

GROUP HEALTH'S ANSWER TO OUR MEDICAL CARE DILEMMA

by

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It is a real privilege to meet with this influential group today to discuss consumer-sponsored and consumer-oriented group health plans. Since 1936, when some of us joined with Dr. James Peter Warbasse in organizing the Bureau of Cooperative Medicine, the group health movement has come of age. Its national organization, the Group Health Association of America, has come to comprise some 75 active and supporting member organizations and several hundred individuals dedicated to improving the availability, efficiency, and quality of medical care. We are convinced that there are answers to the medical care dilemma faced by consumers today. We don't pretend to have all the answers, for some of them must come from government and our universities and professional societies and elsewhere, but we do believe the group health movement has a message of great importance to consumers everywhere.

When we discuss health and medical care, we are in an area of basic importance to the family. Illness and its costs can knock the economy of a family galleywest. The wrong choices made by uninformed consumers can leave them unprotected against the creeping or catastrophic costs of sickness.

Wrong choices, in fact, can lead them down the road to disability and even premature death. On the other hand, informed choices can lead to health protection and maintenance, with family budgeting possible for a wide range of health services. The right to safety, the right to be informed, and the right to choose--these rights of consumers so vigorously expounded by President Kennedy and endorsed by President Johnson have full application to the field of health, medical care, and health insurance.

What I want to talk with you about today is the spreading growth of organizations of doctors and consumers who are working together to provide comprehensive health care on a non-profit basis directly to the individual and family through group medical practice. These group health plans do not simply finance part or all of the costs of certain services provided in the open market. Rather, they make direct provision for the care of their members or subscribers through their own or through closely affiliated, organized groups of personal doctors and specialists, and through their own or through cooperating hospitals. Prepaid group practice plans, because of these characteristics, are often referred to as "direct service plans."

Although most of the major group health plans are less than 20 years old, with their establishment being related to current trends and forces, these direct service programs have their roots in a long and honorable history. In the year 1655, in the frontier settlement of Ville Marie on the Island of Montreal, a contract was signed between 36 French colonists and Master Surgeon Estienne Bouchard whereby Dr. Bouchard undertook "to dress and to physic for all sorts of illness, whether natural or accidental, except the plague, smallpox, leprosy, epilepsy and lithotomy or cutting for the stone, until a complete recovery or as complete as may be possible, in consideration of the sum of one hundred sols each year for each of the above mentioned persons and for their wives and children." This was in the days before medical care costs began to spiral. One authority, coping with sols and livres and beaver pelt equivalents, has come up with \$1.00 per family per year as the cost in modern terms of that quite comprehensive health insurance contract in Ville Marie.^{1/}

President Kennedy wasn't our first President to encourage direct service, prepayment arrangements. George Washington engaged a physician to take care of the people on his estate for 15 pounds a year.^{2/}

The 19th century saw the development of many plans designed to bring essential medical services to isolated miners and lumbermen. The employees and management of the Southern Pacific Railway established a program in 1869 that became the forerunner of numerous railway medical and hospital direct service programs that are still active and still evolving in response to today's trends.

In a few weeks the International Ladies' Garment Workers' Union will be celebrating the 50th anniversary of the opening of the Union Health Center in New York City. This pioneering effort paved the way for today's 90 to 100 union health centers scattered from coast to coast. The Ross-Loos Medical Group in Los Angeles broke new prepayment ground in 1929 as

a physician-sponsored plan. Still another pattern emerged when the first consumer-cooperative prepayment plan was started by the Farmers Union Hospital Association in Elk City, Oklahoma, in 1929.

These and other plans were prototypes, laying the foundation for the greatly increased activity in the group practice-prepayment field that has emerged since the depression of the Thirties and the stringencies of the World War II period.

Many of you have some familiarity with the newer group health plans that have been springing up in the last quarter-century, particularly since the War--the Kaiser Foundation Health Plans, the Health Insurance Plan of Greater New York, Group Health Cooperative of Puget Sound, Group Health Association in the nation's capital, the Union Health Service in Chicago, the Labor Health Institute in St. Louis, the Community Health Association in Detroit, and many others including the Group Health Association in Sault Ste. Marie, Ontario, and the Community Health Services Association in Saskatchewan. These positive new patterns of comprehensive health care are not, of course, materializing in a vacuum. They are largely a direct response to powerful trends in medical care today. It will help in the understanding of these significant developments if we review briefly some of the trends underlying their origin and consider the implications of these trends.

