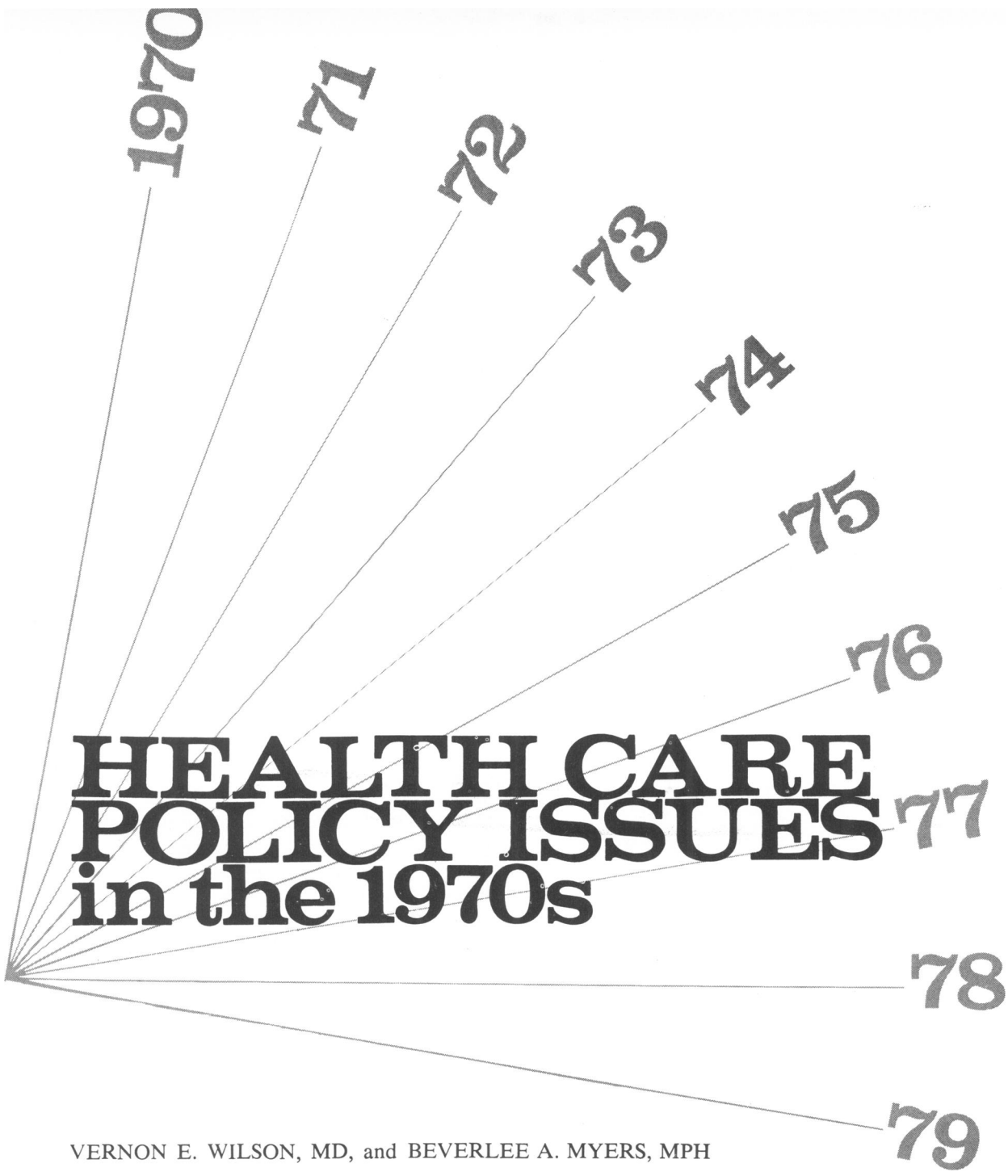

HEALTH CARE POLICY ISSUES in the 1970s

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The Department of Health, Education, and Welfare is essentially consumer oriented, focusing on people and their potentials as well as their problems. In its service-oriented functions, the Department emphasizes the capability of consumers to make their own decisions and the right and responsibility of consumers to make their own choices.

Goals and Process Objectives

The two major goals of the Department, which direct activities of all its agencies, are (*a*) the pursuit of individual, family, and community self-sufficiency and (*b*) the reform of service institutions.

Concerning its health care programs, the Department translates these goals into a movement

toward investing the right to health care in the individual—not in institutions—through various forms of health insurance and health care benefit packages. At the same time, the public and private institutions which provide health care need to be reformed in order to make them more sensitive and responsive to the consumers. This, of course, encompasses our concerns with access, quality of care, distribution of services, and cost control.

