REPORT OF A SPECIAL COMMITTEE ON THE PROVISION OF HEALTH SERVICES

AMERICAN HOSPITAL ASSOCIATION

AMERIPLAN

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

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

AMERICAN HOSPITAL ASSOCIATION
RESOURCE CENTER
840 North Lake Shore Drive
Chicago, Illinois 60611

AMERIPLAN

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

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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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CONTENTS

Letter of Transmittal from the Chairman

Special Committee on the Provision of Health Services

Part I — AMERIPLAN: Its Goals and Programs
- Goals ... 4
- The Health Care Corporation ... 6
- AMERIPLAN Health Benefits ... 8
- The Concept of AMERIPLAN ... 10

Part II — The Health Care Corporation
- Objectives and Operations ... 15
  - Organizational Structure ... 16
  - Internal Operations ... 17
  - Responsibility for Quality ... 18
  - Conduct of Management Research ... 19
  - Fiscal and Statistical Responsibilities ... 19
- Responsibilities to State Health Commission
  - Geographic Assignment ... 19
  - Registration of Individuals ... 20
- Responsibilities to the Public
  - Services to Registrants ... 21
  - Services for Other Persons ... 22
  - Educational Programs ... 22
  - Provision for Community Evaluation ... 23
- Responsibilities for Health Manpower
  - Relationships with Physicians ... 23
  - Licensure of Personnel ... 24
  - Education and Training of Personnel ... 25
  - Utilization of Personnel ... 26

Part III — The Role of Government
- The Federal Level
  - Federal Legislation ... 32
  - The National Health Commission ... 32
- The State Level
  - State Legislation ... 33
  - The State Health Commission ... 34
  - The State Bureau of Health Financing ... 36

Part IV Financing AMERIPLAN
AMERIPLAN Health Care Benefits 40
Health Maintenance and Catastrophic Illness Benefits Package 40
Standard Benefits Package 41
Supplemental Benefits 43
Source of Funds 43
Payment for Health Services 45

Part V The Transition to AMERIPLAN
Required Legislation 50
Prior to Legislation 51
Ambulatory Care Centers 52
Involvement of Physicians 53
The Challenge 53

About the Special Committee on the Provision of Health Services 55

Glossary of Terms 59

Selected Bibliography 63

Phrasefinder 69

PART I

AMERIPLAN: ITS GOALS AND PROGRAMS

I

AMERIPLAN: ITS GOALS AND PROGRAMS

1-001 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.

1-002 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:

1-003 **Health care is an inherent legal right of each individual and of all the people of the United States.**

1-004 From this principle four corollaries follow:

1-005 (1) it is a function of health care to enhance the dignity of the individual and to promote better community life for all;

1-006 (2) it is a function of government to assure the preservation and maintenance of the health of all the people;

1-007 (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;

1-008 (4) health services must be so organized and located that they are readily accessible to all.

1-009 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

1-010 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.

1-017 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.

1-018 The system must be provided financial incentives for keeping people well and, if they are ill, for making them well as soon as possible.

1-019 8. The system must support only those providers that meet standards of effectiveness, quality, and efficiency.

1-020 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.

1-021 9. The system for the delivery of health services must include the private as well as the public sector of the health field.

1-022 The predominant concern and mission of all health care institutions must be the public interest even though their ownership may be private.

1-023 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.

1-024 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.

1-025 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.

1-026 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.

1-027 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.

1-028 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.

1-029 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.

1-030 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

1-031 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.

1-032 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.

1-033 Health Care Corporations would have the following characteristics:

1-034 (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.

1-035 (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.

1-036 (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.

1-037 Various forms of medical practice, including group practice, would be permitted within the Health Care Corporation.

1-038 (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 continuing basis. Such evaluation of quality would be an integral part of AMERIPLAN and a basic responsibility of the Health Care Corporation.

1-039 (5) The Health Care Corporation would identify its manpower needs, and be responsible for the inservice education and training of its health manpower and the recruitment 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 assure that needs would be met without unnecessary construction 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 support 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 exception. Therefore levers must be supplied to motivate change.

1-043 The lever to motivate change by those using the system and those financing the system would be the better quality and greater accessibility of health care, and the new health maintenance benefits that would be created at reasonable cost by establishing Health Care Corporations. 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-

nancing. 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.

1-045 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.

1-046 (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.

1-047 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.

1-048 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.

1-049 (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.

1-050 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.

1-051 (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

1-052 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.

1-053 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.

1-054 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.

1-055 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.

1-056 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.

1-057 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.

1-058 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

2-001 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.

2-002 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.

2-003 The concept of Health Care Corporations has been designed to implement the goals enumerated in Part I. Therefore:

2-004 (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.

2-005 (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.

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.

2-013 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.

2-014 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.

2-015 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.

2-016 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

2-017 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.

2-018 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

2-024 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

2-025 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.

2-026 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.

02-027 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

2-028 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

2-029 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.

2-030 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.

2-031 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.

2-032 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.

2-033 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;

2-043 (9) a setting conducive to personal identification and satisfaction with the Health Care Corporation;

2-044 (10) identical range of services, of a uniform quality, for all;

2-045 (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

2-046 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.

2-047 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.

2-048 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

2-049 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.

2-050 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.

2-051 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

2-052 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.

2-053 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

2-054 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.

2-055 The physician would be an integral part of the Health Care Corporation. Therefore, the Health Care Corporation must:

2-056 (1) implement the principle that all medical judgments related to health care must be made by or under the supervision of physicians;

2-057 (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;

2-058 (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;

2-059 (4) bring the physician into the management structure and involve him in its decision-making processes;

2-060 (5) develop effective means for measuring the quality, utilization, and economic delivery of each of the five components of comprehensive health care;

2-061 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

2-062 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.

2-063 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.

2-064 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

2-065 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.

2-066 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.

2-067 The Health Care Corporation would rely on the accreditation or certification of educational programs for allied health personnel to verify basic educational requirements.

2-068 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.

2-069 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.

2-070 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.

2-071 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.

2-072 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

2-073 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.

2-074 The functions of health care personnel who assist physicians must be established in accordance with their competence and in accordance

with the principle that all medical judgments related to health care must be made by or under the supervision of physicians. The organization and operation of the Health Care Corporation as well as payment 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.

The Federal Level

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;

3-013 (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;

3-014 (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;

3-015 (6) maintain liaison with all federal agencies concerned with health-related programs;

3-016 (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;

3-017 (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

3-018 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.

3-019 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

replace existing Corporations which fail to perform adequately;

3-028 (4) join cooperatively with the Commissions of neighboring states in approving the establishment of Health Care Corporations that span state boundaries;

3-029 (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;

3-030 (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;

3-031 (7) assure that essential planning functions would be carried out to coordinate activities among Health Care Corporations;

3-032 (8) issue certificates of need for the facilities and services of Health Care Corporations;

3-033 (9) function as the administrative agency for government aid and loan programs under AMERIPLAN, as for example, the Hill-Burton program;

3-034 (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;

3-035 (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;

3-036 (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

3-037 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.

3-038 This Bureau would:

3-039 (1) regulate the premium structures of prepayment plans and health insurance companies;

3-040 (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;

3-041 (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;

3-042 (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.

3-043 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;

4-008 (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

4-009 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.

4-010 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.

4-011 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.

4-012 (1) Health Maintenance Benefits:

4-013 (a) immunizations

4-014 (b) well-baby care

4-015 (c) for children, dental services–prophylactic and therapeutic

4-016 (d) multiphasic screening, to include annual history, complete blood count, serology, urinalysis, appropriate chemistries, chest x-ray

4-017 (e) for appropriate age and sex groups, electrocardiograms, pap smears, and rectal examinations

4-018 (f) for patients with positive findings, a physical examination.

4-019 (2) Catastrophic Illness Benefits:

4-020 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.

4-021 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.

4-022 Care in long-term institutions for tuberculosis, mental illness, and for the mentally retarded would be totally excluded.

4-023 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.

4-024 (1) Ambulatory Services: Diagnostic and treatment services provided in physicians' offices, ambulatory care centers, and emergency and outpatient departments of health care institutions.

4-025 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.

4-026 (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.

4-032 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.

4-033 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

4-034 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:

4-035 (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;

4-036 (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 For Health Services

4-045 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.

4-046 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.

4-047 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.

4-048 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.

4-049 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.

V
THE TRANSITION TO AMERIPLAN

5-001 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.

5-002 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.

5-003 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.

5-004 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.

5-005 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

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

5-013 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.

5-014 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.

5-015 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.

5-016 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

5-021 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.

5-022 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

5-023 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.

5-024 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

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?

(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?

(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 reponsibilities 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 with 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 noncurable 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.

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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The Phrasefinder was computer produced by Aspen Systems Corporation.

access to care. **2-001**
access to care. All persons would h **1-035**
access to the Health Care Corporatio **2-036**
accessibility of health care, and th **1-043**
accessible to all. **1-008**
accessible, and how the delivery of **1-041**
accessible, and how the delivery of **2-052**
accident would become operative depe . . . **1-047**
accident. **1-013**
accident. The total benefit package **1-045**
accident. These benefits would be p **1-046**
accident, provided in the Health Mai **1-051**
accommodations for primary and speci . . . **4-027**
accomplished by the cooperative comm . . . **2-054**
accomplishments of which we may be j . . . **1-001**
Accordingly, for those persons there **1-051**
Accordingly, the poor would receive **1-047**
accountability to the registrants by **2-018**
accreditation or certification of ed **2-067**
accreditation or certification progr **3-014**
accreditation processes; **3-030**
achieving more effective allocation **4-002**
acquisition of good health care. **4-001**
acting only in a supervisory capacit **5-019**
active organization and management o . . . **5-021**
active responsibility for the preven **2-020**
actively encouraging the responsible **2-051**
actively respond. All persons in th **1-041**
activities among Health Care Corpora **3-031**
actuarially determine the revenue re **3-011**
acute hospital care, and would empha **1-049**
acute inpatient care, extended care, ... **2-040**
acute mental illness. **1-024**
acute sociological and environmental **1-027**
acute. **1-017**
acute. **2-005**
addiction. **4-027**
addition to its responsibilities for **2-047**
addition to those days of care provi **4-032**
addressed and solved directly affect **1-027**
adds to the cost and amount of neces **1-027**
adequacy and availability of these s **2-061**
adequacy and quality of health care **2-018**
adequacy and quality of their servic **3-022**
adequacy of care and to assist provi **2-014**
adequacy of care by providing the fi **2-004**
adequacy of service contracted for i **2-048**
adequacy of service established purs **3-030**
administer the trust fund for specif **3-012**
administered at the state level with **1-032**
administered by State Health Commiss . . . **2-002**
administration of services. **2-026**
administration of the system. Since **3-005**
Administration, it would be possible **5-014**
administrative agency for government **3-033**
administrative personnel. **2-022**
administrative research to increase **4-050**
administrators. The supply and dist **2-070**
administrators, and to provide excel **1-001**
administrators, must have a major ro **5-021**
adopting regulations to create unifo **3-006**
advance the development of AMERIPLAN **2-002**
advancing the development of AMERIPL . **3-001**
advisory capacity for legislative am **3-017**

affect the health of individuals mus 1-026
affected by AMERIPLAN must believe i . . 5-024
affiliated with a Health Care Corpor 1-036
affiliation agreements or consortia 5-016
against the cost of catastrophic ill 1-047
age and sex groups, electrocardiogra 4-017
age; 1-007
age, occupation, mobility, and size 2-061
aged and all others by a tax collect 1-046
aged and the Health Maintenance and . . . 4-036
aged. 4-040
aged; 4-042
aged, the Standard Benefits Package 1-050
agencies and distribute these funds 2-025
agencies and for providing adequate 2-051
agencies concerned with health-relat 3-015
agencies participating in AMERIPLAN. . . 2-015
agencies responsible for payment for 2-046
agencies with respect to their condu 3-014
agencies, in taking active responsib 2-020
agency composed of five to seven qua . . . 3-008
agency for government aid and loan p . . . 3-033
agency responsible for seeing that H 3-020
agency responsible for the continuin 3-008
agency through regulations for the s 3-001
agency. 3-037
agency, or its responsibilities coul 3-037
agency, receiving and disbursing mon 2-025
agreements or consortia of intereste 5-016
aid and loan programs under AMERIPLA . 3-033
aid the formation and initial operat 5-006
aides; necessary medical supplies; a 4-030
air pollution adds to the cost and a 1-027
alcoholism, and drug addiction. 4-027
alcoholism, drug abuse and acute men . . . 1-024
allied health personnel to verify ba 2-067
allied health professionals necessar 2-071
allied health professionals should b 5-019
alternative choice, the system must 1-023
alternative forms of medical practic 2-057
alternative solutions and to encoura 1-058
ambulatory and institutional care. 4-031
ambulatory care as well as the preve 4-010
ambulatory care center also should b 5-019
ambulatory care center. This develo 5-017
Ambulatory Care Centers 5-017
Ambulatory care centers should be de 5-018
ambulatory care centers, and emergen . . . 4-024
ambulatory care in centers and in ph . . . 2-040
ambulatory care. 5-004
ambulatory care. Also, the ambulato 4-031
ambulatory drug benefit may require . . . 4-031
ambulatory facilities and home care 2-006
ambulatory facilities, extended care 1-016
ambulatory services located convenie 2-037
ambulatory services. 1-049
ambulatory services; an expansion in 5-015
Ambulatory Services: Diagnostic and 4-024
ambulatory, diagnostic, and treatmen 2-037
amendment. 3-017
AMERIPLAN and a basic responsibility . . 1-038
AMERIPLAN 1-052
AMERIPLAN a convergence of resources . 5-015
AMERIPLAN and adopt regulations. The . 2-002
AMERIPLAN and contribute to its conc . . 1-057
AMERIPLAN and for some initial limit . . 5-023
AMERIPLAN and its emphasis on compre 5-004
AMERIPLAN and the need for regulator . 5-023
AMERIPLAN and to qualify its residen . . 3-018
AMERIPLAN and will speed the transit . . 5-024
AMERIPLAN appropriated from general . 4-008
AMERIPLAN benefit packages would mak 1-044
AMERIPLAN by capitation is to encour . . 4-047
AMERIPLAN by utilizing the resources . . 5-001
AMERIPLAN can be made today, by the . 5-017
AMERIPLAN cannot come into existence . 5-024
AMERIPLAN concept of comprehensive h 5-018
AMERIPLAN could develop rapidly -- w . 1-055
AMERIPLAN could hasten commitments b 1-056
AMERIPLAN financing as well as throu . . 4-050
AMERIPLAN has been formulated with p 1-029
AMERIPLAN Health Benefits 1-042
AMERIPLAN health care benefit packag . 4-010
AMERIPLAN Health Care Benefits 4-009
AMERIPLAN immediately upon the imple 5-012
AMERIPLAN in developing comprehensiv 3-017
AMERIPLAN in improving the delivery . . 3-008
AMERIPLAN incorporates methods of fi 1-030
AMERIPLAN incorporates within it all . . 5-002
AMERIPLAN is an organization called . . . 1-031
AMERIPLAN is that every person, if h . . 4-034
AMERIPLAN is that it provides a blue . . . 1-052
AMERIPLAN is the passage of the nece . . 5-006
AMERIPLAN legislation. By broadening . . 5-014
AMERIPLAN must be developed immediat 5-001
AMERIPLAN must be financed through m 4-002
AMERIPLAN must believe in its merits . . 5-024
AMERIPLAN must result in providing H . 4-049
AMERIPLAN or any new or significantl . . 5-001
AMERIPLAN permits access to all five . . 4-051
AMERIPLAN phases in, with Health Car . 2-063
AMERIPLAN progress, legislation shou . . 5-005
AMERIPLAN remain for delineation at . . 1-058
AMERIPLAN system for the delivery of . . 1-010
AMERIPLAN through legislation, would . . 3-001
AMERIPLAN to function. This incenti . . . 3-005
AMERIPLAN to make changes now, befor 1-052
AMERIPLAN to meet the varying needs . 5-007
AMERIPLAN to symbolize the uniting o . 1-009
AMERIPLAN would assure adequate and . 4-001
AMERIPLAN would assure that no indiv . 4-009
AMERIPLAN would be implemented upon 1-053
AMERIPLAN would be limited only to t . 4-049
AMERIPLAN would be that within reaso . 1-051
AMERIPLAN would be the individual re . 5-022
AMERIPLAN would be the involvement o 5-021
AMERIPLAN would emphasize health mai 4-010
AMERIPLAN would have the following c . 4-003
AMERIPLAN would provide the primary . 1-056
AMERIPLAN would speed several signif . 5-015
AMERIPLAN would utilize both federal . . 1-044
AMERIPLAN. 1-052
AMERIPLAN. 2-015
AMERIPLAN. 3-043
AMERIPLAN. 5-008
AMERIPLAN. 5-016
AMERIPLAN. Because of the constrain 1-057
AMERIPLAN. It would consist of bene 1-046

