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TOWARD A HEALTH CARE STRATEGY*

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In the value system of the American society we place a very high priority on health. In fiscal year 1969, we spent $60.3 billion in pursuit of health. This sum represents 6.7 percent of our Gross National Product. Preliminary estimates for the current fiscal year run higher still, in both total and percentage.

The American health enterprise, in which you and I both work, has had this greatness thrust upon it rather suddenly. Most of us remember when the world of medicine was romantically peopled with friendly doctors carrying little black bags and nurses in the image of Florence Nightingale offering soothing hands and tender hearts. That was a comfortable world. We leave it reluctantly.

But leave it we must. For exploding technology and soaring expectations have made that world as anachronistic as the doctor's watch-fob in the Norman Rockwell illustrations. There is no place in such a world to hide a $60-billion industry.

In short, health has been thrust into the world of political process. It is involved in the intense competition for resources--manpower, money, and materials--which characterizes that process. This competition is continuous and unrelenting. It takes place at all levels of government and in the private sector as well.

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Health is in fierce competition with many claimants for social priority. It competes with education, welfare, the rebuilding of cities, national defense, crime control, and with scores of other worthy and necessary pursuits. And within the total health share of the total resources that emerge from this competition, we find another level of competition among desirable endeavors. Decisions must be made on such questions as: How much to pay for care? How much to stimulate and support research? How much to build the basic resources of manpower and facilities? How much to organize these into an effective system? How do we build institutions?

Of all the arenas in which these political processes are in constant interplay, the largest and most visible is the Federal government. The decisions made in that arena exert a major influence on those made at all other levels, including those in the private sector. A few figures will help to indicate the nature and scope of the Federal health investment, and thus why, although we might wish it were otherwise, health is deeply involved in the world of politics.

TABLE 1. *Federal Outlays for Medical Activities (in Millions of Dollars).**

TOTAL FEDERAL OUTLAYS	1960	1966	1969	1970
	$3,507	$5,927	$16,316	$18,277
Provision of hospital & medical services, total	2,165	3,521	12,518	13,977
Direct (beneficiary)	1,702	2,199	2,896	2,996
Indirect (Medicare, Medicaid etc.)	463	1,322	9,622	10,981
Development of health resources, total	1,016	1,955	3,057	3,496
Research	509	1,167	1,476	1,639
Manpower	217	410	841	932
Facilities construction	290	378	595	728
Improving organization & delivery	–	–	145	197
Prevention & control of health problems, total	326	451	741	804

*Source: Special Analysis, 1970 Budget, prepared by the Bureau of the Budget, Executive Office of the President.

Chart 1 shows the distribution of Federal financial resources in three broad categories developed in a special analysis by the Bureau of the Budget. The first of these is the provision of services, both directly to various groups of federal beneficiaries and indirectly through financing mechanisms such as Medicare and Medicaid. The second category is the development of health resources, including manpower facilities, improvements in organization and delivery and the generation of new knowledge through research. The third category consists of outlays for prevention of disease and control of health problems, including environmental problems.

In the decade between 1960 and 1970 federal expenditures for health have grown from 3.5 billion dollars to more than 18 billion. By far the greatest gain has taken place in the area of indirect payment of services. It should also be noted that the rapid upward trend in federal health-research investment, which had already reached the 500-million-dollar level by 1960, continued through the first half of the decade and has tended to level off since that time.

Most notable in the context of this discussion is the outlay identified as improving organization and delivery, which includes the regional medical programs, the partnership for health, and certain programs of the Office of Economic Opportunity and the Children's Bureau. Total expenditures for these system-building programs constitute a very small proportion of the federal health investment.

Chart 2 indicates the distribution of health dollars across the

major federal agencies. The Department of Health, Education, and Welfare (HEW) has by far the largest share, but eight other agencies spend more than 100 million dollars for health, and two of these--the Department of Defense and the Veterans Administration--have health outlays in excess of 1 billion dollars. Within HEW the two largest health expenditures are not in the so-called "health agencies" but in the Social Security Administration and the Social and Rehabilitation Service, which administer Medicare and Medicaid, respectively.

