as an individual and too often treated only for his symptoms; and finally, we found, predictably, that health care is becoming very, very costly.

Because of these and other findings we have recommended a substantial restructuring of our delivery system to make it truly an organized, cohesive system designed to make health care more accessible, more comprehensive, more responsive, and more relevant to the needs of the community. We have attempted to formulate a system as economical, efficient, and effective as our present state of medical knowledge permits—a system aimed at keeping Americans in good health, acknowledging the limitations of the human body and of our rather imperfect environment.

In addition, we have recommended a financing system that would utilize all existing sources of funds—one based on each citizen’s ability to pay, except for the aged, for whom coverage would be prepaid.
Our committee has concluded that change is upon us, that the critical choices to be made by the health field in the next several years will require the best leadership that the health field has to offer, with courage not only to accept rapid change but to shape it constructively in the public interest.

Our goals are lofty, but we believe that they are ultimately attainable. This report can provide a basis from which the entire health field, including physicians, institutional providers of health care services, and the many organizations, governmental agencies, and underwriters of health care benefits, can join forces and work toward an improved health care system. We consider our proposal a beginning, a starting point from which many individuals and groups can contribute to the shaping of a system that has the immediate potential of providing better health services for all of our people and for future generations, a system that will deliver the best that medical science can offer.

Earl Perloff
Chairman
Special Committee on the
Provision of Health Services
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PART I

AMERIPLAN: ITS GOALS AND PROGRAMS
AMERIPLAN: ITS GOALS AND PROGRAMS

The importance of providing good health care for all should be self-evident. Although we have done much in the United States to create outstanding health care institutions, to educate and train competent physicians and hospital administrators, and to provide excellent care for many of our citizens—accomplishments of which we may be justly proud—much remains to be done, and urgently.

As a nation we must provide better quality, more convenient health care for all the people, at reasonable cost, and in a manner in keeping with human dignity. This must be done because we accept one basic, irreducible principle:

Health care is an inherent legal right of each individual and of all the people of the United States.

From this principle four corollaries follow:

(1) it is a function of health care to enhance the dignity of the individual and to promote better community life for all;

(2) it is a function of government to assure the preservation and maintenance of the health of all the people;

(3) health care must be available without regard to any person’s ability to pay and without regard to race, creed, color, sex, or age;

(4) health services must be so organized and located that they are readily accessible to all.

This basic principle and its corollaries can be best and most rapidly implemented through a new nationwide system for the delivery of
health services, to be known as AMERIPLAN to symbolize the uniting of all the health resources of the United States for better care.

Goals

1. To be truly effective and relevant to the problems and opportunities before us, the AMERIPLAN system for the delivery of health services must have the potential to meet the goals which follow. Some of these goals may be relatively easy to attain. Others are more difficult, calling for long-range planning and large investments of money and manpower. Some require little change from the present manner in which health services are delivered; others require considerable changing of habits, commitments and even laws. And some are goals that will become more sharply defined in coming years.

1-011 1. A system for the delivery of health services must be developed which has as a primary objective the optimum health care of each and every person. Untreated illness in the community must be sought out and treated.

1-012 2. The system for the delivery of health services must focus on individual needs, must be personalized through the skills and humanity of health personnel, and must preserve the dignity of the individual.

1-013 3. The system for the delivery of health services must assure that no person becomes financially dependent or suffers loss of dignity as a result of illness or accident.

1-014 4. The system must assure that all children are provided with preventive health care and that no child suffers from untreated illness.

1-015 5. The system for the delivery of health services must provide comprehensive health care. It must be able to provide the following components of care to each individual as needed: health maintenance, primary care, specialty care, restorative care, and health-related custodial care. Comprehensive health care must be developed as rapidly as possible.

1-016 6. The system must be provided financial incentives for en-
couraging utilization of ambulatory facilities, extended care and nursing home facilities, and home care programs, rather than the present incentives which encourage reliance predominantly on hospitalization.

7. The system must be oriented to the maintenance of personal good health and to the prevention of illness, in contrast with the present system which is primarily oriented to the treatment of illness after it becomes acute.

The system must be provided financial incentives for keeping people well and, if they are ill, for making them well as soon as possible.

8. The system must support only those providers that meet standards of effectiveness, quality, and efficiency.

Health care institutions providing quality care in the most economic manner must be continued and developed; institutions not providing such care must be assisted to do so, and institutions unwilling or incapable of providing such care must not be supported.

9. The system for the delivery of health services must include the private as well as the public sector of the health field.

The predominant concern and mission of all health care institutions must be the public interest even though their ownership may be private.

In order to maximize innovation and preserve the benefits of alternative choice, the system must consist of a multiplicity of organizations with varied types of ownership and organizational forms.

10. The system must be designed so that at the outset it provides care for persons suffering from alcoholism, drug abuse, and acute mental illness.

The system must also be designed so that long-term mental health care, non-health-related custodial care, and institutional care provided by all federal, state and
local governmental hospital systems will be integrated into the total system within a reasonable time.

1026 11. Programs to resolve those sociological and environmental problems that affect the health of individuals must be coordinated and integrated with the system for the delivery of health care.

1027 The failure to resolve acute sociological and environmental problems such as poverty, drug abuse, and air pollution adds to the cost and amount of necessary health care of individuals. It must be realized that the pace at which these problems are addressed and solved directly affects the organizational burdens and total effectiveness of the health care system.

1028 To accomplish these goals, the existing system for the delivery of health services must be substantially restructured, including both the methods of delivering health services and the methods of financing health services, so that all available resources may be utilized to provide better health care to all at a reasonable cost.

1029 Therefore, AMERIPLAN has been formulated with priorities given to the accomplishment of these goals, and with the hard choices made of where scarce fiscal, organizational, and manpower resources should be allocated.

1030 AMERIPLAN incorporates methods of financing as one component of restructuring the system for the delivery of health care. Thus it differs significantly from many current proposals that deal only with the financing of health services and fail to provide a solution to the problem of establishing necessary standards and an organized system for the delivery of health services throughout the nation.

The Health Care Corporation

1031 The basic innovation of AMERIPLAN is an organization called a Health Care Corporation having the resources necessary to provide truly comprehensive health care to a defined population. The establishment of Health Care Corporations would allow the health field to move from what some have called a cottage industry to a modern,
coordinated and comprehensive system for the delivery of health care.

To permit the establishment and growth of Health Care Corporations, and to assure uniform availability of adequate health services throughout the country, legislation would be enacted by the federal government which would require the adoption of federal regulations defining the scope, standards of quality, and comprehensiveness of health services and stating the benefits to be provided for all of the people. These regulations would be administered at the state level with care being provided locally by Health Care Corporations.

Health Care Corporations would have the following characteristics:

(1) Each Health Care Corporation would synthesize management, personnel, and facilities into a corporate structure with the capacity and responsibility to deliver the five components of comprehensive health care to the community: health maintenance, primary care, specialty care, restorative care, and health-related custodial care.

(2) Health Care Corporations would cover the comprehensive health needs of every geographic area and of all of the population, with some Health Care Corporations spanning geographic and political boundaries where necessary to assure that all persons have access to care. All persons would have the opportunity and be encouraged to join Health Care Corporations.

(3) The Health Care Corporation would assure optimum service to the community by physicians. Every practicing physician would have the opportunity to be affiliated with a Health Care Corporation, and physicians would have the opportunity and could accept the responsibility of participating in the management of Health Care Corporations.

Various forms of medical practice, including group practice, would be permitted within the Health Care Corporation.

(4) The Health Care Corporation would be responsible for providing professional peer review and other mech-
anisms to evaluate the quality of all health care on a con-
tinuing basis. Such evaluation of quality would be an in-
tegral part of AMERiplAN and a basic responsibility of
the Health Care Corporation.

1-039  (5) The Health Care Corporation would identify its man-
power needs, and be responsible for the inservice educa-
tion and training of its health manpower and the recruit-
ment of all health personnel for its providers.

1-040  (6) The proper growth of Health Care Corporations would
only occur through the most appropriate, economical
use of all resources. Enforceable regulatory controls
would be established by legislation in each state to as-
sure that needs would be met without unnecessary con-
struction or duplication of facilities and services.