AMERIPLAN. The reorganization of ou . . 2-054
AMERIPLAN; 3-012
AMERIPLAN, as for example, the Hill- . . 3-033
AMERIPLAN, basic education for healt . . 2-065
AMERIPLAN, could relieve the physici . . 5-020
AMERIPLAN, due consideration has bee . 1-057
AMERIPLAN, for the first time in the . . . 1-045
AMERIPLAN, government would be a par 3-001
AMERIPLAN, legislation must be enact . . 2-002
AMERIPLAN, the organization responsi . . 2-001
AMERIPLAN, using the organizational . . . 5-003
AMERIPLAN, when interrelated and del . 1-045
AMERIPLAN, which is already developi . . 3-004
AMERIPLAN: 3-014
AMERIPLAN'S development throughout t 3-004
annual amount of health care expendi 4-020
annual budgets to the State Health C 4-047
annual capitation payments for each 4-046
annual dollar limit. Limitations on 4-031
annual family income level, size of 1-047
annual history, complete blood count 4-016
annual income level, size of family, ... 4-020
annual screening programs, but also 5-020
appeal for a change of Health Care C . . . 2-032
appeal for redress of complaints con 2-053
appeals and grievance mechanisms for . . . 2-016
appeals and review of disagreements 3-036
appeals mechanism established by the 2-032
apply to physicians, dentists, nurse 2-064
appointed by the governor to serve f 3-020
appointed by the President to serve 3-008
appropriated from general federal re 4-008
approval by the State Commission, th 2-030
approval of Health Care Corporations 5-012
approval of Health Care Corporations 5-007
approval of Health Care Corporations 5-012
approval of rates would act as a sig 4-047
approval of the State Health Commiss . . . 2-028
approval of these Corporations and t 1-054
approval, accreditation or certifica 3-014
approval, certification, and accredi 3-030
approved and functioning Health Care . . . 5-011
approved by the Social Security Admi 5-014
approved by the State Health Commiss . . . 4-045
approved by the State Health Commiss . . . 4-046
approved for operation and regulated 2-009
approved Health Care Corporations in . . . 3-006
approving the establishment of Healt 3-028
area and of all of the population, w 1-035
area and serve population groups bey 2-028
area following the open registration 2-031
area the Health Care Corporation wou . . . 2-029
area to be served by each Health Car 3-025
area would depend upon their capacit . . . 2-028
area. Quotas established by the Sta 2-030
area, and of all of the population, ... 2-001
areas and the total population. 5-011
areas for which it would have respon 3-036
areas in which health care instituti 5-013
areas lacking such Corporations, aut 3-027
areas of each state, the present sys 2-063
areas of the nation is the ambulator 5-017
areas requiring planning for additio 2-023
areas warrant, the State Health Comm . . . 3-021
assessing the need for and assuring 2-071
assessing the physician needs of the 2-070
assessment of the effectiveness of A 3-008
assign to each Health Care Corporati 2-029
assigned to it or who reside outside 2-030
Assignment 2-028
assignment and therefore co-exist in 2-028
assignment established by the State 2-028
assist physicians in the diagnosis a 2-073
assist physicians must be establishe 2-074
assist physicians. 2-074
assist providers in meeting the stan 2-014
assist states in developing legislat 3-016
assistance from tax resources, their 3-041
assistance in implementing AMERIPLAN . 5-008
assistance of the educational system 2-065
assistance of the health care system 2-065
assisted to do so; and institutions 1-020
assure accountability to the registr 2-018
assure adequate and coordinated fina 4-001
assure availability at the community 2-012
assuring the supply of allied health 2-071
attain. Others are more difficult, ... 1-010
attitudes of each group of providers 2-054
attract physicians to practice withi 2-057
auditing the quality of care and the 3-034
audits to measure the performance of 2-023
augment programs of all professional 2-071
authority for experimentation under 5-014
aware of the need for a period of tr 5-023
aware of the operational problem of 5-023

B

barriers and impediments, principall 3-007
barriers to acquisition of good heal 4-001
barriers to the establishment of cor 3-016
barriers to the formation of Health 3-019
barriers to the sharing of services 3-007
because most Health Care Corporation . . . 4-046
behalf of its registrants for partic 2-051
believe in its merits, must want it 5-024
benefit and financing program under 4-003
benefit may require an annual dollar 4-031
benefit packages and state the scope 3-006
benefit packages now provided throug . . . 5-005
benefit packages of AMERIPLAN, when . . 1-045
benefit packages would be expanded a . . . 4-009
benefit packages would make Medicare . . 1-044
benefit packages would provide incen 4-010
benefit packages, even initially, wo 4-009
benefit packages, the sources of fin 4-038
benefit requirements established pur 3-029
benefit structure would include cont 4-007
benefit structures could include hea 5-014
Benefits 1-042
Benefits -- The present coverage of 4-033
benefits after a state has enacted i 3-005
benefits and services and adequate f 3-004
benefits at least as extensive as th 4-023
benefits at least as extensive as th 4-011
benefits before the enactment of AME 5-014
benefits cannot be employed immediat 4-046

benefits each person would have to r 4-011
benefits for all. This financing pr 4-001
benefits for health maintenance and 1-046
benefits for protection against the 1-051
benefits for the near-poor; 4-039
benefits for the near-poor; 4-041
benefits for the Standard Benefits P 4-031
benefits from prepayment plans and p . . . 4-037
benefits have been exhausted. The t 4-020
benefits if they have the financial 4-033
benefits immediately after exhaustin 1-047
benefits immediately after exhaustin 4-020
benefits in the Health Maintenance a 4-032
benefits in the Health Maintenance a 4-045
Benefits in this category would gene 4-025
benefits never before available to a 1-045
benefits of alternative choice, the 1-023
benefits of the Standard Benefits Pa 4-020
benefits of the Standard Benefits Pa 1-047
benefits of the Standard Benefits Pa 4-020
benefits offered by prepayment plans 5-014
Benefits Package 4-039
Benefits Package 4-041
Benefits Package – To be eligible f 4-011
Benefits Package – To be eligible f 4-023
Benefits Package and any supplementa . . . 4-020
Benefits Package and has registered 1-048
Benefits Package and other supplemen . . . 4-037
Benefits Package and the benefits fo 1-051
Benefits Package and the catastrophi 4-033
Benefits Package are included as sug 4-031
Benefits Package are included as sug 4-032
Benefits Package for all except the 4-036
Benefits Package for the aged and th 4-036
Benefits Package from prepayment pla . . . 1-050
Benefits Package under AMERIPLAN, co . 5-020
Benefits Package would be paid for b 1-050
Benefits Package would be paid for i 1-050
Benefits Package would be paid for o 4-045
Benefits Package. 4-011
Benefits Package. Various packages 1-051
Benefits Package, and would continue . . . 4-033
Benefits Package, and 90 additional 4-032
Benefits Package, each person must b 4-023
Benefits Package, to which all perso 1-048
Benefits Package, whereas persons wi 4-020
Benefits Package, whereas persons wi 1-047
Benefits Package: All persons would 1-049
Benefits Package: This package woul 1-046
benefits proposed for AMERIPLAN, for . . 1-045
benefits provided in the Standard Be 4-033
benefits provided under the Standard 1-051
benefits that are tax-supported; 3-011
benefits that would be created at re 1-043
benefits to be provided all the peop 1-053
benefits to be provided for all of t 1-032
benefits to be provided under AMERIP . . 2-002
benefits to fill the gap between the 4-033
benefits to fill this gap would be a 1-051
Benefits to protect against the cost 1-047
benefits to protect every person in 1-046
benefits under AMERIPLAN by capitati . . 4-047
benefits will expand as Health Care 5-001
benefits would be financed in part t 4-036
benefits would be financed through g 4-036
benefits would be paid for by the fe 1-046
benefits would be purchased through 4-006
benefits would consist of four compo 1-049
benefits would have no limit for med 4-021
benefits would remove many of the im . . . 4-002
benefits. 1-047
benefits. However, the public must a 5-023
benefits; 4-005
benefits, each state would enact leg 3-018
benefits, in order that demand will 5-023
Benefits: 4-012
Benefits: 4-019
Benefits: One of the basic precepts 1-051
blood after three pints: 4-026
blood count, serology, urinalysis, a 4-016
boards. The Health Care Corporation 2-064
bonus, or combinations of these. Pa 4-048
boundaries and could be temporary or . . . 2-013
boundaries where necessary to assure 1-035
boundaries where necessary to assure 2-001
boundaries; 3-028
broaden health care benefit packages 5-005
budget forecasting required, prospec 4-047
budget, planning, utilization and pa 2-022
budgets to the State Health Commissi 4-047
Bureau could be a new agency, or its 3-037
Bureau would: 3-038
Bureaus of Health Care Financing des . . . 5-010

C

capital funds for health care facili 4-049
capitation basis. All other health s 4-045
capitation is to encourage the devel 4-047
capitation method of payment. 4-046
capitation payment methods and to mo . . . 5-014
capitation payment. 4-047
capitation payment. Initially, the H 4-047
capitation payments for all benefits 4-046
capitation payments for each Health 4-046
capitation. 5-015
capitation. While all of these deve 5-005
capitation, salary, salary plus bonu 4-048
catalyst for advancing the developme 3-001
catastrophic illness benefits after 3-005
catastrophic illness benefits each p 4-011
catastrophic illness benefits if the 4-033
catastrophic illness benefits in the 4-032
Catastrophic Illness Benefits Packag 4-039
Catastrophic Illness Benefits Packag 4-011
Catastrophic Illness Benefits Packag 4-032
Catastrophic Illness Benefits Packag 4-036
Catastrophic Illness Benefits Packag 5-020
Catastrophic Illness Benefits Packag 4-045
Catastrophic Illness Benefits Packag 1-051
Catastrophic Illness Benefits Packag 4-023
Catastrophic Illness Benefits Packag 1-048
Catastrophic Illness Benefits Packag 1-046
Catastrophic Illness Benefits: 4-019
catastrophic illness or accident wou 1-047
catastrophic illness or accident. T 1-046
catastrophic illness or accident, pr 1-051

