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Statement of UNITED STATES CATHOLIC CONFERENCE, HOLIC HOSPITAL ASSOCIATION, and NATIONAL CONFERENCE OF CATHOLIC CHARITIES on NATIONAL HEALTH INSURANCE

before the

COMMITTEE ON WAYS AND MEANS

United States House of Representatives

July 2, 1974

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Statement on
NATIONAL HEALTH INSURANCE
before the
COMMITTEE ON WAYS AND MEANS

United States House of Representatives

July 2, 1974

UNITED STATES CATHOLIC CONFERENCE
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Statement on

NATIONAL HEALTH INSURANCE

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"I have come that men may have life and may have it more abundantly."
(John 10:10)

Over the years, the United States, as a relatively young nation, has had to develop a national philosophy of living largely by itself and through its own efforts. The weaving of a peculiarly American philosophy, like that of a rich fabric, has been slow and difficult, filled with starts and stops, but characterized by continuing progress and growing awareness of the importance of relationship among its varied elements. Examples of a developing United States social philosophy abound, and the U.S. Congress and this Committee in particular, have often been the molders and the interpreters of our understanding of ourselves as we grow and mature as a nation.

Among the elements within an evolving national philosophy is our attitude as a people toward health and health care. Few would deny today that every citizen in this country has the right of access to adequate health care, although such a statement at one time was sharply questioned and disputed. Few would deny today that the United States of America possesses an enormous national resource with some of the finest health care institutions and personnel in the world, although at one time we were far behind in the quality of health care and research enjoyed by other nations; and few would deny today the commitment of

the Congress and the federal government to continue and improve upon the dedication to excellence in the provision of health care to our citizens.

The current hearings conducted by this Committee are an example of this commitment. That the Congress recognizes the critical need to update the health care delivery system and make decent comprehensive health care available to all, is in itself a courageous and important step forward in the development of a national social and moral philosophy. And the translation of principle to concrete and beneficial programs further illustrates this commitment.

As representatives of the Catholic Church's concern for adequate health care in America, our basic approach to the issue of national health insurance is rooted in the fundamental tenet that every person has the right to life, to bodily integrity and the means which are necessary and suitable for the development of life. The right to life clearly implies the right to health care; indeed, the two are philosophically and practically inseparable. The right of persons to health care further implies that such health care will be available, and that the route of access to necessary and comprehensive care will not be strewn with impediments.

In spite of the enormous dimension of the national commitment to health, we recognize the inadequacies of the health system. There exist presently widespread disparities throughout the country in the availability of treatment, facilities and personnel. And in a significant number of rural areas, inner cities, ghettos and barrios, there are few medical facilities and, in some cases, no physicians or nurses, contributing to haphazard and generally poor standards of health for millions of people. Health care costs have risen to the point where many will not or cannot seek necessary treatment because of severe or ruinous financial demands.

Such factors are partly responsible for the fact that—despite an estimated health outlay of 90 to 100 billion dollars in fiscal 1975, and a geometric growth in sophisticated medical technology, research and knowledge—in several areas, the United States ranks poorly among developed nations in the application of those advances via the health delivery system. For example, in 1950, the United States ranked fifth in infant mortality rate. Today, the United States ranks fourteenth in infant mortality, behind Canada, Switzerland, Hong Kong, Western Samoa and Fiji. In life expectancy, the United States ranks twelfth for women and twenty-seventh in life expectancy for males behind Spain, Greece and five Communist nations in Eastern Europe.

With such facts and statistics in mind, we strongly endorse the prospect of a national health care insurance program. We believe it is only through a well-planned national approach that the United States can begin to strike a balance between the actual delivery of health care to all persons living within our borders and our undisputed excellence in the areas of health research and technology. We believe that there can be no further delay in recognizing the moral necessity of developing a national health care insurance program within which all participate. The question,

in other words, is not whether we should have a national program; it is how such a program should be developed and implemented.

Our testimony today reflects the principles we would wish to see included in any national health care program which will finally emerge, and seeks to address specifically those elements within several of the pending bills which we likewise feel should be included in the legislation. No one bill, in our view, provides a total and practical solution to the inadequacies in the present health care system, nor does any one bill speak adequately of the preservation of the better aspects of our present delivery system.