1-041  (7) Each Health Care Corporation would develop a suitable
mechanism by which the community could express its
health needs and through which the Corporation could
actively respond. All persons in the community would
have a role in identifying how health services would be
provided, in determining how care could be made more
accessible, and how the delivery of care could best sup-
port the dignity of the individual and his family.

AMERiplAN Health Benefits

1-042  Constructive change in any system occurs only when those using the
system, those financing the system and those delivering care within
the system are motivated to change. The health care system is no ex-
ception. Therefore levers must be supplied to motivate change.

1-043  The lever to motivate change by those using the system and those fi-
nancing the system would be the better quality and greater accessi-
bility of health care, and the new health maintenance benefits that
would be created at reasonable cost by establishing Health Care Cor-
porations. The lever to motivate health care providers to establish
Health Care Corporations would be the strong demand for these
changes by those who use and finance health care.

1-044  AMERiplAN would utilize both federal government and private fi-
AMERIPLAN: ITS GOALS AND PROGRAMS

financing. All health care benefits that are tax-supported would be financed at the federal level, and all present federal and private sources of financing, including prepayment plans and health insurance companies would be utilized. The broader AMERIPLAN benefit packages would make Medicare and Medicaid no longer necessary.

Under benefits proposed for AMERIPLAN, for the first time in the history of our country all of the people would be secure from becoming financially dependent or suffering loss of dignity as a result of illness or accident. The total benefit packages of AMERIPLAN, when interrelated and delivered through Health Care Corporations, would encompass a scope of benefits never before available to any individual or group and at a cost this nation could afford.

(1) Health Maintenance and Catastrophic Illness Benefits Package: This package would be the keystone of AMERIPLAN. It would consist of benefits for health maintenance and benefits to protect every person in the United States against the major costs of catastrophic illness or accident. These benefits would be paid for by the federal government in whole for the poor, and in part for the near-poor through general federal revenues, and for the aged and all others by a tax collected through the Social Security mechanism.

Benefits to protect against the cost of catastrophic illness or accident would become operative depending upon annual family income level, size of family, and amount of health care expenditures. Accordingly, the poor would receive the benefits immediately after exhausting the benefits of the Standard Benefits Package, whereas persons with higher incomes would have to expend a predetermined amount before becoming eligible for these benefits.

To be eligible for the Health Maintenance and Catastrophic Illness Benefits Package, to which all persons would be entitled, each person would have to demonstrate that he has purchased or been provided with the Standard Benefits Package and has registered with a Health Care Corporation.
(2) **Standard Benefits Package**: All persons would be uniformly covered by this package, offered by prepayment plans and private health insurance companies. Its benefits would consist of four components of care—primary, specialty, restorative, and health-related custodial care. These four components of care would provide all of the care most frequently required, such as physicians’ services and acute hospital care, and would emphasize ambulatory services.

This Standard Benefits Package would be paid for in whole for the poor and in part for the near-poor through general federal revenues. For the aged, the Standard Benefits Package would be paid for by a tax collected through the Social Security mechanism. All other persons would purchase the Standard Benefits Package from prepayment plans and private insurance companies.

(3) **Supplemental Benefits**: One of the basic precepts of AMERIPLAN would be that within reasonable limits those who are able to pay for their care should do so. Accordingly, for those persons there would be a gap between the benefits provided under the Standard Benefits Package and the benefits for protection against the cost of catastrophic illness or accident, provided in the Health Maintenance and Catastrophic Illness Benefits Package. Various packages of supplemental benefits to fill this gap would be available through prepayment plans and private health insurance for those who wish to purchase them.

### The Concept of AMERIPLAN

A unique characteristic of AMERIPLAN is that it provides a blueprint of a nationwide system for the delivery of health services that can be implemented today by the health field. Often a field of endeavor waits until change is thrust upon it from the outside. However, it is possible for the health field to use AMERIPLAN to make changes now, before the enactment of legislation, and thus play a central role in shaping the future course of AMERIPLAN.
AMERIPLAN: ITS GOALS AND PROGRAMS

AMERIPLAN would be implemented upon passage of federal legislation stating the benefits to be provided all the people and permitting the adoption of federal regulations for the scope, standards of quality, and comprehensiveness of health services.

The federal legislation would result in the establishment by each state legislature of State Health Commissions to regulate Health Care Corporations and be responsible for the approval of these Corporations and their operation.

Federal and state legislation should be passed as soon as possible so that the system could be fully implemented within several years. AMERIPLAN could develop rapidly—within the decade of the 70’s—and should within that time embrace the entire health field and cover all the people.

Most significantly, the implementation of AMERIPLAN could hasten commitments by all health professionals, especially physicians, to join with health care institutions in a corporate responsibility to provide good health care for all. And AMERIPLAN would provide the primary method through which the public could participate responsibly in determining the future of the nation’s health care system.

Many segments of the health care field such as medical schools, governmental hospitals, and professional groups would contribute markedly toward the development of AMERIPLAN. Because of the constraints of time, details of their participation are omitted from this report, in favor of spelling out in greater detail the participation of one group, the physicians, as leaders in determining the quality of care. But in formulating the concept of AMERIPLAN, due consideration has been given to the impact of the system on all such groups. It is hoped that the many committees currently studying the roles of health professionals, organization of institutions and services, and standards of quality of health care will join in an effort to develop AMERIPLAN and contribute to its concept so that all of the best thinking of the health field may be used in the public interest.

In summary, many details of AMERIPLAN remain for delineation at some future time. The recommendations of this report are intentionally flexible to permit the widest range of alternative solutions and to encourage an immediate beginning to the restructuring of the nation's health care system.
PART II

THE HEALTH CARE CORPORATION
II
THE HEALTH CARE CORPORATION

Objectives and Operation

The Health Care Corporation is the central component of AMERIPLAN, the organization responsible at the community level for the delivery of health services, having the capacity to increase these services as rapidly as possible toward the goal of comprehensive health care. Health Care Corporations would cover the health needs in every geographic area, and of all of the population, crossing political boundaries where necessary to assure that all persons have access to care.

To advance the development of AMERIPLAN, legislation must be enacted at the federal level. This legislation would authorize the establishment of a National Health Commission which would set forth the benefits to be provided under AMERIPLAN and adopt regulations. These regulations would define the scope, standards of quality, and comprehensiveness of health services, and would be administered by State Health Commissions. In turn, the State Health Commissions would approve Health Care Corporations and authorize their operation.

The concept of Health Care Corporations has been designed to implement the goals enumerated in Part I. Therefore:

(1) The Health Care Corporation would have the potential at the community level for improving the quality and adequacy of care by providing the five components of comprehensive health care: health maintenance, primary, specialty, restorative, and health-related custodial care.

(2) The Health Care Corporation would be oriented to the maintenance of personal good health and to the prevention of illness and hospitalization in contrast with the present system which is primarily oriented to the treatment of illness after it becomes acute.
AMERIPLAN

2-006 (3) Financial incentives would be provided to encourage utilization of ambulatory facilities and home care programs, rather than to perpetuate reliance on hospitalization.

2-007 (4) The nation's large existing investment in health personnel, and facilities and services would be utilized as the base from which Health Care Corporations would evolve.

2-008 (5) Health-related custodial care would be provided within the Health Care Corporation for patients with illnesses diagnosed by physicians as non-curable when these patients would require medical and nursing care either in an extended care facility, a nursing care institution, or in a program of home care.

Organizational Structure

2-009 The Health Care Corporation would be a new corporate organization. It could be established in a variety of ways, depending upon community need, resources, and precedent, but it would be approved for operation and regulated by the State Health Commission primarily on the basis of its capability to provide comprehensive quality care to the persons it serves, hereafter known as its registrants. Its sponsorship could be local, or it might be broadly based, operating regionally, or operating nationwide, with regional subdivisions that would provide local service.

2-010 A Health Care Corporation would ordinarily be formed by existing health care provider organizations; it could result from merger; it could be a local government authority or a private corporation.

2-011 Many types of organizations could participate with health care providers in the formation of a Health Care Corporation, including health-oriented educational and social organizations, governmental and private organizations, and organizations of health professionals, such as groups of physicians. Or the Health Care Corporation could be a consortium, representing a cross-section of provider organizations in the community.

