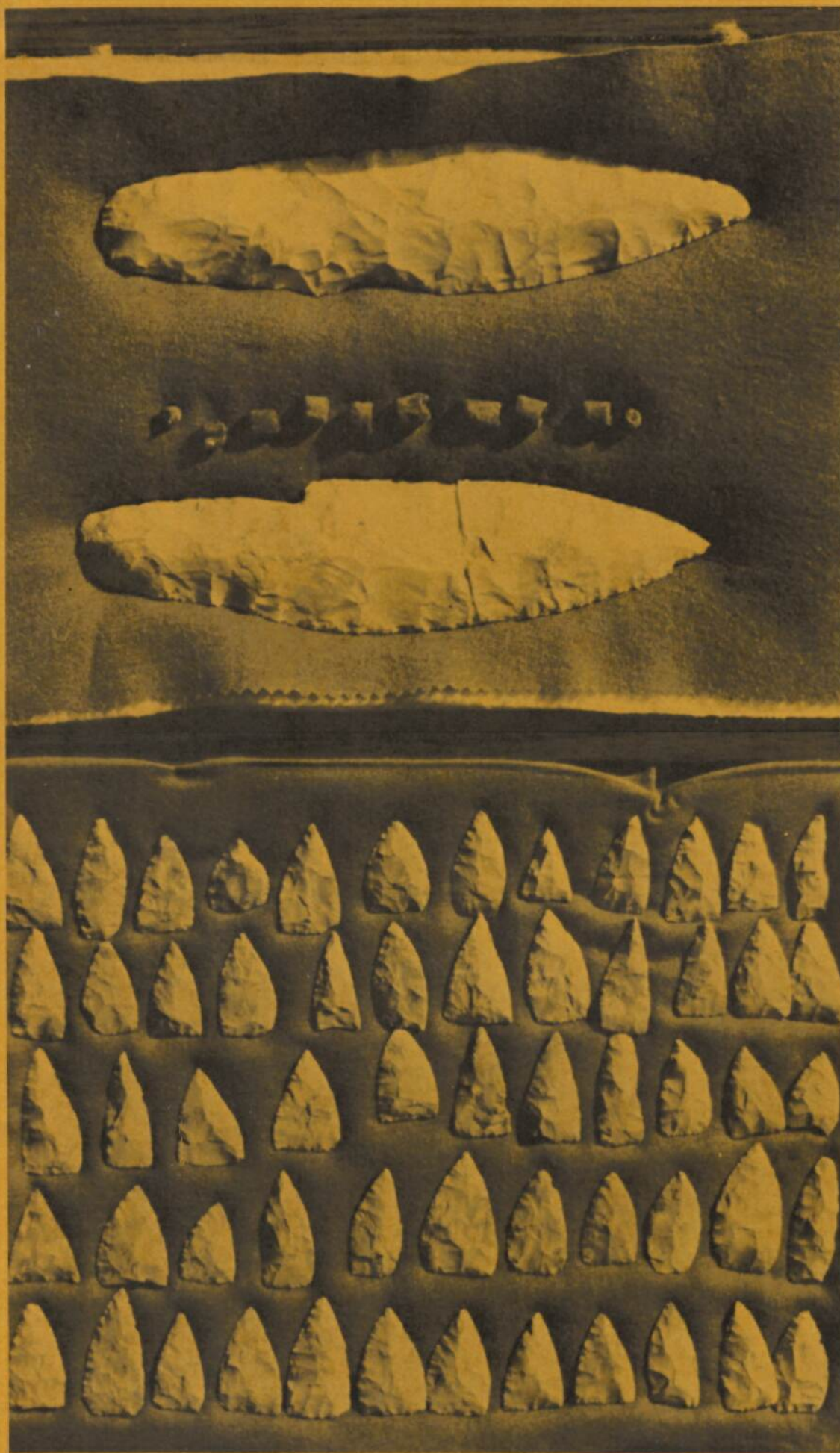




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# National Health Insurance and the People's Health

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Conceptions of "health" and "health care" serve to characterize a society and deeply affect the quality of urban life. Medical pathology with attending institutions and services constitutes the largest industry in the nation, except for defense. Public discussion, raised by anxieties over costs and qualities of services and nudged by a report just completed by a presidential commission, seems headed toward adoption of some form of national health insurance during the next years. The following "manifesto" by three noted observers fires a shot directly across the bow of that discussion.