TABLE 2. *Federal Outlays for Medical Activities (in Millions of Dollars).**

GOVERNMENTAL AGENCY	1968	1969
Department of Health, Education, & Welfare	9,815	$11,500
Health Services & Mental Health Administration	959	1,109
National Institutes of Health	1,285	1,247
Consumer Protection & Environmental Health Service	151	186
Social Security Administration	5,332	6,222
Social & Rehabilitation Service	2,080	2,727
Other	8	9
Department of Defense	1,761	1,921
Veterans Administration	1,440	1,550
Department of Housing & Urban Development	83	142
Department of Agriculture	149	182
Agency for International Development	117	179
Office of Economic Opportunity	103	134
National Aeronautics & Space Administration	103	111
Atomic Energy Commission	100	100
Other	460	497
Total federal outlays for health	$14,131	$16,316

*Source: Special Analyses, 1970 Budget, prepared by the Bureau of the Budget, Executive Office of the President.

Now the world of politics is a very practical one, and I believe that as you think about this $18 billion Federal health investment, you ought to be aware of the over-riding themes of the current Administration. After all, political decision-makers do have a certain method to their madness, though at times it must be difficult to discern.

I think that we can see several broad themes and strategies related to the nation's domestic problems which the new Administration is pursuing. The most dominant theme, of course, is the control of inflation. This has been identified as the primary target problem, and the strategies for its control set much of the framework within which Federal action will take place.

Within this framework, the first major unifying strategy of the Administration's programs in the domestic sphere has been called the New Federalism. Although there are some who regard this as just mere rhetoric, it represents a very conscious effort to establish a division of labor between levels of government in the solution of public problems.

For example, a principal sub-theme of the New Federalism involves a distinction between income transfer and support programs, on the one hand, and service programs in the human resources field on the other. Speaking very broadly, the Administration seems to believe that the Federal government should assume the basic responsibility for income support. This is exemplified by its radically new Family Assistance Plan proposals to be administered federally. By contrast it would have programs for the delivery of services the responsibility of State and local government.

A second important element of the New Federalism involves a form of decentralization. The President's Manpower Training proposals represent a selective but far-reaching delegation of power to State and local governments. The delegation is selective because the programs

will be carefully monitored for effectiveness of performance.

A third component of the New Federalism effort involves revenue sharing. Revenue sharing is based on the assumption that the Federal mechanism for collecting money may be superior, but that many of the uses of funds so collected can best be determined and carried out at state and local levels. After all, if service programs are state and local problems, funds must be provided. This is no minor innovation. It has bipartisan support. It would within several years move $4 billion of Federal funds to state and local units.

A second major theme of the new Administration, beyond the concept of the New Federalism, deals with income strategy. The proposed Family Assistance Program involves supporting some 23 million people as compared with about 10 million today because it strikes at the problem of the working poor, hitherto a truly forgotten American. It also envisions the future expenditure of an additional 4 billion dollars.

Another aspect of the income strategy is an effort to move government programs more toward cash support, with a proportional de-emphasis on "in-kind" programs. In time, the in-kind programs, which would include such things as Medicaid and rent supplements as well as food stamps and the like, would be phased into a total cash support system.

Obviously, this constitutes a sort of reliance upon what the economist calls the market strategy. It rests on the principle that people themselves can make the best choice of their daily expenditures. This market strategy could apply to a number of existing service

programs--for instance, in which persons requiring Federal income support might be given money to buy Head Start or other forms of day-care from the source of their choice in lieu of present arrangements for direct Federal institutional support.

A third major theme which I want to mention briefly is an effort to rationalize the Federal system. Our own field of health offers as graphic an example as any of an array of new programs, each generated by a separate legislative act over the past few years, each designed to fulfill a legitimate and worthy purpose, but all brought into being without adequate reference to their cumulative impact and interaction. Looking outside the immediate purview of health we quickly find a still wider array of programs each of which should be, but rarely is, seen in relation to the others.

Setting the same eligibility criteria for welfare and food stamp programs is one example of rationalizing programs--in this instance, programs administered by different executive departments and presided over by different legislative committees. Other examples include block grants to states and consolidation or simplification of the entire "grantsmanship" process which so many of you know so much better than even I.

Finally, in listing the broad themes discernible in the program of the new Administration, I want to mention the emphasis on what the President has called "the quality of life"--the matter of our physical environment. It is clear that a better environment ranks very high on

the priority list, and I think we can anticipate major attacks on pollution in its many forms in the months ahead.