category would generally include the 4-025
center for the state; establish requ 3-035
center. Nurses and allied health pr 5-019
centers and in physicians' offices, ... 2-040
centers are welcomed by the general 5-017
centers for the primary care compone 5-018
centers should extend hospital suppo 5-018
certificates of need for the facilit 3-032
certification of educational program 2-067
certification of need for health car 5-015
certification programs for AMERIPLAN . . 3-014
certification, and accreditation pro 3-030
certified by specialty boards. The 2-064
characteristic of AMERIPLAN is that 1-052
characteristics: 1-033
charged for their services. 3-022
charges and professional fees. Becau 4-047
chemistries, chest x-ray 4-016
chest x-ray 4-016
child suffers from untreated illness 1-014
children are provided with preventiv 1-014
children, dental services -- prophyl 4-015
choices made of where scarce fiscal, ... 1-029
circumstances to provide the care ec 4-045
citizens -- accomplishments of which 1-001
city limits or across state lines. 2-028
city or area and serve population gr 2-028
clinics should be physically located 5-019
clinics, and mental health clinics s 5-019
collected through federal government 4-008
collected through the Social Securit 4-040
collected through the Social Securit 4-042
collected through the Social Securit 4-036
collected through the Social Securit 1-046
collected through the Social Securit 1-050
collection of data on fiscal operati 3-035
colleges. 2-068
color, sex or age; 1-007
combination of federal financing, pr 4-001
come into existence solely through l 5-024
Commission could delegate to each St . . . 3-013
Commission would be a newly-constitu . . . 3-018
Commission would be responsible for 3-006
Commission would be supported by a q . . 3-008
Commission would be the nation's pri 3-008
commission, not part of any existing 3-018
Commission, the Corporation would be . . . 2-030
commissioners appointed by the gover . . . 3-020
commissioners appointed by the Presi 3-008
Commissions and delegate to them cer . . . 3-021
Commissions of neighboring states in 3-028
committees currently studying the ro 1-057
committees for budget, planning, uti 2-022
communities and some states are pres 5-003
communities that have moved together . . . 5-013
community acceptance of the scope an . . . 2-053
community and the adaptation of serv . . . 2-049
community as cooperative ventures by . . . 5-018
community by physicians. Every prac 1-036
community could express its health n 1-041
Community Evaluation 2-052
community health, such as public and 2-020
community level for improving the qu . . . 2-004
community level for the delivery of 2-001
community level of the five componen . . . 2-012
community life for all; 1-005
community must be sought out and tre . . . 1-011
community need, resources and preced . . . 2-009
community needs for health manpower. . . 2-071
community or area following the open . . . 2-031
community would be able to express i . . . 2-052
community would have a role in ident . . . 1-041
community. 2-011
community. 4-051
community. These centers should ext 5-018
community. They should functionally 5-018
Community-based health services such . . . 5-019
community-wide educational activitie 2-051
community, or he could register with 2-031
community: health maintenance, prim . . . 1-034
community's concern in the resolutio 2-018
companies for the purchase of health 3-013
companies for those for whom the gov . . . 4-043
companies operating within the state 3-029
companies would be used to establish 4-001
companies would be utilized. The br 1-044
companies. 3-039
companies. 4-037
companies. Its benefits would consi 1-049
companies; 4-006
compensated by various methods of pa . . . 4-048
compensation of physicians must be i 4-049
compensation, alternative forms of m 2-057
competence and in accordance with th . . . 2-074
competence as measured by peer revie . . . 2-058
competence of all their employees. 2-063
competence of health care personnel 2-062
competency of all their health care 2-064
competency of these groups would be 2-064
competent physicians and hospital ad 1-001
complaints concerning health service 2-053
comply with the regulations for qual 3-030
comply with the standards of profess 2-015
comply with these regulations. Stat 3-030
components of care -- primary, speci 1-049
components of care and that financin 4-051
components of care to each individua 1-015
components of care would provide all 1-049
components of care. AMERIPLAN would . 4-010
components of care, or transfer betw 2-045
components of comprehensive care in 4-051
components of comprehensive care, in . . . 5-016
components of comprehensive health c . . . 1-034
components of comprehensive health c . . . 4-009
components of comprehensive health c . . . 2-060
components of comprehensive health c . . . 2-004
components of education and of servi 2-072
components of health care to its reg 2-012
components of health care. 2-070
components of the Corporation, and b . . . 2-023
components. Irrespective of ownershi 2-012
comprehensive care in order to raise 4-051
comprehensive care. 2-069
comprehensive care; the certificatio 5-015
comprehensive care, in short, progre 5-016
comprehensive health care and partic 5-004
comprehensive health care as a prima 5-013
comprehensive health care for all. 4-009

Comprehensive health care must be de 1-015
comprehensive health care to a defin 1-031
comprehensive health care to the com . . . 1-034
comprehensive health care within lim 4-009
comprehensive health care. 5-018
comprehensive health care. Health C 2-001
comprehensive health care. It must 1-015
comprehensive health care. The neces 4-049
comprehensive health care; 2-060
comprehensive health care; would aut 3-022
comprehensive health care, report to 3-017
comprehensive health care: health m 2-004
comprehensive health needs of every 1-035
comprehensive health services seems, ... 4-046
comprehensive health services. 4-002
comprehensive quality care to the pe 2-009
comprehensive system for the deliver 1-031
comprehensiveness of health services 1-032
comprehensiveness of health services 1-053
comprehensiveness of health services 3-006
comprehensiveness of health services 3-001
comprehensiveness of health services 2-002
computer storage throughout the syst 5-020
conformed to the regulations of the 3-020
Congress on the phasing-in process, ... 3-017
consideration among other factors, t 2-061
consist of a multiplicity of organiz 1-023
consist of benefits for health maint 1-046
consortia of interested institutions 5-016
consortium, representing a cross-sec 2-011
constitute our present health care s 5-001
constitute the purpose of the system 5-022
constraints of time, details of thei 1-057
continual availability of physician 2-039
continue to be financed from other s 4-032
contract – physicians, dentists, ot 2-019
contract only with providers that me 2-015
contract with Health Care Corporatio 4-049
contract with other health care prov 2-013
contract with prepayment plans and h . . . 3-013
contracted for in behalf of the Corp 2-048
contracts with providers would take, ... 2-021
contributes. In order to achieve an 4-034
contributions of state funds would n 3-005
contributions to defray the cost of 4-039
contributions to defray the cost of 4-041
contributions toward financing the c 4-035
control agency through regulations f 3-001
control mechanisms to regulate the u 4-007
control of the environment, or which 3-002
control over the development of pers 2-063
controlling operations while allowin 5-003
controls would be established by leg 1-040
Cooperation is vital to the successf 5-024
Cooperative arrangements among insti . . . 5-016
cooperative commitment of all provid 2-054
cooperative ventures by hospitals, t 5-018
coordinating role in making certain 4-044
coordination. 5-003
copayment percentage than ambulatory . . 4-031
copayment, as well as initial limita 5-023
Copayment, for example, of 10 to 20 4-031
copayments and limits on specified s 4-007
corporate organization. It could be 2-009
corporate organizations and the shar 3-016
corporate organizations; another wou 3-007
corporate responsibility to provide 1-056
corporate structure with the capacit 1-034
cost among all persons, the followin 4-034
cost and amount of necessary health 1-027
cost by establishing Health Care Cor 1-043
cost of a day in a hospital. 4-028
cost of a day in a hospital. 4-029
cost of a day in a nursing home to t 4-029
cost of a day in an extended care fa 4-028
cost of benefits for the near-poor; 4-039
cost of benefits for the near-poor; 4-041
cost of catastrophic illness or acci 1-047
cost of catastrophic illness or acci 1-051
cost of health care among all person 4-001
cost of health care services. It wo 2-026
cost of illness for all income group 4-001
cost of institutional care may requi 4-031
cost of the education and training o 2-072
cost of these services through the a 2-046
cost this nation could afford. 1-045
cost. 1-028
cost, and in a manner in keeping wit 1-002
cost, and quality. Each Health Care 2-024
cost, can only be incorporated into 3-002
costs by creating upward mobility fo 2-063
costs of catastrophic illness or acc 1-046
costs will not be a financial burden 4-050
costs. 4-033
cottage industry to a modern, coordi 1-031
counseling for the individual and hi 2-042
counseling, the public's failure to 2-049
course of AMERIPLAN. 1-052
cover all the people. 1-055
cover the comprehensive health needs . . . 1-035
cover the health needs in every geog 2-001
coverage all geographic areas and th 5-011
coverage for the near-poor; 4-035
coverage of many persons provided by . . . 4-033
covered by benefits at least as exte 4-023
covered by benefits at least as exte 4-011
covered by this package, offered by 1-049
covering all geographic areas of eac 2-063
created at reasonable cost by establ 1-043
created under AMERIPLAN; 3-012
credentials and performance; 2-058
credit for unused hospital days base 4-028
credit for unused hospital days base 4-029
creed, color, sex or age; 1-007
cultural patterns in the community a 2-049
custodial care and institutional car 1-025
custodial care could be limited to 3 4-032
custodial care days would be limited 4-021
custodial care would be provided wit 2-008
custodial care. 1-034
custodial care. 2-004
custodial care. Comprehensive healt 1-015
custodial care. These four componen 1-049
custodial care; 2-040
custodial care, would continue to be 4-032

D

data base, not only for annual scree 5-020
data of Health Care Corporations; 3-035
data on fiscal operations of health 3-035
data pertaining to the effective adm 2-026
data-gathering and reporting center 3-035
data, including statistics on the ut 2-026
day in a hospital. 4-028
day in a hospital. 4-029
day in a nursing home to the cost of 4-029
day in an extended care facility to 4-028
days based on a ratio relating the c 4-029
days based on a ratio relating the c 4-028
days could be required, for example, ... 4-031
days for care in an extended care fa 4-031
days for hospital care, 30 days for 4-031
days in a nursing home. Because of 4-032
days in a nursing home, and 100 home ... 4-031
days in an extended care facility in 4-032
days of care provided in the Standar 4-032
days per year in semi-private accomm 4-027
days per year which could be increas 4-028
days per year which could be increas 4-029
days per year. 4-031
days would be limited in an extended 4-021
decade of the 70's -- and should wit 1-055
decide how the services of the Corpo 2-021
deciding how institutional services 5-021
decision-making processes; 2-059
define the population group to be se 3-026
demonstrate its potential to provide 2-029
demonstrate that he has purchased or 1-048
demonstrate that many communities an ... 5-003
dental services -- prophylactic and 4-015
dental surgeons, and podiatrists; re 4-026
dentists, nurses, and pharmacists. 2-064
dentists, nurses, and pharmacists, w 2-064
dentists, other health professionals 2-019
department, responsible for implemen 3-018
dependent or suffering loss of digni 1-045
dependent or suffers loss of dignity 1-013
deposited in a separate and specific 4-008
detail the participation of one grou 1-057
detailed information concerning the 2-031
details of AMERIPLAN remain for deli .. 1-058
details of their participation are o 1-057
details on the government's role as 3-043
determination by the Health Care Cor ... 2-017
determination of the needs of its re 2-027
determine in accordance with federal 3-041
diagnosed by physicians as non-curab 2-008
diagnosis and treatment of illness m 2-073
diagnosis, level of care, and facili 4-026
Diagnostic and treatment services pr 4-024
diagnostic, and treatment services, ... 2-037
differentiated. Government must assu 2-072
differing patterns in the use of eac 2-061
differing rural, urban and suburban 2-061
differs significantly from many curr 1-030
difficult, calling for long-range pl 1-010
difficulties and because most Health 4-046
dignity as a result of illness or ac 1-013
dignity as a result of illness or ac 1-045
directly affecting life and health w 3-002
disagreements in those areas for whi 3-036
disburse funds to prepayment plans a 3-042
disbursing money for the payment of 2-025
discharge that responsibility. 2-062
distribute these funds among its pro 2-025
distribution of physicians must be c 2-070
dollar limit. Limitations on instit 4-031
done because we accept one basic, ir 1-002
done much in the United States to cr 1-001
drug abuse and acute mental illness. 1-024
drug abuse and air pollution adds to 1-027
drug addiction. 4-027
drug benefit may require an annual d 4-031
drugs as listed in a national formul 4-025
due consideration has been given to 1-057
due process. 3-036
duplication of facilities and servic 1-040

E

easy to attain. Others are more dif 1-010
economic delivery of each of the fiv 2-060
economic manner must be continued an .. 1-020
economical use of all five component 4-051
economical use of all resources. En 1-040
economically and how evaluation shou ... 5-021
economically responsible for the hea 4-046
economically, make the most effectiv 4-045
economies of scale; the accelerated 5-015
educate and train competent physicia 1-001
education and national licensure for 2-064
education and of service in the Heal 2-072
education and training of health man 2-069
education and training of health man 2-072
education and training of health man 2-072
education and training of its health 1-039
Education and Training of Personnel 2-065
education for health personnel shoul 2-065
education in its provider institutio 2-050
education of adequate numbers of hea ... 4-050
education of health care personnel a 2-072
education of health care personnel, ... 2-066
education of health personnel by uni 2-068
education of health professionals. 2-023
education of the public. The compon 2-072
education would be necessary to emph ... 2-049
education, and the provision of serv 5-016
educational activities sponsored by 2-051
educational and social organizations 2-011
educational and training programs au 2-071
educational costs by creating upward 2-063
educational opportunities, all desig 2-057
educational program. 2-050
Educational Programs 2-049
educational programs and counseling, ... 2-049
educational programs for allied heal 2-067
educational programs would be consis 2-050
educational requirements. 2-067
educational standards for profession 2-066
educational system with the assistan 2-065
educational system would be responsi 2-066
educational system. 2-065

efficient use of resources in the de 4-002
either in an extended care facility, ... 2-008
elected, would include representatio 2-018
electrocardiograms, pap smears, and 4-017
elements of our existing system of h 5-002
eligibility for such support to be e 3-041
eligibility of those persons within 3-041
eligible for health maintenance and 4-011
eligible for payment would be determ ... 4-020
eligible for the Health Maintenance 1-048
eligible for the Health Maintenance 4-023
eligible for these benefits immediat 4-020
eligible for these benefits. 1-047
eligible. 4-020
eliminate for lower income groups tb 4-001
emergency and outpatient departments ... 4-024
emergency and referred specialty ser 2-046
emergency care and for maintaining t 2-047
emergency services and adequate emer ... 2-038
emergency transportation; 2-038
employed immediately both because of ... 4-046
employed or self-employed persons wo ... 4-036
employees. 2-063
enact laws by a specified date, esta 3-006
enact legislation to create a State 3-018
enacted at the federal level. This 2-002
enacted by the federal government wh ... 1-032
enacted its own legislation necessar 3-005
enacted, State Health Commissions fo 5-010
enactment of AMERIPLAN legislation. ... 5-014
enactment of federal legislation; 5-010
enactment of legislation, and thus p 1-052
enactment of the necessary legislati 3-005
enactment sought. 5-005
encourage an immediate beginning to 1-058
Enforceable regulatory controls woul 1-040
enforcement of regulations adopted b 3-010
enroll registrants and commence oper 5-012
entitled, each person would have to 1-048
entry point for each registrant into 2-034
environment, or which, because of th 3-002
environmental problems such as pover ... 1-027
environmental problems that affect t 1-026
establishing AMERIPLAN is the passag .. 5-006
ethnic and cultural patterns in the 2-049
evaluate the quality and adequacy of 2-014
evaluate the quality of all health c 1-038
evaluate the quality of those servic 2-013
evaluate the utilization of faciliti 2-023
Evaluation 2-052
evaluation of its own effectiveness. 2-024
evaluation of its performance, and d 2-027
evaluation of quality would be an in 1-038
evaluation should be made of the eff 5-021
every geographic area and of all of 1-035
examination. 4-018
examinations 4-017
examine the quality of health care o 2-023
exceed the development of resources. 5-023
excellent care for many of our citiz 1-001
existence solely through legislation 5-024
expend a predetermined amount before .. 1-047
expend a predetermined amount before .. 4-020
expenditures would be provided after 4-020
expenditures. For example, the poor 4-020
expenditures. Accordingly, the poor 1-047
experience and as financial resource 5-001
experience, and professional compete 2-058
experimentation under Titles 18 and 5-014
extend hospital supporting services, ... 5-018
extended care and nursing home facil 1-016
Extended Care Facility -- a specifie 4-028
extended care facility and in a nurs 4-021
extended care facility in addition t 4-032
extended care facility to the cost o 4-028
extended care facility, a nursing ca 2-008
extended care facility, 90 days in a 4-031
extended care, nursing home care, ho 2-040
extended period of time, such as lon 3-002
extending to the physician's office 2-023
extensive as those described below. 4-023
extensive as those provided by the S 4-011

