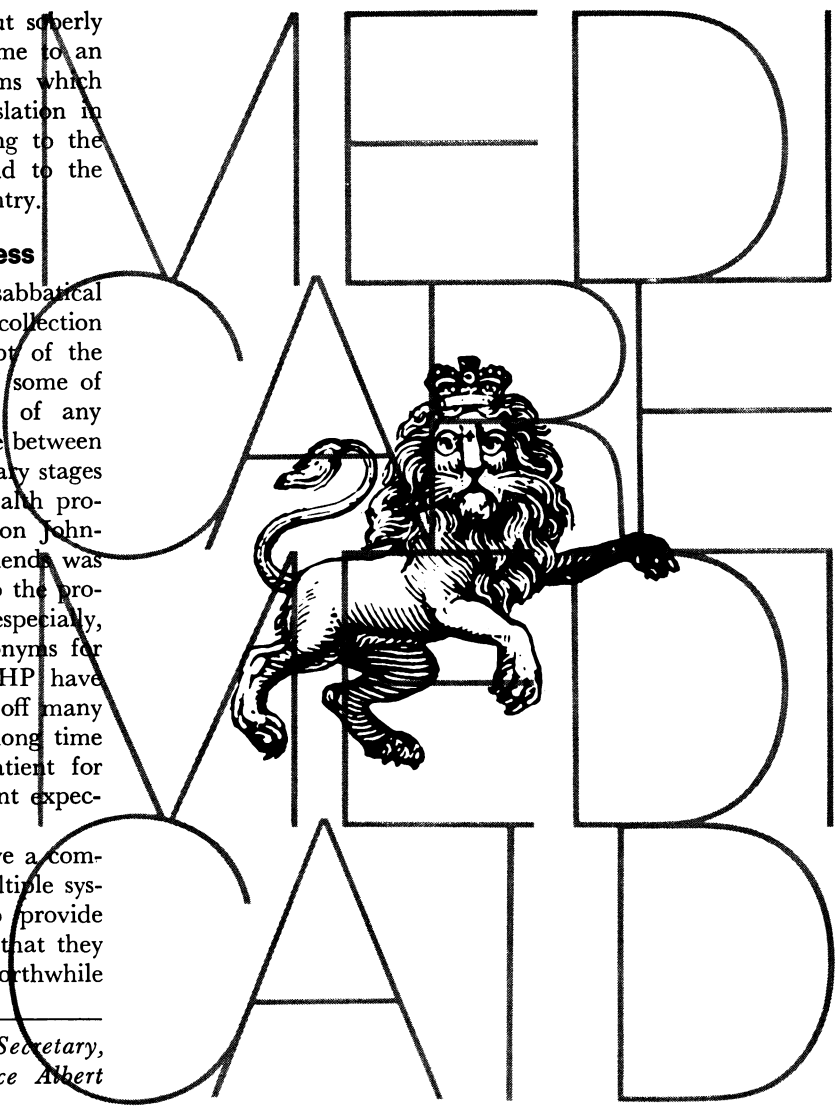
A Foreign View of the United States Under Medicaid and Medicare

THE TITLE given me is deceptively simple but soberly challenging. The length of this essay limits me to an impressionistic comment on complex programs which are landmarks in the history of health legislation in the United States, but I cannot help yielding to the temptation to relate Medicare and Medicaid to the development of the health policies of that country.



A Stage on the Road to Comprehensiveness

I happened to be in the United States on a sabbatical leave in 1964–65, and I still have a marked recollection of the enthusiasm which greeted the concept of the Great Society. I also recall the skepticism of some of my American friends about the likelihood of any eventual effective action. The skepticism arose between the unveiling of the concept and the preliminary stages of much of the legislation for the various health programs introduced in the early years of Lyndon Johnson's presidency. But the skepticism of my friends was confounded and, despite strong antagonism to the proposed legislation, Medicaid, and Medicare especially, soon became household words; and the acronyms for other programs such as RMP and later CHP have since come, by frequent usage, to trip lightly off many tongues. I know that 10 years may seem a long time to those in the New World who are impatient for immediacy, but to those of us with less instant expectations, the period is relatively only short.