For almost 200 years, the Catholic Church in one area or another has been involved in the maintenance and delivery of health care. Presently, over 700 Catholic hospitals provide health care and related services to millions of Americans each year—Catholic and non-Catholic alike. The Catholic hospital system, with its current capacity of 158,000 beds, represents approximately 30 percent of the acute care voluntary beds in the United States. The Catholic community, through its dioceses and network of hospitals, clinics, medical and nursing schools, educational and other health care institutions, is planning expansion and new construction costing over $2 billion, 200 million. The complex health system sponsored by the Catholic community—which is a vital part of the overall American health system—treats some 25 million patients annually and, in related systems, maintains homes for 35,000 dependent children and almost 50,000 aged persons. Our Church engages in health care services in response to the needs of people. Our country's recognition and encouragement of a pluralistic system of health care delivery have complemented our continuing interest in service, as has the concept of individual and institutional integrity which recognizes the fundamental right of free adherence to ethical and/or religious beliefs. We submit that the voluntary Catholic system has made a historic and substantial contribution to the overall system and provides high quality and sensitive alternatives to other equally qualitative modes of health care. Indeed, because of its history and tradition within the health care field, the Church bears witness to the importance and validity of the pluralistic, voluntary nature of health care delivery in the United States. The Church, through its commitment to Christian values, exists primarily to serve, particularly to serve the poor, the aging and the sick among all peoples. Because of that tradition, we will continue to stay in the health care delivery system and seek to expand our services. Indeed, the commitment to a Catholic expression of health care delivery, we believe, is analogous to and compatible with the growing country-wide commitment to a national health care program as expressed in the Congress. We see no necessary conflict between the advent of a national health insurance program and the continued role of the Church in health affairs.

The Church's commitment to the health care field is reflected in the understanding that its people are both providers and consumers of health care. Indeed, we are testifying today, in effect representing millions of consumers as well as speaking for 1200 Catholic institutions

providing health care. Within this understanding of the Church as a community of consumers and providers in terms of health care, we view the coming of national health insurance as a means to enhance the voluntary system of health care.

Consonant with our conviction to build on the strengths of the existing health delivery system, we offer the following legislative suggestions, recognizing that in some respects we are departing from other major provider groups.

COVERAGE

We believe that by attaching restrictions on who may be covered under a national health insurance program, or by attempting to define eligibility, many thousands and possibly millions of persons will either never be covered or will lose protection for a variety of economic reasons, including, in some cases, non-enrollment in the social security system. Distinctions among people, classes of people, or places of national origin are, in terms of the right to health care, an affront to the dignity of man. Therefore, coverage should be universal, including all U.S. citizens, resident aliens and aliens admitted for employment. Any other approach would compromise too severely a truly national approach.

In keeping with our Church's particular concern for those who are deprived of the abundance of life, we recognize that, as in so many areas, it is the poor and the aging who suffer most from the deficiencies of the current system of health care.

Escape from poverty is enormously difficult at best, but the possibility of breaking free is greatly complicated and often rendered impossible by the constant presence of potential debilitating ill health. While there are obvious differences among poor urban and rural communities in respect to health care, they share in a common fate—they receive less than adequate health care. Lack of subscription—individual or group—to health coverage policies, high costs, poorly equipped and understaffed clinics (where such exist at all,) greater susceptibility to disease or accident, higher unemployment or underemployment—all contribute to sharply lower standards of health among the poor. Thus the endemic hopelessness of the ghetto—urban or rural—is maintained, welfare costs constantly escalate, and the price paid for erosion of the human spirit continues to climb. We support, therefore, the "folding-in" of Medicaid within a national program.

BENEFITS

We believe that the legislative enactment of a mandated package of benefits should include the following: preventive services, all physician services and all inpatient, outpatient and medical services. This is intended to include coverage for all catastrophic illnesses, all prescription drugs, post-hospital extended care, nursing home care, medical home health services, rehabilitation services, care for the developmentally dis-

abled, dental care including orthodontia, therapeutic devices, prosthetic devices including hearing aids and eyeglasses, health-oriented social services, mental health services and necessary medical transportation.