F

facilitate and encourage the formati 3-027
facilities and home care programs, r 1-016
facilities and home care programs, r 2-006
facilities and services of Health Ca 3-032
facilities and services would be uti 2-007
facilities and services. 1-040
facilities and services. 2-030
facilities and services. Peer revie 2-023
facilities and services; 3-016
facilities and the necessary funds f 4-049
facilities by health care institutio 3-007
facilities by health care providers. 3-019
facilities into a corporate structur 1-034
facilities; the expansion of health 5-015
facilities, and services can only be 2-054
facilities, and the implementation o 5-003
facilities, existing institutions, a 3-025
facilities, extended care and nursin 1-016
Facility -- a specified number of da 4-028
facility and in a nursing home. 4-021
facility in addition to those days o 4-032
facility to another to maximize effe 2-045
facility to the cost of a day in a h 4-028
facility; physical therapy, speech t 4-026
facility, a nursing care institution 2-008
facility, nursing service; operating 4-026
facility, 90 days in a nursing home, ... 4-031
faculty for the education of health 2-066
family income level, size of family, ... 1-047
family physician acting only in a su 5-019
family physician or to any other phy 5-020
family physicians practicing in the 5-018
family physicians, and specialists, ... 2-070
family with respect to his health an 2-042
family would be deprived of good qua ... 4-009
family. 1-041
family. 2-052
family, and amount of health care ex 1-047
family, and the annual amount of hea 4-020
fears, and lack of knowledge related 2-049
federal agencies concerned with heal 3-015
federal and private sources of finan 1-044

federal and state governments must b 2-072
Federal and state legislation should 1-055
federal benefits, each state would e 3-018
federal financing, prepayment plans, ... 4-001
federal funds to pay for health main 3-005
Federal funds would then be availabl 3-006
federal funds, a function which the 3-013
federal government and private finan 1-044
federal government has a coordinatin 4-044
federal government in meeting its re 3-040
federal government in whole for the 1-046
federal government tax mechanisms fo ... 4-008
federal government to assure that AM ... 4-051
federal government to promote use of 5-014
federal government which would requi ... 1-032
federal government would be responsi ... 4-005
federal government, disburse funds t 3-042
federal income tax returns; 3-041
Federal Legislation 3-006
federal legislation and that health 3-030
federal legislation discussed in Par 5-006
federal legislation stating the bene 1-053
federal legislation would be needed 3-007
federal legislation would come the n 5-007
Federal legislation would provide th 3-005
federal legislation would result in 1-054
federal legislation; 3-029
federal legislation; 5-010
federal legislation, start up funds 5-006
Federal Level 3-006
federal level. This legislation wou 2-002
federal level, and all present feder 1-044
federal loans and provide grants to 5-006
federal regulations defining the sco 1-032
federal regulations for the scope, s 1-053
federal regulations the eligibility 3-041
federal regulations were properly me 3-006
federal regulations; 4-004
federal revenue funds would provide 4-035
federal revenues and collected throu 4-008
federal revenues for the poor and co 4-039
federal revenues for the poor and co 4-041
federal revenues. For the aged, the 1-050
federal revenues; 4-036
federal revenues, and for the aged a 1-046
federal revenues, and for the near-p 4-036
federal, state and local governmenta 1-025
fee for service, capitation, salary, ... 4-048
fees. Because of the budget forecast 4-047
finance AMERIPLAN must result in pro .. 4-049
finance health care. 1-043
finance the Standard Benefits Packag 4-036
financed at the federal level, and a 1-044
financed from other sources. 4-032
financed in part through general fed 4-036
financed through federal funds, a fu 3-013
financed through general federal rev 4-036
financed through multiple sources be 4-002
financial assistance in implementing 5-008
financial barriers to acquisition of 4-001
financial burden to patients. 4-050
financial incentives for encouraging 1-016
financial incentives for keeping peo 1-018
Financial incentives would be provid 2-006
financial requirements for the deliv 4-049
financial resources expand. 5-001
financial resources to pay premium c 4-033
financial risks of a capitation meth 4-046
financial, organizational, and profe 5-001
financially dependent or suffering l 1-045
financially dependent or suffers los 1-013
Financing 3-037
Financing AMERIPLAN. 3-043
financing and regulatory plan design 5-002
financing are recommended: 4-034
financing as one component of restru 1-030
financing as well as through traditi 4-050
financing aspects of the program. 5-012
Financing designated within two year 5-010
financing for the health care system 4-001
financing health services, so that a 1-028
financing is adequate to fully provi 4-051
financing mechanisms are a part of t 5-013
financing methods should be develope ... 4-050
financing of all packages of care fo 4-035
financing of AMERIPLAN is that every .. 4-034
financing of health services and fai 1-030
financing program and a uniform scop ... 4-002
financing program for AMERIPLAN woul 4-009
financing program under AMERIPLAN wo 4-003
financing program would result in an 4-001
financing the coverage for the near- 4-035
financing the health care benefits o 3-040
financing the system and those deliv 1-042
financing the system would be the be 1-043
financing would be as follows: 4-038
Financing would be set forth in the 3-037
financing. 3-004
financing. All health care benefits 1-044
Financing. The Commission would be ... 3-018
Financing; 3-013
financing, education, and the provis 5-016
financing, including prepayment plan 1-044
financing, prepayment plans, and pri 4-001
fiscal agencies and distribute these 2-025
fiscal agency, receiving and disburs 2-025
Fiscal and Statistical Responsibilit 2-025
fiscal operations of health services 3-035
fiscal, organizational and manpower 1-029
forecasting required, prospective ap 4-047
formulary. 4-025
formulated with priorities given to 1-029
formulating the concept of AMERIPLAN . 1-057
franchising of health facilities, an 5-003
full-time, well-compensated commissi 3-020
fund for specified health care benef 3-012
fund. 4-008
fundamentally responsible for the ed 2-072
Funds 4-034
funds among its providers in a respo 2-025
funds available for the health care 4-044
funds for adequate compensation of p 4-049
funds for AMERIPLAN appropriated fro . 4-008
funds for health care facilities and 4-049
funds from appropriate fiscal agenci 2-025
funds should be provided to permit t 5-006
funds to be paid by the federal gove 3-040
funds to pay for health maintenance 3-005

funds to prepayment plans and privat 3-042
funds to prevent the cost of the edu 2-072
funds would not be required, as unde 3-005
funds would provide the financing of 4-035
funds would then be available to the 3-006
funds. The benefit packages, even i 4-009
funds, a function which the Commissi 3-013

G

general education of the public. Th 2-072
General federal revenue funds would 4-035
general federal revenues and collect 4-008
General federal revenues for the poo 4-039
General federal revenues for the poo 4-041
general federal revenues. For the a 1-050
general federal revenues; 4-036
general federal revenues, and for th 1-046
general federal revenues, and for th 4-036
general public and represent, by the 5-017
geographic and political boundaries 1-035
geographic area and of all of the po 1-035
geographic area the Health Care Corp ... 2-029
geographic area to be served by each 3-025
geographic area would depend upon th ... 2-028
geographic area. Quotas established 2-030
geographic area, and of all of the p 2-001
geographic areas and the total popul 5-011
geographic areas of each state, the 2-063
geographic areas warrant, the State 3-021
Geographic Assignment 2-028
geographic assignment and therefore 2-028
geographic assignment established by 2-028
geographic or political boundaries a 2-013
geographic relocation or the end of 2-032
geographically. 2-045
governing board of each Corporation. 3-023
governing board of the Health Care C ... 2-017
governing board would be a matter of ... 2-017
governing board. 2-018
government aid and loan programs und ... 3-033
government are found elsewhere in th ... 3-043
government authority or a private co 2-010
government is not required to pay. 4-043
Government must assure the availabil 2-072
government must supplement these res ... 2-072
government purchase of benefits; 4-005
government to assure the preservatio 1-006
Government would be a major catalyst ... 3-001
government would be a participant in 3-001
Government would remain directly res ... 3-002
government. The financing program an ... 4-002
government's role as a purchaser of 3-043
Government's role in the system woul 3-001
Government's ultimate role would be 3-003
governmental agencies and for provid 2-051
governmental agencies with respect t 3-014
governmental and private organizatio 2-011
governmental and private resources. 4-050
governmental hospital systems will b 1-025
governmental hospitals, and professi 1-057
governmental structures, transportat 3-025
governments must be as fundamentally ... 2-072
governor to serve for staggered term 3-020
grants to aid the formation and init 5-006
grievance mechanisms for the solutio 2-016
group and at a cost this nation coul 1-045
group of providers. 2-054
group practice; planning for compreh 5-015
group practice, broaden health care 5-005
group practice, would be permitted w ... 1-037
group purchasers to be certain of op 4-051
group to be served by each Health Ca ... 3-026
group, the physicians, as leaders in 1-057
groups and geographic areas warrant, ... 3-021
groups beyond city limits or across 2-028
groups of physicians. Or the Health 2-011
groups the financial barriers to acq 4-001
groups who would be affected by AMER . 5-024
groups would be indispensable. Thes 2-064
groups would contribute markedly tow ... 1-057
groups. It is hoped that the many c 1-057
groups. It would eliminate for lowe 4-001
groups, electrocardiograms, pap smea 4-017
guarantee federal loans and provide 5-006
guarantee meaningful policy represen 2-018
guarantee of basic qualifications. 2-064
guidelines and incentives for AMERIP ... 3-004

H

health agencies, in taking active re 2-020
health aides; necessary medical supp 4-030
health and about the management of h ... 2-050
health and health-related problems; 2-042
health and to the prevention of illn 2-005
health and to the prevention of illn 1-017
Health Benefits 1-042
health benefits that are tax-support 3-011
health care among all persons. It w 4-001
health care and must have access to 2-070
health care and that no child suffer 1-014
health care and the competence of he ... 2-062
health care as a result of the lack 4-009
health care benefit and financing pr 4-003
health care benefit packages now pro 5-005
health care benefit packages would p 4-010
health care benefit structures could 5-014
Health Care Benefits 4-009
health care benefits financed throug 3-013
health care benefits of the poor and 3-040
health care benefits that are tax-su 1-044
health care benefits to the poor or 3-042
health care benefits which would be 3-012
health care benefits would be availa 4-004
health care benefits; wider use of p 5-015
Health Care Corporation's facilities 2-030
health care data, including statisti 2-026
health care expenditures would be pr 4-020
health care expenditures. For examp 4-020
health care expenditures. Accordingl 1-047
health care facilities and the neces 4-049
health care facilities; the expansio 5-015
health care field such as medical sc 1-057
Health Care Financing designated wit ... 5-010
health care for all should be self-e 1-001

