COMMENTARY

ON HEALTH EMPLOYMENT

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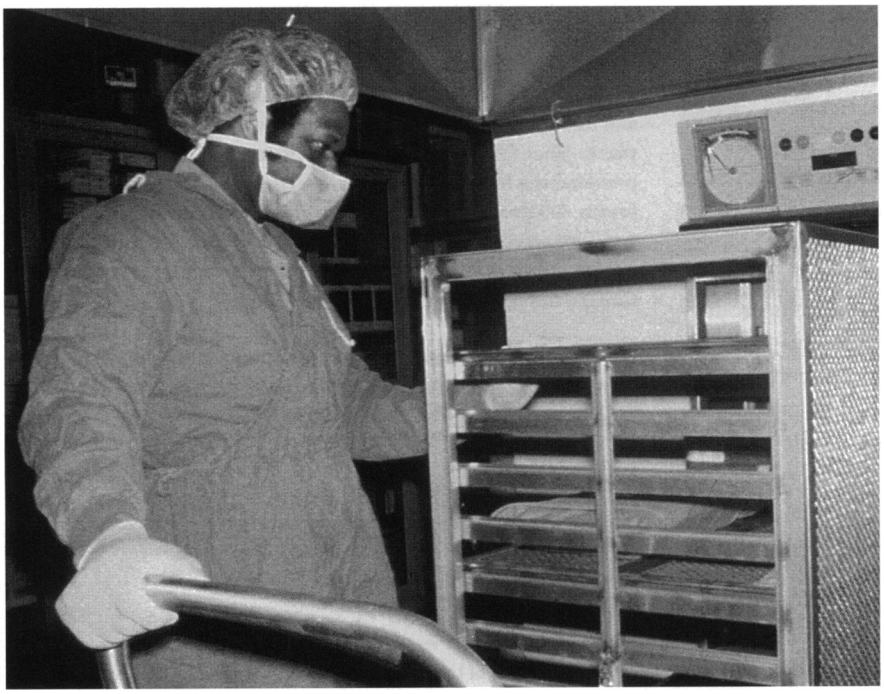
Preparing for Change



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MANY YEARS AGO, as our family car headed onto the Massachusetts Turnpike, one of my children noticed the new automatic toll gates. He asked: "Dad, what happened to the man who used to collect the quarters? Where is he?" Having been well trained in macro economics but not wanting to orient the answer to general equilibrium theory and thus make the response too abstract, I responded that the man now had a fine job making automatic toll collector machines.

I am pleased to say that answer sufficed for the duration of the trip. I am even more pleased to say that, in the course of time, my children discovered that the world doesn't function that smoothly. There is unemployment; there is a maldistribution of income; there are hunger and homelessness; some of us do get hurt and badly. Those who, as their contribution to "progress," have been downsized bear the costs of producing such benefits as saving time at the toll plaza or the availability of inexpensive imported articles of clothing, electronic equipment, or cars. What some of us call "progress," others view differently and, therefore, resist.

Dr. Bishop's article on page 204 isn't about cars or clothing but about health care, a sector that employs almost 10 million people in the United States. The article discusses employment prospects in the field, an especially important subject at a time when there is a revolution in American health care. The health sector is too vital to all of us in both what it does and in the economic and employment impact it has on our towns and cities, states, and nation for us to throw up our hands and say that we'll wait till the revolution is over before we take stock. Dr. Bishop helps us understand where we are and where we may be going. She

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reminds us that it is important to analyze disaggregated data, to examine effects on local areas, and to support an active workforce policy that defines full employment as a priority.

Most discussions of health employment focus on national aggregates and assume away the variations around the means. The picture is far rosier if we ignore these variations. Yet, as Tip O'Neill didn't—but might have—said: "All health employment is local." In that context, we should ask ourselves what we, as people in the health field and as responsible citizens, should ask of our state and local representatives even as we press our national representatives to adopt policies that further full employment and that make resources available to help affected areas.

It seems to me that our agenda should include at least three criteria in judging cost containment efforts and an additional three criteria in evaluating employment impacts.

COST CONTAINMENT

We should keep three considerations in mind in judging cost containment efforts:

1. We should make certain that slowdowns in the rate of increase in health spending reflect rationalization of the health sector—shifts to eliminate waste and inefficiencies. It is imperative that we not become so enamored of cutbacks in expenditures and thus in premiums for medical insurance that we forget that our goal is the efficient production of health care, not simply reductions in the amounts we spend. Thus, resisting cutbacks achieved by reducing the quality of care does not make one a Luddite or someone who wants to stand in the way of progress.

2. We should make certain that what appear to be savings are not the result of shifts from one sector to another, from one pocket to another. Stable premiums are meaningful, but only if they are not achieved by simply shifting costs to the insured though greater cost-sharing. Too often we hear industry proclaim that it has achieved cost containment without acknowledging that it has done so by requiring additional payments by employees. Real savings—not redistribution of existing expenditures—should be the goal and the measure by which we judge success.

