"THE NATIONAL HEALTH SCENE"

By

Irving J. Lewis*
Deputy Administrator
Health Services & Mental
Health Administration
Department of Health,
Education and Welfare
Washington, D.C.

Prepared from remarks
delivered at
Regional Medical Programs
Conference on Allied Health
Airlie House, April 20-29, 1970

*In September, 1970, Mr. Lewis left the Federal government to become Professor, Department of Community Health at the Albert Einstein College of Medicine of Yeshiva University in New York City.

When we talk about the health care scene in America we cannot ever forget that Americans devote $60 billion of the gross national product to various functions of health. With a Federal contribution to that $60 billion in 1971 of about $20 billion, we must understand that health cannot be nonpolitical. Therefore, the way in which problems get solved in the last analysis involves some political answers. Otherwise, one has great difficulty in understanding why his proposals do or do not have any particular result. If it is true, as I am quite certain it is, that the Federal Government cannot ignore the political aspects of health care in the '70's, I have to talk a little bit about the Nixon Administration, and how the political levels of government are going to be looking at health.

The first thing we have to know are the over-riding themes of the Nixon Administration. I am a career official, so this is not a partisan assessment. Political decision-makers do have a method to their madness, though it may sometimes be difficult to discern. Of all the broad themes and strategies the most dominant is control of inflation. This is the primary target. The strategies for its control determine many other strategies in the Nixon Administration.

Within the frame-work of control over inflation the first major unifying strategy on the domestic scene has been called the New Federalism. It is not just rhetoric to avoid action. It represents a conscious effort to establish a division of labor between levels of government in the solution

of social problems. (Incidentally, this is a conviction of many Democrats as well.) For example, a principal subtheme of New Federalism is the distinction between income support, on the one hand, and services, on the other. Payments that transfer funds to support people in their daily lives are regarded by this Administration as a Federal function paralleling similar centralizations in all major federal systems in the world. Rendering of services to people is seen as a function of state, local and metropolitan governments and of other public organizations. The obvious example of this strategy is the new Family Assistance Plan. The services programs within that proposal would be run by other than Federal levels of government, while the Federal Government would pick up the check for income.

Another subtheme of New Federalsim is decentralization, or intergovernmental relations. An example is the President's Manpower Training Program proposal, which involves a selective but far-reaching delegation of power to state and local governments, provided that they can meet appropriate standards. To establish and support service programs at the state and local levels, New Federalism has another subtheme, namely, revenue sharing. Revenue sharing is based on the twin assumptions that the Federal fund-raising efforts are better than those of state and local governments, but that state and local governments are in a better position to determine how the revenue should be utilized. This theme is not a minor innovation and it has bipartisan support. In time it could involve a shift of some $4 billion from the Federal sector of the local sector. The Family Assistance Plan will involve increased Federal expenditures of a minimum of $4-1/2 billion. With expenditures of this magnitude to back up New Federalism, it can hardly be seen as only rhetoric.

A second major theme of the Administration is the nature of the income strategy itself. The Family Assistance Plan involves supporting about 23 million people compared with about 10 million now on welfare because it does try to strike at the problem of the working poor. Despite some Administration denials, it is a guaranteed income approach. Another aspect of the income strategy is to de-emphasize "in-kind" programs, such as Medicaid and food stamps. In time the Administration will apparently try to phase out "in-kind" programs and substitute cash payments instead. In fact, the proposed Health Insurance Plan may be the first major step in this direction. This change rests on the principle that people themselves can make the best choice of their daily expenditures, and is extended to areas of service such as day-care. I am not judging the theme; I am simply trying to set it out.

A third major theme of the Administration is the attempt at rationalization of Government. The field of health offers many examples of a bewildering array of programs, few of them fitted to each other, either in design or in execution. Outside the field of health there are the same phenomena. One way by which rationalization is achieved is by grants consolidation and simplification, which buttresses the earlier strategy of decentralization and the principle that state and local governments carry out the service programs. Another way of rationalizing programs is to set the same personal eligibility criteria for interrelated programs. In the welfare and food stamp programs, for example, which are administered by different departments, there is an attempt to establish the same eligibility criteria. The Family Assistance Plan has that concept built in.