We believe that a preventive approach to mental health care should especially be encouraged, including the developing of community-based mental health services. Automatic cut-off limits on mental health services, such as a 30-day limit, should be discouraged in favor of an emphasis on quality control and peer review. Services provided by other certified mental professionals—in addition to psychiatrists—should be included in any final legislation.

The daily tragedies ranging from serious automobile, industrial and home accidents to the spreading incidence of severe long-term coronary disease, cancers and other crippling illnesses are incalculably compounded by the financial blows which too often accompany them. In a nation marked by its generosity and abundance in so many spheres, there is no longer any justification—medical, moral or monetary—for the prospect of severe financial difficulty or ruin being visited upon any individual or family as the direct or indirect result of serious injury or sickness. Elimination of a system which permits treatment and recovery only through great personal loss would top many an American's list of redressed grievances.

We would endorse the principles and concern which led to the inclusion of catastrophic coverage first in the Long-Ribicoff bill and retained and liberalized somewhat in the Kennedy-Mills measure. Liberal universal catastrophic coverage is only meaningful in the context of a total national health insurance program and, therefore, should not be enacted separately. The benefit package we have endorsed and our recommendation which follows—folding in Medicaid and Medicare and endorsing a long term care provision—would give us the catastrophic coverage we need in an overall, total program.

HEALTH EDUCATION

Our conviction about the right of all to health care prompts us to speak within the context of preventive health care for an equally strong program of health education. Indeed, without such a program, even a liberally funded approach to preventive medicine could result only in marginal success. In spite of our country's vast and diverse commitment to education in general, there is no similar commitment to national and widespread health education, a condition symptomatic of the deficiencies within our present health care delivery system. We view national health insurance as an important vehicle for emphasizing health education through education and information programs. These programs should complement and stimulate health education programs in the school systems and community institutions. Health education on this large scale would be primarily preventive in tone, covering illnesses and ailments which people can take steps to prevent themselves, without unnecessary medical and institutional involvement. We maintain that a carefully developed program of national health insurance, accompanied by solid

health maintenance education will result in the long run in substantially decreased medical services and institutional costs. We believe that such a program is crucial for the health of the country, and see a national health insurance system as the most logical context within which to proceed.

PREVENTIVE MEDICINE

We believe there should be substantially more emphasis on preventive medicine and services than is reflected in most of the pending bills. We recognize that there may be present financial limitations in respect to immediate creation of a far-ranging effort to institutionalize, in effect, the practice of preventive medicine. Legislation should include authorities for the development of preventive health services and strong encouragement for the conversion of our present inclination to treatment of episodic illnesses to an approach which places more emphasis on comprehensive prevention of sickness.

The Congress, in its wisdom, took an important step in this direction last year through passage of the Health Maintenance Organization Act of 1973. We would like to see more funds allocated under national health insurance for the development of HMO's and for other methods which favor a preventive approach to health care. A national system of health care which places increasing emphasis on person-oriented preventive treatment should ultimately succeed in reducing the per capita cost of health care. Emphasis on preventive treatment—as well as health education—should reduce the high number of unnecessary hospitalizations. Physical check-ups, routine eye and dental examinations, chest X-rays, etc., should become commonplace features of coverage, as well as full screening tests for severe ailments such as diabetes, cancer or high blood pressure. As representatives of the Church, our concern relates to keeping persons and families physically, mentally and spiritually healthy. We can think of no better general approach to this end than a well-planned, accessible preventive system of health care.

LONG-TERM CARE

Recognition of the needs of the old and poor really may be viewed as the forerunner of the general need for national health insurance. The need for health care increases as one grows older, both in terms of treatment and the use of medicine. Aging persons are naturally prone to a greater variety of illnesses and the necessity of ongoing health care is far more likely to become a permanent condition of life, rather than episodic. Yet this greater need for health care among the aged occurs most often when their financial resources are dwindling, or fixed as on a pension, and is poignantly illustrated in the nursing home situation in this country.

The needs of our elderly citizens and others for long-term care have never been satisfactorily met. The separation of levels and types of care has been a particular problem in the maintenance of the health and well-being of the elderly whose needs are often so great.

