CHARLES H. MAYO: Current medical delivery system is really pretty much of a fragmented delivery system. And what I mean this is that each hospital, we can consider perhaps hospitals as the place where medicine really takes place, each hospital becomes a sort of a city unto itself.

And in Minneapolis and Saint Paul, you find hospitals running at a sort of an autonomous. They could run by themselves so that you have-- they could do everything from cobalt to open heart. There are many of them. We really don't need this type of-- this is redundant wasteful and I think not very thinking.

PAUL GRUCHOW: I think they're unnecessary costs that come into the medical system because of the way it works now.

CHARLES H. MAYO: As an example, the private practitioner. We need these people, but we need them to be joined together into groups. So as an example, you might have an illness that you'd go to a general practitioner. He would diagnose your case, but over the best of his knowledge and say, perhaps you might see a neurologist. Well, of course your general practitioner would present you with a bill for his diagnosis and send you on to a neurologist.

Neurologists would look at you and say, well, I think that this and this that perhaps an orthopedic surgeon might do you some good. So he'd present you with his diagnosis and his bill, send you on to the orthopedic surgeon, who might perform his operation. He of course give you his diagnosis and his bill as well.

And then after that, perhaps you might need some rehabilitative or correctional type therapy, of which there the doctor who was doing physiotherapy will take the orthopedic diagnosis and work on you and present you his bill. So it becomes a fragmented service.

Where I feel that if you had a whole group, one might be able to go to the doctor, have a consultation, and get taken care of and then be presented with a bill, rather than having this fragment because each person is taking his pound of flesh. And pretty soon, you're suffering in your wallet.

PAUL GRUCHOW: So if you have a team of physicians, the total bill is likely to be smaller.

CHARLES H. MAYO: Right. I think so.

PAUL GRUCHOW: Is one of the aspects of this plan, a prepayment in any way?

CHARLES H. MAYO: Yes, it would be. It would be set up, not unlike Social Security. So instead of a Social Security fund, you'd have a health security fund. And this would be in order the money would have to come from general revenues and personal income tax. So for the working man, he would be getting-- 1% of his income would be going to health care.

The fellow who was in self-employed would probably get 2.5% of his income up to $15,000, same as with a working man or employed man. And those who were employers would pay a 3.5% tax as an employee or no employer's tax. And then the rest would come from general revenue.

PAUL GRUCHOW: How much money would the kind of national health system this bill poses cost?

CHARLES H. MAYO: Well, I would say, not under 70 billion per year, because this is about what we're paying now. And we are on a inflationary trend. So you can count on 70 billion. And if we go on a natural, what we in our society as a we could count on an increase yearly.

But when you get down to it, if you look at that 70 billion which we are spending now, probably $72 billion, but you round it off to the closest billion mark, it represents about a little over 7% of the gross national product or income that we spend on health. And I feel-- you look at-- we have the greatest medicine in the world. But there's far more than medicine for health. I think prevention.

You look at radio advertising and newspaper advertising that are concerned with health, and you find that the people who have a vested interest are the ones pushing the health education programs in the United States. For instance, everybody knows that Haley's M-O is for the stomach, and Preparation H is for hemorrhoids, and no doses to keep you awake and tranquil or whatever to put you to sleep.

What is that? Excedrin, I think, they're obscene. Some of these advertisers-- and here we as physicians blandly listen to it and let it go. I think it's unfortunate situation that we allow those people who have really a vested interest in their own gain to give out health educational material.

PAUL GRUCHOW: I guess I don't understand exactly how the health security proposal embodied in the Kennedy-Griffiths bill brings about changes in the delivery system. Are there proposals in the bill that provide shade and things like that? Yeah, how do they change in any fundamental way the way the system works now?

CHARLES H. MAYO: As an example, say that it were act in an enactment. And so we had our system as it were or as it is now, how would we continue to change? In the health security or in the trust fund, there would be certain monies set aside to improve and innovate.

So what we're looking at, you can see it in the University of Minnesota and all the university, how to get new health personnel out. This is one way. Well, it would provide money for this. So about 5% of the money of the health Security Trust fund would be allocated for innovative and new development so that you could try-- for an example, I think each, year about 30,000 corpsman are allotted from the Navy and the army and all.

There's tremendous valuable resource there that the medical profession is now just beginning to look at, that these people may be helpful to us in setting up battalion aid type stations in the rural communities. People who can answer to a distress call say from a farmer who has caught his hand in a picking machine, corn picker, or some other type of emergency.

This fellow has been trained. $25,000, they estimate, has gone into a corpsman training. This might be a valuable source. And there are people are looking at this.

PAUL GRUCHOW: Does this bill provide any fundamental answer to the problem of distribution of health manpower?

CHARLES H. MAYO: Yes.

PAUL GRUCHOW: For example, would it help rural Minnesota where there aren't?

CHARLES H. MAYO: It certainly would.

PAUL GRUCHOW: And how?

CHARLES H. MAYO: Say a group practice wanted to say, I'd like to set up a satellite station in the Nett Lake Reservation. And we would like to do this as a pilot study because we think that setting up a station like this might help rural Minnesota. Well, the bill is flexible enough to say, yes, go ahead. We will fund this as part of our research and development type thing.

So we recognize that they'd give incentives, incentives to practice in the core city, incentives to go out into the rural sections too. So it's full of hope and opportunities to innovate.

PAUL GRUCHOW: What kind of assurances are there in the bill that something won't happen like what happened with Medicare? That is, it solves some problems of cost for the elderly people involved but it also increases the general cost of medical care across the country?

CHARLES H. MAYO: Well, this was a very interesting phenomenon with the Medicare, because with the Medicare, as it was originally planned, were cost controls. And the AMA finally said, we will let this go if we could just put in the clause "customary and usual charge", which just went skyrocketing and it became a boon to payment for the doctor.

And we've heard of people getting rather-- well, they just off taking care of people and just making their rounds seeing people. In the health security bill, there will be cost control and review of things so that it can't go out, unless it's passed through a committee that increase in prices.