health care for all the people, at r 1-002
health care for all. And AMERIPLAN ... 1-056
health care institution or the healt 5-022
health care institutions in a corpor 1-056
health care institutions must be the 1-022
health care institutions providing a 2-040
Health care institutions providing q 1-020
health care institutions representin 5-013
health care institutions to provide 2-012
health care institutions. 2-019
health care institutions. 3-007
health care institutions. 4-024
health care institutions. 5-017
health care institutions. Wherever 2-072
health care institutions, to educate 1-001
health care is an inherent legal rig 3-003
Health care is an inherent legal rig 1-003
health care must be available withou 1-007
health care must be jointly shared b 4-002
health care must be made by or under ... 2-056
health care must be made by or under ... 2-074
health care needs. 4-044
health care of each and every person 1-011
health care of individuals. It must 1-027
health care on a continuing basis mu 2-023
health care on a continuing basis. 1-038
health care personnel and to sustain 4-050
health care personnel as state gover 2-072
health care personnel who assist phy 2-074
health care personnel with the skill 2-073
health care personnel would also app 2-064
health care personnel would reside i 2-062
health care personnel. Health Care 2-068
health care personnel, and for setti 2-066
health care provided in long-term tu 4-032
health care provider organizations; 2-010
health care providers and use of var 5-015
Health care providers can begin now 5-013
health care providers in the formati 2-011
health care providers not participat 3-030
health care providers of facilities 3-016
health care providers to establish H 1-043
health care providers who are part o 4-049
health care providers. 3-019
health care providers, regardless of 2-013
health care services. It would be r 2-026
health care services. Representatio 2-018
health care services, including the 2-024
health care system is commensurate w ... 4-044
health care system is no exception. 1-042
health care system with the assistan 2-065
health care system. 1-027
health care system. 1-056
health care system. 1-058
health care system. A combination o 4-001
health care system. Inservice train 2-065
health care system. Medical schools 2-070
health care system. Yet, it would b 5-001
health care system, the health care 4-003
health care team, by referral of pat 2-023
health care to all at a reasonable c 1-028
health care to enhance the dignity o 1-005
health care to its registrants. It 2-012
health care will join in an effort t 1-057
health care would be deposited in a 4-008
health care would result. AMERIPLAN .. 5-015
health care. 1-026
health care. 1-031
health care. 1-043
health care. 2-070
health care. 3-002
health care. 4-001
health care. Major changes would be 5-002
health care. Thus it differs signif 1-030
health care; 3-025
health care, and the new health main 1-043
health care, non-health-related cust 1-025
health care, now and in the foreseea 4-032
health clinics should be physically 5-019
Health Commissions and delegate to t ... 3-021
health data-gathering and reporting 3-035
health delivery system and provide i 4-002
health facilities, and the implement 5-003
health field and cover all the peopl 1-055
health field itself. Such centers ar 5-017
health field may be used in the publ 1-057
health field to move from what some 1-031
health field to use AMERIPLAN to mak .. 1-052
health field. 1-021
health field. Often a field of ende 1-052
health field: an increasing emphasi 5-015
Health Financing 3-037
Health Financing would be set forth 3-037
Health Financing. The Commission wo ... 3-018
Health Financing; 3-013
health insurance companies for the p 3-013
health insurance companies for those 4-043
health insurance companies operating 3-029
health insurance companies would be 4-001
health insurance companies would be 1-044
health insurance companies. 3-039
health insurance companies. 4-037
health insurance companies. Its ben 1-049
health insurance companies; 4-006
health insurance for those who wish 1-051
health insurance, particularly for i 4-033
health level of the community. 4-051
health maintenance and ambulatory ca ... 4-010
health maintenance and ambulatory ca ... 5-004
health maintenance and benefits to p 1-046
health maintenance and catastrophic 3-005
health maintenance and catastrophic 4-011
Health Maintenance and Catastrophic ... 1-046
Health Maintenance and Catastrophic ... 1-048
Health Maintenance and Catastrophic ... 1-051
Health Maintenance and Catastrophic ... 4-011
Health Maintenance and Catastrophic ... 4-023
Health Maintenance and Catastrophic ... 4-032
Health Maintenance and Catastrophic ... 4-036
Health Maintenance and Catastrophic ... 4-039
Health Maintenance and Catastrophic ... 4-045
Health Maintenance and Catastrophic ... 5-020
health maintenance benefits before t 5-014
health maintenance benefits that wou 1-043
health maintenance benefits under AM ... 4-047
Health Maintenance Benefits: 4-012
health maintenance component of care ... 5-019
health maintenance of its registrant 4-046

health maintenance program of the He 5-020
health maintenance would be the entr 2-034
health maintenance. 2-049
health maintenance. 5-014
health maintenance; 2-035
health maintenance; greater efficien 5-015
health maintenance, primary care, sp 1-015
health maintenance, primary care, sp 1-034
health maintenance, primary, special 2-004
Health Manpower 2-054
health manpower and control over the . . . 2-063
health manpower and the recruitment . . . 2-069
health manpower and the recruitment . . . 1-039
health manpower from becoming the bu . . 2-072
health manpower needs and setting pe . . . 2-068
health manpower needs, for recruitin 2-066
Health manpower resources must be mo . . 2-073
health manpower. 2-071
health manpower, government must sup . . 2-072
health needs and through which the C . . . 1-041
health needs and through which the C . . . 2-052
health needs in every geographic are 2-001
health needs of every geographic are 1-035
health of all the people; 1-006
health of individuals must be coordi 1-026
health personnel by universities and 2-068
health personnel for its providers. 1-039
health personnel should be deployed, ... 5-021
health personnel should be phased ou 2-063
health personnel should be the respo 2-065
health personnel to verify basic edu 2-067
health personnel. 2-066
health personnel. It would identify 2-069
health personnel, and facilities and 2-007
health personnel, and must preserve 1-012
health personnel, and to maximize in 2-063
health problems; and assure accounta 2-018
health professional. The improvemen 5-022
health professional, should be the f 2-050
health professionals necessary to me 2-071
health professionals should be able 5-019
Health professionals will be aware o 5-023
health professionals. 2-023
health professionals. All persons a 5-024
health professionals, and health car 2-019
health professionals, especially phy 1-056
health professionals, organization o 1-057
health professionals, such as groups 2-011
health programs. 3-001
health record; 2-041
health records which would satisfy t 2-026
health resources of the United State 1-009
health resources. However, without a 5-003
Health Visits -- a specified number 4-030
health visits. A maximum limit on t 4-031
health which are not properly a part 3-002
health-oriented educational and soci 2-011
health, such as public and voluntary 2-020
health, the treatment of his illness 5-022
help overcome barriers and impedimen . . . 3-007
Hill-Burton program; 3-033
Home -- a specified number of days p . . . 4-029
home as possible; 2-037
home care programs, rather than the 1-016
home care programs, rather than to p 2-006
home care. 2-008
home care, home-health care, and hea . . . 2-040
home care, social service, well-baby 5-019
home facilities and home care progra 1-016
home health aides; necessary medical 4-030
Home Health Visits -- a specified nu 4-030
home health visits. A maximum limit 4-031
home to the cost of a day in a hospi 4-029
home. 4-021
home. Because of the limit on resou 4-032
home-health care, and health-related 2-040
home, and 100 home health visits. A 4-031
Hospital -- a specified number of da 4-027
hospital administrators, and to prov 1-001
hospital care, and would emphasize a 1-049
hospital care, 30 days for care in a 4-031
hospital days based on a ratio relat 4-028
hospital days based on a ratio relat 4-029
hospital supporting services, such a 5-018
hospital systems will be integrated 1-025
hospital. 4-028
hospital. 4-029
hospitalization in contrast with the 2-005
hospitalization. 1-016
hospitalization. 2-006
hospitals, and professional groups w 1-057
hospitals, their medical staffs, and 5-018

I

ill, for making them well as soon as 1-018
illness after it becomes acute. 1-017
illness after it becomes acute. 2-005
illness benefits after a state has e 3-005
illness benefits each person would h 4-011
illness benefits if they have the fi 4-033
illness benefits in the Health Maint 4-032
Illness Benefits Package 4-039
Illness Benefits Package -- To be el 4-011
Illness Benefits Package are include 4-032
Illness Benefits Package for all exc 4-036
Illness Benefits Package under AMERI . . . 5-020
Illness Benefits Package would be pa 4-045
Illness Benefits Package. Various p 1-051
Illness Benefits Package, each perso 4-023
Illness Benefits Package, to which a 1-048
Illness Benefits Package: This pack 1-046
Illness Benefits: 4-019
illness for all income groups. It w 4-001
illness in the community must be sou 1-011
illness must be developed. 2-073
illness or accident would become ope 1-047
illness or accident. 1-013
illness or accident. The total bene 1-045
illness or accident. These benefits 1-046
illness or accident, provided in the 1-051
illness. 1-014
illness. 1-024
illness. Such educational programs 2-050
illness, and for the mentally retard 4-022
illnesses and the maintenance of his 5-022
illnesses diagnosed by physicians as 2-008

immunizations 4-013
implement the community's concern in ... 2-018
improvement of the registrant's heal 5-022
improving the delivery of health ser 3-008
improving the quality and adequacy o 2-004
incapable of providing such care mus 1-020
incentive in using that component of 4-045
inchoate, uncoordinated system. An 5-003
including both the methods of delive 1-028
income groups the financial barriers 4-001
income groups. It would eliminate f 4-001
income level, size of family, and am 1-047
income level, size of family, and th 4-020
income tax returns; 3-041
income would have to expend a predet ... 4-020
incomes would have to expend a prede ... 1-047
increase group practice, broaden hea 5-005
increasing centralization of managem 5-016
indefinite duration. 2-013
independent agency composed of five 3-008
independent regulatory concept of co 5-003
independent state commission, not pa 3-018
indispensable. These standards shou 2-064
individual and his family with respe 2-042
individual and his family. 1-041
individual and his family. 2-052
individual and of all the people of 1-003
industry to a modern, coordinated an 1-031
information concerning the individua 2-031
Information maintained by the Corpor ... 2-027
information services concerning the 2-051
inpatient basis, including the profe 4-025
inpatient care, extended care, nursi 2-040
inservice education and training of 1-039
Inservice training should be the res 2-065
institution or the health profession 5-022
institution or the health profession 2-050
institution, or in a program of home 2-008
institutional care could be 90 days 4-031
institutional care may require a low 4-031
institutional care provided by all f 1-025
institutional care. The higher cost 4-031
institutional care, is now greater t 4-033
institutional charges and profession 4-047
institutional days could be required 4-031
institutional providers could be enc 5-016
institutional services should be org 5-021
Institutional Services, including, i 4-026
institutions already have comprehens 5-013
institutions and services and standa 1-057
institutions for the mentally retard 4-032
institutions for tuberculosis, menta 4-022
institutions not providing such care 1-020
institutions of the Corporation that 2-045
institutions to increase the individ 2-050
institutions unwilling or incapable 1-020
institutions. Ultimately the system 5-016
institutions, and institutions for t 4-032
institutions, and patterns of social 3-025
insurance companies for the purchase 3-013
insurance companies for those for wh 4-043
insurance companies operating within 3-029
insurance companies would be used to ... 4-001
insurance companies would be utilize 1-044
insurance companies. 3-039
insurance companies. 4-037
insurance companies. Its benefits w 1-049
insurance companies; 4-006
insurance for those who wish to purc 1-051
insurance, particularly for institut 4-033
insurers, providers, and government. 4-002
investments of money and manpower. 1-010
involvement in management responsibi ... 5-021
itself. Such centers are welcomed by 5-017
IV, Financing AMERIPLAN. 3-043

J

join cooperatively with the Commissi 3-028

K

knowledge about his health and about 2-050
knowledge of such providers and work ... 2-033
knowledge related to the use of pers 2-049

L

laboratory and x-ray services, and t 5-018
laboratory services on an outpatient 4-030
laboratory services; medical social 4-026
laws by a specified date, establishi 3-006
laws to overcome legal barriers to t 3-019
laws. And some are goals that will 1-010
leaders in determining the quality o 1-057
legal barriers to the establishment 3-016
legal barriers to the formation of H 3-019
legal due process. 3-036
legal right of all the people of the 3-003
legal right of each individual and o 1-003
legal right to health care and must 2-070
legal, to the formation of Health Ca 3-007
Legislation 3-006
Legislation 3-018
Legislation 5-006
Legislation 5-013
legislation and that health care pro 3-030
legislation be enacted, State Health 5-010
legislation discussed in Part III. A 5-006
legislation in each state to assure 1-040
legislation is anticipated. 3-005
Legislation is nevertheless necessar 3-004
legislation must be enacted at the f 2-002
legislation necessary for administra 3-005
legislation or by the wishes of heal 5-024
legislation required for AMERIPLAN t ... 3-005
legislation should be passed as soon 1-055
legislation should be prepared and i 5-005
legislation stating the benefits to 1-053
legislation to create a State Health 3-018
legislation to overcome legal barrie 3-016
legislation would also motivate stat 3-006
legislation would authorize the esta 2-002
legislation would be enacted by the 1-032
legislation would be needed to help 3-007

legislation would be the formal orga 5-012
legislation would come the necessary 5-007
legislation would establish a Nation 3-006
Legislation would only be one aspect 3-004
legislation would provide for rapid 5-012
legislation would provide the necess 3-005
legislation would result in the esta 1-054
legislation. Legislation is neverth 3-004
legislation. The Bureau could be a 3-037
legislation. By broadening the autho 5-014
legislation; 3-029
legislation; 5-010
legislation, also discussed in Part 5-007
legislation, and thus play a central 1-052
legislation, start up funds should b 5-006
legislation, would act as the contro 3-001
legislative amendment. 3-017
legislative recommendations of this 5-003
legislative, organizational and fina 5-008
legislature of State Health Commissi 1-054
legislatures to enact laws by a spec 3-006
legislatures would need to pass laws 3-019
lever to motivate change by those us 1-043
lever to motivate health care provid 1-043
levers must be supplied to motivate 1-042
licensure as a guarantee of basic qu 2-064
licensure for physicians, dentists, ... 2-064
licensure of health personnel should 2-063
Licensure of Personnel 2-062
listed in a national formulary. 4-025
little change from the present manne 1-010
loan programs under AMERIPLAN, as fo . 3-033
loans and provide grants to aid the 5-006
local government authority or a priv 2-010
local governmental hospital systems 1-025
local governmental structures, trans 3-025
local service. 2-009
local, or it might be broadly based, ... 2-009
locally by Health Care Corporations. 1-032
locus for the health maintenance com 5-019
long-range planning and large invest 1-010
long-term institutions for tuberculo 4-022
long-term mental health care. 3-002
long-term mental health care, non-he 1-025
long-term tuberculosis and psychiatr 4-032