Finally, another broad theme firmly announced by the Administration is emphasis on what the President calls the "quality of life." A better environment ranks very high on his priority list. We can anticipate a lot of disagreements as to how to achieve it, but I believe that this Administration will make many attacks on the environmental front.

It is my view that initiatives in the health care field through the '70's have to take account of these themes and broad strategies. I am not prepared as of this time to say whether the strategies are directly applicable to health, and I have some doubt that the complex private-public mix which characterizes health can be fitted into them. So we can expect that in Congress and in the Executive Branch there will be a debate to see whether the public-private "mix" in health problems is reconcilable with the strategies or whether it requires a different strategy. Perhaps we will discover how strongly held is our social value of a public/private "mix."

One of the fundamental problems with designing new health care initiatives is that the professionals do not really know what they ought to be. They wish they did but how we can square our professional or expert views with the political system has thus far eluded us. In short, we do not know where to put our money in order to deal with the so-called health care crisis. When a President surveys the Federal budgetary scene, given the fact that his number one target is control of inflation, I do not think it ought to surprise us that he might well put the limited money available into the areas of environment or crime control where he can see more precise and immediate pay-offs in terms of response to needs of the American people than in what we call the area of health care.

Those are a few general thoughts about the so-called general health care crisis. It is a health care crisis, but until it is a political crisis there is not going to be any governmental action.

In the past, as we looked at the health crisis our first concern was to see the response of the consumer. Why are people not receiving the benefits of what we know today? The consumer wonders why our nation is fifteenth in the world in infant mortality and twenty-second in life expectancy for males. He asks why the mothers of half of the babies born in public hospitals have had no pre-natal care, or a poor child should have four times the risk of dying before thirty than does the non-poor. The big question is not how much money should go into health. After all, who can say what life is worth? The big question is whether, as expenditures rise, we will be better off at $100 billion, which is the best estimate for 1975. I doubt that we will without great changes.

To understand where to go in the future, we ought to understand where we came from. We have to know about history if we are to understand what we could do in the '70's. The first need is to understand the mythologies we have followed. After the failure of the National Health Insurance proposals under President Truman in the late 1940's, we embarked on a major effort in bio-medical research. There was a popular view that massive governmental support of bio-medical research would set in motion a chain of events that would automatically improve health care for all. We had privately supported research and a number of brilliant advances in science and technology resulted. We helped shape the medical schools, for good or ill. We helped shape the hospitals by the way in which we held out our

dollars. In the process we produced a technology which is extremely costly. But then as we moved into the '60's, we found the other America which we had not been looking at. We began to think about our middle-class selves, and we realized that the massive advances in bio-medical research by themselves were not going to bring about health for those who needed it most. In fact, they were not necessarily going to bring the advances even to people who could pay for it. So we succumbed to a second myth, believing if the only thing standing between the other America and the best in health care was the lack of money, we could pour our resources and our good intentions into providing money tickets into the system through programs like Medicare and Medicaid.

In 1955 expenditures for health for this country were $17 billion; in 1965, $37 billion. Now they are $60 billion. By 1975 the estimate is $100 billion. The significant point is that Medicare and Medicaid account for most of the increase. We must never forget the tremendous social insurance gains made in these programs, but neither can we ignore the key disastrous characteristics in the present financing programs.

First, they have overburdened the capacity of the system to respond. This overburdening has been one of the major causes of the price rises in the medical market, which hurts the middle class every bit as much as it hurts the poor.

Second, the present financing arrangements through money tickets actually inhibits better and newer methods of health care delivery. In fact, they even produce reimbursement barriers to innovative methods of health care.

The Watts Neighborhood Health Center may not be the best center in the world, but it is a well-run $5 million operation that effectively serves the poor. Although the group includes 30% Medicaid eligible, less than 10% of the Watts budget is reimbursed by Medicaid because of the nature of the Medicaid financing rules and regulations and State control.