I think it is accurate to state that initiatives in the health care field will have to be formulated to take account of the broad strategies that I have outlined. Whether the strategies are directly applicable to health, remains to be seen. The private-public mix that characterizes health care is probably as complex as any in our society. It has been the object of enormous attention and growth, with a random harvest of mixed blessings, in the years just past.

A fundamental problem with designing new health care initiatives is that we are not yet really clear as to what the initiatives should be or where to put our money to deal with the so-called health care crisis. As to the major themes which I have just outlined, it may well be, in fact, that the peculiar public-private character of the health industry is especially difficult to reconcile with some of these themes. In these circumstances, and in view of the enormous amount of money already going into health--$18 billion Federal funds, $60 billion Gross National Product--one can well envision that a President might prefer to make new investments in improving the environment where he could feel more certain about the results.

What is this health care crisis, anyway? If you ask the consumer, the answer comes back in the form of some strident questions about what he is getting for his money. He may not know the figures, but he is aware of the enormous investment the nation is making in health. He

wonders why all the people are not receiving the benefits of what we know today. He wonders why our nation is 15th in the world in infant mortality and 22nd in life expectancy for males, why one-half of the babies born in public hospitals are born to mothers who have had no prenatal care, and why a poor child has four times the risk of the non-poor of dying before he reaches 30 years of age.

The big question is not how much money should go into health, for after all, who can say what life is worth? Rather it is whether we would be better off at the $100 billion level, and what changes we would make in how we spend it. I think it is fair to say that we have arrived at our present state of crisis by pouring our resources and good intentions into courses of action that turned out to have elements of mythology about them.

The first myth was that massive governmental support of biomedical research would set in motion a chain of events that would automatically improve health care for all. We supported research and harvested brilliant advances in the science and technology of medicine. This activity shaped the medical schools of today, for good or ill, and in large measure determined the nature of today's medical practice. But it did not, by any means, bring about the delivery of these benefits to everyone; especially it failed to deliver them to those who need them most. And in the process the newly generated technology placed a heavy additional strain on the delivery system--in costs, in manpower, and in other ways.

Then, as we began to recognize the "Other America" of 40 or 50 million poor whites, blacks, Mexican-Americans, Indians, and others outside the reach of the system, we succumbed to the second myth--that the only thing standing between these people and the best in health care was lack of money. We poured our resources and our good intentions into providing money tickets into the system through programs like Medicare and Medicaid. These programs have accounted for by far the major share of Federal increase in expenditures since 1965.

But again we found that automatic delivery of the best in health care to everybody did not happen. The hard fact is that 76 percent of the total Federal expenditure for health is financing the entry into a health care system that is not capable of responding. We have learned to our bitter regret that in many places entrance into the system does not exist, and that added purchasing power of Medicaid and Medicare has led to the dilution in quality of care, increase in cost, and the movement of more people into the hospital element of the system. What is therefore first on the agenda to deal with the crisis in health care is the need to control our methods of financing and then a major effort by society--Government at all levels and voluntary at all levels--to build and shape a medical care system that matches our willingness to spend $60 billion or maybe $100 billion a year.

I am not saying that the expenditures for research and the financial assistance programs were not needed and a public good. Quite the contrary. But it is clear that these two approaches, each based on principles that

were part valid and part myth, do not solve the problem of health care delivery either singly or together. To do that we need to give major attention to efforts and resources to fashion a delivery system.

If there is a basic imbalance between the financing of health care services and the capacity of the health care system to respond, then we need a strategy of change which will expand capacity. The strategy which I would suggest rests on a concept of investment as opposed to consumption. Although we may improve the management of our financing mechanisms, and we may offer incentives to raise efficiency and lower costs, let us not delude ourselves into thinking that change can come about through such actions. To create a health care system will be no minor fix-up operation.

As a concept, investment means diverting some resources from current consumption in order to increase and improve consumption at a future time. Attaining the benefits of the investment can only happen after the investment has been made.

Our financing mechanisms in health have been concentrated on funding current consumption of health services. Since the pressures on financing current consumption will be very great in the coming years, it will be very difficult to generate sufficient investment funds from the current patterns of financing health care. Furthermore, the health care system has not traditionally funded much of its capital investment from current income, a prominent example being the financing of hospital facilities through charitable gifts, Federal grants, and local tax revenues.