M

maintain liaison with all federal ag 3-015
maintenance benefits in the Health M ... 4-045
maintenance of his well-being consti 5-022
maintenance of one continuous person ... 2-041
maintenance of personal good health 1-017
maintenance of personal good health 2-005
maintenance of the health of all the 1-006
management by serving on management .. 2-022
management committees for budget, pl ... 2-022
management functions, a greater avai 5-016
management of Health Care Corporatio .. 1-036
management of Health Care Corporatio .. 2-022
management of Health Care Corporatio .. 5-021
management of his illness. Such edu 2-050
Management Research 2-024
management responsibility should beg 5-021
management structure and involve him ... 2-059
management structure of the Health C 2-022
management to decide how the service ... 2-021
management. It would be the respons 2-021
management. In several systems finan 5-013
management, personnel, and facilitie 1-034
Manpower 2-054
manpower and control over the develo 2-063
manpower and the recruitment and dep .. 2-069
manpower and the recruitment of all 1-039
manpower from becoming the burden of .. 2-072
manpower necessary to serve these id 2-070
manpower needs and setting performan .. 2-068
manpower needs within each component . 2-069
manpower needs, and be responsible f ... 1-039
manpower needs, for recruiting and d 2-066
manpower resources must be more effe ... 2-073
manpower resources should be allocat 1-029
manpower. 2-071
manpower. Some require little chang 1-010
manpower, facilities, and services c 2-054
manpower, government must supplement . 2-072
matter of determination by the Healt 2-017
matters directly affecting life and 3-002
maximize effective use of the compon 2-045
meaningful policy representation for 2-018
means for measuring the quality, uti 2-060
mechanisms approved by the Social Se ... 5-014
mechanisms are a part of the total e 5-013
mechanisms for appeals and review of 3-036
mechanisms for health care would be 4-008
mechanisms for the solution of probl 2-016
mechanisms such as prospectively det 5-005
mechanisms to evaluate the quality o 1-038
mechanisms to evaluate the utilizati 2-023
mechanisms to examine the quality of 2-023
mechanisms to regulate the use of se 4-007
mechanisms would be responsible for 2-074
mechanisms, fulfilled its responsibi 3-034
Medicaid no longer necessary. 1-044
Medicaid, prompt state enactment of 3-005
medical administrators. The supply 2-070
medical and nursing care either in a 2-008
medical audits to measure the perfor 2-023
medical judgments related to health 2-056
medical judgments related to health 2-074
medical practice and advanced educat ... 2-057
medical practice, including group pr 1-037
medical practitioners of all types, ... 2-070
medical record and eventually such r 5-020
medical record of such services, and 2-046
medical record would be available to 5-020
medical record would serve as an inp 5-020
medical research so that these costs 4-050
Medical schools have a responsibilit 2-070
Medical schools must assess the phys 2-070
medical schools, governmental hospit 1-057
medical social service; professional 4-026
medical staff of the Health Care Cor 2-022
medical staff of the Health Care Cor 2-023
medical staffs, and family physician 5-018
medical supplies; and social service 4-030
medical, surgical, obstetrical, pedi 4-027

medically necessary care and service 4-021
Medicare and Medicaid no longer nece ... 1-044
Medicare with incentive reimbursemen ... 5-014
medicine and health maintenance; gre ... 5-015
mental health care. 3-002
mental health care, non-health-relat 1-025
mental health clinics should be phys 5-019
mental illness. 1-024
mental illness, and for the mentally 4-022
mentally retarded would be totally e 4-022
mentally retarded, as well as non-he 4-032
merger; it could be a local governme 2-010
merits, must want it to succeed, and 5-024
mobility for health personnel, and t 2-063
mobility in the management structure 2-022
mobility, and size of the population 2-061
money and manpower. Some require li ... 1-010
money for the payment of health serv 2-025
motivated to change. The health car 1-042
moving toward unifying their health 5-003
much in the United States to create 1-001
Multiphasic screening, part of the h 5-020
multiphasic screening, to include an 4-016
multiple sources because the respons 4-002

N

nation could afford. 1-045
nation is the ambulatory care center 5-017
nation we must provide better qualit 1-002
nation. 1-030
nation's educational system with the 2-065
nation's educational system would be 2-066
nation's health care needs. 4-044
nation's health care system. 1-056
nation's health care system. 1-058
nation's large existing investment i 2-007
nation's primary agency responsible 3-008
national formulary. 4-025
National Health Commission 3-008
National Health Commission and to gu ... 5-006
National Health Commission for the p ... 5-009
National Health Commission of a time 5-007
National Health Commission which wou .. 2-002
National Health Commission would: 3-009
National Health Commission. 3-018
National Health Commission. The Sta 3-020
National Health Commission. The Comm . 3-006
National Health Commission; 3-010
National Health Commission, and comp .. 2-015
national level the activities of vol 3-014
national licensure as a guarantee of 2-064
national licensure for physicians, d 2-064
national standards for the measureme 2-064
nationwide effort to coordinate such 5-003
nationwide system for the delivery o 1-052
nationwide system for the delivery o 1-009
nationwide, with regional subdivisio 2-009
near to the registrant's home as pos 2-037
near-poor in the state; 3-040
near-poor through general federal re 1-050
near-poor through general federal re 1-046
near-poor. 3-042
near-poor; 4-035
near-poor; 4-039
near-poor; 4-041
near-poor, whose benefits would be f 4-036
need for a period of transition to A 5-023
need for and assuring the supply of 2-071
need for funds to be paid by the fed 3-040
need for health care facilities; the 5-015
need for health services; 2-036
need for regulators on use of servic 5-023
need for the facilities and services 3-032
need not be prolonged since AMERIPLA . 5-002
need to pass laws to overcome legal 3-019
need, resources and precedent, but i 2-009
needed among the various components ... 2-023
needed incentives and coordination. 5-003
needed services effectively and upon 2-028
needed to help overcome barriers and 3-007
needed: health maintenance, primary 1-015
needs and for preparing a balanced s 2-070
needs and setting performance standa 2-068
needs and that the individual, rathe 2-050
needs and through which the Corporat ... 1-041
needs and through which the Corporat ... 2-052
needs for health manpower. 2-071
needs in every geographic area, and 2-001
needs of every geographic area and o 1-035
needs of its registrants. 2-027
needs of the health care system. Me 2-070
needs of the 50 states in fulfilling 5-007
needs within each component of compr .. 2-069
needs would be met without unnecessa ... 1-040
needs. 4-044
needs. The Health Care Corporations 2-071
needs; differing patterns in the use 2-061
needs, and be responsible for the in 1-039
needs, for recruiting and developing 2-066
needs, must be personalized through 1-012
negotiate with and pay providers on 2-016
negotiate with and receive funds fro 2-025
neighboring states in approving the 3-028
network and which presently exists i 5-017
non-curable when these patients woul 2-008
non-health related custodial care, w 4-032
non-health-related custodial care an 1-025
non-registered individuals as long a 2-048
non-registered individuals; however, ... 2-030
non-registrants seeking emergency ca 2-047
normal requirements of legal due pro 3-036
numbers of health care personnel and 4-050
Nurses and allied health professiona 5-019
nurses, and pharmacists. Therefore 2-064
nurses, and pharmacists, with specia 2-064
nursing care either in an extended c 2-008
nursing care institution, or in a pr 2-008
nursing care; physical, occupational 4-030
Nursing Home -- a specified number o ... 4-029
nursing home care, home-health care, ... 2-040
nursing home facilities and home car 1-016
nursing home to the cost of a day in 4-029
nursing home. 4-021
nursing home. Because of the limit 4-032
nursing home, and 100 home health vi 4-031
nursing service; operating room; del 4-026

O

obstetrical, pediatric, and psychiat 4-027
occupation, mobility, and size of th 2-061
occupational and speech therapy; psy 4-030
occupational therapy and psychothera 4-026
occurs only when those using the sys 1-042
offered by prepayment plans and heal 3-029
offered by prepayment plans and priv 1-049
offered by prepayment plans and priv 5-014
office practice. Since the Health C 2-023
offices, ambulatory care centers, an 4-024
offices, interrelated health care in 2-040
offices, wherever located, with supp 5-018
one aspect of the concept of AMERIPL . . 3-004
open registration and agree to maint 2-029
open registration period if that Cor 2-031
operating experience and as financia 5-001
operating Health Care Corporations. 5-013
operating nationwide, with regional 2-009
operating regionally, or operating n 2-009
operating room; delivery room; x-ray 4-026
operating within the state meet the 3-029
Operation 2-001
operation and regulated by the State 2-009
operation of Health Care Corporation 5-006
operation of the Health Care Corpora 2-074
operation. 1-054
operation. 2-002
operation; assure the adequacy and q 3-022
operational functions. 3-021
operational problem of the transitio 5-023
Operations 2-017
operations of Health Care Corporatio 3-023
operations of health services, utili 3-035
operations under AMERIPLAN immediate 5-012
operations while allowing freedom of 5-003
operative depending upon annual fami . . . 1-047
orderly transition to AMERIPLAN, usi . . . 5-003
ordinarily be formed by existing hea 2-010
our citizens -- accomplishments of w 1-001
our country all of the people would 1-045
outpatient basis. 4-030
outpatient departments of health car 4-024
overcome barriers and impediments, p . . . 3-007
overcome legal barriers to the estab 3-016
ownership and organizational forms. 1-023
ownership are interrelated. These in 5-013
ownership may be private. 1-022
ownership or sponsorship, the Health 2-012
ownership, for services that it woul 2-013

P

paid by the federal government in me . . . 3-040
paid for by a tax collected through 1-050
paid for by the federal government i 1-046
paid for in whole for the poor and i 1-050
paid for on a capitation basis. All 4-045
paid for on the basis of prospective 4-045
pap smears, and rectal examinations 4-017
paramedical personnel, into the comm . . . 5-018
part-time nursing care; physical, oc 4-030
particularly for institutional care, ... 4-033
pass laws to overcome legal barriers 3-019
passage of federal legislation stati 1-053
passage of federal legislation would 5-007
passage of the necessary federal leg 5-006
passage of the necessary legislation 5-012
passed as soon as possible so that t 1-055
patient care. In addition, physicia 2-022
patient education in its provider in 2-050
patient would be referred. 5-020
patient's family physician or to any 5-020
patient's medical record of such ser 2-046
patient's own Health Care Corporatio 2-046
patients as needed among the various 2-023
patients in health care institutions 2-072
patients with illnesses diagnosed by 2-008
patients with positive findings, a p 4-018
patients would require medical and n 2-008
patients. 2-047
patients. 4-050
pay and without regard to race, cree 1-007
pay for health maintenance and catas 3-005
pay for the training and education o 4-050
pay for their care should do so. Ac 1-051
pay for them. 2-033
pay premium costs. 4-033
pay providers on an equitable basis 2-016
pay. 4-043
payment for care of these persons. 2-046
Payment for health care expenditures 4-020
Payment For Health Services 4-045
Payment for physicians' professional 4-048
payment for services under AMERIPLAN . 4-049
Payment for the health maintenance b . . . 4-047
payment mechanisms such as prospecti . . . 5-005
payment mechanisms would be responsi . . 2-074
payment methods and to move existing . . . 5-014
payment of health services. It woul 2-025
Payment to Health Care Corporations . . . 4-045
payment would be determined by annua . . 4-020
payment. 4-046
payment. 4-047
payment. These could include fee fo 4-048
payment. Initially, the Health Care 4-047
payment, including capitation. 5-015
payments for all benefits cannot be 4-046
payments for each Health Care Corpor . . . 4-046
payments to prepayment plans and pri . . . 4-043
payments would be made for the purch . . 4-037
pediatric, and psychiatric care, inc 4-027
peer review and other mechanisms to 1-038
peer review and other mechanisms to 2-023
peer review mechanisms, fulfilled it 3-034
peer review of his credentials and p 2-058
Peer review would identify problem a 2-023
Peer review, as a function of the or 2-023
percent could be required for both a 4-031
percentage than ambulatory care. Al 4-031
perform adequately; 3-027
performance of the physician and the 2-023
performance standards for health car 2-068
performance; 2-058
performance, and determination of th 2-027
performed directly for the Health Ca 4-048

performed for registrants as well as 4-048
person's ability to pay and without 1-007
personal good health and to the prev 2-005
personal good health and to the prev 1-017
personal health record; 2-041
personal health records which would 2-026
personal health services. A program 2-049
personal identification and satisfac 2-043
personalized through the skills and 1-012
Personnel 2-062
Personnel 2-065
Personnel 2-073
personnel by universities and colleg 2-068
personnel for its providers. 1-039
personnel requirements for this comp 5-019
personnel shortages, minimize educat 2-063
personnel should be deployed, how ca . . . 5-021
personnel should be phased out and t 2-063
personnel should be the responsibili 2-065
personnel to assist physicians. 2-074
personnel to verify basic educationa 2-067
personnel. 2-022
personnel. 2-066
personnel. As AMERIPLAN phases in, . . . 2-063
personnel. It would identify manpow 2-069
personnel, and facilities and servic 2-007
personnel, and facilities into a cor 1-034
personnel, and must preserve the dig 1-012
personnel, and to maximize individua 2-063
personnel, into the community. They 5-018
pharmacists. Therefore national sta 2-064
pharmacists, with specialty training 2-064
pharmacy, x-ray and laboratory servi 4-030
phased out and the Health Care Corpo . . . 2-063
phases in, with Health Care Corporat 2-063
phasing-in process after passage of 5-012
phasing-in process of AMERIPLAN a co . . 5-015
phasing-in process would require: 5-009
phasing-in process, and serve in an 3-017
philosophy of AMERIPLAN and its emph . 5-004
philosophy of keeping people out of 5-017
physical examination. 4-018
physical therapy, speech therapy, oc 4-026
physical, occupational and speech th 4-030
physically located in the center. N 5-019
physician acting only in a superviso 5-019
physician and the entire health care 2-023
physician into the management struct 2-059
Physician involvement in management . . . 5-021
physician manpower necessary to serv . . . 2-070
physician needs of the health care s 2-070
physician of a large portion of rout 5-020
physician or to any other physician 5-020
Physician participation is fundament 2-054
physician services; 2-039
physician to whom the patient would 5-020
physician would be an integral part 2-055
physician would have the opportunity 1-036
physician. 5-022
physician's office practice. Since 2-023
physician's role in the predominant 2-057
physician's staff privileges in the 2-058
Physicians 2-054
Physicians 5-021
physicians and health care instituti 2-012
physicians and hospital administrato 1-001
physicians and podiatrists, and in a 4-025
physicians as non-curable when these 2-008
physicians in management. In several 5-013
physicians in such corporate organiz 3-007
physicians in the active organizatio 5-021
physicians in the diagnosis and trea 2-073
physicians individually must have th 2-022
physicians must be consistent with t 2-070
physicians must be established in ac 2-074
physicians must be included. It shou 4-049
physicians practicing in the communi 5-018
Physicians should make it their resp 5-022
physicians to be certified by specia 2-064
physicians to practice within the He 2-057
physicians would be required to part 2-022
physicians would have have the oppor . . . 1-036
physicians would have the choice of 4-048
physicians would have the same upwar . . . 2-022
physicians. 2-074
physicians. Every practicing physic 1-036
physicians. Or the Health Care Corp 2-011
physicians. The organization and op 2-074
physicians; 2-056
physicians, a commitment directly re 2-054
Physicians, along with professional 5-021
physicians, and specialists, as well 2-070
physicians, as leaders in determinin 1-057
physicians, dental surgeons, and pod 4-026
physicians, dentists, nurses, and ph 2-064
physicians, dentists, nurses, and ph 2-064
physicians, dentists, other health p 2-019
physicians, to join with health care 1-056
physicians, with the following inclu 4-030
physicians' offices, ambulatory care 4-024
physicians' offices, interrelated he 2-040
physicians' offices, wherever locate 5-018
physicians' professional services co 4-048
physicians' services and acute hospi 1-049
pints: 4-026
plan designed to motivate these orga 5-002
planning and large investments of mo 1-010
planning for additional services and 2-023
planning for comprehensive care; the 5-015
planning functions would be carried 3-031
planning, evaluation of its performa 2-027
planning, financing, education, and 5-016
planning, utilization and patient ca 2-022
plus bonus, or combinations of these 4-048
podiatrists; restorative services ap 4-026
podiatrists, and in addition, prescr 4-025
policies offered by prepayment plans 3-029
policy representation for its regist 2-018
policy-making body. The composition 2-017
political boundaries and could be te 2-013
political boundaries where necessary 1-035
political boundaries where necessary 2-001
pollution adds to the cost and amoun 1-027
poor and contributions to defray the 4-039
poor and contributions to defray the 4-041
poor and in part for the near-poor t 1-050
poor and make contributions toward f . . . 4-035
poor and the near-poor in the state; 3-040

