RATIONALIZING THE MIX OF PUBLIC AND PRIVATE EXPENDITURES IN HEALTH

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The more one struggles to foresee the characteristics of the post-July, 1966, American health care economy, to classify the data that will measure those characteristics, and to speculate about future trends, the more one is troubled by the terms "public and private sectors," "public and private expenditures," as they have customarily been used. These over-simplifications do not quite seem to fit the new facts nor quite convey an accurate sense of the shift that is occurring in the public philosophy. Also, they may not provide the disciplines represented at this seminar quite the right rubrics for classifying empirical observations nor the right insights for devising useful analytical tools.

Nevertheless, these phrases are accepted shorthand in this community and the issues implied in the assigned topic of this paper, regardless of its exact wording, are central to the inquiry of this Public Policy Seminar: What trends can be expected to occur? What issues will new and future developments raise? What goals are envisaged? What means will be available, and which should be selected for achieving these goals? What choices will be open, and perhaps most important, what machinery will be available, should be available, for making the choices, selecting the means?

All of these hinge not only on what will be the role of government expenditures from tax funds in a mixed medical care economy, but also on the role and management of a broader definition of public funds and public resources—one that would include nonprofit insurance, voluntary hospitals, and other forms of community investment. Perhaps even

more importantly they hinge on what will be the role, the capability and the composition of public authority, administrative as well as legislative, local as well as federal.

Under these circumstances the ideological connotations—pro and con—that have come to be attached to the term "the public sector" are no longer either quite realistic or quite useful. A much broader starting point is now needed. Perhaps the more appropriate term is "the public interest." To break out the critical choices and to assess the alternatives, it is necessary to ask, not the single question, "What is public, what is private?," but rather a series of questions about the nation's health resources: "Who has access and who utilizes?" "Who pays, when, and by what means?" "Who rations?" "Who manages?"

The first two of these questions relate to the distribution of the benefits of medical knowledge, and of the costs of these benefits, among the entire population.

The third question involves the proportion of total national resources to be allocated to personal health care, and the distribution within this allocation as between various types of care—prevention, treatment, rehabilitation and so forth. It encompasses such decisions as, for example, whether an intensive battery of tests will be provided selected populations at high risk or with symptomology, or whether a less intensive, but more extensive array of screening procedures will be administered a much larger segment of the population (annual physical examinations for everyone, for example).

The fourth question relates to the locus and quality of decision-making in regard to all of these.

Finally, underlying all of these is a fifth and basic question—from where will come the leadership, the initiative, the incentive, to improve the management of medical care resources, so that rising health care expectations can be met, the new public promise honored?

Within the broad limits already stipulated or to be added by the federal government, the answers to these questions for a long time to come will largely be determined by the states and the localities, and within these by the capability of the professional community to respond to the internal dynamics of the medical care establishment itself and to the pressures on this establishment that will be generated by the great new waves of effective medical care demand consequent upon the appropriation of large sums by the federal government.

Starting, then, with that general view of the world, this paper attempts to set forth some general observations and considerations

about the national framework that has been and is being constructed to govern medical care arrangements, and to consider, against this background, what may occur as the diverse localities of the nation put their particular imprint on what comes out of federal fiscal pipelines.

The full scope of the historic shift in public policy that was accomplished in the last Congress, as well as the full measure of what has been left to be resolved, comes into clearer focus when viewed against the following quotation from a fifteenth-century seminarian, Geiler von Keisersberg:

> A physician should have compassion with everybody, especially the poor who has not much to give. He should not only help such a one from compassion and for God's sake, but he should also be at his service everyday. Afterwards he may take all the more from the rich who could afford to pay.

In writing on the statute books the goal of universal access to the benefits of medical knowledge, the country has completed a long, historical process of shifting from the individual physician to the entire body politic the responsibility for compassion—and for making the decisions as to how much shall be taken from whom, and by what mechanism, to carry out that responsibility.