One of the authors, Professor John McKnight, offers the following thoughts by way of introduction.

A hallmark of industrialized societies is the development of commercial insurance. The dictionary mistakenly suggests that we insure ourselves to 'protect against loss.' But consider the reality. Are we insuring our car against accidents, our house

against fire, our health against illness and our life against death? Of course not. No company is willing to insure that our car, house, health or life will not be destroyed. They merely guarantee to pay a fee if they are destroyed.

The folklore of insurance may lead some people to assume that paying a company monthly premiums somehow protects their car, home, health and life. Most of us know better. We know that as we drive our car, it is no safer because it is insured. We know that our house is just as likely to burn after we pay the fire insurance premium. We recognize that even though we paid our life insurance today, our death is just as imminent tomorrow. But do we believe that our health will be no better, or worse, if we have health insurance?

The Cresset offers this essay in the interest of creating a more healthy discussion.

—RHL

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THE SOURCES of human health are varied. They include at least four elements:

1. Self-activated behavior, e.g. breast-feeding rather than artificial feeding; walking rather than riding; not smoking; temperate use of food and drink.
2. Communal behavior, e.g. caring by family members, neighbors, and friends; promotion of feelings of belonging by voluntary associations.
3. Environmental factors, e.g. physical factors, including sanitation, air pollution, transportation, and lead poisoning; unemployment, economic depressions, and conditions of work.
4. Therapeutic information, tools, and skills, e.g. vaccines, aspirin, scalpels, antibiotics, and knowing how to use them.

The data show that in *both* developed and underdeveloped societies, the first three elements are by far the major health determinants. Medical techniques of therapy and prevention are much less important. Even immunizing agents in underdeveloped countries are of lower priority in eradicating disease than the provision of proper sanitation, nutrition, and housing.

Therefore, the critical health issue in any society is the development of cultural values, social relationships, and public policies that provide universal and personal access to all the sources of health listed above.

To achieve this goal, we must overcome the popular notion that health care can be "delivered." This concept defines health care as a "commodity" and requires a class of

professionals to dispense "it." Once a professional or his "allied health workers" are defined as the principal source of health, then the therapeutic health sources become dominant, although they are the least important. The other three sources of health become subordinated or totally neglected in the allocation of resources relevant to health. The institutional arrangements that derive from this inversion of priorities limits the opportunity of all to equal and individual access to and use of these resources. Thus, this inverted arrangement, called the "health delivery system," is basically health-denying and reactionary.

As a result, the current national debate on various systems of channeling the national wealth into "the delivery system" offers only a choice between essentially conservative health-denying approaches. Regardless of the particular scheme advocated, those with a vested interest in "health delivery" win. Physicians and their allied institutions (hospitals, the drug industry, insurance companies), having narrowed the definition of health sources to the services they control and provide, now stand to maximize that control by taxing every American.

The people lose several ways.

First, these schemes preclude a rational decision on the proper allocation of resources designed to promote a healthful society. They assume that "health" is in a doctor's office or a hospital ward, and deprive us of the basic right to decide how resources should be used to deal with the critical social and economic determinants of health.

Second, the universal health system tax acts as an astigmatic lens

that magnifies the importance of professionally-controlled sources of health while denying the personal vision of self activated and communal determinants of health. Why should we care for ourselves and others if our care by professionals is insured?

Third, all these health plans concentrate the control of therapeutic resources in the hands of professionals and their para-professional hand-maidens. There are some non-industrialized nations developing approaches that provide people health information, tools, and skills for their personal utilization in an attempt to prevent them from having to become patients. At the same time, the United States seems intent on pursuing policies that will *insure* (pun intended) every citizen being designated a patient and the entire nation a hospital.