2-012 The Health Care Corporation would be a provider of health services
and be organized, preferably through its own resources, to assure availability at the community level of the five components of health care to its registrants. It would be founded on a commitment by physicians and health care institutions to provide all of those components. Irrespective of ownership or sponsorship, the Health Care Corporation would be directly responsible for the delivery of health services.

The Health Care Corporation could contract with other health care providers, regardless of their ownership, for services that it would be unable or unsuited to provide, and it would evaluate the quality of those services. Its arrangements with such providers could cross geographic or political boundaries and could be temporary or of indefinite duration.

Each Health Care Corporation would cooperate directly with professional organizations established to evaluate the quality and adequacy of care and to assist providers in meeting the standards established by such organizations.

The Health Care Corporation would contract only with providers that meet the regulations established by the National Health Commission, and comply with the standards of professional organizations and agencies participating in AMERIPLAN.

The Health Care Corporation would negotiate with and pay providers on an equitable basis for services rendered and establish appeals and grievance mechanisms for the solution of problems with providers.

Internal Operations

The governing board of the Health Care Corporation would have ultimate responsibility and authority; it would be the policy-making body. The composition of the governing board would be a matter of determination by the Health Care Corporation.

Each Health Care Corporation would guarantee meaningful policy representation for its registrants. Such representation would identify the problems of registrants; implement the community's concern in the resolution of health problems; and assure accountability to the registrants by the Corporation for the adequacy and quality of health
care services. Representation for registrants would be provided within the organizational structure of the Corporation, and if the Health Care Corporation so elected, would include representation on its governing board.

2-019 The Health Care Corporation would have specific responsibility for the quality and effective delivery of care by all of its providers, including those with whom it would contract—physicians, dentists, other health professionals, and health care institutions.

2-020 The Health Care Corporation would assure liaison between its providers of service and all other organizations concerned with community health, such as public and voluntary health agencies, in taking active responsibility for the prevention of illness.

2-021 Each Health Care Corporation should have skilled professional management. It would be the responsibility of management to decide how the services of the Corporation should be developed, what form its contracts with providers would take, and how services to its registrants would be delivered.

2-022 As members of the medical staff of the Health Care Corporation, physicians would be required to participate in management by serving on management committees for budget, planning, utilization, and patient care. In addition, physicians individually must have the opportunity and accept the responsibility to participate in the management of Health Care Corporations. Based upon their qualifications, physicians would have the same upward mobility in the management structure of the Health Care Corporation as professional administrative personnel.

Responsibility for Quality

2-023 Professional peer review and other mechanisms to examine the quality of health care on a continuing basis must be a basic responsibility of the Health Care Corporation. Peer review, as a function of the organized medical staff of the Health Care Corporation, would be established throughout the Corporation, extending to the physician's office practice. Since the Health Care Corporation would be responsible for the quality of care, it would assure quality by a continuing appraisal of the effectiveness of care, by medical audits to measure the performance of the physician and the entire health care team, by
referral of patients as needed among the various components of the Corporation, and by review mechanisms to evaluate the utilization of facilities and services. Peer review would identify problem areas requiring planning for additional services and the continuing education of health professionals.

Conduct of Management Research

Because of the newness of the concept of Health Care Corporations, these Corporations would conduct research in the delivery of health care services, including the organization of those services, their effectiveness, cost, and quality. Each Health Care Corporation would be responsible for a continuing evaluation of its own effectiveness.

Fiscal and Statistical Responsibilities

The Health Care Corporation would act as a fiscal agency, receiving and disbursing money for the payment of health services. It would negotiate with and receive funds from appropriate fiscal agencies and distribute these funds among its providers in a responsible manner.

The Health Care Corporation would maintain personal health records which would satisfy the requirements of the State Health Commission for gathering and reporting health care data, including statistics on the utilization and cost of health care services. It would be responsible for providing data pertaining to the effective administration of services.

Information maintained by the Corporation would have to be adequate for all the functions of the Corporation such as planning, evaluation of its performance, and determination of the needs of its registrants.

Responsibilities to State Health Commission

Geographic Assignment

Each Health Care Corporation would have a primary geographic assignment established by the State Health Commission. Several such Corporations might have the same geographic assignment and therefore co-exist in a city or area and serve population groups beyond
city limits or across state lines. The co-existence of Health Care Corporations in one geographic area would depend upon their capacities to coordinate needed services effectively and upon the approval of the State Health Commission.

Registration of Individuals

Within its geographic area the Health Care Corporation would have to demonstrate its potential to provide care for all who would voluntarily register during regular periods of open registration and agree to maintain their registration for a fixed period, for example, one year. The State Health Commission would assign to each Health Care Corporation for recruitment, a quota of individuals who failed to register.

It would be the responsibility of the Health Care Corporation to encourage the registration of non-registered individuals; however, after a reasonable period, subject to approval by the State Commission, the Corporation would be allowed to fill its quota of registrants by meeting the requests for registration made by individuals not assigned to it or who reside outside of its geographic area. Quotas established by the State Health Commission would be based on the capacity of the Health Care Corporation's facilities and services.

An individual could register with the Corporation of his choice if there were two or more Health Care Corporations in his community, or he could register with a Health Care Corporation in another community or area following the open registration period if that Corporation had not filled its quota of registrants. Each Health Care Corporation would provide detailed information concerning the individual's right to registration and the advantages of such registration. All regulations for registration would be established by the State Health Commission.

A registrant could change Health Care Corporations as a result of geographic relocation or the end of his period of registration. He could appeal for a change of Health Care Corporations on the basis of cause through an appeals mechanism established by the State Health Commission.

Registrants of Health Care Corporations could be referred to other Health Care Corporations or providers outside the Corporation for
specialized services the Corporation could not provide. It would be the responsibility of the Corporation to have knowledge of such providers and work with them. Registrants could at any time purchase services from providers that would not be part of the Health Care Corporation should they wish to pay for them.

Responsibilities to the Public

Services for Registrants

2-034 The primary responsibility of the Health Care Corporation would be the provision of services for its registrants. The program of health maintenance would be the entry point for each registrant into the services of the Corporation. The Corporation would assure the following for each of its registrants:

2-035 (1) a continuing program of health maintenance;

2-036 (2) access to the Health Care Corporation whenever there would be need for health services;

2-037 (3) the availability of essential ambulatory, diagnostic, and treatment services, with ambulatory services located conveniently and as near to the registrant’s home as possible;

2-038 (4) round-the-clock emergency services and adequate emergency transportation;

2-039 (5) continual availability of physician services;

2-040 (6) continuity of care through ambulatory care in centers and in physicians' offices, interrelated health care institutions providing acute inpatient care, extended care, nursing home care, home-health care, and health-related custodial care;

2-041 (7) maintenance of one continuous personal health record;

2-042 (8) counseling for the individual and his family with respect to his health and health-related problems;
(9) a setting conducive to personal identification and satisfaction with the Health Care Corporation;

(10) identical range of services, of a uniform quality, for all;

(11) transfer from one facility to another to maximize effective use of the components of care, or transfer between provider institutions of the Corporation that are widely separated geographically.

Services for Other Persons

Whenever the Health Care Corporation provides emergency and referred specialty services in behalf of those registered with other Health Care Corporations it would be reimbursed for the cost of these services through the agencies responsible for payment for care of these persons. The Corporation would be responsible for preparing the patient’s medical record of such services, and transmitting the record to the patient’s own Health Care Corporation.

In addition to its responsibilities for its own registrants and for the registrants of other Health Care Corporations, the Health Care Corporation would also be responsible for serving non-registrants seeking emergency care and for maintaining the records of such patients.

The Health Care Corporation could provide other health services to non-registered individuals as long as such services would in no way diminish the quality or adequacy of service contracted for in behalf of the Corporation’s registrants.

Educational Programs

Health Care Corporations, together with third-party purchasers of care, would have a responsibility to overcome, through educational programs and counseling, the public’s failure to use services in the most appropriate manner. This responsibility would require the study of ethnic and cultural patterns in the community and the adaptation of services to those patterns. It would require eliminating taboos, fears, and lack of knowledge related to the use of personal health services. A program of education would be necessary to emphasize the individual’s responsibility for the prevention of illness and for his own health maintenance.
In addition, the Health Care Corporation would be responsible for the establishment of programs in patient education in its provider institutions to increase the individual's knowledge about his health and about the management of his illness. Such educational programs would be consistent with the goal that health services must meet individual needs and that the individual, rather than the institution or the health professional, should be the focus of the educational program.