What that mechanism will be—how the costs of care will be distributed over the economy and among the people—is a question that this Congress has only opened up: it will be at the center of public deliberations for a long time to come. So also will be the pace at which the notion of compassion is translated into the idea of entitlement.

It is a long time since the decision regarding who should pay for compassion was solely in the hands of the physician. Institutionalization—the process of socializing—of both compassion and the decision as to who should pay for it goes back to the beginning of organized charity and to the Elizabethan poor laws. It underlies the Welfare medical care program in the United States, the Hill-Burton program, federal support of research and medical education. What is more important and less frequently recognized is the extent to which that important social decision is involved in routine hospital bookkeeping. It takes place every time a hospital's charge for an appendectomy or a maternity delivery includes some part of the cost of that hospital's cobalt machine or equipment for open-heart surgery. Every debate over community-versus-experience rating involves precisely that issue. That process, of shifting or spreading or transferring medical care costs and "loading" medical charges, occurs throughout the medical care economy. It is one part of the reasonable costs problem in Medicare. It is

part of the issue raised at an earlier seminar in regard to the costs of nursing education.

In the past, these decisions have been made by individual practitioners, by institutions, sometimes by government, but chiefly on an ad hoc basis, and nearly always without relating such decisions in one sector of medical care to similar decisions in other sectors.

Having staked out the goal which, for short, will be called "universal access," having in effect accepted the responsibility of reallocating income to improve the distribution of medical purchasing power as a public responsibility, the nation is far from through with the thorny issues of equity and feasibility in financing medical care, even that limited portion of medical care that is now on the federal statute books. Indeed, having made these issues now for the first time not just visible but very conspicuous, Congress has only begun to cope with them.

For it is impossible to attain compassion with everybody simply by "taking all the more from the rich who can afford to pay." As Irving Kristol put it in a recent article in *The New Leader* magazine: ". . . there are alas not enough rich and they don't have enough money to affect the economics of the matter in any substantial way. . . ."

"The economics of the matter" will not be examined here in detail. But two observations, juxtaposed, will suffice to underscore the constraints:

1. American families with incomes below $7,500 spend only one-third as much on medical care as do families with incomes above $7,500.

2. Of all tax receipts from American families, an estimated 46 per cent came from families with incomes below $8,000—30 per cent from families with incomes below $6,000.

Even such fragmentary figures suggest that, although a health program financed from general taxes can indeed modify the distribution of health care costs and health care benefits as between income classes, it provides very limited magic to relieve the substantial burden of these costs that fall on the middle income slice of the population. It does insure that the burden is leveled out over time, rather than falling catastrophically when illness strikes. But it is possible to argue, as Kristol does argue, that what Medicare will do in effect is to

> . . . wisely compel [those who are already the main beneficiaries of our expanding economy] to insure themselves against . . . medical disasters . . .

insure themselves because, in effect, what they receive in benefits is pretty much what they have paid out in taxes. . . .

These figures are cited here to make an additional and a slightly different point. With the present quite primitive information too little is known about how the costs—social as well as individual—of medical care and the costs of medical neglect are distributed in society.

Perhaps the most far-reaching consequences of the new order will be an entirely new capability to measure, analyze and understand—as well as to manage—the medical care economy, as systematic data accumulate from experience under the new legislation. Not only will society for the first time have the ability to get at economic costs, rather than making do, as is now the case, with arbitrary cost allocations reflected in charges and prices, but will also be in a position to really measure how and on whom the costs fall and who receives the benefits.

As real tools develop with which to examine these questions, the area of technical judgment, in regard to many of the thorny issues of public policy, will broaden and the ideological gap will be substantially, though perhaps not correspondingly, narrowed.

Observing the history of Congressional performance in regard to atomic energy and federal science policy in general, one concludes that even in these highly technical areas, lay members of Congress specializing in these aspects of public policy have developed a remarkable capability of dealing with highly complex technical matters. Once the data and the analytical tools become available, the entire quality of the public decision-making process is likely to be enormously different from that which has characterized the public debate in the medical care field in the past 25 years. Needless to say, that will not occur immediately, and the public policy fabric of the future will continue to be woven with threads that reach back into history.