The twin goals of nondependency and institutional reform can be achieved through a variety of means. They could be achieved, for example, through massive Federal investment—even control—of the health care system or by restructuring incentives and relying on market forces to bring about desired change. It is as important, therefore, to understand the process objectives of the Department—the "how do we get there" objectives—as it is to understand its goals.

The Department's process objectives can perhaps be best summarized in two words—pluralism and reprivitization. Peter Drucker, in "The Age of Discontinuity" (*1*), coined "reprivitization," which in essence means a policy of using nongovernmental institutions to execute and operate governmentally determined objectives. Drucker suggests that government is not a good manager and not an effective performer; thus it should stop doing things for people and start concentrating on its role as social leader and policymaker. Private institutions, he says, should be relied on to carry out policies, provide services, and operate programs.

Pluralism, as described by Drucker, implies ". . . a galaxy of suns rather than one big center surrounded by moons that shine only by reflected light" (*1a*). This is a pluralism of specialized institutions that are interdependent—none could exist by itself alone—they all need each other, and, theoretically, they need to work together.

Perspective

It is generally agreed that the Federal Government, under any Administration or under any Congress, has failed to enunciate a coherent national health care policy. The basic schizophrenia of the health care field is its inability to establish manageable health care goals. Much of the problem stems from the carrying out of the largest part of the Federal responsibility for health care as an appendage to income maintenance programs, to military and veterans programs, to regional economic development activities, to employee benefit programs, to poverty programs, to rural and urban development objectives, to manpower training activities, and even to space exploration and transportation activities. Health care concerns permeate the Federal establishment, and there is no process to locate responsibility for national health care goals among the individual fiefdoms.

Leaving aside for the moment the research, development, and regulatory activities of the Federal Government, the two major functions which various parts of the Federal establishment carry out in the health care arena are paying for the purchase of health services and providing for the delivery of services, either directly or indirectly by creating health delivery systems.

In our opinion, the crucial issue in health care is the apparent discrepancy in Federal policy between its two functions of purchasing health services and creating the resources for delivering them. We refer to this dilemma as the dollars and delivery dichotomy, which has been described more fully in an earlier paper (*2*). The following is a brief review of some of the basic differences in the Federal strategies which may help to understand the policy problems.

Policy Problems

On one side, we have the financing programs—Medicare, Medicaid, and others present and future—which seek to influence the demand for health care by certain populations. On the supply side, we have programs to develop resources to build supply capacity such as manpower education and training, grants and loans for construction of facilities, and project grants for health centers, mental health, and migrants. For our purposes, the following are four major areas which characterize the differences in Federal strategy on these two approaches.

Impact on Federal budget. The financing programs are characterized by essentially open-ended dollar amounts and what has been called "uncontrollable" budget demands (*3*). Thus, the amount of money Medicare or Medicaid spends in any year depends not on what is budgeted for the program in advance, but how many services the beneficiary population uses and the costs of those services. These expenditures are actuarily predictable, but given the nature of the programs, they are not subject to budget control except in the gross sense of cutting back on

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population coverage or benefits paid. On the other hand, the delivery, or supply creating programs, operate under limited dollar amounts that are clearly subject to budget control, with annual appropriations determining the level of expenditure. (Within HEW, the financing programs, or the uncontrollables, account for 80 percent of the Department's health expenditures.)

Difference in administration. Generally, the financing programs are operated by agencies whose primary function or purpose is not health care; it is income maintenance, employee benefits, defense, or other operations. The resource building programs are generally administered on the health side of HEW; some exceptions are OEO and FHA. This separation in administration is not necessarily incompatible, although it may partly account for different priorities in the two strategies.

Differences in focus. The financing programs deal with defined population groups and the delivery programs generally focus on geographic areas, although within a geographic area there may be an additional focus on specific populations such as children or migrants. This point should be viewed in light of the following one of entitlement.

Differences in philosophy of entitlement. The financing programs (with some minor nonconformity in the Medicaid program) generally have a philosophy of universal entitlement for the specific population groups reached and the services covered. Thus, once beneficiary status is determined, the benefits are essentially automatic and, in health insurance, should be uniformly available to those determined to be eligible. Of course, in a health care context, the entitlement is conditioned by two factors: the need for a particular service as determined by a professional and the availability of an appropriate source of care. In contrast with the universal entitlement philosophy, the delivery programs award funds on a selective basis, usually founded on need, and generally with a time limit on use of Federal funds. This strategy is conditioned by the constraints on total funds available, since there are always more applications than can possibly be funded.