The Health Care Corporation would be responsible in behalf of its registrants for participating in community-wide educational activities sponsored by voluntary and governmental agencies and for providing adequate information services concerning the availability and use of health services. It would have a responsibility for actively encouraging the responsible use of services by its registrants.

Provision for Community Evaluation

Each Health Care Corporation would be required to develop a mechanism through which the community would be able to express its health needs and through which the Corporation could respond. Registrants of the Corporation would have opportunities for representation in identifying how health services should be provided, in determining how care could be made more accessible, and how the delivery of care could best support the dignity of the individual and his family.

In addition, the Health Care Corporation would develop means for testing community acceptance of the scope and quality of its services and a mechanism through which the individual registrant could appeal for redress of complaints concerning health services.

Responsibilities for Health Manpower

Relationships with Physicians

Physician participation is fundamental to AMERIPLAN. The reorganization of our limited resources in manpower, facilities, and services can only be accomplished by the cooperative commitment of all providers, including physicians, a commitment directly related to the system's sensitivity to the goals, motives, and attitudes of each group of providers.
The physician would be an integral part of the Health Care Corporation. Therefore, the Health Care Corporation must:

1. implement the principle that all medical judgments related to health care must be made by or under the supervision of physicians;

2. provide incentives to attract physicians to practice within the Health Care Corporation. Such incentives should include various methods of compensation, alternative forms of medical practice, and advanced educational opportunities, all designed to enhance the physician's role in the predominant task of the Health Care Corporation, to keep its registrants well;

3. assure that the extent of the physician's staff privileges in the Health Care Corporation is established through rules and regulations in accordance with his training, experience, and professional competence as measured by peer review of his credentials and performance;

4. bring the physician into the management structure and involve him in its decision-making processes;

5. develop effective means for measuring the quality, utilization, and economic delivery of each of the five components of comprehensive health care;

and through such measurements set priorities of services, taking into consideration among other factors, the age, occupation, mobility, and size of the population served; differing rural, urban, and suburban needs; differing patterns in the use of each health service and the adequacy and availability of these services.

Licensure of Personnel

Since responsibility for the quality of health care and the competence of health care personnel would reside in the Health Care Corporation, the Corporation must have the authority to discharge that responsibility.
To alleviate personnel shortages, minimize educational costs by creating upward mobility for health personnel, and to maximize individual potential, Health Care Corporations require flexibility in the use of health manpower and control over the development of personnel. As AMERIPLAN phases in, with Health Care Corporations covering all geographic areas of each state, the present system of licensure of health personnel should be phased out and the Health Care Corporations made responsible for the competence of all their employees.

The responsibility of the Health Care Corporations for the competency of all their health care personnel would also apply to physicians, dentists, nurses, and pharmacists. Therefore national standards for the measurement of competency of these groups would be indispensable. These standards should include verification of professional education and national licensure for physicians, dentists, nurses, and pharmacists, with specialty training for physicians to be certified by specialty boards. The Health Care Corporation would rely on this national licensure as a guarantee of basic qualifications.

Education and Training of Personnel

In the development of AMERIPLAN, basic education for health personnel should be the responsibility of the nation's educational system with the assistance of the health care system. Inservice training should be the responsibility of the health care system with the assistance of the educational system.

The nation's educational system would be responsible for the recruitment of individuals to meet health manpower needs, for recruiting and developing adequate faculty for the education of health care personnel, and for setting educational standards for professional and technical health personnel.

The Health Care Corporation would rely on the accreditation or certification of educational programs for allied health personnel to verify basic educational requirements.

Health Care Corporations would be responsible for defining health manpower needs and setting performance standards for health care personnel. Health Care Corporations would participate through appropriate training programs in the education of health personnel by universities and colleges.
The Health Care Corporation would be required to coordinate, among its providers, the education and training of health manpower and the recruitment and deployment of health personnel. It would identify manpower needs within each component of comprehensive care.

Medical schools have a responsibility for assessing the physician needs of the health care system. Medical schools must assess the physician manpower necessary to serve these identified needs and for preparing a balanced supply of medical practitioners of all types, particularly primary and family physicians, and specialists, as well as teachers, researchers, and medical administrators. The supply and distribution of physicians must be consistent with the principle that all persons have an inherent legal right to health care and must have access to all five components of health care.

Other professional schools have the responsibility of assessing the need for and assuring the supply of allied health professionals necessary to meet identified needs. The Health Care Corporations would be required to assure that their educational and training programs augment programs of all professional schools to meet community needs for health manpower.

Both federal and state governments must be as fundamentally responsible for the education of health care personnel as state government is for the general education of the public. The components of education and of service in the Health Care Corporation would be identified and differentiated. Government must assure the availability of adequate funds to prevent the cost of the education and training of health manpower from becoming the burden of patients in health care institutions. Wherever private resources are unable to support such education and training of health manpower, government must supplement these resources.

Utilization of Personnel

Health manpower resources must be more effectively utilized, and health care personnel with the skills to assist physicians in the diagnosis and treatment of illness must be developed.

The functions of health care personnel who assist physicians must be established in accordance with their competence and in accordance
THE HEALTH CARE CORPORATION

with the principle that all medical judgments related to health care
must be made by or under the supervision of physicians. The organi-
ization and operation of the Health Care Corporation as well as pay-
ment mechanisms would be responsible for maximizing the use of
personnel to assist physicians.
PART III

THE ROLE OF GOVERNMENT
III

THE ROLE OF GOVERNMENT

3-001 Under AMERIPLAN, government would be a participant in a coordinated system for delivering health services. Government’s role in the system would be varied and significant, as would the roles of the providers, and other participants in the system. Government would be a major catalyst for advancing the development of AMERIPLAN through legislation, would act as the control agency through regulations for the scope, standards of quality, and comprehensiveness of health services, and would be a purchaser of care through tax-supported health programs.

3-002 Government would remain directly responsible for those matters directly affecting life and health which are not properly a part of the system for delivering health services, such as control of the environment, or which, because of their cost, can only be incorporated into the system over an extended period of time, such as long-term mental health care.

3-003 Government’s ultimate role would be to assure the fulfillment of the basic principle that health care is an inherent legal right of all the people of the United States.

3-004 Legislation would only be one aspect of the concept of AMERIPLAN, which is already developing and will continue to develop independently of legislation. Legislation is nevertheless necessary to provide guidelines and incentives for AMERIPLAN’S development throughout the country with uniform benefits and services and adequate financing.

3-005 Federal legislation would provide the necessary incentive to each state for the adoption of the legislation required for AMERIPLAN to function. This incentive would be in the form of federal funds to pay for health maintenance and catastrophic illness benefits after a state has enacted its own legislation necessary for administration of the system. Since matching contributions of state funds would not be required, as under Medicaid, prompt state enactment of the necessary legislation is anticipated.
Federal Legislation

3-006 This legislation would establish a National Health Commission. The Commission would be responsible for adopting regulations to create uniform benefit packages and state the scope, standards of quality, and comprehensiveness of health services. The legislation would also motivate state legislatures to enact laws by a specified date, establishing State Health Commissions to assure that the federal regulations were properly met. Federal funds would then be available to the approved Health Care Corporations in each state.

3-007 Additional federal legislation would be needed to help overcome barriers and impediments, principally legal, to the formation of Health Care Corporations. A principal objective would be to permit the inclusion of physicians in such corporate organizations; another would be the removal of barriers to the sharing of services and facilities by health care institutions.

The National Health Commission

3-008 This Commission would be the nation's primary agency responsible for the continuing assessment of the effectiveness of AMERIPLAN in improving the delivery of health services. It would be an independent agency composed of five to seven qualified, full-time, well-compensated commissioners appointed by the President to serve for staggered terms of relatively long tenure, for example, six years. The Commission would be supported by a qualified professional staff.