In line with our recommendation of universal coverage and no premium payment, we feel that Medicare should be folded into a single overall health insurance program and only phased out as new legislation is implemented. We would specifically recommend the inclusion in any bill of the concept of long-term care as envisioned in Title II of the Kennedy-Mills bill (H.R. 13870, S. 3286.) For the first time, the range of care possibilities envisioned by this title seems aimed realistically at the range of need experienced, and offers the possibility of tailoring care to insure the maximum maintenance in as normal a community setting as possible. The establishment of entitlement to a multiplicity and full range of services not necessarily related to hospitals is excellent.

We do have some specific concerns which should be built into the eventual long-term care title.

As with our earlier recommendation on health insurance as a whole, coverage should be universal. The long-term care title should be mandatory in the states. It should not involve the payment of a premium. The mandated consumer participation in the proposed title is excellent. The "consumer's" freedom of choice should be preserved. We would also urge recognition of the provision of services for the elderly within the context of religious-cultural traditions.

The long-term care title should provide for medical social work, dental care and routine preventive services and other ancillary services needed by the aged.

We feel that the title should be worded to prohibit a provider from becoming the community long-term care center. And, in the field of long-term care, there should be specific incentives for non-profit providers of service.

Title XIX of the Social Security Act, Medicaid, would be repealed. But since some 70 percent of the money for long-term care presently comes through Title XIX, we would urge that this part of Title XIX be phased out only as the new long-term care provisions are actually phased in. In addition, we feel federal standards for long-term care facilities should be clearly mandated in the legislation.

The present practice of separating levels of care for fiscal purposes frequently results in moving elderly patients arbitrarily, resulting in great disorientation and often destroying the will to live. It also results in arbitrary definitions of what is one level of care, and what is another. We would urge the provision of a uniform system of monitoring which is humane and does not freeze in levels of care which require moving patients to less expensive facilities providing less service for fiscal reasons alone. There should be prospective reimbursement to providers on a cost-related basis for actual care rendered rather than reimbursement on the basis of levels of care.

FINANCING

Three years ago our three organizations testified on behalf of using the principle of social insurance in financing any national health insur-

ance program. Now we wish to make that more concrete. In order to distribute most equitably the cost of health care on as wide a base as possible, we believe health insurance should be financed by a mix of tax on employer payrolls, a tax on the self-employed and general federal revenues. No tax should be assessed on income received from public assistance, supplemental security income, social security or unemployment and workmen's compensation. This approach would help greatly to ensure that nobody suffers from lack of coverage. And the method should eliminate the demeaning means test relative to health care. Any means test is injurious to a person's dignity, is almost impossible to administer fairly or efficiently, and accomplishes little.

A major difference between the various bills before this Committee is in the financing mechanisms. The Administration's Employer Health Insurance Plan (H.R. 12684 and S. 2970) is voluntary, which we think is unsound public policy because it may encourage employers to provide some more immediate employee benefit while discouraging employee participation in a more costly health insurance plan. It has some additional untoward side effects. The estimated premium for a family (three-fourths of which would be paid by the employer) is $600. The estimate per single individual is $240. The possibility of additional payroll expense could serve to promote the hiring of single and/or temporary employees. Even if this did not develop into a trend, another possible detrimental feature is the regressive aspect of the fixed premiums. Lower income persons, paying a family premium do so in proportionately larger amounts in relation to their income.

Other bills have similar regressive effects, or create separate tiers of care for the poor and non-poor, or operate on the experience-rating system of limited groups and do not share the cost of national health insurance over a sufficiently wide base. And some bills would not pool the purchasing power in a manner which can have a salutary effect in improving the delivery system.

We endorse the establishment of a national trust fund within the Social Security Administration to handle the collection and disbursement of funds—in terms of purchasing and reimbursing services. The contributions of employers and the self-employed, which would be collected on a national basis, should be earmarked specifically for the national health insurance program and should not be a part of the general federal budget. Amounts of monies involved should be strictly on the public record. Such an approach, accompanied by broad federal guidelines, would illustrate the truly national character of the program. Under these federal guidelines, we see private insurance companies as fiscal intermediaries, suppliers of supplementary insurance and developers and managers of health maintenance organizations on a reasonable cost basis.