Clearly the economy, already quite mixed, will become more so. The extent of government intervention, including but not limited to, the chaneling of funds to directly underwrite the medical care of individual patients, will increase. That will not occur in any tidy fashion or according to any single blueprint, but will continue as in the past to reflect a variety of public purposes and be accomplished by a variety of devices. A good deal of the sorting out that will have to be done to make rational order out of this variety will be left to the localities. The federal government can be expected to set in motion certain additional forces that will press the localities to accelerate the sorting out, and will

also prescribe certain additional boundaries within which this process can occur.

Among these boundary conditions are likely to be an expanded and increasingly systematic floor of entitlement for the least affluent and the most vulnerable. Also to be expected is fiscal support for the most expensive and for the least commonly used medical care resources and conditions. Those moves will, in turn, increasingly lift the burden of costs off of user charges at the time of service and off of the voluntary insurance system. In still another area, new federal legislation can certainly be expected, in the future as in the past, to channel the flow of resources in selected directions—to improve the capacity and underwrite the cost of care for particular disease entities; to encourage the construction of certain types of facilities, or the training of certain types of manpower, or the development of particular patterns of service, or the emphasis on certain aspects of care such as multiphasic screening, or to give priority to certain groups in the population—perhaps the poor, the minorities, the children, perhaps geographic areas with concentrated local needs whose origins are basically national rather than local in character.

All of these together will undoubtedly expand the fiscal dimensions of what is now called the public sector, though it is not at all certain that its proportionate role will increase by an equal amount, since quite possibly direct consumer expenditures may also expand.

If anything like this is what really lies in the crystal ball, then the administration proposals introduced in the 89th Congress, which give new support and impetus to local and regional planning and to the systematic and rational management of health care services and health care resources, may in the end have more far-reaching consequences than is suggested by their rather modest dimensions and the absence of ruffles and flourishes surrounding their introduction.

At least this is how it appears, viewed from the perspective of New York City, where one-third of all the medical care and half the cost of institutional care received by city residents has long been paid for out of public funds and where the new administration has recorded its intention of developing a systematic network of health services that would, at a cost the community can afford, better serve the unmet needs of the city's poor, help to contain the rising costs of health insurance premiums and of health care in general for middle as well as low income families, and deal with the desperate lack of arrangements for the elderly infirm and the mentally ill of all ages and all classes.

Basically, the professional community agrees that what is required in New York, in broad outline, is regionalization that will permit economical grouping of expensive and rarely used resources at the apex of a planned system on the one hand, and that will on the other hand provide broad-based, adequately staffed neighborhood medical services for common conditions and for ongoing health maintenance.

To accomplish this it will be necessary for the city to weld together four presently separate city departments providing health care for New York City residents; to mold into one system 22 municipal hospitals and nearly a hundred voluntary institutions, in which more than a million people are hospitalized each year. Even prior to Medicare and Medicaid, on an average day nearly half of the 33,000 New Yorkers in general care hospitals were ward patients: some of them may have had health insurance; all of them, whether in voluntary or municipal hospitals, were already receiving some degree of subsidized care, whether it was the contributed services of physicians, the contribution that high-charge private patients perhaps unknowingly make to the ward deficit, or the directly subsidized care provided each year for 300,000 patients in municipal hospitals or purchased by the city for another 140,000 patients in the wards of voluntary hospitals.

The number one issue on the health care planning agenda of the city is the development, out of these separate medical care pieces, of a coordinated network of facilities so organized and so integrated as to meet the varying needs of all residents in all the boroughs of the city without waste and duplication, on the one hand, and without such glaring gaps as occur when ambulances must make half a dozen stops before finding a hospital to which the patient can be admitted. The facilities must be capable of maintaining high standards of medical excellence to attract qualified staff and afford security and dignity to the patient.

Coupled with the necessity for systematizing these in-hospital resources is the requirement of a greatly expanded pool of extended care facilities for those who no longer require the high cost services of an acute-medicine type of hospital and, at the other end of the spectrum, the expansion, particularly for the low income population—largely without access to family doctors in private practice—of adequate, accessible ambulatory care centers to provide comprehensive health services at the local community level.