Thus, since investment is usually the energy of change, bringing about the desired changes and improvements in the health care system during the 70's will require increased direct investments in the expansion of capacity and the inducement of improvements in organization and coverage of services. I emphasize direct investment to stimulate change because it is unlikely that the spontaneous changes within the health care system will meet the challenge.

These are some of the investments that will have to be made. In addition to closing some of the basic gaps in manpower and facilities, we will need to invest in innovative use of health manpower. We must increase our investment in research and development in new methods of health care as well as the support of biomedical research. We must invest in the planning and management capabilities that are still very underdeveloped for a $60 billion industry. We will need to further invest in better information, data, and statistics which will guide the workings of the health care system. We must provide seed money for improved care patterns. This seed money will serve as glue for the existing financing mechanisms which will not presently fund a more efficient and effective pattern of health services. Most important of all for the immediate future is an investment in filling the gaps in primary ambulatory care, which is the main barrier to improved health services for the poor and increasingly for the not so poor.

No strategy is going to work, however, unless we face up to some awesome decisions that we have been politely and carefully avoiding

for many years. John Gardner once observed that we are anxious, but immobilized. We can break loose from this anxiety-paralysis syndrome only if we ask some really searching questions and answer them honestly. Questions like these:

Can we, in the light of national health care needs and the state of our resources, cling to the principle of fee-for-service as the general rule?

Can we follow the freedom-of-choice principle as far as we would like to, in the light of those same needs and resources?

Can we leave such programs as Medicare and Medicaid uncontrolled?

Can a community hospital continue to operate its "business" on the basis of just filling its beds, or must it reach out to organize and serve community ambulatory care needs?

If we are to effect change and not have a nationalized system like that of Great Britain, perhaps the creation of new community institutions and investment in their support may be the most critical investment requirement of all. For health care is ultimately a personal and family affair, and the best setting in which it can be provided is the community. But there is in the health world today no institution which can with <u>real authority plan</u> and <u>manage</u> the organization and delivery of health care on the community scene.

We have a bewildering array of individuals, agencies, and institutions. We have an equally bewildering array of governmental programs seeking to support the disparate efforts of these autonomous entities.

We do not have a responsible focal point for exercising community trusteeship of health resources for the benefit of and responsive to its people.

The nature of this missing institution is not yet well defined, but some of the ingredients are clear. It must be a peculiarly private-public mix, with strong consumer involvement. This proviso may make health professionals acutely uncomfortable but the professionals have to recognize that they cannot go it alone. It must be based on a principle of geographic responsibility, and it must be strong enough to exact from the medical resources of the area--physicians, hospitals, and others--the performance of defined health care functions on a geographic basis.

Can this kind of community institution be reconciled with the broad themes of the new Administration? Perhaps it cannot, especially with the strong intergovernmental-relations flavor of the New Federalism. If not, you in the health field will have to demonstrate how and why health care is different, requiring different approaches.

It seems to me that the question is not whether sweeping changes in the organization and delivery of health care will be made, but rather who will make and direct them. The answer to this will depend upon the willingness or the unwillingness of the health field to face up to its awesome decisions.

In conclusion, let me ask whether health care is an end in itself? Are we ultimately concerned only with the prolongation of life and the

improvement of physical and mental health, narrowly defined? Such a purpose may motivate the individual researcher or the practitioner, but society's vision must be greater and, if you will, move to a higher plane. I would suggest that our ultimate purpose is to enhance the quality of living, in all its dimensions, and that everything we do should be viewed in this context.

An increasingly prevalent and corrosive characteristic of the spirit of the American citizen today is real or apparent individual despair and lack of confidence that he can deal with the problems of society. Citizens affected by this spiritual condition are unlikely to work to improve their health, education, or welfare because they do not believe that such improvement is possible. This lack of individual confidence extends to the efforts of government, and I think to all other organized efforts as well.

I believe that the restoration of trust, and optimism--confidence that the citizen is not helpless and that progress is possible--is an undertaking to engage the entire nation. Government, for its part, needs to develop and carry out strategies that will advance the rebirth of the necessary sense of individual pride and progress. Placement of responsibility for health service programs in the community, where the people are, represents such a strategy. But it is for the people in the community to answer the hard questions, face the awesome decisions, and effect the changes that society demands of them through the <u>action</u> (not words and hopes) of citizens of a democracy.