We might well put first the scientific advances of recent decades in the field of medicine. There have been amazing changes in a generation and the horizons of medical science are constantly being pushed back. Miracle drugs - isotopes - polio and measles vaccines - unlocked secrets of heredity - open heart surgery - transplantation of organs - and the list can go on and on.

A natural trend concurrent with this explosion of medical knowledge is specialization. Several years ago 51 specialties and subspecialties had already been defined within the medical profession alone. There are a number of kinds of subspecialists today in the basic field of internal medicine who don't understand what their fellows in the same specialty are talking about as they pursue their interests on the frontiers of science.

Obviously we face a constantly changing and expanding concept of adequate standards of medical care. Adequacy of care at any one point in time involves the application of all the accepted practices in medicine to the needs of the patient. To the extent that the patient lacks access as needed to the whole range of scientific medical services - preventive, diagnostic, therapeutic, and rehabilitative - that patient is not getting adequate care. All of our vaunted scientific and technological advances in medicine have real meaning only as they have full application in meeting the needs of all patients who can be benefited by them.

Another trend is closely related to advancing science and specialization and the expanding concept of adequacy of care - the steadily rising costs of medical care. Total expenditures for health and medical care in

the United States have risen dramatically from \$3.6 billion in 1928-29 to \$33 billion in 1962-63.^{3/} Taking per capita expenditures over this period and in terms of constant dollars, to eliminate the factors of population growth and inflation, there has been an increase of some 150 per cent.^{4/} Private expenditures for health services used to account for about 4 cents in the consumer's expenditure dollar, and they now use 6 cents.^{5/} Perhaps the most striking feature of these rising costs is seen in the spiraling medical care component of the Consumer Price Index. Month after month, year after year, medical care prices go up. While average prices in the CPI have risen 8.9 per cent since 1957, and all services 14.9 per cent, medical care services have gone up 22.2 per cent, largely, one might add, because of the skyrocketing costs of hospital care and hospital insurance.^{6/}

Still another significant trend, that is changing the whole role of medicine, is found in the aging of our population and the increase in chronic disease. Since the turn of the century, as the acute communicable diseases have been brought under control, we have seen a shift from disease of the young to diseases of the aging. As Dr. George James, New York City's Health Commissioner, said recently, "There is less and less medicine with the nice simplicity of boy meets germ, boy gets germ, boy sees doctor, boy loses germ, boy gets well."^{7/} As medicine tackles the growing problem of control of the chronic degenerative diseases, the task becomes one of early detection of illness, of alleviation, of prevention of disability, of postponing death. The need is for medical management and continuous medical supervision. To discharge his responsibility effectively, the personal physician must be able to mobilize all needed medical resources in aid of his patient - special diagnostic and therapeutic services, varying forms of institutional or home care, and the knowledge and skills of various professions and agencies including rehabilitation, nursing, and social agencies.

Finally, we face a steadily increasing demand for medical service, with the right to health taking its place with the other accepted "rights of man." Time permits only mention of the whole complex of factors responsible for this--advances in education, rising income levels, urbanization, our aging population, expanding concepts of the dignity and worth of the individual, the growth of prepayment for medical care, and the constant flow of information to the public about every aspect of health and disease. The economic power of the informed and organized consumer is being exerted increasingly in the direction of broader benefits through prepayment plans.^{8/}

This increasing demand for broader health care through prepayment comes at a time when our population growth is outstripping our production of doctors of medicine and when practically all health personnel are in short supply. Recent recognition of the special needs in the field of education in the health professions has come too late to reverse current downhill trends for several years. If medical needs are to be met, the situation demands the wise and frugal use of our resources and points to the urgent need to develop patterns of medical and hospital care with built-in efficiencies and economies.

As we have reviewed some of the major current trends in medical care, their implications have been mentioned or may be self-evident. Could anyone question that rapid advances in medicine are of limited value unless physicians quickly know and understand them, and apply them in meeting the needs of their patients? What chance has the confused patient in the face of on-rushing specialization unless a knowledgeable personal physician supervises his health on a continuing basis and calls for other specialist and technical skills as needed? Can spiraling medical costs be controlled without introducing new and better ways of organizing and financing medical care?

