A Beam of Light through the Fog

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A recent article by Professor George Silver (1980) provides a useful description of current developments in national health insurance plans, several of which make provision for coverage of "catastrophic" health needs. It would appear that certain aspects of cleft lip and palate would qualify for such coverage. Some recommendations are made here for ensuring inclusion of the disorder in any national health insurance plan.

The workings of government, federal and state, are marvelous to behold and exceedingly difficult to discern. A prime example is the role of government in the provision of financial assistance for health care. Those interested in the issue but without the needed time to follow proceedings carefully are frequently frustrated with the inability to find out about current events and developments. We have attempted to do so for several years but without outstanding success, to put it mildly.

Occasionally, however, there comes a beam of light through the fog, and one shone recently in the article by George Silver in a recent issue of Saturday Review (Silver 1980).

Professor Silver is a recognized authority in the field of public health and has commented frequently in books and magazines about public health problems and health care delivery. We recommend his writings to those interested in the general topic.

His article in Saturday Review is particularly instructive. In it he provides some needed information about evolution of "health" insurance, as well as a highly readable survey of three proposals for national health insurance that apparently are being evaluated by federal groups and the Congress.

He labels the three plans according to their advocates: President Jimmy Carter, Senator Edward Kennedy, and Senator Russell Long. Following is an abstract of the information he presents about the three plans. We recommend strongly that the reader not depend only on our reporting but, rather, read, firsthand, Professor Silver's article.

Senator Kennedy has proposed a kind of credit plan, in which insurance is available to everyone with essentially no limit on use, except for psychiatric services (a curious deletion, we think). Funds come from both employer and employee, including the self-employed. Privately controlled insurance companies provide the fiscal basis for the plan. There is a ceiling, not yet determined, on expenditures. The target date for implementation, if the plan were legislated, is 1983. Professor Silver considers the plan to be seriously defective mainly because of high bureaucratic costs which will contribute to inflation.

The Carter plan seems less ambitious. It establishes a ceiling on the total that any person would have to spend for health care; the national health insurance then assumes responsibility for costs that are in excess of the ceiling. Free care is provided to pregnant women and infants under one year of age. Special attention is directed toward assistance for the poor, and the law would set a new federal poverty level, increasing by some 50% the number of eligible under that provision. The notion of "catastrophic" coverage is referred to several times in this plan. Contributions are made by employer and employee, and implementation generally is by governmental agencies, particularly for special groups. Professor Silver is critical of the Carter plan, claiming that it contributes to inflation and serves to perpetuate the two-tier system of health care, with poor people receiving poor care in comparison to their fellow citizens who are better off economically.

Silver contends that the Long plan is the leading contender for passage. This plan provides coverage for the remainder of a calendar (or fiscal) year after a family spends $2000 for health care. Thus, the notion of a plan for catastrophic need is advanced. For obvious
reasons, the plan is inflationary, since the general intent will be to pass the $2000 barrier as soon as possible. Silver supposes that the plan will be viewed favorably because of demonstrated success of catastrophic health insurance laws in Rhode Island and Hawaii.

The relevancy of this discussion seems obvious for readers of the Cleft Palate Journal and members of the American Cleft Palate Association and the American Cleft Palate Educational Foundation.

1. Cleft lip and palate and related congenital anomalies constitute one of the most frequently occurring major classifications of birth defects.

2. Contemporary standards for treatment of cleft lip and palate dictate that contributions by a number of specialists are required to obtain satisfactory treatment results (Morris et al. 1978).

3. Previously published findings (Morris and Tharp 1978) indicate that, in 1977, comprehensive treatment for cleft lip and palate, if paid for on a fee-for-service basis, might cost a total of $30,000. Assuming an 18% per year increase (as estimated by the Consumers Price Index for health care), the 1980 costs for the same treatment are $41,700! This figure is minimal since not all aspects of care were considered.

4. There are existing resources available to families for helping to meet these costs (Morris and Tharp 1978), but distribution of resources is uneven, eligibility criteria are unclear, and the amount of assistance is frequently small when compared to the need.

5. As a consequence of all these factors (frequency of occurrence, complexity of required treatment, expense of treatment, and lack of resources available to the family), cleft lip and palate clearly qualifies as a catastrophic health problem and merits careful study for inclusion under any of the above three plans or any plans yet to be developed. Furthermore, the need to accomplish that objective is urgent because ground work is now being laid in federal legislative circles that will determine future direction of any national health insurance plans.

**Recommendations**

ACPA and ACPEF leaders, including our present ones, have made a number of efforts of this kind. Progress has been difficult and slow, mainly because of lack of time and expertise on the part of members in matters of lobbying. It is seldom possible to use volunteer labor effectively for such ventures. Most of us have many other activities that take precedence, and few of us have the necessary skills for reaching the key people in such matters.

What can we do about this important matter? Here are some suggestions:

1. Discuss the general matter with available representatives of existing health insurance companies that provide coverage for your patients. The chances are good that existing insurance plans will influence the development of future ones.

2. Discuss the general matter with parents of patients who seem likely to be interested enough in the problem to be activists about it. Public spokesmen who represent the consumer are frequently more effective than professionals in lobbying efforts.

3. Write to your federal legislators about the matter, putting the case as simply and logically as possible. In your letter, avoid the appearance of serving your own professional (and personal) interests.

4. Encourage the leaders of ACPA-ACPEF to consider retaining a professional lobbyist, probably on a part-time basis, for the purpose of selling this proposition to legislators more effectively and efficiently than can our members.

A related possibility for the ACPA-ACPEF leadership is to contact other professional organizations to determine whether any of them have similar concerns or have mounted such lobbying efforts. If so, they might welcome our assistance in those efforts.

5. Continue to consider this important issue by means of letters to the Editor of CPJ, other guest editorials, or other forums for discussion so that we all may come to a clearer understanding of the issues. It's an important matter to that segment of the public which we are dedicated to serve!

**References**