CO-INSURANCE AND DEDUCTIBLES

We have noted, of course, the differences among the pending bills on the issue of co-insurance and deductibles. We would say, on both subjects, that they have no place in a national health insurance program, and

we would urge the Committee to eliminate all deductibles and co-insurance within a national plan. It is alleged that the presence of deductibles and co-insurance militates against overutilization of the health care system, in respect both to use of physician services and provider care. We contend that this is theory at best, with no firm body of supportive evidence. On the contrary, most utilization is determined by physicians in the provider system. We would also submit that the pricing policy in our current system inhibits and limits access to health care on the part of untold numbers of persons who need care. Furthermore, if deductibles and co-insurance were totally eliminated from the national plan, we believe that any initial over-use which might result will be more than offset by judicious use of peer review and an important emphasis on preventive health care and health maintenance education. We also believe that inclusion of the deductible and co-insurance systems and figures in any one of the pending plans will prove onerously difficult and expensive to administer. Dropping them altogether, we feel, would ultimately result in significant savings for the system, and end once and for all the financial and personal inequities associated with the practice.

ADMINISTRATION, STATE AND LOCAL ROLES, DELIVERY OF SERVICES

A national health insurance program would be unwise and excessively costly unless coupled with steady and substantial improvements in health care delivery. So we believe the financial leverage of that health insurance program ought to be used to secure substantial improvements in the delivery system. Secondly, while professional judgments and the responsibility of physicians for diagnosis and treatment must be assured, subject to peer review, national standards for health care services should be mandated for both individual and institutional providers of health care services.

So, while endorsing the fiscal role of the federal government, we feel equally strongly that the rate-setting, regulation, and certificate-of-need systems must be separate from mandated involvement of the federal government. The state governments must be in a position to assure the availability, the access, quality, and viability of the needed health services. We see strong state involvement in regulatory activities, rate setting and health planning as the core of a national health insurance system in which the cost control rests with the federal government and the voluntary, pluralistic approach to health care options and delivery are enhanced by greater participation on the part of the states.

We feel the most logical way to proceed is through establishment of state health commissions, as proposed in H.R. 1, with the authority to regulate providers and the responsibility to assure that quality health care is available and accessible to all residents. State health commissions should be constituted independent of state control after having been duly created by the states in accordance with mandated federal guidance.

Each state health commission, in other words, would be the principal agency responsible for regulatory and related functions. In order to reduce any potential conflict within a commission, we would make two suggestions. First, there should be adequate local provider and consumer participation in the planning, rate review and certificate-of-need functions. Such local participation would preclude arbitrary and capricious decisions made at the state level. Secondly, there should be two equally responsible divisions within each state health commission—a rate review division and a planning/certificate-of-need division. Hopefully, this would eliminate competition relative to discussion and action on operating funds (rate review) and capital funds (planning/certificate-of-need).

We recommend that the local government (town, city, county) be the facilitator of coordinated planning among providers with strong consumer involvement. Regional and local comprehensive planning groups should be continued and fostered as the conveners of local providers and consumers with the responsibilities to promote needed services and to advise the state health commission on certificates-of-need and rates.

In order to assist the states in these endeavors, we recommend the establishment of broad federal standards, possibly accompanied by a federal contingency plan to impose regulatory, rate setting and certificate-of-need granting on a state or groups of states which are unable or unwilling to develop the means to implement the national health insurance program.

We recognize that professional and institutional providers must meet high standards of quality, efficiency and effectiveness. We likewise contend that national standards must be consonant with reasonable geographic and regional standards. Again, therefore, we would like to emphasize our belief that the respective roles of the federal and state governments be integrated under a truly national health care insurance program. We would call for federal specification of a broad set of benefits for all persons and the provision of incentives for state and local agencies.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The basic intent of P. L. 92-603, relating to Professional Standards Review Organizations, is to provide peer medical review of the quantity and quality of medical services rendered, particularly in respect to the aged and the poor. Overutilization was a principal object of concern when the legislation was being considered, as reflected in the Senate Finance Committee's report that: "in view of the per diem costs of hospital and nursing facility care, and the costs of medical and surgical procedures, the economic impact of . . . overutilization becomes extremely significant."