Third, we have short-changed the youth of America. Sixty-five percent of the Federal health budget goes to the aged, all of Medicare and a substantial part of Medicaid. Only 10% of the Federal expenditure of close to $20 billion can be said to go for children and youth. Sixty-eight percent of Medicaid goes to institutional care, heavily for nursing homes for older people. We have learned to our bitter regret that in many places entrance into the medical care system does not exist and is as much a problem for the middle class as for the poor. The added purchasing power of Medicare and Medicaid has probably led to the dilution of quality of care, it increased cost, and moved more people into the hospitals and institutions in the health care system.

For the Federal government to get at the basic elements in the health care scene there must be a goal, a sense of purpose. There is need for more all-embracing programs than the Federal government has set in motion. It is useful to have in mind the necessary basic elements of the health care system. It is not difficult for health experts to define these and they have been expounded by the HEW Task Force on Medicaid. They include at least these elements:

1. The health care system ought to provide for comprehensive services ranging from preventive to long-term institutional care, and it ought to provide continuity.
2. Medical care systems at local levels ought to be dealing with defined populations.
3. The systems ought to provide for integrated management of a variety of institutions and individuals.
4. There ought to be a broadly-based risk sharing, achieved through insurance mechanisms in one form or another, heavily weighted in the direction of per capita prepayment or payment.

Opponents of health insurance, public of private, too often take a simplistic approach. They say the system is not ready to respond, we have to wait until the system has the capacity. If we do than, in the long run we will all be dead, and the system will never be able to respond. I would suggest a concept of investment as opposed to consumption, which is what the present Medicare-Medicaid systems are. More important, the concept would establish firmly what too many advocates of national health insurance have not recognized: that the system is not capable of responding and that the financing systems cannot be allowed to go on independently of the capacity producing systems.

If we are to move in the direction of some of the elements, including broad risk-sharing, the financing system must include within it the basis for investment. We can improve the management of our financing systems. We can offer all sorts of incentives to increase efficiency and to lower costs, but as long as we live in a reasonably affluent society we should not assume that incentives alone and tinkering with financing systems will

bring about the kind of change we are talking about. Creating a health care system is no minor fix-up operation.

What is investment? It is the diversion of resources from current consumption in order to achieve the benefits in the future of the investment. We may have to put our financing first into investment, into programs such as Regional Medical Programs as an institutional device for bringing the changes about. This kind of program might even have to be financed out of payroll taxes, an obvious departure from traditional methods of budgeting.

The Federal budget for health in 1971 will be $2 billion higher than it was in 1970, and it will be all in Medicare and Medicaid. We need the concept of investment in the capacity-producing side of the health care system, but we do not have the concept linked firmly to our financing system to pay the bills. Blue Cross and the insurance companies do not have it; the Federal government financing systems do not have it. We will not get there overnight just by knocking on President Nixon's door saying we would like another $100 billion. To get this kind of concept adopted there has to be a strategy of investment which will insure that financing mechanisms will get the hospital to move into ambulatory care. Investment is needed to produce the ambulatory care service.

To get there, a number of fundamental questions bearing on institutional problems have to be faced. A lot of people are still moving away from these questions. Here are a few of them, as I see it.

In the light of national health care needs and resources, can we cling to the principle of fee for service as a general rule? This is not a question of medical care administration for just the experts to work out. It is a fundamental political and social problem for the American people.

Can we in our legislation follow the freedom of choice principle as far as we would like to?

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 needs?

Investment means more than just money for services. Unfortunately, no social or political body has real authority to plan and manage the organization and delivery of health on the community scene. I deliberately stress "no real authority to plan and manage." If we are to effect change and not have a nationalized system like that of Great Britain perhaps the most critical requirement is the creation of new community organization and the investment of funds to support it. We have a bewildering array of individuals, agencies and institutions, and an equally bewildering array of government programs which support the disparate efforts of all these autonomous entities. We do not have a responsible focal point for exercising community trusteeship of health resources, unfortunately, there is no consensus in society that we ought to have one.