The Medicare and Medicaid programs have a common design of filling obvious gaps in the multiple systems that operate in the United States to provide medical care, and it is against that objective that they have to be judged in the first place. Any worthwhile

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judgment about their effectiveness and efficiency is well beyond the scope of this article and, indeed, beyond the capacity of any single comentator; indeed *pace* this collection, the judgment may have to be left to future historians. Although there is enough evidence to suggest both programs have gone some distance in meeting the major goals of their initiators—and indeed any measures which enhance the dignity of the aged and the poor have to be judged successful—their real interest to me as a confirmed policy watcher and analyzer is the limitations in action that they indicate and whether the lessons they teach have universal application.

In the context of Government action, their natural history is particularly interesting. I come from a society where the financial restraints give little room for maneuver or mistakes and in which, before legislation is drafted, great emphasis is placed on turning over every dangerous-looking stone likely to trip up those eventually called to administer the law. It did not occur to me in 1965, as it has since—when I have not infrequently marvelled at the fascinating and sometimes exciting course of health legislation in the U.S. Congress before adequate funds are available to implement some quite separately definitive law—that it was possible to pass enabling legislation such as that incorporated in the Social Security Amendments of 1965 without exhaustive consideration of the potential cost or effect.

Surely one of the major lessons to be learned, as far as cost to the Federal Government is concerned, is the relative open-endedness of the commitment for Medicare underwritten by the Federal Government, an open-endedness that is endemic in the cash-insurance method of purchasing services. The message seems clear: unless fees and utilization can together be controlled within reasonable bounds, is the principle of universal entitlement, financed through national health insurance, ever likely to be acceptable? Medicaid, title XIX, is of course a quite different proposition, for its nature as a federally aided, State-operated and administered program predicates control of a sort, if only through the sluggishness that invariably accompanies the separation of the administrative authorities. I have come to believe that, together, these two programs can be looked at as delivering important lessons about governmental intervention in health systems, lessons not only in the ways the programs are responsible for financial contributions and the consequent accountability requirements but, generally, since they have also directly provoked subsequent legislation introducing statutory requirements for quality assurance. If, as it seems, this latter consequence owes not a little to the hope of containing the costs of public programs, the ideas and creative thinking that Medicare and Medicaid stimulate are not easily contained within the public sector.

To the foreigner, the subtle differences between the categorical programs provided under titles XVIII and XIX are not easily apparent. Pithy statements such as title XVIII is "compulsory social insurance; and incentive subsidy for the purchase of third party coverage" and that title XIX "provides matching grants to the States for public purchase of medical care" hide so many pitfalls for the unwary that I am conscious I shall have to pick my way cautiously round the hazards.

Catalyzing Health Policy Questions

It is not easy for the Briton, especially, to grasp that Medicare and Medicare reflect the systems-culture of public administration in the United States, which is quite different from the systems-culture of public administration in the United Kingdom. The programs are operated through mechanisms that are overwhelmingly financially based and controlled in the Social Security Administration, mechanisms that are quite separate from the health agencies of the Department

of Health, Education, and Welfare. The implications of this separation are startling to anyone schooled in the idea that health policy is indivisible. Yet even this description is an oversimplication of the reality that Medicare is a direct Federal financing system operating throughout the United States, whereas the Medicaid program is part of the welfare system of the Federal Government, but it is operated by the States without much in the way of monitoring from any agencies concerned with what are recognized as the determinant issues of health. Indeed the whole picture seems incredible unless one knows something of the history of Federal health programs and of the legislative and executive scenes and, since there cannot be too many foreign observers around who are connisseurs of this unique system, it is extremely difficult to attempt to give other than a very personal view of the programs. Indeed, I cannot really avoid also commenting on them against the background of the changes that have occurred over the past few years in the appreciation and attitude of those concerned with health matters on the political, professional, and public fronts in the United States.