Because utilization review, as such, was found not to prevent such overutilization, "regional norms of diagnosis," to be applied by area Professional Standards Review Organizations, were aimed at alleviating

costly overutilization and, therefore, improving the quality of care. Our organizations support these basic objectives. But, because Professional Standards Review Organizations are just beginning to be placed into operation and because there is not yet sufficent empirical evidence to support the conclusion that they will successfully perform their functions, it is strongly recommended that their development and operation be accompanied by a formal and ongoing evaluation program.

Specifically, we would make the following recommendations. First, we think there must be statutory protection against possible intrusion into patient record confidentiality by Professional Standards Review Organizations' non-medical personnel. Secondly, we believe that, under Professional Standards Review Organizations' procedure, physicians should be subject to liability for disapproved medical services. Thirdly, there should be relief or appeal procedures in the law which recognize that some of the "norms of diagnosis" to be followed by Professional Standards Review Organizations may be unreasonable, arbitrary or unmanageable, for example, medical school standards in some settings. Fourth, Professional Standards Review Organizations' deliberations should not be subject to public scrutiny because of adverse effects on physician review procedures. If Professional Standards Review Organizations' minutes were subject to public disclosure, physicians may be hesitant to review objectively a peer's medical procedures. And finally, attention must be paid to the problem of possible administrative delays in hospital reimbursement under Professional Standards Review Organizations' procedures.

THE ROLE OF THE CONSUMER IN NATIONAL HEALTH INSURANCE

The responsibility for maintaining good health and for high standards of health is shared by those who need or receive services as well as those who provide the care. The relative paucity of health care providers in poor or minority communities is clear testimony to an over-emphasis on provider determination of services and locations. We believe that any integrated system of health care delivery and any national health insurance plan must provide for substantial and equitable participation by consumers in determination of policy and review. Such participation should be both mandated and encouraged. The bills before the Committee vary widely on this subject, according the issue differing levels of importance. We would urge that the subject receive priority attention.

Mr. Ullman's measure (H.R. 1) establishes the principle of consumer participation in local delivery mechanisms. We agree that institutional and group providers should have equitable consumer representation on their boards. H.R. 22 and S. 3, sponsored by Mrs. Griffiths, Mr. Corman and Senator Kennedy, provide for consumer participation in an advisory capacity as regards determination of policy and the administration of the program. We believe that consumers should justly be involved in any local, state or regional planning agencies and in federal and state agencies charged with designing and implementing the elements of a national

program. In the latter respect, we urge a National Health Services Advisory Council be established to relate to the National Trust Fund and State Health Services Advisory Councils be established to relate to the State Health Commissions. Advisory councils should be in a position to contribute both to the development of fiscal policy and to standards-setting procedures. Half the membership of these councils should be composed of consumers of health care services and half of providers. We also favor the provision that these advisory councils have included among their responsibilities the review of any proposed regulations or regulation changes prior to publication in the Federal Register. Experience with the Medicare-Medicaid Amendments of 1972 and other legislation, in corresponding with the Department of Health, Education and Welfare on the matter of social services, shows how implementing regulations can be subject to numerous and often conflicting interpretations.

Regarding our support of the Title II long-term care provisions of H.R. 13870, the Kennedy-Mills bill, we favor the definition of consumer participation in the governing boards of the community long-term care centers, and we urge a consumer role in state long-term care agencies as well.

Earlier we said consumer participation should be both mandated and encouraged. We note that it is easier to mandate participation than it is to encourage meaningful involvement. Consumers, especially the poor, minorities and the aged, will need special education and assistance to participate strongly and meaningfully. Indeed, we feel that attention should be given to providing consumer representatives professional, technical or other staff back-up, responsible to them, so that they do not participate at a disadvantage in relation to providers who substantially control the language and know the complexities of the system.

We believe that consumer initiatives in respect to bringing health services into a community must actively be encouraged. Accordingly, we feel that the legislation should provide clearly for federal override of any state regulations or legislation which curtails or discourages consumer initiatives in relation to federal health funds and programs. Without such protection, consumer participation will vary widely and significantly among the states, to the detriment of a national health insurance program. We urge also appropriate procedures for appeals.