Just a few short years ago I would have urged the compelling need for sound experimentation in meeting the needs associated with current trends in medical care. There is still ample room for developing improvements and extensions of existing programs, but I believe we have passed the experimental stage and can demonstrate that new group health plans in various communities throughout the nation are coping effectively with fundamental problems and achieving the kinds of gains their members had the faith to anticipate.

As growing numbers of unions, cooperatives, other organized consumers, employers, and forward-looking physicians turn hopefully to the new pattern of medical care linking group medical practice with prepayment, they are by no means unaware of the contribution that has been made in the past 25 years by the prevailing types of voluntary health insurance--the Blue Cross and Blue Shield plans and commercial insurance. Through these plans about 70 per cent of our population have at least some protection against the unpredictable costs of illness. What concerns many of us is that these plans fail to reach tens of millions of people, they afford only limited protection, they generally fail to cover care in the office and home--where 80 to 90 per cent of all medical services are rendered in well organized programs, they ban payment for preventive services and fail to facilitate the early detection of disease, they pay virtually no attention to the quality of services for which they pay, and they not only fail to conserve our medical resources and to control medical care costs but rather seem to stimulate constantly rising utilization of hospital beds, inflation of medical fees, and the continued rapid spiraling of medical care costs.

In contrast, we find a growing movement in the United States and Canada dedicated to the principle that medical care insurance can have direct goals in the field of health as well as of finance. The group health movement is unimpressed by mere sickness insurance. It recognizes that prepayment can be at once a financial protective mechanism and the necessary financial base for a comprehensive health service organization. Thus we find in the group practice prepayment field dedicated boards of directors and physicians building programs designed to keep people well, to detect illness early, to supply definitive care, and to minimize the effects of chronic disease or disability. Although there are differences among these programs in sponsorship and basic organization, variations in medical staff organization, differing approaches in providing hospital care, and variations in the details of benefits and charges, they are all characterized by this sort of positive, medically oriented motivation.

The architects of these programs have designed plans providing for virtually the entire range of scientific medical services. For effectiveness and economy, they have introduced rational organization into medical care and fostered coordination of services. They have seen no point in squandering money on expensive hospital care when the same service can be given in the doctor's office or group center, or when early diagnosis might obviate the necessity for a hospital stay. They have divided up the overall task in an eminently sensible way, looking to the physicians of the medical group to supply high quality care with the pledge that they will be protected from lay interference in medical matters, and looking to the lay leadership for control of policy and administrative functions to be carried out in the interest of the consumers of health services.

What is group medical practice? One of the best definitions of the sort of group practice we are talking about, the kind that can provide comprehensive care, is that given by Dr. Caldwell B. Esselstyn, who heads the outstanding Rip Van Winkle Clinic in Hudson, New York, and serves as Chairman of the Board of the Group Health Association of America. He describes group practice as "the formation of a team of physicians with separate skills but common philosophies who pool these skills for the benefit of the patient and who organize themselves so as to have a mutual responsibility both to their patients and to each other."⁹

Why so much emphasis on group medical practice in the group health movement? This arises out of the conviction that medical care of high quality doesn't just happen but is a highly complex matter that, among other things, requires the introduction of some organization in the provision of services. What has been achieved in our best hospitals may serve as illustration. Any of you who has served on the board of such a hospital must have been impressed by the way standards are being raised through the actions and influence of our university medical centers, various councils within organized medicine, medical specialty boards and societies, and the Joint Commission on the Accreditation of Hospitals. If you analyze these efforts, you'll find they comprise the careful selection of individuals for training or for special professional privileges, the setting of standards, and insistence on proper organization of services and on constant evaluation of performance. What group health leaders wish to see is simply full application of these same principles in the everyday medical services their members will receive outside hospitals. Through the organization of group medical practice there can be the careful selection of qualified professional workers. Physicians are selected by other physicians, thus affording the patient safeguarded choice of doctors. High standards of medical performance can be set. The well-organized group can operate within the kind of framework of quality standards, continuing education, and self-imposed controls that typifies our finest medical and hospital organizations.