3-009 In fulfilling its responsibilities, the National Health Commission would:

3-010 (1) review the activities of State Health Commissions to assure their enforcement of regulations adopted by the National Health Commission;

3-011 (2) actuarially determine the revenue requirements for health benefits that are tax-supported;

3-012 (3) administer the trust fund for specified health care benefits which would be created under AMERIPLAN;
THE ROLE OF GOVERNMENT

(4) contract with prepayment plans and health insurance companies for the purchase of health care benefits financed through federal funds, a function which the Commission could delegate to each State Bureau of Health Financing;

(5) coordinate at the national level the activities of voluntary organizations and governmental agencies with respect to their conduct of approval, accreditation, or certification programs for AMERIPLAN;

(6) maintain liaison with all federal agencies concerned with health-related programs;

(7) assist states in developing legislation to overcome legal barriers to the establishment of corporate organizations and the sharing among health care providers of facilities and services;

(8) periodically assess the progress of AMERIPLAN in developing comprehensive health care, report to the President and Congress on the phasing-in process, and serve in an advisory capacity for legislative amendment.

The State Level

State Legislation

In order to participate in AMERIPLAN and to qualify its residents to receive federal benefits, each state would enact legislation to create a State Health Commission and establish or designate a State Bureau of Health Financing. The Commission would be a newly-constituted and independent state commission, not part of any existing department, responsible for implementing the regulations adopted by the National Health Commission.

Where necessary, state legislatures would need to pass laws to overcome legal barriers to the formation of Health Care Corporations and to the sharing of services and facilities by health care providers.
The State Health Commission

3-020 The State Health Commission would be the agency responsible for seeing that Health Care Corporations conformed to the regulations of the National Health Commission. The State Health Commission would consist of five to seven qualified, full-time, well-compensated commissioners appointed by the governor to serve for staggered terms of relatively long tenure, for example, six years. The State Health Commission would be supported by a qualified professional staff.

3-021 If the size of population groups and geographic areas warrant, the State Health Commission could establish Regional Health Commissions and delegate to them certain operational functions.

3-022 The State Health Commission would approve the organizational structure of Health Care Corporations and their capacity to deliver comprehensive health care; would authorize their operation; assure the adequacy and quality of their services; and approve the rates charged for their services.

3-023 The State Health Commission, however, would have no responsibility for the internal operations of Health Care Corporations, leaving these to the governing board of each Corporation.

3-024 The State Health Commission would:

3-025 (1) establish the geographic area to be served by each Health Care Corporation, including in the process consideration of the total population of the state, its distribution, local governmental structures, transportation facilities, existing institutions, and patterns of social organization, as well as existing resources for the delivery of health care;

3-026 (2) define the population group to be served by each Health Care Corporation;

3-027 (3) facilitate and encourage the formation of Health Care Corporations as rapidly as possible, using appropriate incentives, then require existing Health Care Corporations to serve areas lacking such Corporations, authorize the establishment of new Health Care Corporations, or
THE ROLE OF GOVERNMENT

replace existing Corporations which fail to perform adequately;

(4) join cooperatively with the Commissions of neighboring states in approving the establishment of Health Care Corporations that span state boundaries;

(5) assure that policies offered by prepayment plans and health insurance companies operating within the state meet the uniform benefit requirements established pursuant to federal legislation;

(6) assure that Health Care Corporations comply with the regulations for quality and adequacy of service established pursuant to federal legislation and that health care providers not participating in Health Care Corporations comply with these regulations. State Health Commissions would utilize existing voluntary organizations in the approval, certification, and accreditation processes;

(7) assure that essential planning functions would be carried out to coordinate activities among Health Care Corporations;

(8) issue certificates of need for the facilities and services of Health Care Corporations;

(9) function as the administrative agency for government aid and loan programs under AMERIPLAN, as for example, the Hill-Burton program;

(10) assure that each Health Care Corporation, through its peer review mechanisms, fulfilled its responsibility for auditing the quality of care and the utilization of services;

(11) function as a health data-gathering and reporting center for the state; establish requirements for the collection of data on fiscal operations of health services, utilization of services, and other health-related data of Health Care Corporations;
(12) establish appropriate mechanisms for appeals and review of disagreements in those areas for which it would have responsibility for the regulation of Health Care Corporations. All of its proceedings would be conducted within the normal requirements of legal due process.

The State Bureau of Health Financing

The responsibilities of the State Bureau of Health Financing would be set forth in the state legislation. The Bureau could be a new agency, or its responsibilities could be placed in an existing agency.

This Bureau would:

(1) regulate the premium structures of prepayment plans and health insurance companies;

(2) validate the need for funds to be paid by the federal government in meeting its responsibility for financing the health care benefits of the poor and the near-poor in the state;

(3) determine in accordance with federal regulations the eligibility of those persons within the state who require assistance from tax resources, their eligibility for such support to be established through use of forms submitted with federal income tax returns;

(4) when delegated to do so by the federal government, disburse funds to prepayment plans and private insurance companies for the premiums for health care benefits to the poor or the near-poor.

Other comments on the role of government are found elsewhere in this report. For example, details on the government's role as a purchaser of care for various segments of the public are found in Part IV, Financing AMERIPLAN.
PART IV

FINANCING AMERIPLAN
IV
FINANCING AMERIPLAN

4.001 AMERIPLAN would assure adequate and coordinated financing for the health care system. A combination of federal financing, prepayment plans, and private health insurance companies would be used to establish a uniform scope of benefits for all. This financing program would result in an equitable sharing of the cost of health care among all persons. It would remove hardships resulting from the cost of illness for all income groups. It would eliminate for lower income groups the financial barriers to acquisition of good health care.

4.002 AMERIPLAN must be financed through multiple sources because the responsibility for achieving more effective allocation and more efficient use of resources in the delivery of health care must be jointly shared by all—registrants, insurers, providers, and government. The financing program and a uniform scope of benefits would remove many of the impediments to the development of an integrated health delivery system and provide inducements to coordinate the delivery of comprehensive health services.

4.003 To achieve an equitable and effective health care system, the health care benefit and financing program under AMERIPLAN would have the following characteristics:

4.004 (1) health care benefits would be available to all in specific packages, identical in all states as required by federal regulations;

4.005 (2) the federal government would be responsible for all necessary government purchase of benefits;

4.006 (3) whenever possible, benefits would be purchased through prepayment plans and private health insurance companies;

4.007 (4) the benefit structure would include control mechanisms to regulate the use of services, such as copayments and limits on specified services;
(5) funds for AMERIPLAN appropriated from general federal revenues and collected through federal government tax mechanisms for health care would be deposited in a separate and specifically designated fund.

**AMERIPLAN Health Care Benefits**

From its inception, the financing program for AMERIPLAN would assure that no individual or family would be deprived of good quality health care as a result of the lack of funds. The benefit packages, even initially, would include the five components of comprehensive health care within limitations of existing resources. These benefit packages would be expanded as additional resources become available and would eventually result in the goal of full comprehensive health care for all.

The AMERIPLAN health care benefit packages would provide incentives for proper utilization of the five components of care. AMERIPLAN would emphasize health maintenance and ambulatory care as well as the prevention of illness.

Health Maintenance and Catastrophic Illness Benefits Package—To be eligible for health maintenance and catastrophic illness benefits each person would have to register with a Health Care Corporation. In addition, he would have to be covered by benefits at least as extensive as those provided by the Standard Benefits Package.

(1) Health Maintenance Benefits:

(a) immunizations

(b) well-baby care

(c) for children, dental services—prophylactic and therapeutic

(d) multiphasic screening, to include annual history, complete blood count, serology, urinalysis, appropriate chemistries, chest x-ray

(e) for appropriate age and sex groups, electrocardiograms, pap smears, and rectal examinations
(f) for patients with positive findings, a physical examination.

(2) Catastrophic Illness Benefits:

Payment for health care expenditures would be provided after the benefits of the Standard Benefits Package and any supplemental benefits have been exhausted. The time an individual would become eligible for payment would be determined by annual income level, size of family, and the annual amount of health care expenditures. For example, the poor would be eligible for these benefits immediately after exhausting the benefits of the Standard Benefits Package, whereas persons with higher income would have to expend a predetermined amount before becoming eligible.

These benefits would have no limit for medically necessary care and services except that the number of health-related custodial care days would be limited in an extended care facility and in a nursing home.