Pressures to Codify and Rationalize

It may be news to some critics of the system, who prefer the order enshrined in the principle of comprehensiveness, but the categorical health programs of the United States over the past 50 years are impressive on most counts as a many-splendored, idealistic spectrum whose hues are somewhat dimmed by the apparent chaos that has been superimposed by the pluralistic financing of medical care, a philosophy that many seem prepared to go to the stake to retain. Nevertheless, the policy of making additions categorically has an empirical effect, and it will be strange if the movement for an eventual codification of policies does not gather force. If indeed the scheme of organizations and controls embodied in the National Health Planning and Resources Development Act of 1974 gets effectively off the ground, one likely result may be to catalyze the lessons and experience acquired from all the programs bringing services to sections of the population, such as the elderly and the deprived, within a developing structure that will give these lessons greater perspective and visibility.

I do not imply that both Medicare and Medicaid have not been analyzed exhaustively, but it seems to me these analyses will also have to be examined in the light of the waning boom in health care development and of the increasing pressures to rationalize the services provided by the multiplicity of arrangements financed by Medicare and Medicaid. Also figuring in this re-examination is the great interest in the "dimensions of medicine" that is currently developing (this dialog is now more than a plaything of intellectual dilettantes, as evidenced in the positional thrust of such publications as "Effectiveness and Efficiency" and the recent "The Future Directions of Health Care") and which has introduced an element of scientific criticism of medical intervention that seems bound to affect what society will believe to be necessary for the basic provision of health services. Even the politicians now speak freely about the limits to which society will go in making health services a public responsibility, although some ignore the marked inconsistency in accepting at the same time the popular philosophy of universal access to the best in medical care without barriers of economics or race.

It is as true in the provision of health services as in scientific matters generally that successes in the acquisition of new knowledge about the effect of organization and structure and the exploration of new territories in process and outcome create problems. The more awareness there is that the issues of health generally and of the onslaughts of disease are not as clear cut as they appeared to be a decade ago and that unchecked demand is on an exponential curve, the more drives there will be to make optimum use of scarce and expensive resources. These pressures put a premium on schemes of rationalization of every conceivable sort; sometimes they come in the guise of management science and sometimes through checks on the rising demands of welfare. Since one result of the swelling of interest in health affairs since World War II has been the vast increase in studies of health matters, with a consequent expansion in the corps of experts drawn from every conceivable discipline (as well as some that were inconceivable not so long ago), the expansion in services and the inevitable reactions involving rationalization of mechanisms and structures seem inevitable.

The appeal to management scientists to theorize about and clamor for systems to rationalize services to insure optimum use of resources, including the efficiency and effectiveness of services to the population as a whole, is often given unwitting boosts from legislation that is designed for other purposes. A recent example is the designation under the planning law of some 200 health service areas, with operating agencies to fit each area, albeit with a not-yet-clear perception of the relative roles of Federal and State governments and agencies in a variety of programs all ripe for development. This law also presents in its own right enough problems for a generation of policy analysts, economic planners, community physicians, and management scientists. Any measure which gives form to a system in effect sets up a base camp for the next assault on the desirable summit, whether it is another category of service or the peak of comprehensive services.

Much will depend on the outcome of measures to control inflation, and these measures are independent of the health system. It is difficult from the standpoint of the British experience to see how, once launched on a particular policy of rationalization that appears to confer benefits through better use of resources and that gives providers the advantages of smoother cash flow, any broad-based movement designed to channel more

resources into the system can be stopped. The attractions, too, of single solutions such as national health insurance become compelling to politicians, especially if they discover they can point to lessons from previous enactments and to the truth that evolution is more credible than revolution.