Group practice offers the member of a health plan choice of personal or family physician, choice of pediatrician for the children, easy referral to other specialists, the convenience of obtaining all ordinary care including x-rays and laboratory services under one roof, and because of the cooperative, team approach, the assurance of being able to get emergency

care around the clock, seven days a week, twelve months a year. With the plan doctors on salary or in a partnership, moreover, it is reassuring to the patient that the economics of medical practice are transformed. The medical group has a vested interest in health rather than in disease. If preventive and health maintenance services will keep their patients healthier, the load carried by the doctors becomes lighter. No doctor has a personal financial interest in any specific service to any individual. Finally, the knowledgeable patient can be confident that his doctor is not suffering the deterioration that too frequently goes with the professional isolation of solo, fee-for-service practice. Group practice has a built-in factor making for better care. Dr. Alan Gregg of the Rockefeller Foundation affirmed that "Medical care is of high quality to the extent it is observed and observable."^{10/} William W. McPeak of the Ford Foundation put it this way: "--the quality of a doctor's care is in large part a measure of the extent to which his work is subject to scrutiny by his professional peers."^{11/}

What does group practice offer the physician? From the standpoint of his professional life, group practice can offer the doctor ready access to all the services his patient needs, it can give him the stimulation of constant contacts with professional colleagues, it can supplement the scientific program of his hospital and medical society, and it can provide more amply than solo practice for attendance at professional meetings, for postgraduate training, and for participation in research.

From the standpoint of his personal life, group practice tends to offer the physician a higher average net income, greater personal security, and generally more human working conditions in terms of hours of professional activity during the week, periodic intervals when responsibilities can be laid aside, and vacations of decent duration with pay.

It is not surprising that group practice is spreading at an accelerating pace. In 1960 the Public Health Service reported on a survey which revealed 1151 multi-specialty groups in this country, with over 10,000 full-time physicians.^{12/} The number had more than tripled in just 14 years. Most of these groups, of course, are private groups not linked with group health plans. Their national organization has been studying patterns of prepayment, sensing the winds of change about them. I believe many of these medical groups would be willing to explore a cooperative relationship with a consumer-sponsored group health plan.

One or two other observations should be made on the economics of group practice prepayment. Experience shows that comprehensive medical services may be offered at a cost that is not excessive. The sharing of physical facilities by a group plays a part in this, as does the sharing of the services of auxiliary staff. Full use of nurses and technicians and other paramedical personnel conserves the time of the physicians. The remuneration of doctors in groups is typically through salaries or the distribution of partnership income. The group health type of plan can allocate adequate premium of dues income to the medical group to meet its operating budget. Financing is thus geared to a predictable outlay. No such built-in safeguards are possible in any plan based on paying a fee for every specific service. One might add that while preventive services are actively promoted

in group health plans, offering them under fee-for-service arrangements would be financially catastrophic.

It may be helpful if I review the highlights of several of the major comprehensive care plans. Through their essentially common principles and yet varied approaches one can perhaps get a concept of this significant movement now comprising some four million persons.

One of the best known and largest of these plans is the Health Insurance Plan of Greater New York, established in 1947 as a community organization through the leadership of Mayor Fiorello LaGuardia.^{13/} The purpose was to make available a program of complete medical care to city employees and other employed persons and their dependents. HIP has attained an enrollment of some two-thirds of a million persons who obtain care through 32 affiliated groups of family doctors and specialists.

HIP provides remarkably comprehensive medical care, with almost no extra charges, including care in the home, medical group center, and hospital. There is stress on health education and preventive services. Continuing evaluations of the quality of care being received by enrollees has been a commendable feature of this program. HIP does not pay for hospital care; most subscribers are in Blue Cross and hospitalization is obtained through any of the community hospitals in which physicians of the various groups have privileges.

The second "giant" among comprehensive care plans is the Kaiser Foundation Health Plan, which grew out of an industry-sponsored prepaid medical service for shipyard workers and their families in the San Francisco Bay area during the War.^{14/} From a few thousand initial subscribers, this program had grown by last summer to 940,000 participants in California, Oregon, and Hawaii.^{15/} The program has its own extensive network of Kaiser Foundation Hospitals and 40 or more medical group centers. In each major area the physicians in the full-time medical groups comprise large medical partnerships, the Permanente Medical Groups, which contract with the Health Plan.

The Kaiser-Permanente program offers comprehensive services to its subscribers, tailoring various contracts to the pocketbooks of the consumers. They pioneered in insisting that each subscriber have a choice between the Kaiser Plan and at least one significantly different program such as Blue Cross-Blue Shield or an indemnity plan. They have also shown that ultra-modern hospitals and clinics can be built from the proceeds of a competitive prepayment program.