Care in long-term institutions for tuberculosis, mental illness, and for the mentally retarded would be totally excluded.

Standard Benefits Package—To be eligible for the Health Maintenance and Catastrophic Illness Benefits Package, each person must be covered by benefits at least as extensive as those described below.

(1) Ambulatory Services: Diagnostic and treatment services provided in physicians’ offices, ambulatory care centers, and emergency and outpatient departments of health care institutions.

Benefits in this category would generally include the same services as available on an inpatient basis, including the professional services of physicians and podiatrists, and in addition, prescription drugs as listed in a national formulary.

(2) Institutional Services, including, in the appropriate facility, nursing service; operating room; delivery room; x-
(5) funds for AMERIPLAN appropriated from general federal revenues and collected through federal government tax mechanisms for health care would be deposited in a separate and specifically designated fund.

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(2) Institutional Services, including, in the appropriate facility, nursing service; operating room; delivery room; x-
ray and laboratory services; medical social service; professional services of physicians, dental surgeons, and podiatrists; restorative services appropriate to diagnosis, level of care, and facility; physical therapy, speech therapy, occupational therapy and psychotherapy, etc.; and blood after three pints:

4-027 Care in a Hospital—a specified number of days per year in semi-private accommodations for primary and specialty medical, surgical, obstetrical, pediatric, and psychiatric care, including treatment for tuberculosis, alcoholism, and drug addiction.

4-028 Care in an Extended Care Facility—a specified number of days per year which could be increased by a credit for unused hospital days based on a ratio relating the cost of a day in an extended care facility to the cost of a day in a hospital.

4-029 Care in a Nursing Home—a specified number of days per year which could be increased by a credit for unused hospital days based on a ratio relating the cost of a day in a nursing home to the cost of a day in a hospital.

4-030 Home Health Visits—a specified number of visits per year, on the recommendation of and under the supervision of physicians, with the following included: part-time nursing care; physical, occupational and speech therapy; psychotherapy; home health aides; necessary medical supplies; and social service, pharmacy, x-ray and laboratory services on an outpatient basis.

4-031 The following initial limitations on the scope of benefits for the Standard Benefits Package are included as suggestions only. Copayment, for example, of 10 to 20 percent could be required for both ambulatory and institutional care. The higher cost of institutional care may require a lower copayment percentage than ambulatory care. Also, the ambulatory drug benefit may require an annual dollar limit. Limitations on institutional care could be 90 days for hospital care, 30 days for care in an
extended care facility, 90 days in a nursing home, and 100 home health visits. A maximum limit on total institutional days could be required, for example, 180 days per year.

The following initial limitations on use of catastrophic illness benefits in the Health Maintenance and Catastrophic Illness Benefits Package are included as suggestions only. Health-related custodial care could be limited to 30 days in an extended care facility in addition to those days of care provided in the Standard Benefits Package, and 90 additional days in a nursing home. Because of the limit on resources available for health care, now and in the foreseeable future, health care provided in long-term tuberculosis and psychiatric institutions, and institutions for the mentally retarded, as well as non-health related custodial care, would continue to be financed from other sources.

Supplemental Benefits—The present coverage of many persons provided by prepayment plans and private health insurance, particularly for institutional care, is now greater than the benefits provided in the Standard Benefits Package, and would continue. Other persons would be able to purchase supplemental benefits to fill the gap between the Standard Benefits Package and the catastrophic illness benefits if they have the financial resources to pay premium costs.

Source of Funds

A basic principle in the financing of AMERIPLAN is that every person, if he is able, contributes. In order to achieve an equitable sharing of cost among all persons, the following sources of financing are recommended:

1. General federal revenue funds would provide the financing of all packages of care for the poor and make contributions toward financing the coverage for the near-poor;

2. A specific tax collected through the Social Security mechanism on all employed or self-employed persons would be used to finance the Standard Benefits Package
for the aged and the Health Maintenance and Catastrophic Illness Benefits Package for all except the poor, whose entire benefits would be financed through general federal revenues, and for the near-poor, whose benefits would be financed in part through general federal revenues;

4-037 (3) Direct private payments would be made for the purchase of the Standard Benefits Package and other supplemental benefits from prepayment plans and private health insurance companies.

4-038 In terms of the benefit packages, the sources of financing would be as follows:

Health Maintenance and Catastrophic Illness Benefits Package—

4-039 (1) General federal revenues for the poor and contributions to defray the cost of benefits for the near-poor;

4-040 (2) A specific tax collected through the Social Security mechanism for all other persons, including the aged.

Standard Benefits Package—

4-041 (1) General federal revenues for the poor and contributions to defray the cost of benefits for the near-poor;

4-042 (2) A specific tax collected through the Social Security mechanism for the aged;

4-043 (3) Direct private payments to prepayment plans and private health insurance companies for those for whom the government is not required to pay.

4-044 The federal government has a coordinating role in making certain that the total source of funds available for the health care system is commensurate with the nation’s health care needs.
Payment to Health Care Corporations by purchasers of care should be structured to give the Corporation an incentive in using that component of care which is most appropriate under the circumstances to provide the care economically, make the most effective use of the Corporation's resources, and keep its registrants well. Thus, the maintenance benefits in the Health Maintenance and Catastrophic Illness Benefits Package would be paid for on a capitation basis. All other health services would be paid for on the basis of prospectively determined rates as approved by the State Health Commission.

A system of annual capitation payments for each Health Care Corporation, as approved by the State Health Commission, for comprehensive health services seems, at this time, to be the best single method of giving the Health Care Corporation the incentive to be economically responsible for the health maintenance of its registrants. However, capitation payments for all benefits cannot be employed immediately both because of technical difficulties and because most Health Care Corporations, in their formative years, should not be asked to bear the inherent financial risks of a capitation method of payment.

Payment for the health maintenance benefits under AMERIPLAN by capitation is to encourage the development of total capitation payment. Initially, the Health Care Corporation would submit annual budgets to the State Health Commission as a basis for the state to prospectively approve the Corporation's institutional charges and professional fees. Because of the budget forecasting required, prospective approval of rates would act as a significant step toward full capitation payment.

Within Health Care Corporations, physicians would have the choice of being compensated by various methods of payment. These could include fee for service, capitation, salary, salary plus bonus, or combinations of these. Payment for physicians' professional services could be weighted in terms of productivity and service performed for registrants as well as responsibilities for other professional services performed directly for the Health Care Corporation.

The method used to finance AMERIPLAN must result in providing Health Care Corporations with sufficient resources to meet full financial requirements for the delivery of comprehensive health care.
AMERIPLAN

The necessary capital funds for health care facilities and the necessary funds for adequate compensation of physicians must be included. It should also be noted that payment for services under AMERIPLAN would be limited only to those health care providers who are part of or contract with Health Care Corporations.

4-050 Innovative administrative research to increase the effectiveness and efficiency of the delivery of health services should be supported by AMERIPLAN financing as well as through traditional governmental and private resources. Additional financing methods should be developed to pay for the training and education of adequate numbers of health care personnel and to sustain medical research so that these costs will not be a financial burden to patients.

4-051 It is the responsibility of the federal government to assure that AMERIPLAN permits access to all five components of care and that financing is adequate to fully provide this care to all of the population. It is the responsibility of the Health Care Corporation and group purchasers to be certain of optimum, economical use of all five components of comprehensive care in order to raise the health level of the community.
PART V

THE TRANSITION TO AMERIPLAN
V
THE TRANSITION TO AMERIPLAN

A firm foundation exists for AMERIPLAN by utilizing the resources which constitute our present health care system. Yet, it would be unreasonable to expect that AMERIPLAN or any new or significantly changed system could be brought into being at a single moment. Change requires adjustment to new ideas and organization by all of those affected. AMERIPLAN must be developed immediately, but within available financial, organizational, and professional resources. Its benefits will expand as Health Care Corporations gain operating experience and as financial resources expand.

This period of transition and development, however, need not be prolonged since AMERIPLAN incorporates within it all of the best elements of our existing system of health care. Major changes would be primarily in the organization of the system for the delivery of health services and in a financing and regulatory plan designed to motivate these organizational changes.