poor or the near-poor. 3-042
poor would be eligible for these ben 4-020
poor would receive the benefits imme 1-047
poor, and in part for the near-poor 1-046
poor, whose entire benefits would be 4-036
population group to be served by eac 3-026
population groups and geographic are 3-021
population groups beyond city limits 2-028
population of the state, its distrib 3-025
population served; differing rural, ... 2-061
population. 5-011
population. The establishment of He 1-031
population. It is the responsibility 4-051
population, crossing political bound 2-001
population, with some Health Care Co . . . 1-035
portion of routine primary care. Th 5-020
poverty, drug abuse and air pollutio 1-027
practitioners of all types, particul 2-070
pre-admission testing. The medical 5-020
premium costs. 4-033
premium structures of prepayment pla . . . 3-039
premiums for health care benefits to 3-042
prepayment plans and health insuranc . . . 3-013
prepayment plans and health insuranc . . . 3-029
prepayment plans and health insuranc . . . 1-044
prepayment plans and health insuranc . . . 3-039
prepayment plans and private health 4-043
prepayment plans and private health 4-037
prepayment plans and private health 1-049
prepayment plans and private health 4-006
prepayment plans and private health 1-051
prepayment plans and private health 4-033
prepayment plans and private insuran 3-042
prepayment plans and private insuran 5-014
prepayment plans and private insuran 1-050
prepayment plans, and private health 4-001
prescription drugs as listed in a na 4-025
presently exists in several areas of 5-017
presently moving toward unifying the 5-003
preservation and maintenance of the 1-006
preserve the benefits of alternative 1-023
preserve the dignity of the individu 1-012
President and Congress on the phasin 3-017
President to serve for staggered ter 3-008
prevent the cost of the education an 2-072
prevention of illness and for his ow 2-049
prevention of illness and hospitaliz 2-005
prevention of illness through health 5-014
prevention of illness. 2-020
prevention of illness. 4-010
prevention of illness, in contrast w 1-017
preventive health care and that no c 1-014
preventive medicine and health maint 5-015
primary agency responsible for the c 3-008
primary and family physicians, and s 2-070
primary and specialty medical, surgi 4-027
primary care component of the AMERIP . 5-018
primary care. The results of such t 5-020
primary care, specialty care, restor 1-015
primary care, specialty care, restor 1-034
primary geographic assignment establ 2-028
primary method through which the pub . . 1-056
primary objective and that some incl 5-013
primary objective the optimum health 1-011
primary responsibility of the Health 2-034
primary responsibility of the physic 5-022
primary, specialty, restorative, and 1-049
primary, specialty, restorative, and 2-004
principally legal, to the formation 3-007
Prior to Legislation 5-013
priorities given to the accomplishme 1-029
priorities of services, taking into 2-061
private as well as the public sector 1-021
private corporation. 2-010
private financing. All health care 1-044
private health insurance companies f 4-043
private health insurance companies w 4-001
private health insurance companies. 4-037
private health insurance companies. 1-049
private health insurance companies; 4-006
private health insurance for those w 1-051
private health insurance, particular 4-033
private organizations, and organizat 2-011
private payments to prepayment plans . . . 4-043
private payments would be made for t . . . 4-037
private resources are unable to supp 2-072
private resources. Additional finan 4-050
private sources of financing, includ 1-044
private. 1-022
privileges in the Health Care Corpor 2-058
proceedings would be conducted withi . . . 3-036
productivity and service performed f 4-048
professional administrative personne 2-022
professional administrators, must ha 5-021
professional and technical health pe 2-066
professional competence as measured 2-058
professional education and national 2-064
professional fees. Because of the bu 4-047
professional groups would contribute 1-057
professional management. It would b 2-021
professional organizations and agenc 2-015
professional organizations establish 2-014
professional peer review and other m 1-038
Professional peer review and other m 2-023
professional resources. Its benefit 5-001
professional schools have the respon 2-071
professional schools to meet communi 2-071
professional services could be weigh 4-048
professional services of physicians 4-025
professional services of physicians, ... 4-026
professional services performed dire 4-048
professional staff. 3-008
professional staff. 3-020
professional. The improvement of th 5-022
professional, should be the focus of 2-050
professionals necessary to meet iden 2-071
professionals should be able to prov 5-019
professionals will be aware of the n 5-023
professionals. 2-023
professionals. All persons and grou 5-024
professionals, and health care insti 2-019
professionals, especially physicians 1-056
professionals, organization of insti 1-057
professionals, such as groups of phy 2-011
prolonged since AMERIPLAN incorporat . 5-002
prophylactic and therapeutic 4-015
prospective approval of rates would 4-047
prospectively approve the Corporatio 4-047

prospectively determined rate and ca 5-014
prospectively determined rates and c 5-005
prospectively determined rates as ap 4-045
prospectively determined rates for h 5-015
protect against the cost of catastro 1-047
protect every person in the United S 1-046
protection against the cost of catas 1-051
provider institutions of the Corpora 2-045
provider institutions to increase th 2-050
provider of health services and be o 2-012
provider organizations in the commun 2-011
provider organizations; it could res 2-010
providers and work with them. Regis 2-033
providers could be encouraged throug 5-016
providers could cross geographic or 2-013
providers in a responsible manner. 2-025
providers in meeting the standards e 2-014
providers in numerous communities th ... 5-013
providers of service and all other o 2-020
providers on an equitable basis for 2-016
providers outside the Corporation fo 2-033
providers that meet standards of eff 1-019
providers that meet the regulations 2-015
providers that would not be part of 2-033
providers would take, and how servic 2-021
providers. 1-039
providers. 2-016
providers. 2-054
providers, and government. The finan 4-002
providers, and other participants in 3-001
providers, including physicians, a c 2-054
providers, including those with whom 2-019
providers, the education and trainin 2-069
provides a blueprint of a nationwide 1-052
provides care for persons suffering 1-024
provides emergency and referred spec 2-046
Provision for Community Evaluation 2-052
Provision must be made for the adopt 5-007
provision of health care would resul 5-015
provision of health services. Such 5-013
provision of services for its regist 2-034
provision of services. This would r 5-016
provision of the five components of 5-016
psychiatric care, including treatmen 4-027
psychiatric institutions, and instit 4-032
psychotherapy; home health aides; ne 4-030
psychotherapy, etc.; and blood after 4-026
Public 2-034
public and represent, by the field, ... 5-017
public and voluntary health agencies 2-020
public are found in Part IV, Financi 3-043
public could participate responsibly 1-056
public interest even though their ow 1-022
public interest. 1-057
public must also be made aware of th 5-023
public sector of the health field. 1-021
public. The components of education 2-072
public's failure to use services in 2-049
purchase of benefits; 4-005
purchase of health care benefits fin 3-013
purchase of the Standard Benefits Pa 4-037
purchase services from providers tha 2-033
purchase supplemental benefits to fi 4-033
purchase the Standard Benefits Packa 1-050
purchase them. 1-051
purchased or been provided with the 1-048
purchased through prepayment plans a ... 4-006
purchaser of care for various segmen 3-043
purchaser of care through tax-suppor 3-001
purchasers of care should be structu 4-045
purchasers of care, would have a res 2-049
purchasers to be certain of optimum, ... 4-051
purpose of the system and the primar 5-022

Q

qualifications. 2-064
qualifications, physicians would hav 2-022
quota of individuals who failed to r 2-029
quota of registrants by meeting the 2-030
quota of registrants. Each Health C 2-031
Quotas established by the State Heal 2-030

R

race, creed, color, sex or age; 1-007
range of alternative solutions and t 1-058
rate and capitation payment methods 5-014
rate setting for health services, th 5-003
rates and capitation. While all of 5-005
rates as approved by the State Healt 4-045
rates charged for their services. 3-022
rates for health care providers and 5-015
rates would act as a significant ste 4-047
ratio relating the cost of a day in 4-029
ratio relating the cost of a day in 4-028
readily accessible to all. 1-008
realized that the pace at which thes 1-027
reasonable cost by establishing Heal 1-043
recommendation of and under the supe ... 4-030
recommendations of this report are i 1-058
recommendations of this report, woul 5-003
recommended: 4-034
record and eventually such records w 5-020
record of such services, and transmi 2-046
record to the patient's own Health C 2-046
record would be available to the pat 5-020
record would serve as an input for t 5-020
record; 2-041
records of such patients. 2-047
records which would satisfy the requ 2-026
records would be maintained through 5-020
recruiting and developing adequate f 2-066
recruitment and deployment of health ... 2-069
recruitment of all health personnel 1-039
recruitment of individuals to meet h 2-066
recruitment, a quota of individuals 2-029
rectal examinations 4-017
redress of complaints concerning hea 2-053
referral of patients as needed among 2-023
regard to any person's ability to pa 1-007
regard to race, creed, color, sex or 1-007
regardless of their ownership, for s 2-013
Regional Health Commissions and dele ... 3-021
regional subdivisions that would pro 2-009
regionally, or operating nationwide, ... 2-009

register during regular periods of o 2-029
register with a Health Care Corporat 2-031
register with a Health Care Corporat 4-011
register with the Corporation of his 2-031
register. 2-029
registered with a Health Care Corpor 1-048
registered with other Health Care Co 2-046
registrant's health, the treatment o 5-022
registrant's home as possible; 2-037
registrant's medical record and even 5-020
Registrants 2-034
registrants and commence operations 5-012
registrants and for the registrants 2-047
registrants as well as responsibilit 4-048
registrants by meeting the requests 2-030
registrants by the Corporation for t 2-018
Registrants could at any time purcha 2-033
registrants for participating in com 2-051
Registrants of Health Care Corporati 2-033
registrants of other Health Care Cor 2-047
Registrants of the Corporation would 2-052
registrants well. 2-057
registrants well. Thus, the mainten 4-045
registrants would be delivered. 2-021
registrants would be provided within 2-018
registrants. 2-027
registrants. 2-048
registrants. 2-051
registrants. Each Health Care Corpo 2-031
registrants. It would be founded on 2-012
registrants. Its sponsorship could 2-009
registrants. Such representation wo 2-018
registrants. The program of health 2-034
registrants. However, capitation pay 4-046
registrants; implement the community 2-018
registrants, insurers, providers, an 4-002
registrants: 2-034
registration and agree to maintain t 2-029
registration and the advantages of s 2-031
registration for a fixed period, for 2-029
registration made by individuals not 2-030
Registration of Individuals 2-029
registration of non-registered indiv 2-030
registration period if that Corporat 2-031
registration would be established by 2-031
registration. All regulations for r 2-031
registration. He could appeal for a 2-032
regulate Health Care Corporations an 1-054
regulate the premium structures of p 3-039
regulate the use of services, such a 4-007
regulated by the State Health Commis ... 2-009
regulation of Health Care Corporatio 3-036
regulations adopted by the National 3-018
regulations adopted by the National 3-010
regulations defining the scope, stan 1-032
regulations established by the Natio 2-015
regulations for quality and adequacy 3-030
regulations for registration would b 2-031
regulations for the scope, standards 1-053
regulations for the scope, standards 3-001
regulations in accordance with his t 2-058
regulations of the National Health C 3-020
regulations the eligibility of those 3-041
regulations to create uniform benefi 3-006
regulations were properly met. Fede 3-006
regulations would be administered at 1-032
regulations would define the scope, ... 2-002
regulations. State Health Commissio 3-030
regulations. These regulations would 2-002
regulations; 4-004
regulators on use of services, such 5-023
regulatory concept of controlling op 5-003
regulatory controls would be establi 1-040
regulatory plan designed to motivate 5-002
reimbursed for the cost of these ser 2-046
reimbursement mechanisms approved by .. 5-014
Relationships with Physicians 2-054
relatively easy to attain. Others a 1-010
relocation or the end of his period 2-032
reorganization of our limited resour 2-054
reporting center for the state; esta 3-035
requests for registration made by in 2-030
require a lower copayment percentage ... 4-031
require an annual dollar limit. Lim 4-031
require assistance from tax resource 3-041
requirements established pursuant to 3-029
requirements for health benefits tha 3-011
requirements for the collection of d 3-035
requirements for the delivery of com 4-049
requirements for the organization of 5-007
requirements for this component of c 5-019
requirements of legal due process. 3-036
requirements of the State Health Com ... 2-026
requirements. 2-067
requires adjustment to new ideas and 5-001
requiring greater start up time and 5-008
requiring planning for additional se 2-023
Research 2-024
research in the delivery of health c 2-024
research so that these costs will no 4-050
research to increase the effectivene 4-050
researchers, and medical administrat 2-070
reside in the Health Care Corporatio 2-062
reside outside of its geographic are 2-030
residents to receive federal benefit 3-018
resolve acute sociological and envir 1-027
resources and precedent, but it woul 2-009
resources are unable to support such 2-072
resources available for health care, ... 4-032
resources become available and would ... 4-009
resources expand. 5-001
resources for the delivery of health 3-025
resources for the provision of healt 5-015
resources in manpower, facilities, a 2-054
resources in the delivery of health 4-002
resources may be utilized to provide 1-028
resources must be more effectively u 2-073
resources necessary to provide truly 1-031
resources of the United States for b 1-009
resources should be allocated. 1-029
resources to meet full financial req 4-049
resources to pay premium costs. 4-033
resources which constitute our prese 5-001
resources. 2-072
resources. 5-023
resources. Additional financing met 4-050
resources. Enforceable regulatory c 1-040
resources. Its benefits will expand 5-001