Group Health Cooperative of Puget Sound illustrates another type of sponsorship, that of the cooperative movement.^{16/} Group Health Association in Washington, D. C., is again a member-controlled organization served by a full-time medical group, with an impressive, new central clinic and out-lying facilities in three locations. The members have been hospitalized in Washington's best hospitals since a famous Supreme Court decision in

the early Forties that brought to an end the discrimination that had prevailed against G.H.A.'s doctors.^{17/} The membership, predominantly federal employee families, exceeded 53,000 at the end of 1963.^{18/}

Several other group practice-prepayment plans were mentioned previously and one might add to the list a variety of others such as the Community Health Association in Detroit.^{19/} Practically all of these programs are consumer-sponsored and any exceptions are consumer-oriented. Their comprehensiveness of benefits stands in contrast to the sickness insurance offerings of medical society sponsored and commercial insurance plans.

We look forward to steady growth of our membership and affiliations with other hospital-based medical groups and community hospitals. To the extent necessary, we shall stimulate the organization of new group practices. We are hopeful that medical staff opposition in community hospitals will not induce hospital trustees to bar doctors from their institutions who are willing to work with a consumer organization. If trustees go along with such discriminating practices, we may be forced to build hospitals to meet the legitimate needs of our membership and the community.

Are these prepaid group practice, comprehensive care plans achieving the results hoped for by the consumer groups sponsoring or served by them? I believe that in large part they are. Let's look briefly at the evidence in terms of comprehensiveness of coverage, control of costs, quality of care, and improvement of health.

Turning first to comprehensiveness of benefits, it would seem reasonable to compare plans in respect to the proportion of enrollees receiving any benefits at all during the year. Under the Federal Employees Health Benefits Program, in which over six million persons have a wide range of choice of type of prepayment plan, we find some rather dramatic figures in the report just issued covering the year ended October 31, 1962.^{20/} Of the persons in families choosing the government-wide high option Blue Cross-Blue Shield Service Benefit Plan or high option Indemnity Benefit Plan, just 19 per cent received benefits. In contrast, of those choosing group practice plans, whether high or low option, 80 per cent received benefits.

In 1960 the United Steelworkers issued a thorough study exploring the value of various medical care contracts in meeting costs.^{21/} They estimated that for their union member families under the Kaiser Plan the costs of 93 per cent of physicians' services were being met as compared with 52 per cent for Blue Shield and from 46 to 50 per cent for commercial insurance. They estimated further that under group practice plans some 80 per cent of currently insurable costs are covered as compared with some 60 per cent for standard United Steelworker plans. An earlier study, by the Health Information Foundation, showed that H.I.P. was paying 80 per cent of the gross costs of physicians' services as compared with 59 per cent for Group Health Insurance, New York City's "free choice," comprehensive care plan.^{22/}

In addition to providing broader coverage at competitive rates, these direct service plans have built-in governors that resist rising costs. These are found partly in the group practice framework with its economies, its budgetable expense for the services of doctors on salary or sharing partnership income, and its system of incentives that differ from those of the solo practitioner on fee-for-service. Within this framework and that of a broad ambulatory service, there is evidence of some sort of governor holding down increasingly expensive hospital utilization and surgical care.

In 1962 Blue Cross Plans nationally had to pay for an average of 1120 days of care per thousand persons, the level of use having gone up steadily for years.^{23/} In Michigan the figure was 1430 days after a similar but faster rise.^{24/} On the other hand, the Kaiser Health Plan in Northern California reported 609 days per thousand for 1962^{25/} and for the previous six years no rate higher than 657. The figure for Group Health Association in Washington was 599 days per thousand^{26/} and that for Group Health Cooperative in Seattle, 658.^{27/} Our CHA group practice rate in Detroit has settled down from a comparatively high rate the first year, 1961, to a rate less than half the Blue Cross rate in Michigan.

Skeptics have tried to explain away these savings through group health plans in the past, but it seems likely that the data coming from the Federal Employees Health Benefits Program will still these critics. For the year ended October 31, 1962, hospital utilization for those in the nationwide, high option Blue Cross-Blue Shield Plan was 882 days per thousand, for those in the nationwide, high option indemnity plan it was 760 days per thousand, and for those in high option group practice plans the figure was just 460 days per thousand.^{28/}

One factor in the lower volume of hospital care required by group practice plan enrollees seems to be the lower rate of surgical operations, a factor that may be related to quality as well as economy. The Health Information Foundation found that surgical care represented 8 per cent of costs in G.H.I., the free choice plan, but only 4 per cent of costs in H.I.P.^{29/} The Steelworkers' group in Blue Shield had 69 operations per thousand annually, whereas in the Kaiser Plan they had just 33 operations per thousand.^{30/}