Effects of Differences

What are the effects of these different characteristics in terms of discrepant Federal policies? Certainly, the health service financing programs have great impact on the nature of the delivery system, and the reverse is also true. One could hope that the two approaches would move in tandem and be mutually supportive. Have they?

In 1965, when the Federal initiative was to finance health services for the aged under Medicare, the capacity building programs were putting their major investments in service systems for families, children, and youth. Of course, priority was given to developing resources that would serve the poor who were to be covered by Medicaid, but Medicaid was viewed as only a small effort in comparison with Medicare. Perhaps today there would be a different character to the nursing home industry if Federal investment had been concentrated on extended care facilities.

The universal entitlement philosophy influences what benefits will be covered by the financing program—if a service is covered then it should

be available to all beneficiaries on an equitable basis. If a service is not widely available, then it usually should not be covered. The Medicare experience illustrates three kinds of decisions that were made at the interface between demand and supply.

First, hospital and physician care were determined to be desirable benefits, and it was decided that their supply was adequate to meet the demand—no additional Federal investment in supply was needed. Second, extended care facilities were not available in that form, but it was determined that the demand created by the Medicare coverage would stimulate the essentially proprietary industry to create the necessary supply. Third, home care was determined to be a desirable alternative to hospital care, but since such services were not uniformly available, it was determined to make a Federal investment in their creation, since supply would probably not be created by market mechanisms.

The foregoing perhaps seems overly rational and simplistic, and it is. We know that some aged people live in areas where there is not an adequate supply of physicians and hospital beds, to say nothing of extended care facilities and home care. The demand did not create an adequately distributed supply of services, either through market mechanisms or Federal intervention. Nor is there an equitable distribution in the quality of services covered. There are still hospitals and extended care facilities participating in Medicare which do not meet basic standards, but continue to be certified because we have promised beneficiaries that they have a right to the services when they need them, and thus we certify what is available.

At the same time that we recognize these deficiencies, Federal investment dollars are going into the creation of services which are not generally covered by the financing programs. Notable examples are mental health services, dental care for children, physician's assistants, transportation and outreach services, and preventive services. This is not to say that Federal investment funds should not be used to demonstrate the desirability and feasibility of providing such services, in anticipation that, if proved of value, they might be subject to coverage under financing programs. It simply points out that the demand and supply strategies frequently have incongruent objectives, and that the universal entitlement philosophy makes it difficult to incorporate innovation, when that innovation cannot be available to all beneficiaries on an equitable and universal basis.

To summarize, in the 1960s a large number of Federal programs were initiated which dealt with the financing of health care for certain parts of the population and with creating certain kinds of delivery systems. In large part, both approaches have fallen short of their goals, and the public's expectations have not been met. On the one side, the financing programs created a demand which was not matched by the supply, influencing inflation in the absence of either market mechanisms or Federal intervention to correct the problems. On the other side, services were created and delivery systems put in place in a few selected locations which were not capable of self-perpetuation because no permanent sources of financing could be matched with the services provided.

Thus, there are at least five major areas where the dollars and the delivery need to come closer together—in definition of the population served, in definition of the services to be provided and covered, in methods of payment to providers, in controls and accountability, and in support of innovation.

The population issue is one that may not be solved until there is some form of national health insurance which provides at least basic benefits for all, or nearly all, of the population.

The benefit packages of health centers, for example, will need to conform more closely to the benefits provided under existing and future insurance coverage. At the same time, the insurance proposals need to adapt to changing capacity of the system to deliver services and to expand benefits of proved insurability and accessibility.

The methods of payment to providers need to accommodate to other than the fee-for-service system, where alternatives exist. Coverage for health maintenance organizations is one facet. But payment to health centers on cost bases, rather than charges or fees, would help to alleviate some of the present problems. At the same time, centers need to know their costs, need to be able to cost out their benefit packages, and to keep accounting systems which permit this.

The financing programs represent the greatest potential leverage over quality, costs, utilization, and general accountability of the health care system, in the absence of direct and extensive regulation of the health care industry. These controls through the financing programs will increasingly be utilized in conjunction with health planning

agency sanctions, peer review approaches, performance monitoring, and prepayment. Health centers should be prepared to participate in, and be subject to, such methods of control and accountability.

Finally, innovation and experimentation in the organization and delivery of new kinds of health services will continue to be needed. Until they are proved, they cannot be supported universally by financing programs. But the financing programs can use their experimental authority to both stimulate and demonstrate feasible approaches. In addition, there is ample experimental authority for health services development in the Health Services and Mental Health Administration, which will continue to support innovation.