The instrument for achieving this result is a universal "health" tax designed to provide a guaranteed annual income to the members of the health delivery team:

This massive concentration of power and money in the therapeutic industry will have predictable effects. Institutional growth will be stimulated, while obscured by the rhetorical veil of "paraprofessionalism," by placing more manpower and capital in the hands of the health industry. Like every other industry, the growth will be rationalized as an effort to provide more of a "good thing." As the Council of Economic Advisors said in last year's report to the President, "if it is agreed that economic output is a good thing, it follows by definition that there is not enough of it."

The critical question for the American people is to analyze the



## THE CASE OF TENNESSEE WILLIAMS


"good thing." The GNP is made up of positive benefits and negative costs. The same is true of the products of the health industry. Every drug has its dangers. Every routine annual examination has its risks. At some point, the negative costs begin to overbalance the positive benefits. Thus, we may be moving toward the time when physicians disable more patients than they cure. Even now, there is considerable evidence that medical services do not effect total mortality rates, but simply shift the segment of the population that will survive. Therefore, we must develop a new accounting system for the health industry (as well as for the GNP) that will provide a monitoring function to make sure that increasing investment of resources does not result in increasing danger to the people's health. In the absence of a cost-benefit analysis of the health industry, it would be folly to pour more money into the present system.

A second negative cost that will be intensified by national health insurance is the so-called preventive health care services. What is the real value of the monthly pre-natal doctor visits, the regular well-infant examinations, the multiple school examinations, the camp examinations for adolescents, the annual executive checkup, and the prepaid medical schemes that purport to provide early diagnosis and preventive maintenance care? Evidence continues to mount regarding the uselessness of these procedures. Historically, these practices came into vogue during the Great Depression when physicians' incomes were not what they are today, thus creating new markets for their products. Given substantial new capital, we can expect sky-rocketing growth

in the negative cost of this national placebo.

Finally, we can expect the health industry to direct an ever-increasing percentage of its newly acquired health taxes toward terminal life-extension technologies. Like any other growth industry, the health system will direct its products where the demand seems unlimited—protection from death. Serving the death-denial market will require a complex industrial, research, and professional support system. Increasing percentages of the health dollar will promote public-relations-oriented research extravaganzas designed to create "breakthroughs" that appear to delay death by a few weeks or months.

In summary, we predict that national health insurance will stimulate the delivery of disabling medical services, intensify reliance on useless preventive measures, and radically exaggerate the death-denying tendencies of the existing system. While these negative costs mount, we will be ignoring the positive health benefits available from the basic sources of health previously described.

It is predictable that the escalating costs of national health insurance will quickly and surely educate the American people to the fact that they have struck a bad bargain. The health return on their investment will be no better than the educational returns from the escalating investment in the school system. They will soon recognize that health cannot be insured by providing a guaranteed annual income to the medical system. Just as the public is now legitimately rebelling against schools, they are destined to revolt against a tax-supported medical system that applies the ancient practice of blood-letting to our body politic. 

When Solon, moralist, law-giver, and rationalist, rebuked Thespis for being successful with his stories in dialogue, he supposedly said: "Are you not ashamed to tell so many lies?" Ever since playwrights have made us cry and laugh about the lies they told us. And lies—the escape of a human being from reality into a world of his own imagination—has been the major subject-matter of Tennessee Williams' work. (He said in a recent article in the *Sunday New York Times*: "... the most important theme that I have essayed in my writing for the theatre: the mendacity that underlies the thinking and feeling of our affluent society.") He likes to follow his characters on the narrow road between reality and illusion; he loves to see them stumble into the blue mist of uncertainties where life plays football with their fates. Williams is attracted and repulsed by the cruel ambiguities that wait for his heroes and heroines around the next corner.

He is a compulsive confessor, not only in his plays, but also when he feels like apologizing for them in the *New York Times*. He has written many plays, perhaps too many, but some of them have been very good and of lasting value—if we can still believe in posterity in this period of the graffiti. In 1945 Laurette Taylor helped Tennessee Williams to become America's great new hope with *The Glass Menagerie*. Did he fulfill the promise we wrested from him in our impatient naivete to have