The nature of the missing organization is not well defined but some of its ingredients seem clear. It has to be a private-public mix with strong consumer involvement. It has to be based on a principle of geographic responsibility. It must be authoritative enough to exact from the medical resources of the ares (physicians, hospitals, and others) the performance of defined health care functions on a geographic basis. That sort of body gets right into the battle as to whether planning and regulation

are to be combined. It illuminates --or will-- the mission of the Federal government in the health area. There is ample confusion as to whether or not the Federal government has a defined mission to organize and create a health care system to meet the needs of all Americans. The debate in the American society has really not yet focused on such a mission for the Federal government. Although society does not yet say that ought to be the mission of the Department of Health, Education and Welfare, I have some personal views that it ought to be.

The level of debate over medical care has moved from the question of paying bills to the question of how society organizes and delivers health care. How do we make sure that the $100 billion in 1975 will not be just a transfer payment but will actually be an expenditure by the American society to bring about changes in the system and delivery of a larger quantity and higher quality of service? The two or three years ahead are essentially years of increasing debate such as is going on in this meeting, rather than the arrival at solutions.

Regional Medical Programs were a response to a particular need at a particular time as were Comprehensive Health Planning, Mental Retardation Programs, Community Mental Centers and so on. In the meantime, the Federal government is trying to develop a uniform policy to cover all programs. Several main legislative initiatives have been taken, and it even looks as if the government knew what we were doing. Under the present congressional system we deal with a host of different committees -- House Ways and Means Committee, the Senate Finance Committee, the House Interstate and Foreign Commerce Committee and the Senate Labor and Welfare Committee being the

principal aims of congress in health. In the Department of Health, Education, and Welfare we developed a set of bills dealing with financing, facilities, planning, organization and delivery of health services. The financing amendments are called the Health Cost Effectiveness Amendments of 1970 or the President's economy measure or messare. Facilities appear mainly in the Hill-Burton Amendments of 1970. Planning, organization and delivery are in the Health Services Improvement Act of 1970 and the Community Mental Health Centers Act. Clearly, all are designed to get at particular health care problems without actually taking on the institutional settings involved.

A key indicator of the proglem is physician distribution. In the urban core in 1943 we had one doctor for every 500 persons. In the suburbs we had one doctor for every 2,000. Today we have one doctor for every 10,000 in the urban core and in the suburbs we have one doctor for every 500. The urban core does not have the doctors, the suburban core does. We have to provide for redressing that imbalance. We need institutional arrangements for working on capacity. Regional Medical Programs are hopefully trying to bring the doctors where the people live, stressing the ambulatory as opposed to in-patient care.

In our legislative proposals we had several main points to make. The Health Services Improvement Act maintains that Regional Medical Programs, Health Statistics and Health Services Research and Partnership for Health have a common objective, the improved organization and delivery of health care. We also proposed a variety of model systems under that act. We also

established requirements as to the planning agency. Then, when we came to the Hill-Burton Amendments we tried to stress ambulatory care, and encouraged alternatives to acute in-patient care. We tried to change the emphasis from grants to loan guarantees because there is $300 or $400 million coming to hospitals now out of the Medicaid-Medicare Program which was not coming during the period of big grants. We also attempted the same approach in the Community Mental Health Programs, namely, incentives and better matching arrangements not only to continue those facilities which had been organized, but to move them into the poverty areas where the facilities are not now being afforded.

The Health Cost Effectiveness Amendments provide incentives to states to control costs. Under the new proposals there are incentives to all sorts of organizations, including profit-making ones, to provide ambulatory care. The Health Maintainence Organization proposal cannot be divorced from the proposal that states be given a higher matching ratio for services which are rendered in an ambulatory care setting as opposed to services which are rendered in an institutional setting. To many the HMO is the first health initiative to square with the Nixon themes, in this case, the reliance on a market strategy. These several proposals all link together with the proposal under the Health Services Improvement Act that we try to develop model systems of health care for which a certain amount of money is reserved.

In concluding, I would like to add: "Is health care an entity in itself?" Are we ultimately concerned only with the prolongation of life and the improvement of physical and mental health, narrowly defined? Such

purposes may well motivate the individual researcher, or the practitioner, but society's vision, and I think yours collectively, should be greater and move to a higher plane. I would suggest that our ultimate purpose is to enhance the quality of living in all its dimensions. Everything we do should be viewed in this context. Thus viewed, the effort to organize effective action at the community level is part of the necessary action by a responsible citizenry to demonstrate faith in the democratic model of government.