Policy and Program Changes

What does all this mean for the future direction of health services delivery and funding? What does it imply for the immediate actions which we in the Health Services and Mental Health Administration must take, and which grantees and planning agencies must take?

We know that eventually there will be some form of national health insurance. The actions we take now may well influence the direction of that national effort.

We know that health maintenance organizations are a major part of a bipartisan strategy to influence the delivery of health services. We also recognize, however, that health maintenance organizations will not be the modal pattern of health services delivery—they will not within the foreseeable future serve a majority of the population. But existing delivery systems which contain most, if not all, of the elements of a health maintenance organization can begin to move in that direction. The health maintenance organization conforms well with the population orientation of the financing programs, as opposed to the geographic orientation of most of the service delivery programs. Health maintenance organizations, then, are definitely viable in the near future.

Improvements in health planning and management structures are also foreseeable in the immediate future. These, of course, will take a geographic focus.

We also expect, in line with the movement toward general revenue sharing, that some form of special health revenue sharing will be proposed, under which many of the existing formula and project grant authorities would be consolidated into block grants to the States. When, or even if, this will take place is not known. It may have a timing related to enactment of national health insurance.

In the meantime, we are forced to face reality. We must recognize what John Gardner called the "crunch between expectations and resources" (*4*). The following passage from a speech of Gardner, when he was Secretary of Health, Education, and Welfare, is particularly appropriate.

> How do you make rational choices between goals when resources are limited—and will always be limited relative to expectations? . . . Forced choices are of course not the only consequence of a limit on resources. We can have our cake and eat at least some of it if we can get a higher yield from the dollars, talent, and institutional strength available to us. But that raises questions of good management and unit cost that are painful to most people active in the social fields. Once in talking with a physician, who was ministering to poor people, I asked about unit costs of his government-supported clinic, and he said "I'm not an efficiency expert, I just want to heal sick people." What he was refusing to face is that somewhere up the line hard decisions will necessarily be made and a limit placed on resources available for delivery of health care. So if he is in fact functioning with high unit costs, the number of sick people he can treat will be correspondingly few. Without knowing it he had made a decision on resource allocation.

Resource allocation decisions are being made at all levels, and, at this point in time, they are being made with an eye to constraining the Federal budget.

This brings us back to the issue of controllables versus uncontrollables in the HEW budget. With a ceiling on the HEW budget, but with the financing programs essentially not subject to budget control, obviously we can expect that the proportion they consume of the Department's health expenditures will increase beyond the present 80 percent. Also, the resources we have to allocate to building the capacity to deliver services will shrink both proportionately and absolutely. How do we set priorities for allocation of these limited resources and still try to achieve the goals of nondependency and institutional reform?

First, we use the financing programs we now have, and potentially will have in the future, as the major mechanism to achieve equity of access to health care for individuals and as a leverage to improve the health care system.

Second, we change the Federal role in health care from one of leadership by example to one of leadership by expertise; from a role of program operator to a role of setting program objectives;

from doing things for people to knowing how to help people do things for themselves.

And third, we use the capacity building programs to effect institutional reform, not to provide services, and adopt an investment strategy that is keyed to the financing programs and their benefit packages.

With respect to the first point, Arthur Hess, Deputy Commissioner of the Social Security Administration, clearly stated the issue in 1970, speaking before the Southern Branch of the American Public Health Association:

> Of the 60 billion dollars in health expenditures for fiscal 1969 . . . fully two thirds . . . represented expenditures by third party payors. Quite candidly, it is absurd to expect significant changes in the direction of improving the health care system of this Nation, unless and until those who account for ⅔ of the economic transfers enlarge their scope of concern to include the use of this large leverage for the improvement of this Nation's health care system.

And with the prospect of national health insurance this leverage will certainly increase. We have already discussed the kinds of leverage that these programs can and should exert, and we need not dwell on that issue. However, the concept of equity may need some discussion here. By equity, we mean that the financing programs invest in all persons, of approximately the same economic circumstances, the right to access to essentially the same set of health services. Medicare achieves this kind of equity for the aged population. Within a State, although not nationally, Medicaid approaches this kind of equity for the categorical poor.

However, Rashi Fein (*5*) reminds us that equity is not synonymous with equality. For services that are not covered, society does permit those who can afford it to purchase additional services. In addition, while Medicare brings equity in the services it covers, by assuring an average quality of service to all, it permits individuals who are interested in a higher quality, and who can pay for it, to seek it; for example, to go to specialists who charge above the usual, customary, and prevailing fees.