resources. These benefit packages w 4-009
resources. However, without a nation 5-003
resources, and keep its registrants 4-045
resources, their eligibility for suc 3-041
resources, to assure availability at 2-012
respond. All persons in the communi 1-041
Responsibilities 2-025
responsibly in determining the futur 1-056
restorative care and health-related 1-015
restorative care, and health-related 1-034
restorative services appropriate to 4-026
restorative, and health-related cust 2-004
restorative, and health-related cust 1-049
restructured, including both the met 1-028
restructuring of the nation's health 1-058
restructuring the system for the del 1-030
retained as a continuing part of eac 5-020
retarded would be totally excluded. 4-022
retarded, as well as non-health rela 4-032
revenue funds would provide the fina 4-035
revenue requirements for health bene 3-011
revenues and collected through feder 4-008
revenues for the poor and contributi 4-039
revenues for the poor and contributi 4-041
revenues. For the aged, the Standar 1-050
revenues; 4-036
revenues, and for the aged and all o 1-046
revenues, and for the near-poor, who 4-036
right of all the people of the Unite 3-003
right of each individual and of all 1-003
right to health care and must have a 2-070
right to registration and the advant 2-031
round-the-clock emergency services a 2-038
rules and regulations in accordance 2-058
rural, urban and suburban needs; dif 2-061

S

salary plus bonus, or combinations o 4-048
salary, salary plus bonus, or combin 4-048
salutary trends in the health field: 5-015
schools have a responsibility for as 2-070
schools have the responsibility of a 2-071
schools must assess the physician ma 2-070
schools to meet community needs for 2-071
schools, governmental hospitals, and 1-057
screening programs, but also for pre 5-020
screening, part of the health mainte 5-020
screening, to include annual history 4-016
sector of the health field. 1-021
seeing that Health Care Corporations 3-020
seeking emergency care and for maint ... 2-047
seems, at this time, to be the best 4-046
segments of the health care field su 1-057
segments of the public are found in 3-043
self-employed persons would be used 4-036
self-evident. Although we have done 1-001
semi-private accommodations for prim ... 4-027
sensitivity to the goals, motives, a 2-054
separate and specifically designated 4-008
separated geographically. 2-045
serology, urinalysis, appropriate ch 4-016
serve areas lacking such Corporation 3-027
serve as an input for the data base, ... 5-020
serve for staggered terms of relativ 3-008
sex groups, electrocardiograms, pap 4-017
sex or age; 1-007
shared by all -- registrants, insure 4-002
sharing among health care providers 3-016
sharing of cost among all persons, t 4-034
sharing of services and facilities b 3-007
sharing of services and facilities b 3-019
sharing of such activities as planni 5-016
sharing of the cost of health care a 4-001
shortages, minimize educational cost 2-063
significant and salutary trends in t 5-015
smears, and rectal examinations 4-017
social organization, as well as exis 3-025
Social Security Administration, it w 5-014
Social Security mechanism for all ot 4-040
Social Security mechanism for the ag 4-042
Social Security mechanism on all emp 4-036
Social Security mechanism. 1-046
Social Security mechanism. All othe 1-050
social service; professional service 4-026
social service, pharmacy, x-ray and 4-030
social service, well-baby clinics, a 5-019
sociological and environmental probl 1-027
sociological and environmental probl 1-026
Source of Funds 4-034
sources and utilize new payment mech ... 5-005
sources because the responsibility f 4-002
sources of financing are recommended ... 4-034
sources of financing would be as fol 4-038
sources of financing, including prep 1-044
sources. 4-032
specialists, as well as teachers, re 2-070
specialized services the Corporation 2-033
specialty boards. The Health Care C 2-064
specialty care, restorative care and 1-015
specialty care, restorative care, an 1-034
specialty medical, surgical, obstetr 4-027
specialty services in behalf of thos 2-046
specialty training for physicians to 2-064
specialty, restorative, and health-r 1-049
specialty, restorative, and health-r 2-004
speech therapy; psychotherapy; home 4-030
speech therapy, occupational therapy 4-026
sponsored by voluntary and governmen ... 2-051
sponsorship could be local, or it mi 2-009
staffs, and family physicians practi 5-018
Standard Benefits Package 4-041
Standard Benefits Package -- To be e 4-023
Standard Benefits Package and any su ... 4-020
Standard Benefits Package and has re 1-048
Standard Benefits Package and other 4-037
Standard Benefits Package and the be 1-051
Standard Benefits Package and the ca 4-033
Standard Benefits Package are includ 4-031
Standard Benefits Package for the ag 4-036
Standard Benefits Package from prepa ... 1-050
Standard Benefits Package would be p ... 1-050
Standard Benefits Package would be p ... 1-050
Standard Benefits Package. 4-011
Standard Benefits Package, and would ... 4-033
Standard Benefits Package, and 90 ad 4-032
Standard Benefits Package, whereas p 1-047

Standard Benefits Package, whereas p 4-020
Standard Benefits Package: All pers 1-049
standards and an organized system fo 1-030
standards established by such organi 2-014
standards for health care personnel. 2-068
standards for professional and techn 2-066
standards for the measurement of com 2-064
standards of effectiveness, quality, ... 1-019
standards of professional organizati 2-015
standards of quality and comprehensi 1-032
standards of quality and comprehensi 1-053
standards of quality and comprehensi 3-001
standards of quality of health care 1-057
standards of quality, and comprehens 2-002
standards of quality, and comprehens 3-006
standards should include verificatio 2-064
state and local governmental hospita 1-025
state approved and functioning Healt 5-011
state boundaries; 3-028
State Bureau of Health Financing 3-037
State Bureau of Health Financing wou ... 3-037
State Bureau of Health Financing. T 3-018
State Bureau of Health Financing; 3-013
State Bureaus of Health Care Financi 5-010
state commission, not part of any ex 3-018
State Commission, the Corporation wo ... 2-030
state enactment of the necessary leg 3-005
state for the adoption of the legisl 3-005
state funds would not be required, a 3-005
state government is for the general 2-072
state governments must be as fundame ... 2-072
state has enacted its own legislatio 3-005
State Health Commission 2-028
State Health Commission 3-020
State Health Commission and establis 3-018
State Health Commission as a basis f 4-047
State Health Commission could establ 3-021
State Health Commission for gatherin 2-026
State Health Commission primarily on ... 2-009
State Health Commission would approv .. 3-022
State Health Commission would assign ... 2-029
State Health Commission would be bas ... 2-030
State Health Commission would be sup ... 3-020
State Health Commission would be the ... 3-020
State Health Commission would consis ... 3-020
State Health Commission would: 3-024
State Health Commission. 2-028
State Health Commission. 2-031
State Health Commission. 2-032
State Health Commission. 4-045
State Health Commission. Several su 2-028
State Health Commission, for compreh ... 4-046
State Health Commission, however, wo ... 3-023
State Health Commissions and the for 5-007
State Health Commissions formed, and ... 5-010
State Health Commissions to assure t 3-006
State Health Commissions to assure t 3-010
State Health Commissions to regulate 1-054
State Health Commissions would appro ... 2-002
State Health Commissions would utili 3-030
State Health Commissions. In turn, ... 2-002
State Legislation 3-018
state legislation be enacted, State 5-010
state legislation should be passed a 1-055
State legislation would provide for 5-012
state legislation. The Bureau could 3-037
state legislation, also discussed in 5-007
state legislature of State Health Co 1-054
state legislatures to enact laws by 3-006
state legislatures would need to pas 3-019
State Level 3-018
state level with care being provided 1-032
state lines. The co-existence of He 2-028
state meet the uniform benefit requi 3-029
state the scope, standards of qualit 3-006
state to assure that needs would be 1-040
state to prospectively approve the C 4-047
state who require assistance from ta 3-041
state would enact legislation to cre 3-018
state. 3-006
state; 3-040
state; establish requirements for th 3-035
state, including within their covera 5-011
state, its distribution, local gover 3-025
state, the present system of licensu 2-063
States against the major costs of ca 1-046
states are presently moving toward u 5-003
states as required by federal regula 4-004
States for better care. 1-009
states in approving the establishmen 3-028
states in developing legislation to 3-016
states in fulfilling the requirement 5-007
states prepared to participate in th 5-008
states requiring greater start up ti 5-008
States to create outstanding health 1-001
States. 1-003
States. 3-003
Statistical Responsibilities 2-025
statistics on the utilization and co 2-026
strong demand for these changes by t 1-043
Structure 2-009
suggestions only. Copayment, for ex 4-031
suggestions only. Health-related cu 4-032
suitable mechanism by which the comm .. 1-041
summary, many details of AMERIPLAN r . 1-058
supervision of physicians. The orga 2-074
supervision of physicians; 2-056
supervision of physicians, with the 4-030
supervisory capacity. 5-019
Supplemental Benefits -- The present 4-033
supplemental benefits from prepaymen ... 4-037
supplemental benefits have been exha 4-020
supplemental benefits to fill the ga 4-033
supplemental benefits to fill this g 1-051
Supplemental Benefits: One of the b 1-051
surgeons, and podiatrists; restorati 4-026
surgical, obstetrical, pediatric, an 4-027

T

taking active responsibility for the 2-020
taking into consideration among othe 2-061
task of the Health Care Corporation, ... 2-057
tax collected through the Social Sec 4-040
tax collected through the Social Sec 4-042
tax collected through the Social Sec 4-036
tax collected through the Social Sec 1-046

tax collected through the Social Sec 1-050
tax mechanisms for health care would 4-008
tax resources, their eligibility for 3-041
tax returns; 3-041
tax-supported health programs. 3-001
tax-supported would be financed at t 1-044
tax-supported; 3-011
teachers, researchers, and medical a 2-070
therapeutic 4-015
therapy and psychotherapy, etc.; and 4-026
therapy; psychotherapy; home health 4-030
therapy, occupational therapy and ps 4-026
therapy, speech therapy, occupationa 4-026
third-party purchasers of care, woul 2-049
three pints: 4-026
through a new nationwide system for 1-009
timetable developed by the National 5-009
timetable for AMERIPLAN to meet the .. 5-007
Titles 18 and 19 of Medicare with in 5-014
total benefit packages of AMERIPLAN, .. 1-045
total capitation payment. Initially, ... 4-047
total effectiveness of the health ca 1-027
training and education of adequate n 4-050
training for physicians to be certif 2-064
training of health manpower and the 2-069
training of health manpower from bec ... 2-072
training of health manpower, governm ... 2-072
training of its health manpower and 1-039
Training of Personnel 2-065
training programs augment programs o ... 2-071
training programs in the education o 2-068
training should be the responsibilit 2-065
training, experience, and profession 2-058
transfer between provider institutio 2-045
transfer from one facility to anothe 2-045
transitional process is to achieve a 5-004
transmitting the record to the patie 2-046
transportation facilities, existing 3-025
transportation; 2-038
treated. 1-011
treatment for tuberculosis, alcoholi 4-027
treatment of his illnesses and the m 5-022
treatment of illness after it become 1-017
treatment of illness after it become 2-005
treatment of illness must be develop 2-073
treatment services provided in physi 4-024
treatment services, with ambulatory 2-037
trust fund for specified health care 3-012
tuberculosis and psychiatric institu 4-032
tuberculosis, alcoholism, and drug a 4-027
tuberculosis, mental illness, and fo 4-022

U

uniform availability of adequate hea 1-032
uniform benefit packages and state t 3-006
uniform benefit requirements establi 3-029
uniform benefits and services and ad 3-004
uniform quality, for all; 2-044
uniformly covered by this package, o 1-049
universities and colleges. 2-068
Untreated illness in the community m 1-011
untreated illness. 1-014
unused hospital days based on a rati 4-028
unused hospital days based on a rati 4-029
urban and suburban needs; differing 2-061
urinalysis, appropriate chemistries, ... 4-016
utilization and cost of health care 2-026
utilization and patient care. In ad 2-022
utilization of ambulatory facilities 2-006
utilization of ambulatory facilities 1-016
utilization of facilities and servic 2-023
Utilization of Personnel 2-073
utilization of services; 3-034
utilization of services, and other h 3-035
utilization of the five components o 4-010
utilization, and economic delivery o 2-060

V

validate the need for funds to be pa 3-040
varied and significant, as would the 3-001
verification of professional educati 2-064
verify basic educational requirement 2-067
Visits -- a specified number of visi 4-030
visits per year, on the recommendati 4-030
visits. A maximum limit on total in 4-031
voluntarily register during regular 2-029
voluntary and governmental agencies 2-051
voluntary health agencies, in taking 2-020
voluntary organizations and governme ... 3-014
voluntary organizations in the appro 3-030

W

weighted in terms of productivity an 4-048
welcomed by the general public and r ... 5-017
well and, if they are ill, for makin 1-018
well-baby care 4-014
well-baby clinics, and mental health 5-019
wherever located, with supporting se 5-018
While all of these developments vita 5-005
work for its success. This is the c 5-024
work with them. Registrants could a 2-033

X

x-ray 4-016
x-ray and laboratory services on an 4-030
x-ray and laboratory services; medic 4-026
x-ray services, and the services of 5-018