Dr. George Baehr, former President of H.I.P., has stated that as a nation, "We are wasting billions of dollars each year on unneeded and inefficient private medical and hospital services and this money could be spent much more profitably under our free enterprise system to prevent illness, to improve the quality of medical care, to prevent crippling disabilities and rehabilitate the disabled."^{31/} I must say it is intriguing to think of the savings being effected through the group health approach. Dropping the use of hospital care for a million people from 1,000 days per thousand to 750 days, at \$40 a day, saves \$10,000,000 annually and eliminates the need for 850 hospital beds worth over \$20,000,000 at today's replacement value. These savings are of course being applied by group health plans to providing preventive and other broad ambulatory services.

Are group practice plans improving the quality of medical care? Quality of medical service is extremely hard to measure. Those of us who are involved in these plans are convinced that our programs lead to improved quality, a conviction that admittedly must be subjected to new and better methods of analysis in the coming years. In the meantime there are good reasons for our conviction - careful selection of group physicians, performance of specialized services by those trained in such skills, medical staff organization for ambulatory as well as hospital practice, the ever-present judgment of a doctor's peers, easy consultation without economic hindrance, adequate and accessible diagnostic facilities, opportunities for teaching and research, and review of performance by outside authorities.

There have been studies, of course, relating to quality of care. In H. I. P., for example, it was shown that 95 per cent of all the H. I. P. - insured infants were immunized against whooping cough, diphtheria, tetanus, and smallpox in their first year of life.^{32/} A Columbia University study found that 83 per cent of surgical procedures in H. I. P. were performed by recognized specialists in surgery, compared with 62 per cent under Blue Shield and 57 per cent under G. H. I.^{33/}

Quality and the question of improvement in health tend to merge in the finding that the infant death rate in H. I. P. from 1955 to 1957 was 23.1 per thousand births compared with 27.9 for other New York City babies delivered in hospitals by private physicians.^{34/} A greater proportion of H. I. P. mothers were receiving prenatal care during the first three months of pregnancy. Moreover, H. I. P. deliveries were by specialists in obstetrics, a quality standard characteristic of group practice plans.

We have considered some of the major achievements of these consumer-sponsored and consumer-oriented health plans. Real progress has been made. It is important, however, that you understand that this progress has been made against heavy odds and that obstacles lie in the way of consumer groups seeking better health care through group health plans.

The Group Health Association of America is dedicated to establishing the consumer's right to choose the method by which he will receive and pay for medical care, including the right to organize his own health plan.

Despite the official tolerance of the A.M.A. in respect to group practice prepayment plans, the right of consumers to organize and benefit from such plans is seriously impeded in many localities by the opposition of fee-for-service practitioners of medicine and the medical societies and hospital medical staffs which they dominate. This opposition takes the form of discrimination against physicians who wish to serve members of the plan. There may be denial of membership in professional societies, denial of hospital staff privileges, refusal to refer patients for specialty care, and other direct and indirect actions. Consumers are not powerless in these situations, once they know the facts and decide to fight. The denial of hospital staff privileges to physicians in H. I. P. medical groups resulted in the enactment just one year ago of a New York State law making it unlawful for a hospital to deny staff membership because of a doctor's participation in a medical

group practice plan. In a similar situation, the Legislative Assembly of Saskatchewan enacted a statute last month setting up a Hospital Appeal Board with binding powers to deal with cases of alleged discrimination against physicians serving in the consumer-sponsored community clinics which have sprung up in that Province.

In about half the states of the Union the consumer's right to choose his plan of medical care is denied or impeded by law or by decisions of courts or attorneys general that have the effect of law.³⁵ This denial of the rights of consumers is found in its most extreme form in states with so-called Blue Shield laws which in effect forbid the operation of medical care plans that are not dominated by organized medicine or that do not provide for "free choice of physician." Here again, consumers are not powerless. They rallied in Ohio recently to obtain enabling legislation for consumer sponsored plans. A statute enacted this year in West Virginia goes at least part way toward the same goal and consumer groups are determined to see the act broadened next year.

Your Council can be of enormous help in the whole struggle I have outlined for the right of the consumer to health, his right to be informed about pathways to high standard medical care, and his right to choose the way he will receive and pay for care. If some of us with bias in these directions can help you in this task, please call on us.

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