Finally, we suggest that a definition of the word "consumer" be provided in the legislation which will exclude providers and government officials (who are also consumers) from the terms of the definition, and will specifically include equitable representation for the poor, minorities and the elderly.

FAMILY PLANNING

In light of our commitment to a positive national health insurance program, we must also state our convictions as regards family planning services within potential legislation. The proposed emphasis on preven-

tive health care and on mandating a broad set of benefits should not, in our view, include family planning services—particularly sterilization and abortion procedures—as parts of those benefits. We unequivocally oppose their inclusion in any legislation.

For the purpose of today's testimony, we will especially address the subject of abortion as one of the family planning services which might be covered under the terms of national health insurance. We strongly oppose any program that includes abortion as a method of family planning. The Congress has prohibited funding abortion as a method of family planning, and this prohibition must be extended to national health insurance. We cannot over-emphasize our belief, as stated in the papal encyclical of Pope John XXIII, "Peace on Earth," that "any human society, if it is to be well-ordered and productive, must lay down as a foundation this principle, namely, that every human being is a person, that is, his nature is endowed with intelligence and free will. By virtue of this, he has rights and duties of his own, flowing directly and simultaneously from his very nature. These rights are therefore universal, inviolable and inalienable."

Further in that encyclical letter, Pope John affirms that "every man has the right to life, to bodily integrity, and to the means which are necessary and suitable for the proper development of life."

We firmly maintain that the practice of abortion is absolutely violative of the right to life and its development. Health care must include protection of the child in utero. We submit that the right to privacy, as defined in the Supreme Court decision of January, 1973, cannot take precedence over the immutable right to life itself. We believe that the preponderance of scientific evidence clearly shows that the fetus is a living, individual human being whose pre-natal development is but the first phase of the long and continuous process of human development that begins at conception and terminates at death. We hold that, regardless of the circumstances of origin, human life is valuable from conception to death because God is the ultimate Creator of each human being, and because human life is valuable in and of itself simply because of its own inherent sanctity. We also feel that someone must speak forcefully on this subject within the context of potential national health legislation because we strongly believe that the right to life is a basic principle of all health care services. Moreover, if the taking of human life through abortive procedures is sanctioned federally, equally destructive practices —such as euthanasia and sterilization, particularly of the mentally retarded—will become commonplace in the future, as evidenced by incidents that have been carried out in federally funded programs in the past. Moreover, public opinion surveys continually show that the majority of Americans oppose abortion on request.

As representatives of the Church, we must assert that whenever a conflict arises between the law of God and any human law, we are bound to follow God's law. With respect to religious beliefs, conscientious convictions, moral directives and ethical codes, we strongly urge the

Committee to include adequate protection for individuals and institutions within national health insurance legislation. Congress has already taken cognizance of the need for conscientious protection by incorporating relevant provisions in the Health Programs Extension Act of 1973, Public Law 93-45. In addition, many states have adopted, or are in the process of adopting, protective legislation.

In summary, we believe that participation by persons and institutions in any system of national health insurance must not be contingent upon nor result in the violation of deeply held beliefs by persons of many faiths. Catholic people and Catholic health care institutions could not participate in any plan which would require the violation of such beliefs, most emphatically in the areas of abortion services.

CONCLUSION

We would urge the enactment of a total health care insurance program now, though we recognize the program itself will have to be phased in over a period of time. The phasing aspect will allow the program to mature—particularly in terms of administration and experience—and will allow for an orderly transition to the full package of benefits which, understandably, will require time to achieve.

This concludes the testimony, Mr. Chairman, of our three organizations. We would like to emphasize once again that by appearing today, we are confirming the commitment of the Catholic Church and the thousands of priests, sisters, lay persons and health personnel associated with the Catholic expression of health care in the United States. They and we are vitally interested in the proposed legislation, and we and our staffs stand ready at any time to assist the Committee and its staff in the formulation and clarification of a national health insurance program. You and the Committee are to be commended for the comprehensive hearings you have held and for your understanding of the need for this legislation. Thank you very much for the opportunity to discuss our concerns and wishes with you.