3. Finally, we must also make certain that cost containment is not achieved by making access more difficult and care less available to the un- and underinsured. It is easy to reduce the growth in expenditures by not providing care to those who need it. Just as it is not an accomplishment to contain housing costs by increasing the number of homeless people, so, too it is not a great accomplishment to save money by increasing the number of people without adequate health care.

EMPLOYMENT IMPACTS

In evaluating changes in health expenditures and their effects on health sector employment, we must be mindful of three considerations:

(*a*) Dr. Bishop is quite correct in reminding us that, in general, health care is not an "exportable" product (ah, how much simpler health economics would be if we could produce health care services in Battle Creek, Michigan, box them, and ship them to distribution centers to be put on shelves or stored in inventory). Many of the dollars saved through less rapid growth in health care expenditures, therefore, will be spent in the local community. I believe we are entitled to ask: "On what will they be spent?" The dollars now spent on health care are what might be called quasi-public dollars. True, most savings will occur in the "private" sector. But the health enterprise has been and, in spite of the rapid growth of for-profits, remains largely a not-for-profit community endeavor. Many community facilities were founded and continue to be financed with charitable dollars, that is, funds that are made available for public purposes. I call these quasi-public dollars because the charitable deduction tax benefit does not apply if funds are used for purely private purposes.

It is true, of course, that mayors can not simply seize the dollars saved through efficiency and reallocate them to other purposes (including unmet health needs). Yet, if all we do is walk away and leave the savings in private hands without discussion and without debate, we will have made a decision to reallocate social welfare dollars to a different set of purposes. It is not clear that is what we want to do, but we have no mechanism (other than general taxation) for doing otherwise or even discussing the matter. I believe we need that discussion.

Some local areas may reach a consensus to use tax mechanisms to capture savings (say, for example, taking dollars that had been going for inpatient hospital care and using them for other health needs not adequately being met—for example, nursing home care, home care, or school-based health programs). Other localities may

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prefer to use savings for non-health care social welfare expenditures (including the retraining of displaced health workers), and still others may elect to treat the savings as additions to private incomes (in the first instance adding to profits and, presumably, over a period of time increasing individual wage and salary incomes). Put simply: if firms and individuals spend less for health insurance and for health care, should we not discuss what happens to the dollars we save? Should they be used to finance other health care expenditures, other social welfare expenditures, or private consumption and investment? Of course, there is no single answer to such budgeting questions, but it would be helpful and responsible to create mechanisms that would help assure adequate discussion.

(*b*) We should learn from the experience of individual communities with closings of armed forces bases. Although the skills of displaced health sector employees are very different from those of personnel on armed forces bases, there are lessons to be learned from the success stories. One of those lessons is the importance of planning and of active involvement by all segments of the community. Good things do not just happen by themselves. Once again, the role of elected officials can not be minimized. They are the representatives of the entire community and are in the best position to convene the interested and affected parties.

(*c*) Dr. Bishop's paper should serve to alert all parts of the community to the fact that the world does not change equally for all of us. One can not overstate the importance of her reminder that, in the past, health sector growth has provided abundant new jobs for relatively unskilled workers and that these stable jobs have been especially important for minority women. The power of that observation is apparent to anyone who has wandered through the corridors of our large urban hospitals. We must recognize that a high proportion of the income of minority neighborhoods is derived from health sector employment. If that income declines and there is no apparent substitute, major portions of our cities will be extremely hard hit.

The task of finding replacement jobs is likely to be difficult at best, given the additional supply of labor as a consequence of "welfare reform" and of the mismatch between suburban jobs and metropolitan transportation networks. Yet, the problem must be solved—for the urban and rural communities most directly affected have few reserves or cushions on which to fall back.

TRUE SELF-INTEREST

For those who are enamored of "self-interest" and would eschew a calculus that speaks of community and calls upon us to recognize the costs that others might be called upon to bear, a reminder is in order. Even if self-interest is one's guiding star, living in a political democracy means that we advance our self-interest only by taking account of the self-interest of others. Political economists would note that the benefits of rationalizing the health sector, of achieving greater efficiency, and of containing costs can be achieved more readily if such rationalizations, efficiencies, and elimination of unnecessary expenditures are not resisted. We will make less progress if those who would lose their jobs or incomes see no alternatives other than trying to block change.

It is in our self-interest to reduce those frictions. We can best do that if we ask ourselves how we would feel were we the losers. The benefits can be very large; we will be left with substantial gains even if some of those benefits are used to reduce the costs of change.

We owe a large debt to Dr. Bishop for her article. It illuminates a field that all of us involved with the public's health should understand. Beyond that, it alerts us all to the need to prepare for tomorrow. American health care is in the midst of a revolution, but that does not mean we should suffer from paralysis till things are somewhat more stable. It was during, not after, the Second World War that we considered the problems of reconversion and began the discussions that led to enactment of the Full Employment Act. Like the Boy Scouts, we should "be prepared." We must adopt a more active stance on health sector employment issues. ■