Indeed, the lessons of Medicare and Medicaid will, eventually, help define agency roles within and outside the DHEW, since the lessons raise such questions as (*a*) monitoring performance centrally in relation to particular goals (*b*) the need for controlling and "capping" total expenditures, and (*c*) the degree of laissez faire to be practiced by the Federal Government in relation to State government actions. It is clear that Medicaid agencies in the major States such as New York, California, Massachusetts, Illinois, and Texas lead in providing arrangements for meeting health care costs, but the question is whether these wealthier States have shown sufficient leadership to induce other States to follow them or, if these wealthier States fail, to vindicate those who think that the Federal Government must prod and push to gain equal services for all U.S. citizens. Thus, in theory, the Early Periodic Screening, Diagnosis, and Treatment program is an imaginative policy. What is its performance rating, and what lessons can be learned from it?

Because the age structure of the U.S. population is such that unless there is a major recession or extreme inflation, there is unlikely to be scandalous neglect of the elderly, except perhaps through occasional disasters, for at least another 20 years. The real problems which will likely have to be faced involve the deprived of all ages; therefore I wonder if one might not eventually see the merging of the Medicare and Medicaid programs.

One of the great differences early evident to me between the United Kingdom and the United States is that the greater economic capacity of the United States has permitted it, until recently, to take a more cavalier attitude to innovation (or even to the conservative approach) and to absorb mistakes in experiments and in conservatism, and therefore to enjoy greater flexibility than has existed in Britain for years. I sometimes wonder, however, whether this flexibility may change in the near future as the language of priorities becomes more shrill than formerly.

Are the Real Needs Being Met?

I suppose, too, that just as the National Health Service was hailed at its inception as bringing down the economic walls surrounding high quality medical care, the Great Society concept of eliminating economic barriers to access to the best medical services has been easy to welcome and grasp. Acceptance of the concept has continued in later Republican presidencies, and it is now almost inherent in public policy. Therefore, it is not too difficult, looking back over the past 10 years, to postulate that once ideas such as the elimination of cost barriers for specific groups in the population have been widely and popularly accepted, it is but a short step to the acceptance of a universal right of access to high quality medical care, without too much attention being paid to the likely cost of implementing such a principle.

It is often forgotten that universal entitlement includes everybody and not, as it often subsumed, just those sections of the population that are disadvantaged or underprivileged economically or those who, because of age or social deprivation, are great consumers of care. Yet it is notable that in the United Kingdom's system, which provides services rather than the means to pay for them, the services are not necessarily consumed by the economically disadvantaged or underprivileged in the population for whom they are primarily designed. There is, therefore, a case for the assertion that universal entitlement for a national or for a categorical group can effectively mask the performance of universal entitlement among the underprivileged. One cannot avoid speculating how effectively this masking effect is likely to be debated before the next round of reforms and especially in relation to the real problems of administering comprehensive programs with differing objectives and covering a wide range of persons.

Indeed, there are no simple solutions to the goal of insuring that services are delivered to those in greatest need—those whom the legislators had most in mind. There is a great deal of experience in many countries to indicate that blanket solutions, which are often administratively popular for their relative simplicity, do not always cover the special groups they are designed for. In every country with liberal provisions for the care of the deprived and the elderly, there is, therefore, eventually another question of how social policy can be formulated to give sharper direction to the relief of need.

To my mind, it would be fascinating for these reasons to study closely the history and performance of title XVIII and XIX arrangements for lessons about feasibility that can be related to any proposals for radical changes to expand services to other population groups. The experiments now extant in cost containment and the requirements for control of the process can teach sharp lessons about the realities of financing and control mechanisms in relation to implications for planning; it would be interesting to see if the arrangements designed to bring benefits for those in greatest need have actually worked.

If I can end on an apparently light, but in reality, a serious note—one thing is certain—one special group that has been and probably always will be in dire need are the various Medicare and Medicaid providers, who have been given pipelines to income without which many could not survive. How does this now essential strut of the health care structure affect actual services? And more to the point, how can this fact be utilized to insure more effective services?