The equity goal, rather than the equality goal, is a result of social choices on priorities in allocating resources. It expresses a social preference that more people should have access to at least a minimum adequate level of services, rather than having a few people receive a much more comprehensive, high-quality set of services. One could suggest that neighborhood health centers, children and youth projects, and other such kinds of programs aim toward the goal of equality, at least for the areas they serve. But, they do not achieve the goal of equity, when so many other areas and their people must do without even the minimum amount of services.

The second change we suggested was moving the Federal role in health care to one of leader rather than manager. We speak here principally of the role of the Health Services and Mental Health Administration. As our agency considered the issues and future changes outlined in this presentation, we wrestled with the fact that on the one hand we had 16 different programs, each with appropriate role and functions, while on the other hand we had limited resources and would have to make choices. How could we best utilize the resources we were likely to have available? HSMHA programs are a microcosm of the entire health care field—in one way or another they provide services, they regulate health care providers, they do research, they train manpower, they purchase services, they prevent disease and disability, and they build facilities. Could we continue to do all things for some people? Or should we try to do some things for all people?

Obviously, in some situations we have no choice—we have legal responsibility for some beneficiaries and statutory requirements to carry out other activities. But within these constraints, we decided that the highest priorities in the agency must go to those activities that would ultimately have the greatest impact on improving the health services for all of the population.

With the financing programs aiming for equity of access, the HSMHA role would increasingly emphasize research, development, and demonstration to bring about the necessary knowledge and expertise to improve the delivery of health services. We would need to gain a more adequate knowledge base through more comprehensive and responsive statistical and data systems, such as the cooperative Federal-State-local statistical system. We need to develop and strengthen the State and local planning and management structures to make them more responsive to local needs and priorities. And we need to improve our capacity to provide technical assistance to State and local and public and private agencies, so that they could translate the knowledge gained from research and development into improved delivery systems.

Now we come to the third major change—

the investment strategy. This strategy applies principally to our project grant programs that support the development of health service delivery systems—neighborhood health centers, family health centers, family planning clinics, mental health centers, and maternal, infant, and children and youth centers.

In essence, the investment strategy recognizes the need to invest in the creation and reorganization of services to make them more accessible, efficient, and capable of providing services of good quality to populations that might otherwise not have such services available. But the investment in the creation and improvement of health care resources is viewed as a one-time, seed money approach with continuing support for ongoing operations of new or reorganized delivery systems deriving from third-party or direct-patient payments. As third-party payments assume increasing proportions of specific projects, the grant funds would decrease and be released for investment in other areas where supply of resources is inadequate. In this context, the investment strategy aims to seek increased amounts of third-party payments to existing projects and to emphasize support of services which have the potential for receiving such payments.

Conclusion

This may appear to be changing policy in midstream, and some project grantees may view it that way. However, we recall how the old policy —which promised that our health centers would provide services to people—evolved. A major impetus to that policy was the 1968 Poor People's Campaign, which made a series of demands to the Department of Health, Education, and Welfare and others. At that time, HEW promised to use health services development grant funds, linked with funds from all other kinds of project grant programs, to develop, support, and provide health services for poor people and to give these people major control over the operation of the health centers. That promise was kept to perhaps less than 10 percent of the poor people in this country. There was no hope that resources would ever be sufficient to use the project grant mechanism to provide services to all the poor people who might need them.

Such an approach cannot hope to achieve equity. It may be agreed that centers that provide a comprehensive range of good quality personal health services—those that emphasize outreach and preventive services and those that are concerned with the environmental, social, employment, and legal problems of their clients—are of value to the people they reach. But what about the large number of people they do not reach, for whom no services are available? If there is a choice, for example, between adding mental health or dental care services to an existing health center versus creating a new family health center with more limited benefits to serve a previously unserved population, which choice is appropriate? This is not an easy choice, nor is it one which professionals find to their liking. But we must change our viewpoints, and, equally important, we must explain them to the communities concerned.

Policies and people and practices change, and all are called upon to accommodate to this acceleration of change. As stated so vividly by Alvin Toffler (*6*):

> Rising novelty renders irrelevant the traditional goals of our chief institutions. . . . Acceleration produces faster turnover of goals, a greater transcience of purpose. Diversity or fragmentation leads to a relentless multiplication of goals. Caught in this churning, goal-cluttered environment, we stagger, future shocked, from crisis to crisis, pursuing a welter of conflicting and self cancelling purposes.

Some will feel a sense of excitement mixed with uneasiness in being confronted with the prospect of rapid change in national health care policies. Some will question the ultimate impact of these changes and new directions in policy. Certainly we in HSMHA will be among those in the forefront in evaluating the impact.

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