The detailed inventory of problems and of proposals to deal with them is contained in a recently issued Report of the Mayor's Advisory Task Force on Medical Economics.

Many consider that New York City is a nation unto itself, and that its problems, and reports that discuss them, are somehow quite different from and not relevant to those of the rest of the country.

Nonetheless, in vast sections of the country public hospitals comprise an important segment of the existing resources for health care; in these areas, as in New York City, the problems of moving forward toward a rationalized system that permits the systematic use of all resources will not be too different from the problems confronting New York City.

Moreover, as the national society moves in the direction that New York long has taken, of commitment to the use of the public authority to accomplish social change, New York—once considered atypical of the nation—now becomes, particularly in the health field, one of the country's chief laboratories for implementing this commitment.

As the country becomes more fully aware of the implications of the newly enacted Titles XVIII and XIX, it will also become more concerned about the unleashing of great new waves of consumer demand for medical services; concern that it will swamp existing resources and available manpower, that beneficiaries will be disappointed and providers overwhelmed. In the short run, cause for concern is justified; but enough evidence is available to show that the promise of effective demand is beginning to break a number of log jams on the supply side, to stimulate response in areas where need has long been known to exist, but action despaired of. The construction of extended care facilities, plans to hire and provide on-the-job training for large numbers of people who fall into no conventional category of health manpower, the attention beginning to be paid by hospitals to coping with the expected increase in utilization, the concern of medical schools with the total complex of institutions in their communities—all give promise that traditional American ingenuity will be rapidly engaged in meeting these crises. The net result will be that many innovations which have long been needed will quite suddenly begin to occur as the medical care establishment, given now the assurance that money will be available to pick up the chit, prepares to cope with the inundation.

SUMMARY

The rationalization of medical care arrangements can be expected to evolve in a variety of patterns in different localities, as a result of a kind of pincer operation, with federal action—funds and guidelines—

comprising one set of forces, and local initiative, within and outside the medical establishment the other. Together they will gradually shape into more rational systems the fragmented resources and unsatisfactory arrangements that now characterize medical care.

Provider components may be expected to continue to operate under a variety of ownerships and managements, but to become increasingly coordinated and to develop entirely new formats of service, in response to deliberate planning, both self-generated and externally imposed, and as a result of funding which will carry with it specifications as to quality, performance, specialization and responsiveness to need.

On the demand side, further federal action can be expected along the lines indicated, increasing the spread of fiscal access to the least affluent and the most vulnerable by systematic funding rather than ad hoc grants, at one end of the spectrum, and at the other end, underwriting the most expensive elements of care and thus increasingly leveling off the burdens now carried by the voluntary insurance system.

As Congress levies and appropriates larger sums for these purposes, it can be expected to become increasingly concerned with and expert in regard to the husbanding of these funds, to search for and devise and require procedures to improve the management and the yield of resources.

Within the boundaries established by the federal government these trends will undoubtedly occur at different paces and take different forms in different localities. As the scenario unrolls, new alternatives, new issues of public policy, will be revealed. In coping with these, as a by-product of new fiscal reporting systems alone, much more sophisticated analytical tools will be developed. As the area of technological competence increases, the ideological gap in dealing with these problems can be expected to narrow.

Fundamental resource allocation conflicts will continue, as between health and other social services such as education and housing, and, within the health area, as between the young and the aged, the needs of the mentally ill and the need for dental care, as between treatments for common diseases which commonly occur and treatments for rare diseases that rarely occur. In the area of choices too, the capability for measuring costs and benefits, including social costs and broadly viewed human benefits, is bound to improve as factors that are presently hidden and inscrutable become increasingly visible and measurable.

The issues will not be easy, but having at long last determined to

close the book on the nineteenth century social climate, the country is now in a position to exploit twentieth century capabilities in arriving at balanced choices and in developing the management techniques and delivery systems to implement them.