Rapidly developing trends toward rate setting for health services, the franchising of health facilities, and the implementation of the independent regulatory concept of controlling operations while allowing freedom of organization, demonstrate that many communities and some states are presently moving toward unifying their health resources. However, without a nationwide effort to coordinate such trends what is likely to result is continued fragmentation and the development of yet another inchoate, uncoordinated system. An orderly transition to AMERIPLAN, using the organizational and legislative recommendations of this report, would provide needed incentives and coordination.

The first step in the transitional process is to achieve acceptance of the philosophy of AMERIPLAN and its emphasis on comprehensive health care and particularly, health maintenance and ambulatory care.

This acceptance would speed the development of organizations with the capacity to become Health Care Corporations, would increase
group practice, broaden health care benefit packages now provided through various sources and utilize new payment mechanisms such as prospectively determined rates and capitation. While all of these developments vital to AMERIPLAN progress, legislation should be prepared and its enactment sought.

Required Legislation

5-006 The first step in formally establishing AMERIPLAN is the passage of the necessary federal legislation discussed in Part III. As a part of this federal legislation, start up funds should be provided to permit the establishment of the National Health Commission and to guarantee federal loans and provide grants to aid the formation and initial operation of Health Care Corporations.

5-007 After the passage of federal legislation would come the necessary state legislation, also discussed in Part III. Provision must be made for the adoption by the National Health Commission of a timetable for AMERIPLAN to meet the varying needs of the 50 states in fulfilling the requirements for the organization of State Health Commissions and the formation and approval of Health Care Corporations.

5-008 It would be necessary to set deadlines in order that those states prepared to participate in the system from the start would not be penalized by states requiring greater start up time and more legislative, organizational and financial assistance in implementing AMERIPLAN.

5-009 The timetable developed by the National Health Commission for the phasing-in process would require:

5-010 (1) that appropriate state legislation be enacted. State Health Commissions formed, and State Bureaus of Health Care Financing designated within two years after the enactment of federal legislation;

5-011 (2) that within two years thereafter, state approved and functioning Health Care Corporations be formed throughout each state, including within their coverage all geographic areas and the total population.

5-012 The single most important part of the phasing-in process after passage of the necessary legislation would be the formal organization
group practice, broaden health care benefit packages now provided through various sources and utilize new payment mechanisms such as prospectively determined rates and capitation. While all of these developments vital to AMERIPLAN progress, legislation should be prepared and its enactment sought.

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5-012 The single most important part of the phasing-in process after passage of the necessary legislation would be the formal organization
and approval of Health Care Corporations. State legislation would provide for rapid approval of Health Care Corporations so that such Corporations would be able to enroll registrants and commence operations under AMERIPLAN immediately upon the implementation of the financing aspects of the program.

Prior to Legislation

5013 Health care providers can begin now to form operating Health Care Corporations. There are several existing areas in which health care institutions representing various forms of ownership are interrelated. These institutions already have comprehensive health care as a primary objective and some include a key role for physicians in management. In several systems financing mechanisms are a part of the total effort to integrate the provision of health services. Such systems, as well as those providers in numerous communities that have moved together to coordinate services, could qualify as Health Care Corporations without marked organizational change.

5014 In addition, health care benefit structures could include health maintenance benefits before the enactment of AMERIPLAN legislation. By broadening the authority for experimentation under Titles 18 and 19 of Medicare with incentive reimbursement mechanisms approved by the Social Security Administration, it would be possible for the federal government to promote use of prospectively determined rate and capitation payment methods and to move existing benefits offered by prepayment plans and private insurance companies toward the concept of the prevention of illness through health maintenance.

5015 Through the phasing-in process of AMERIPLAN a convergence of resources for the provision of health care would result. AMERIPLAN would speed several significant and salutary trends in the health field: an increasing emphasis on preventive medicine and health maintenance; greater efficiency and effectiveness through economies of scale; the accelerated development and use of ambulatory services; an expansion in group practice; planning for comprehensive care; the certification of need for health care facilities; the expansion of health care benefits; wider use of prospectively determined rates for health care providers and use of varied methods of payment, including capitation.

5016 Cooperative arrangements among institutional providers could be
encouraged through the use of affiliation agreements or consortia of interested institutions. Ultimately the system would achieve an increased sharing of such activities as planning, financing, education, and the provision of services. This would result in increasing centralization of management functions, a greater availability of central services and a more effective provision of the five components of comprehensive care, in short, progress toward AMERIPLAN.

Ambulatory Care Centers

5-017 An example of a service which would become central and widespread in the fully developed Health Care Corporation network and which presently exists in several areas of the nation is the ambulatory care center. This development is cited to illustrate a major example of how progress toward AMERIPLAN can be made today, by the health field itself. Such centers are welcomed by the general public and represent, by the field, a commitment to change and to the philosophy of keeping people out of health care institutions.

5-018 Ambulatory care centers should be developed throughout the community as cooperative ventures by hospitals, their medical staffs, and family physicians practicing in the community. These centers should extend hospital supporting services, such as laboratory and x-ray services, and the services of paramedical personnel, into the community. They should functionally coordinate physicians' offices, wherever located, with supporting services and thus become the principal centers for the primary care component of the AMERIPLAN concept of comprehensive health care.

5-019 The ambulatory care center also should be the principal locus for the health maintenance component of care. Community-based health services such as home care, social service, well-baby clinics, and mental health clinics should be physically located in the center. Nurses and allied health professionals should be able to provide the total personnel requirements for this component of care, the family physician acting only in a supervisory capacity.

5-020 Multiphasic screening, part of the health maintenance program of the Health Maintenance and Catastrophic Illness Benefits Package under AMERIPLAN, could relieve the physician of a large portion of routine primary care. The results of such testing would be retained as a continuing part of each registrant's medical record and eventually
such records would be maintained through computer storage throughout the system. The medical record would serve as an input for the data base, not only for annual screening programs, but also for pre-admission testing. The medical record would be available to the patient’s family physician or to any other physician to whom the patient would be referred.

Involvement of Physicians

Fundamental to the success of AMERIPLAN would be the involvement of physicians in the active organization and management of Health Care Corporations. Physicians, along with professional administrators, must have a major role in deciding how institutional services should be organized, how health personnel should be deployed, how care could be rendered economically, and how evaluation should be made of the effectiveness of health services. Physician involvement in management responsibility should begin immediately.

Physicians should make it their responsibility to be certain that the focal point of AMERIPLAN would be the individual registrant of the Health Care Corporation rather than the health care institution or the health professional. The improvement of the registrant’s health, the treatment of his illnesses, and the maintenance of his well-being constitute the purpose of the system and the primary responsibility of the physician.

The Challenge

Health professionals will be aware of the need for a period of transition to AMERIPLAN and for some initial limitation on the scope of benefits. However, the public must also be made aware of the operational problems of the transition to AMERIPLAN and the need for regulators on use of services, such as copayment, as well as initial limitations on benefits, in order that demand will not exceed the development of resources.

Cooperation is vital to the successful implementation of AMERIPLAN and will speed the transition period. A program such as AMERIPLAN cannot come into being solely through legislation or by the wishes of health professionals. All persons and groups who would be affected by AMERIPLAN must believe in its merits, must want it to succeed, and must work for its success. This is the challenge.
ABOUT THE SPECIAL COMMITTEE ON
THE PROVISION OF HEALTH SERVICES

The committee was authorized by the Board of Trustees of the American Hospital Association in August 1969 following a staff report and a discussion on the implementation of the Statement on Financial Requirements of Health Care Institutions and Services. The Statement, approved by the AHA House of Delegates earlier in the year, embodies numerous Association policies and enunciates the principle that “the community must provide for proper financing of its health care system and that the health care system must accept, on its part, the community’s right to insist on proper planning within that system.”

The Board believed that a statement so broad in its implications and so fundamental to the provision of health services called for a major review of the health services system by a special committee.

The committee consisted of 15 members: three were practicing physicians; seven, administrators of hospitals or hospital systems; two were attorneys; one, a member of the clergy; and two, hospital trustees. The group represented a wide range of experience in health care delivery, including areawide planning, the provision of services in urban and rural areas and in widely varying geographic areas, the development of health policy, the function of government in the health field, health law, and the functions of health field organizations. Several members of the committee had had training in more than one professional field.

The committee was asked to take a comprehensive view of the nation’s health care system and to make recommendations on how the system might be made more effective. Implicit in the charge was a review of Association policy with respect to the system, with the committee having freedom to make recommendations not necessarily consonant with that policy. The report of the committee, it was agreed, would be published regardless of its implications for Association policy, present or future.

Work began in October 1969, and the task was completed early in
ABOUT THE SPECIAL COMMITTEE

November 1970. During this time the committee met approximately once each month for two and one-half day sessions, reviewed numerous studies, reports, and legislation (enacted and proposed), and visited with leaders in medicine, health insurance, Blue Cross, group practice, organized labor, law, and education.

With the assistance of Association staff, the committee based its discussions on five areas as follows:

(1) What organizational changes should be introduced to provide more effective delivery of institutional health care services?

(a) What kinds of health care should be provided institutionally?

(b) What should be the basic organizational units for the provision of institutional health care?

(c) How should the units be organized (including ownership)?

(d) What should be the best mechanisms to insure adequate health care for the poor and the disadvantaged?

(e) How should the activities of different organizational units be coordinated?

(f) What should be the relationships of these institutions to other health care providers?

(g) What roles should health care institutions play in providing sufficient numbers and kinds of health manpower?

(h) What mechanisms should be provided to allow consumer evaluation of the effectiveness of institutional health care?

(2) What should be the most effective organization for the delivery of physicians' services?
AMERIPLAN

(a) What should be the responsibilities of the hospital?

(b) What should be the relationships of the hospital to the primary physician?

(c) How should physicians be organized to provide services to the poor in rural and urban areas?

(d) How should medical services be paid?

(e) What should the organization of physicians be (group vs. solo)?

(f) What should be the relationships of physicians to the organization, management, and delivery of comprehensive health care services?

(g) What should be the relationships of the hospital medical staff to the local medical society?

(h) What changes in the number and kinds of manpower are necessary to increase physician productivity?

(3) How should the quality of health care be evaluated?

(a) What are the appropriate responsibilities of each of the components of health care?

(b) What are the appropriate methods or techniques of evaluation? (e.g., peer group.)

(c) How can these methods and techniques be applied to affix the appropriate responsibilities with each of the components of health care?

(d) What should be the role of the Joint Commission on Accreditation of Hospitals?

(4) What kinds of incentives and/or controls should be employed in the delivery of institutional health care services?
ABOUT THE SPECIAL COMMITTEE

(a) Should provider charges or cost be controlled, and if so, by whom? (e.g., cost commissions.)

(b) Should provider quality and performance standards be imposed, and if so, by whom?

(c) Should the provider location and scope of services be controlled, and if so, by whom? (e.g., planning, franchising.)

(d) Could market-type incentives be employed?

(5) What should be the most effective approach to the financing of patient care, facilities, education, and research?

(a) What should be the role of government—federal, state and local?

(b) What should be the role of prepaid health insurance and how should it differ between for-profit and non-profit?

(c) How should health care for the poor be financed?

(d) What should be the responsibilities of individuals and should incentives or deterrent factors be employed to influence utilization patterns?

(e) What should be the role of the intermediaries, if any, and how should these intermediaries be organized?

From a synthesis of each of these topics the Committee formulated goals for the provision of health services and developed elaborations or sub-goals. To implement the goals and to substantially restructure the system, AMERIPLAN is recommended by the Committee.

The Committee intentionally omitted many details in its recommended program, recognizing the need for flexibility throughout a viable system. Its primary aim was to define a national program that would assure local autonomies, alternatives for the individual, and the preservation of assets that will contribute to the realization of comprehensive health care for all.
GLOSSARY OF TERMS

AMERIPLAN — the synonym for the national health care program as recommended by the Special Committee on the Provision of Health Services of the American Hospital Association. AMERIPLAN includes the organization of all health resources for delivery of care as well as the legislative, regulatory and financing programs contained in the report of the committee.

Approval — the determination that a program or procedure meets formal criteria established in governmental regulation or by a voluntary agency.

Capitation — the method of paying for specific health services available to an individual based on a prospectively determined rate per individual and per unit of time.

Comprehensive health care — provision of the following services in order to meet the total health needs of the patient.

1. health maintenance
2. primary care
3. specialty care
4. restorative care
5. health-related custodial care.

Emergency care — care sought by a patient in other than the usual or routine manner, for the following reasons:

1. accident or other medical crisis
2. necessary medical care when travelling away from home
3. inability to contact usual provider of care, such as a physician, when the patient believes care is urgent.

Group practice — medical practice by a number of physicians, preferably multi-disciplinary, formally organized to provide professional services to patients, with varied predetermined payment arrangements for their services.

Health care institutions — establishments with permanent facilities and medical services for patients, including inpatient care institutions, outpatient care institutions with organized medical staffs, and home care institutions.

Health care provider — a Health Care Corporation, a health care institution, group or individual providing personal health services.

Health Maintenance — that component of comprehensive health care in which services are provided to meet the goal of maintaining the health
of the individual by preventing illness and detecting disease before it becomes symptomatic.

**Health-related custodial care** — that component of comprehensive health care in which services are provided to meet the goal of maintaining the well-being of the non-curable patient to the maximum degree possible and providing terminal care.

The patient must have a non-curable disease diagnosed by a physician still requiring medical and/or nursing care, either in an extended care facility, a nursing care institution, or through home care, for palliation or terminal care.

**Criteria for required care:**

1. The patient is bedridden, or unable to get in or out of bed without assistance, or
2. The patient requires nursing care procedures that cannot be performed by the patient or non-nursing personnel (family, companion, etc.). (Examples: complicated dressings, irrigations, I.V. medications, etc.) or
3. The patient experiences frequent episodes of sudden, acute illness requiring emergency treatment that cannot be controlled by medication. (Examples: uncontrolled diabetes, epilepsy, paroxysmal tachycardia, fibrillation, etc.) or
4. The patient requires constant physical restraints to prevent injury to self or others. (Examples: senility or mental illness.)

This term does not include domiciliary care.

**Multiphasic screening** — a predetermined series of tests and examinations utilized to evaluate the state of health of an individual and performed primarily by allied health care personnel and/or automated diagnostic equipment.

**National formulary** — a list of drugs approved by the federal government for which payment may be made under AMERIPLAN.

**Noncovered services** — services of a Health Care Corporation not included in the health insurance benefits of AMERIPLAN.

**Peer review** — the mechanism used by the organized medical staff of a Health Care Corporation to evaluate the quality of the total health care provided by the Health Care Corporation. This evaluation includes not only physician services but services performed by all health personnel. The mechanism evaluates performance of individuals as well as the appropriateness of the types and locations of services used to meet the patient’s needs.
Glossary of Terms

Poor and Near-Poor — for the purposes of this report, poor refers to those persons who, on the basis of national standards giving consideration to income, family composition, and living costs in a given area, will qualify for total support for health care costs from federal funds; near-poor refers to those persons who, on the basis of similar national standards, will qualify for partial support for health care costs from federal funds.

Prepayment plans and private insurance companies — non-governmental organizations approved by the National Health Commission, offering to subscribers or beneficiaries prepayment or health insurance benefit coverage.

Primary care — that component of comprehensive health care which has as its goal the continuation of the maintenance of health and in which episodic illness is treated within the capabilities of the primary physician.

Private — non-governmental, including not-for-profit and for-profit organizations.

Registrant — an individual who designates in writing a specific Health Corporation to provide his health care.

Restorative care — that component of comprehensive health care the goal of which is to return the patient to a state of health as near to normal as possible. Some services common to this component of comprehensive health care are physical medicine, physical therapy, occupational therapy, speech therapy, vocational rehabilitation, and psychiatric care.

Specialty care — that component of comprehensive health care necessary to supplement primary care to meet the patient’s needs, requiring the knowledge of a physician who is a board certified specialist.
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PHRASEFINDER

To use the Phrasefinder, first decide the words or phrase you want to locate in the report. Find these words in the Phrasefinder. Indexed words are printed in bold face. The context in which the indexed word appears in the report is printed in light face to the right of the indexed word. The paragraph in which each entry appears is in bold face to the right of the entry, for example 2-050, which indicates that this is paragraph 50 of Part II of the report.

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